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VENDOR RESPONSE CHECKLIST

VENDOR RESPONSE CHECKLIST

The following checklist is provided to assist bidders in ensuring all requirements are met and all required submissions are included with the bid.

✓ Completed Bidder Registration submitted prior to bid submission (One time)

✓ Invitation to participate received from Procurement Officer prior to bid submission (For each bid)

Technical Proposal (Original and copies requested in hardcopy and electronic format – See Section 2.1)

✓ Signature Sheet
✓ Tax Clearance Certificate
✓ Immigration Reform and Control Certification
✓ Boycott of Israel form
✓ Transmittal Letter
✓ Bidder Information
✓ Qualifications
✓ Experience
✓ Timeline
✓ Methodology
✓ References
✓ Bidder Contracts/Subcontractor information, if applicable
✓ Technical Literature, address Specifications
✓ Completed and signed Event Details document
✓ Any Amendments or Supplemental forms provided
✓ Exceptions to RFP noted, if applicable

Cost Proposal (Original and copies requested in hardcopy and electronic format – See Section 2.1)

✓ Cost Sheet
✓ Completed and signed Event Details document

Emailed bids are not accepted. Bids must be received in our office prior to 2PM CST on the closing date to be considered. Bids must be marked as follows:

Department of Administration
Procurement and Contracts
Proposal # EVT0005464
Closing Date: January 5, 2018
900 SW Jackson, Suite 451 South
Topeka, KS 66612-1286

NOTE: In order to properly and completely respond to this Request for Proposal, bidders must carefully review all sections and respond as required.

Event Details Document

STATE OF KANSAS
Event Details

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0005464	Sell	RFx	1
Event Round	**Version**		
1	1		
Event Name			
KanCare 2.0 Medicaid & CHIP Capitated Managed Care			
Start Time		**Finish Time**	
10/27/2017 15:12:39 CDT		01/05/2018 14:00:00 CST	

Event Currency: US Dollar
Bids allowed in other currency: No

Bidder: PUBLIC EVENT DETAILS

Submit To: Department of Administration
Procurement and Contracts
900 SW Jackson
Suite 451-South
Topeka KS 66612-1286
United States

Contact: Aubrey L Waters
Phone: 785/296-2401
Email: aubrey.waters@ks.gov

Event Description

Request for Proposal (RFP) to establish a contract or contract(s) with qualified managed care organizations for KanCare 2.0 Medicaid and CHIP Capitated Managed Care Services for Kansas Department of Health and Environment (KDHE) and Kansas Department for Aging and Disability Services (KDADS).

General Comments

- **********
  0005 - Request for Proposal pursuant to K.S.A. 75-37,102

- **********
  MANDATORY REQUIREMENT: If you are interested in bidding on this transaction you MUST BE OFFICIALLY INVITED to the event. Contact the person named above at least 24 HOURS BEFORE the official finish date and time to request the official invitation.

  Due to State of Kansas SMART Strategic Sourcing System requirements, any bidder with an interest in bidding on any State of Kansas SOURCING EVENT must officially request an invitation from the Procurement Officer (Event Contact) at least 24 hours before the Bid Event official finish date and time. If you fail to request such in a timely fashion, your bid may be rejected in its entirety.

  EXCEPTION: If you have received a Bid Event Document with your company's name in the upper right hand corner of the document, your company has already been invited to the bid event.

  If you are not a registered bidder/vendor with the state of Kansas you must register as a bidder AND request official invitation at least 24 hours before the Bid Event official finish date and time. To register as a bidder visit our website: www.admin.ks.gov/offices/procurement-and-contracts

- **********
  BIDDER MUST OBTAIN A CURRENT TAX CLEARANCE CERTIFICATE
  A "Tax Clearance" is a comprehensive tax account review to determine and ensure that the account is compliant with all primary Kansas Tax Laws administered by the Kansas Department of Revenue (KDOR) Director of Taxation. Information pertaining to a Tax Clearance is subject to change(s), which may arise as a result of a State Tax Audit, Federal Revenue Agent Report, or other lawful adjustment(s).

  INSTRUCTIONS: To obtain a Current Tax Clearance Certificate, you must:
  • Go to http://ksrevenue.org/taxclearance.html to request a Tax Clearance Certificate
  • Return to the website the following working day to see if KDOR will issue the certificate
  • If issued an official certificate, print it and attach it to your bid response
  • If denied a certificate, engage KDOR in a discussion about why a certificate wasn't issued

  Bidders (and their subcontractors) are expected to submit a current Tax Clearance Certificate with every event response.

  REMINDER: You will need to sign back into the KDOR website to view and print the official tax clearance certificate.

  Information about Tax Registration can be found at the following website:
  http://www.ksrevenue.org/busregistration.html

  Procurement and Contracts reserves the right to confirm tax status of all potential contractors and subcontractors prior to the release of a purchase order or contract award.

  In the event that a current tax certificate is unavailable, Procurement and Contracts reserves the right to notify a bidder (one that has submitted a timely event response) that they have to provide a current Tax Clearance Certificate within ten (10) calendar days, or Procurement and Contracts may proceed with an award to the next lowest responsive bidder, whichever is determined by the Director of Purchases to be in the best interest of the State.

STATE OF KANSAS
Event Details (cont.)

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0005464	Sell	RFx	2
Event Round	**Version**		
1	1		
Event Name			
KanCare 2.0 Medicaid & CHIP Capitated Managed Care			
Start Time		**Finish Time**	
10/27/2017 15:12:39 CDT		01/05/2018 14:00:00 CST	

Event Currency: US Dollar
Bids allowed in other currency: No

Bidder: PUBLIC EVENT DETAILS

Submit To: Department of Administration
Procurement and Contracts
900 SW Jackson
Suite 451-South
Topeka KS 66612-1286
United States

Contact: Aubrey L Waters
Phone: 785/296-2401
Email: aubrey.waters@ks.gov

****

During the 2012 Session, the Kansas Legislature enacted a Bidder Preference Program which created three (3) bid preferences. To see if you qualify for any of the preferences, please go to the following website for more information:
www.admin.ks.gov/offices/procurement-and-contracts/bidder-preference-program.

To claim this preference, the bid response must include the Preference Request Form and you must respond to the applicable Bidder Preference category in the question under the General Questions section on the following page(s).

****

During the 2014 Session, the Kansas Legislature enacted the Disabled Veteran Owned Business bidder preference program. For more information or to see if you qualify, please go to the following website:
http://admin.ks.gov/docs/default-source/ofpm/procurement-contracts/disabled-veteran-preference-program.doc

To claim this preference, the bid response must include a copy of the letter from Procurement and Contracts certifying your company as a Disabled Veteran Owned Business and you must respond to the applicable Disabled Veteran Owned Business category in the question under the General Questions section on the following page(s).

****

Emailed or Fax Bids Submission will NOT be accepted for this Bid Event.

- ATTC - See the attachment for additional information.

****

Pre-proposal Conference - A pre-proposal conference will be held at 9:00Am CST, on November 20, 2017, at the following location:

Eisenhower State Office Building
4th Floor Auditorium
700 SW Harrison Street
Topeka, KS 66603

Attendance is not required at the pre-proposal conference. Questions requesting clarification of the Bid Event must be submitted electronically (MS Word, no tables) to the Procurement Officer (Event Contact) indicated above prior to 12PM CST on November 13, 2017. Impromptu questions may be permitted and spontaneous unofficial answers provided, however bidders should understand that the only official answer or position of the State of Kansas will be presented in writing.

Failure to notify the Procurement Officer (Event Contact) of any conflicts or ambiguities in the Bid Event may result in items being resolved in the best interest of the State. Any modification to this Bid Event as a result of the pre-proposal conference, as well as written answers to written questions, shall be made in writing by addendum and dispatched to all bidders associated to this event. Only written communications are binding.

Answers to questions will be available in the form of an addendum on the Procurement and Contracts' website, www.admin.ks.gov/offices/procurement-and-contracts.

It shall be the responsibility of all participating bidders to acquire any and all addenda and additional information as it is made available from the web site cited above. Vendors/Bidders not initially invited to participate in this Bid Event must notify the Procurement Officer (Event Contact) of their intent to bid at least 24 hours prior to the event's closing date/time. Bidders are required to check the website periodically for any additional information or instructions.

STATE OF KANSAS
Event Details (cont.)

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0005464	Sell	RFx	3
Event Round	**Version**		
1	1		
Event Name			
KanCare 2.0 Medicaid & CHIP Capitated Managed Care			
Start Time		**Finish Time**	
10/27/2017 15:12:39 CDT		01/05/2018 14:00:00 CST	

Event Currency: US Dollar
Bids allowed in other currency: No

Bidder: PUBLIC EVENT DETAILS

Submit To: Department of Administration
Procurement and Contracts
900 SW Jackson
Suite 451-South
Topeka KS 66612-1286
United States

Contact: Aubrey L Waters
Phone: 785/296-2401
Email: aubrey.waters@ks.gov

General Questions

Question	UOM	Best	Worst	Response
Does your organization accept the State of Kansas terms and conditions as stated?				YES

Required: Yes Mandatory ResponseNo

Response Comments

Is a current Tax Clearance Certificate included with this bid event submission (Instructions included in RFP document)? — YES

Required: Yes Mandatory ResponseNo

Response Comments

Is a completed Immigration Reform and Control form included with this bid event submission (form provided in RFP document)? — YES

Required: Yes Mandatory ResponseNo

Response Comments

Please select ONE category from the following list with regard to a Bidder Preference. If selecting a Bidder Preference category, supporting documentation must accompany this bid response. (Note: #3 "State Use Purchases" category does not apply to Requests for Proposals)

Options:		Select One
	Not claiming any Bidder Preference Category	NO
	Claiming the Disabled Veteran Owned Business Category	NO
	Claiming the State Use Purchases Bidder Preference Category	NO
	Claiming the Certified Business Bidder Preference Category	NO

Required: Yes Mandatory Response: No

Response Comments

Payments Terms are "Net 30 days ARO". Show discount(s) if payment is made in less than thirty days. Discounts offered will NOT be considered in determining the low bid. — YES

STATE OF KANSAS
Event Details (cont.)

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0005464	Sell	RFx	4
Event Round	**Version**		
1	1		
Event Name			
KanCare 2.0 Medicaid & CHIP Capitated Managed Care			
Start Time		**Finish Time**	
10/27/2017 15:12:39 CDT		01/05/2018 14:00:00 CST	

Event Currency: US Dollar
Bids allowed in other currency: No

Bidder: PUBLIC EVENT DETAILS

Submit To: Department of Administration
Procurement and Contracts
900 SW Jackson
Suite 451-South
Topeka KS 66612-1286
United States

Contact: Aubrey L Waters
Phone: 785/296-2401
Email: aubrey.waters@ks.gov

Required: Yes Mandatory ResponseNo

Response Comments

Procurement Card (P-Card): Presently, many State Agencies use a State of Kansas Procurement Card (Visa-branded P-Card) in lieu of a state warrant to pay for some of its purchases. No additional charges will be allowed for using the card.
May agencies use their P-Card for contract purchases?

NO

Required: Yes Mandatory ResponseNo

Response Comments

Political Subdivisions: Political subdivisions (City, County, School Districts, etc.) are permitted to utilize contracts administered by Procurement and Contracts. Conditions included in this contract shall be the same for political subdivisions. The State has no responsibility for payments owed by political subdivision. The vendor must deal directly with the political subdivision.
Is pricing available to political subdivisions?

NO

Required: Yes Mandatory ResponseNo

Response Comments

STATE OF KANSAS
Event Details (cont.)

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0005464	Sell	RFx	5
Event Round	**Version**		
1	1		
Event Name			
KanCare 2.0 Medicaid & CHIP Capitated Managed Care			
Start Time		**Finish Time**	
10/27/2017 15:12:39 CDT		01/05/2018 14:00:00 CST	

Event Currency: US Dollar
Bids allowed in other currency: No

Bidder: PUBLIC EVENT DETAILS

Submit To: Department of Administration
Procurement and Contracts
900 SW Jackson
Suite 451-South
Topeka KS 66612-1286
United States

Contact: Aubrey L Waters
Phone: 785/296-2401
Email: aubrey.waters@ks.gov

Line Details

No Bid: ☐

Line: 1 **Item ID:** **Line Qty:** 1.00 **UOM:** Each **Bid Qty:**
Required: No **Reserve Price:** No **Min/Max Qty:** No min / No max

Description: KanCare 2.0 Medicaid and CHIP Capitated Managed Care Services

Question	UOM	Best	Worst	Response
Do not enter pricing here. Pricing is to be provided in the Cost Sheet.				N/A

Required: No Mandatory Response: No

Response Comments

Pricing is provided in Cost Sheet.

STATE OF KANSAS
Event Details (cont.)

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0005464	Sell	RFx	6
Event Round	**Version**		
1	1		
Event Name			
KanCare 2.0 Medicaid & CHIP Capitated Managed Care			
Start Time		**Finish Time**	
10/27/2017 15:12:39 CDT		01/05/2018 14:00:00 CST	

Event Currency: US Dollar
Bids allowed in other currency: No

Bidder: PUBLIC EVENT DETAILS

Submit To: Department of Administration
Procurement and Contracts
900 SW Jackson
Suite 451-South
Topeka KS 66612-1286
United States
Contact: Aubrey L Waters
Phone: 785/296-2401
Email: aubrey.waters@ks.gov

Bidder Information

Firm Name: Sunflower Health Plan, Inc.

Name: Chris Coffey **Signature:** **Date:** 1/02/2018

Phone #: 913-401-4118 **Fax #:** 877-401-4118

Street Address: 8325 Lenexa Drive, Suite 200

City & State: Lenexa, KS **Zip Code:** 66214

Email: ccoffey@sunflowerhealthplan.com

STATE OF KANSAS
Event Details (cont.)

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0005464	Sell	RFx	7
Event Round	**Version**		
1	1		
Event Name			
KanCare 2.0 Medicaid & CHIP Capitated Managed Care			
Start Time		**Finish Time**	
10/27/2017 15:12:39 CDT		01/05/2018 14:00:00 CST	

Event Currency: US Dollar
Bids allowed in other currency: No

Bidder: PUBLIC EVENT DETAILS

Submit To: Department of Administration
Procurement and Contracts
900 SW Jackson
Suite 451-South
Topeka KS 66612-1286
United States

Contact: Aubrey L Waters
Phone: 785/296-2401
Email: aubrey.waters@ks.gov

Appendix A - Line Specifications

Line: 1 **Item ID:** **Line Qty:** 1 **UOM:** Each
Description: KanCare 2.0 Medicaid and CHIP Capitated Managed Care Services

Item Specifications

Manufacturer:			
Mfg Item ID:			
Item Length:	0	**Item Height:**	0
Item Width:	0	**Dimension UOM:**	
Item Volume:	0	**Volume UOM:**	
Item Weight:	0	**Weight UOM:**	
Item Size:		**Item Color:**	

Shipping Information

Schedule:	1	**Ship To:**	KDHE -Div of Mgmt & Budget
Quantity:	1		KDHE -Div of Mgmt & Budget
Due Date:	01/05/2018		1000 SW Jackson
Freight Terms:			Ste 570
Ship Via:	Common Carrier		Topeka KS 66612
			United States

STATE OF KANSAS
Event Details (cont.)

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0005464	Sell	RFx	8
Event Round	**Version**		
1	1		
Event Name			
KanCare 2.0 Medicaid & CHIP Capitated Managed Care			
Start Time		**Finish Time**	
10/27/2017 15:12:39 CDT		01/05/2018 14:00:00 CST	

Event Currency: US Dollar
Bids allowed in other currency: No

Bidder: PUBLIC EVENT DETAILS

Submit To: Department of Administration
Procurement and Contracts
900 SW Jackson
Suite 451-South
Topeka KS 66612-1286
United States

Contact: Aubrey L Waters
Phone: 785/296-2401
Email: aubrey.waters@ks.gov

Appendix B - Terms & Conditions

1. It is the bidder's responsibility to submit questions, acknowledge addenda and attend pre-bid conferences as indicated in this event or attachment(s). When communicating always refer to the Bid Event ID.

2. Conflict of Interest: With the submission of a response for this bidding event, you certify that you do not have any substantial conflict of interest sufficient to influence the bidding process of this event. A conflict of substantial interest is one which a reasonable person would think would compromise the opening bidding process.

3. BIDDER MUST OBTAIN A CURRENT TAX CLEARANCE CERTIFICATE A "Tax Clearance" is a comprehensive tax account review to determine and ensure that the account is compliant with all primary Kansas Tax Laws administered by the Kansas Department of Revenue (KDOR) Director of Taxation. Information pertaining to a Tax Clearance is subject to change(s), which may arise as a result of a State Tax Audit, Federal Revenue Agent Report, or other lawful adjustment(s). INSTRUCTIONS: To obtain a Current Tax Clearance Certificate, you must: 1) Go to: http://ksrevenue.org/taxclearance.html to request a Tax Clearance Certificate; 2) Return to the website the following working day to see if KDOR will issue the certificate; 3) If issued an official certificate, print it and attach it to your bid response; and 4) If denied a certificate, engage KDOR in a discussion about why a certificate wasn't issued. Bidders (and their subcontractors) are expected to submit a current Tax Clearance Certificate with every event response. REMINDER: You will need to sign back into the KDOR website to view and print the official tax clearance certificate. Information about Tax Registration can be found at the following website: http://www.ksrevenue.org/busregistration.html. Procurement and Contracts reserves the right to confirm tax status of all potential contractors and subcontractors prior to the release of a purchase order or contract award. In the event that a current tax certificate is unavailable, Procurement and Contracts reserves the right to notify a bidder (one that has submitted a timely event response) that they have to provide a current Tax Clearance Certificate within ten (10) calendar days, or Procurement and Contracts may proceed with an award to the next lowest responsive bidder, whichever is determined by the Director of Purchases to be in the best interest of the State.

4. Immigration and Reform Control Act of 1986 (IRCA): All contractors are expected to comply with the Immigration and Reform Control Act of 1986 (IRCA), as may be amended from time to time. This Act, with certain limitations, requires the verification of the employment status of all individuals who were hired on or after November 6, 1986, by the contractor as well as any subcontractor or sub-contractors. The usual method of verification is through the Employment Verification (I-9) form. With the submission of this bid, the contractor hereby certifies without exception that such contractor has complied with all federal and state laws relating to immigration and reform. Any misrepresentation in this regard or any employment of persons not authorized to work in the United States constitutes a material breach and, at the State's option, may subject the contract to termination for cause and any applicable damages. Unless provided otherwise herein, all contractors are expected to be able to produce for the State any documentation or other such evidence to verify Contractor's IRCA compliance with any provision, duty, certification, or like item under the contract. Bidders must submit a Certification Regarding Immigration Reform & Control form with every event response. The form can be found at the following website: http://www.admin.ks.gov/docs/default-source/ofpm/procurement-contracts/irca.doc (Click "Cancel" if asked to enter User name and Password).

5. Competition: The purpose of this Request is to seek competition. The bidder shall advise Procurement and Contracts if any specification, language or other requirement inadvertently restricts or limits bidding to a single source. Notification shall be in writing and must be received by Procurement and Contracts no later than five (5) business days prior to the event closing date. The Director of Purchases reserves the right to waive minor deviations in the specifications which do not hinder the intent of this Request.

6. Acceptance or Rejection: The State reserves the right to accept or reject any or all bid responses or part of a response; to waive any informalities or technicalities; clarify any ambiguities in responses; modify any criteria in this Event; and unless otherwise specified, to accept any item in a response.

7. Disclosure of Bid Event Content and Proprietary Information: All bid responses become the property of the State of Kansas. The Kansas Open Records Act (K.S.A. 45-215 et seq) requires public information be placed in

STATE OF KANSAS
Event Details (cont.)

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0005464	Sell	RFx	9
Event Round	**Version**		
1	1		
Event Name			
KanCare 2.0 Medicaid & CHIP Capitated Managed Care			
Start Time		**Finish Time**	
10/27/2017 15:12:39 CDT		01/05/2018 14:00:00 CST	

Event Currency: US Dollar
Bids allowed in other currency: No

Bidder: **PUBLIC EVENT DETAILS**

Submit To: Department of Administration
Procurement and Contracts
900 SW Jackson
Suite 451-South
Topeka KS 66612-1286
United States
Contact: Aubrey L Waters
Phone: 785/296-2401
Email: aubrey.waters@ks.gov

the public domain at the conclusion of the selection process, and be available for examination by all interested parties. More information on this subject can be found at the following website: http://admin.ks.gov/offices/chief-counsel/kansas-open-records-act.

8. Debarment of State Contractors. Any Contractor who defaults on delivery or does not perform in a satisfactory manner as defined in this Agreement may be barred for a period up to three (3) years, pursuant to K.S.A. 75-37,103, or have its work evaluated for pre-qualification purposes. Contractor shall disclose any conviction or judgment for a criminal or civil offense of any employee, individual or entity which controls a company or organization or will perform work under this Agreement that indicates a lack of business integrity or business honesty. This includes (1) conviction of a criminal offense as an incident to obtaining or attempting to obtain a public or private contract or subcontract or in the performance of such contract or subcontract; (2) conviction under state or federal statutes of embezzlement, theft, forgery, bribery, falsification or destruction of records, or receiving stolen property; (3) conviction under state or federal antitrust statutes; and (4) any other offense the State determines to be so serious and compelling as to affect responsibility as a state contractor. For the purpose of this section, an individual or entity shall be presumed to have control of a company or organization if the individual or entity directly or indirectly, or acting in concert with one or more individuals or entities, owns or controls twenty-five (25) percent or more of its equity, or otherwise controls its management or policies. Failure to disclose an offense may result in disqualification of the Proposal or termination of the Agreement, as determined by the State.

9. Accounts Receivable Set-Off Program: If during the course of this contract the Contractor is found to owe a debt to the State of Kansas, agency payments to the Contractor may be intercepted / setoff by the State of Kansas. Notice of the setoff action will be provided to the Contractor. Pursuant to K.S.A. 75-6201 et seq. Contractor shall have the opportunity to challenge the validity of the debt. If the debt is undisputed, the Contractor shall credit the account of the agency making the payment in an amount equal to the funds intercepted. K.S.A. 75-6201 et seq. allows the Director of Accounts and Reports to set off funds the State of Kansas owes Contractors against debts owed by the contractor to the State of Kansas. Payments set off in this manner constitute lawful payment for services or goods received. The Contractor benefits fully from the payment because its obligation to the State is reduced by the amount subject to setoff.

Last Updated: 01/15/2014

Signed Amendments

Office of Procurement & Contracts
900 S.W. Jackson St., Room 451 South
Topeka, KS 66612

Kansas
Department of Administration

Phone: (785) 296-2376
Fax: (785) 296-7240
http://admin.ks.gov/offices/procurement-and-contracts

Sarah Shipman, Secretary

Sam Brownback, Governor

AMENDMENT
Request for Proposal

Amendment Date: November 15, 2017

Amendment Number: 1

Bid Event ID: EVT0005464

Closing Date: January 5, 2018, 2:00 PM CST

Procurement Officer: Aubrey Waters
Telephone: 785-296-2401
Fax: 785-296-7240
E-Mail Address: aubrey.waters@ks.gov
Web Address: http://admin.ks.gov/offices/procurement-and-contracts/

Item: KanCare 2.0 Medicaid & CHIP Capitated Managed Care

Agency: Kansas Department of Health and Environment (KDHE)

Conditions:

1. The agenda for the non-mandatory pre-bid conference is provided on page 2.

There are no other changes at this time.

A signed copy of this Amendment must be submitted with your bid. If your bid response has been returned, submit this Amendment by the closing date indicated above.

I (We) have read and understand this amendment and agree it is a part of my (our) bid response.

NAME OF COMPANY OR FIRM: Sunflower Health Plan, Inc.

SIGNED BY: _____

TITLE: Plan President & CEO DATE: January 2, 2018

EVT0005464 - KANCARE 2.0 PRE-BID CONFERENCE AGENDA

A non-mandatory pre-bid conference is scheduled for November 20, 2017 at 9:00AM CST at the following location:

Eisenhower State Office Building
4th Floor Auditorium
700 SW Harrison Street
Topeka, KS 66603

Time	Description	Presenter
9:00 – 9:30 AM	Potential bidders check-in at front Security desk	
9:30 – 9:45 AM	Welcome to attendees & pre-bid instructions	Tracy Diel, Director of Procurement and Contracts
9:45 AM – 1:00 PM	Actuarial Presentation	Actuarial Team
1:00 PM	ADJOURN	

Index cards will be provided for questions to be submitted after the Actuarial Presentation. An opportunity will also be provided for questions to be submitted by email to the Procurement Officer. No answers will be given the day of the conference. Answers will be provided by Amendment at a later date. The Actuarial Presentation will be provided on the bid event website.

Office of Procurement & Contracts
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Topeka, KS 66612

Kansas
Department of Administration

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Fax: (785) 296-7240
http://admin.ks.gov/offices/procurement-and-contracts

Sarah Shipman, Secretary

Sam Brownback, Governor

AMENDMENT
Request for Proposal

Amendment Date:	November 21, 2017
Amendment Number:	2
Bid Event ID:	EVT0005464
Closing Date:	January 5, 2018, 2:00 PM CST
Procurement Officer:	Aubrey Waters
Telephone:	785-296-2401
Fax:	785-296-7240
E-Mail Address:	aubrey.waters@ks.gov
Web Address:	http://admin.ks.gov/offices/procurement-and-contracts/
Item:	KanCare 2.0 Medicaid & CHIP Capitated Managed Care
Agency:	Kansas Department of Health and Environment (KDHE)

Conditions:

1. The Actuarial Presentation is provided as a separate attachment.
2. The deadline for the 2nd round of bidder questions is due Tuesday, November 28, 2017 at 12:00PM CST.

There are no other changes at this time.

A signed copy of this Amendment must be submitted with your bid. If your bid response has been returned, submit this Amendment by the closing date indicated above.

I (We) have read and understand this amendment and agree it is a part of my (our) bid response.

NAME OF COMPANY OR FIRM: Sunflower Health Plan, Inc.

SIGNED BY: _____

TITLE: Plan President & CEO DATE: January 2, 2018

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Office of Procurement & Contracts
900 S.W. Jackson St., Room 451 South
Topeka, KS 66612

Kansas
Department of Administration

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http://admin.ks.gov/offices/procurement-and-contracts

Sarah Shipman, Secretary

Sam Brownback, Governor

AMENDMENT
Request for Proposal

Amendment Date: November 22, 2017

Amendment Number: 3

Bid Event ID: EVT0005464

Closing Date: January 5, 2018, 2:00 PM CST

Procurement Officer: Aubrey Waters
Telephone: 785-296-2401
Fax: 785-296-7240
E-Mail Address: aubrey.waters@ks.gov
Web Address: http://admin.ks.gov/offices/procurement-and-contracts/

Item: KanCare 2.0 Medicaid & CHIP Capitated Managed Care

Agency: Kansas Department of Health and Environment (KDHE)

Conditions:

1. The Actuarial Presentation from the pre-bid conference held Monday, November 20, 2017 has been added to the Bidder's Library.
2. Bidders must follow the process outlined below in order to gain access to the KanCare 2.0 Bidders Library:
   Email Aubrey Waters at aubrey.waters@ks.gov requesting access and include the following information:
   - Name of individual making request
   - Name of Organization
   - Email address of individual or organization making the request
3. The first round of Bidder Questions with answers will be posted Monday November 27, 2017, and will show up on the bid event site the next day.
4. The deadline for the second round of bidder questions has been extended to Thursday, November 30, 2017 at 12:00PM CST. Questions should be submitted to aubrey.waters@ks.gov in Word format as a list, no tables. Please be sure to reference the section for each question.

There are no other changes at this time.

A signed copy of this Amendment must be submitted with your bid. If your bid response has been returned, submit this Amendment by the closing date indicated above.

I (We) have read and understand this amendment and agree it is a part of my (our) bid response.

NAME OF COMPANY OR FIRM: Sunflower Health Plan, Inc.

SIGNED BY: _____

TITLE: Plan President & CEO DATE: January 2, 2018

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Office of Procurement & Contracts
900 S.W. Jackson St., Room 451 South
Topeka, KS 66612

Kansas
Department of Administration

Phone: (785) 296-2376
Fax: (785) 296-7240
http://admin.ks.gov/offices/procurement-and-contracts

Sarah Shipman, Secretary

Sam Brownback, Governor

AMENDMENT
Request for Proposal

Amendment Date: November 27, 2017

Amendment Number: 4

Bid Event ID: EVT0005464

Closing Date: January 5, 2018, 2:00 PM CST

Procurement Officer: Aubrey Waters
Telephone: 785-296-2401
Fax: 785-296-7240
E-Mail Address: aubrey.waters@ks.gov
Web Address: http://admin.ks.gov/offices/procurement-and-contracts/

Item: KanCare 2.0 Medicaid & CHIP Capitated Managed Care

Agency: Kansas Department of Health and Environment (KDHE)

Conditions:

1. The first round of Bidder Questions and Agency Answers is provided as a separate Excel attachment.
2. A revised version of Attachment L is provided as a separate attachment.
3. Please submit the second round of Bidder Questions in the provided Excel file provided titled Question Submission Format to aubrey.waters@ks.gov.

There are no other changes at this time.

A signed copy of this Amendment must be submitted with your bid. If your bid response has been returned, submit this Amendment by the closing date indicated above.

I (We) have read and understand this amendment and agree it is a part of my (our) bid response.

NAME OF COMPANY OR FIRM: Sunflower Health Plan, Inc.

SIGNED BY: _____

TITLE: Plan President & CEO DATE: January 2, 2018

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Office of Procurement & Contracts
900 S.W. Jackson St., Room 451 South
Topeka, KS 66612

Kansas
Department of Administration

Phone: (785) 296-2376
Fax: (785) 296-7240
http://admin.ks.gov/offices/procurement-and-contracts

Sarah Shipman, Secretary

Sam Brownback, Governor

AMENDMENT
Request for Proposal

Amendment Date: November 29, 2017

Amendment Number: 5

Bid Event ID: EVT0005464

Closing Date: January 5, 2018, 2:00PM CST

Procurement Officer: Aubrey Waters
Telephone: 785-296-2401
Fax: 785-296-7240
E-Mail Address: aubrey.waters@ks.gov
Web Address: http://admin.ks.gov/offices/procurement-and-contracts/

Item: KanCare 2.0 Medicaid & CHIP Capitated Managed Care

Agency: Kansas Department of Health and Environment (KDHE)

Conditions:

1. The responses to questions from the pre-bid Actuarial Presentation are provided as a separate Excel attachment titled Actuarial Responses.
2. The deadline for the second round of questions has been extended to December 6, 2017 at 12:00PM CST. Please submit the second round of Bidder Questions in the provided Excel file titled Question Submission Format to aubrey.waters@ks.gov.
3. A Mandatory Actuarial Teleconference for all prospective bidders to ask follow-up questions is tentatively scheduled for December 13, 2017 beginning at 9:00AM CST. At least one representative from each bidder must be in attendance. To register, email aubrey.waters@ks.gov with the name of attendees and company name. Attendees will be notified if there is any change to the scheduled date and time.
4. Change to wording on page 250 of the document titled Specifications EVT0005464: page 250, section 7.E.:
   o Currently states: "(e.g., projected quality incentives earned)"
   o Should be reflected in the amendment: "(e.g., projected quality withhold unearned)"

There are no other changes at this time.

A signed copy of this Amendment must be submitted with your bid. If your bid response has been returned, submit this Amendment by the closing date indicated above.

I (We) have read and understand this amendment and agree it is a part of my (our) bid response.

NAME OF COMPANY OR FIRM: Sunflower Health Plan, Inc.

SIGNED BY: _____

TITLE: Plan President & CEO DATE: January 2, 2018

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900 S.W. Jackson St., Room 451 South
Topeka, KS 66612

Kansas
Department of Administration

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Fax: (785) 296-7240
http://admin.ks.gov/offices/procurement-and-contracts

Sarah Shipman, Secretary

Sam Brownback, Governor

AMENDMENT
Request for Proposal

Amendment Date: December 1, 2017

Amendment Number: 6

Bid Event ID: EVT0005464

Closing Date: January 5, 2018, 2:00PM CST

Procurement Officer: Aubrey Waters
Telephone: 785-296-2401
Fax: 785-296-7240
E-Mail Address: aubrey.waters@ks.gov
Web Address: http://admin.ks.gov/offices/procurement-and-contracts/

Item: KanCare 2.0 Medicaid & CHIP Capitated Managed Care

Agency: Kansas Department of Health and Environment (KDHE)

Conditions:

1. The State of Kansas would like to determine if there is a need to have an additional meeting regarding the Actuarial portion only of the RFP. Please respond by Monday, December 4, 2017 by 2PM CST to aubrey.waters@ks.gov with which option your company would prefer:

   1) Our company feels that the pre-bid meeting held on November 20, 2017, and the two in-writing question and answer periods is sufficient to formulate our bid, and no further meeting is needed regarding the Actuarial portion of the RFP.
   2) Our company would prefer to have a mandatory tele-conference regarding the Actuarial portion of the RFP.
   3) Our company would prefer to have an in-person mandatory meeting in Topeka, KS regarding the Actuarial portion of the RFP.

There are no other changes at this time.

A signed copy of this Amendment must be submitted with your bid. If your bid response has been returned, submit this Amendment by the closing date indicated above.

I (We) have read and understand this amendment and agree it is a part of my (our) bid response.

NAME OF COMPANY OR FIRM: Sunflower Health Plan, Inc.

SIGNED BY: _____

TITLE: Plan President & CEO DATE: January 2, 2018

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Office of Procurement & Contracts
900 S.W. Jackson St., Room 451 South
Topeka, KS 66612

Kansas
Department of Administration

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http://admin.ks.gov/offices/procurement-and-contracts

Sarah Shipman, Secretary

Sam Brownback, Governor

AMENDMENT
Request for Proposal

Amendment Date: December 7, 2017

Amendment Number: 7

Bid Event ID: EVT0005464

Closing Date: January 5, 2018, 2:00PM CST

Procurement Officer: Aubrey Waters
Telephone: 785-296-2401
Fax: 785-296-7240
E-Mail Address: aubrey.waters@ks.gov
Web Address: http://admin.ks.gov/offices/procurement-and-contracts/

Item: KanCare 2.0 Medicaid & CHIP Capitated Managed Care

Agency: Kansas Department of Health and Environment (KDHE)

Conditions:

1. A Mandatory Actuarial Teleconference for all prospective bidders to ask follow-up questions is scheduled for Friday, December 15, 2017 beginning at 9:00AM CST. At least one representative from each bidder must be in attendance. To register, email aubrey.waters@ks.gov with the name and email addresses of attendees and company name.

2. Revision the RFP Document, Section 2.1. Submission of Proposals:
   Bidder's proposal shall consist of:
   - One (1) original and fifteen (15) copies of the Technical Proposal, including the signed Event Details document, applicable literature and other supporting documents;
   - One (1) original and fifteen (15) copies of the cost proposal including the signed Event Details document,
   - Fifteen (15) electronic / software version(s) of the technical and cost proposals are required. This shall be provided on CD or flash drive, in Microsoft® Word, Excel or searchable PDF®. Technical and cost responses shall be labelled and submitted on separate media for a total of thirty (30).

There are no other changes at this time.

A signed copy of this Amendment must be submitted with your bid. If your bid response has been returned, submit this Amendment by the closing date indicated above.

I (We) have read and understand this amendment and agree it is a part of my (our) bid response.

NAME OF COMPANY OR FIRM: Sunflower Health Plan, Inc.

SIGNED BY: _____

TITLE: Plan President & CEO DATE: January 2, 2018

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Office of Procurement & Contracts
900 S.W. Jackson St., Room 451 South
Topeka, KS 66612

Kansas
Department of Administration

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http://admin.ks.gov/offices/procurement-and-contracts

Sarah Shipman, Secretary

Sam Brownback, Governor

AMENDMENT
Request for Proposal

Amendment Date: December 12, 2017

Amendment Number: 8

Bid Event ID: EVT0005464

Closing Date: January 5, 2018, 2:00PM CST

Procurement Officer: Aubrey Waters
Telephone: 785-296-2401
Fax: 785-296-7240
E-Mail Address: aubrey.waters@ks.gov
Web Address: http://admin.ks.gov/offices/procurement-and-contracts/

Item: KanCare 2.0 Medicaid & CHIP Capitated Managed Care

Agency: Kansas Department of Health and Environment (KDHE)

Conditions:

1. The second round of Bidder Questions and Agency Answers is provided as a separate Excel attachment titled KanCare 2.0 Questions and Answers Round 2.
2. A revised version of Attachment D is provided as a separate attachment.

There are no other changes at this time.

A signed copy of this Amendment must be submitted with your bid. If your bid response has been returned, submit this Amendment by the closing date indicated above.

I (We) have read and understand this amendment and agree it is a part of my (our) bid response.

NAME OF COMPANY OR FIRM: Sunflower Health Plan, Inc.

SIGNED BY: [signature]

TITLE: Plan President & CEO DATE: January 2, 2018

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Office of Procurement & Contracts
900 S.W. Jackson St., Room 451 South
Topeka, KS 66612

Kansas
Department of Administration

Phone: (785) 296-2376
Fax: (785) 296-7240
http://admin.ks.gov/offices/procurement-and-contracts

Sarah Shipman, Secretary

Sam Brownback, Governor

AMENDMENT
Request for Proposal

Amendment Date: December 21, 2017

Amendment Number: 9

Bid Event ID: EVT0005464

Closing Date: January 5, 2018, 2:00PM CST

Procurement Officer: Aubrey Waters
Telephone: 785-296-2401
Fax: 785-296-7240
E-Mail Address: aubrey.waters@ks.gov
Web Address: http://admin.ks.gov/offices/procurement-and-contracts/

Item: KanCare 2.0 Medicaid & CHIP Capitated Managed Care

Agency: Kansas Department of Health and Environment (KDHE)

Conditions:

1. The responses to questions from the mandatory Actuarial conference are provided as a separate word document titled Clarification to Mandatory Actuarial Conference.
2. Change to wording in Section 5.18 WORK PROGRAM
   o Currently states: "*Working Healthy* Policy Manual."
   o Should be reflected in the amendment: "(*Work* Policy Manual)"
3. Change to Attachment L-Service Coordination Matrix Revised
   a. Add *Work* to the Population listing with HCBS TBI, HCBS PD, HCBS FE, HCBS AUTISM, HCBS TA

There are no other changes at this time.

A signed copy of this Amendment must be submitted with your bid. If your bid response has been returned, submit this Amendment by the closing date indicated above.

I (We) have read and understand this amendment and agree it is a part of my (our) bid response.

NAME OF COMPANY OR FIRM: Sunflower Health Plan, Inc.

SIGNED BY: _____

TITLE: Plan President, & CEO DATE: January 2, 2018

Signature Sheet

SIGNATURE SHEET

Item: KanCare 2.0 Medicaid & CHIP Capitated Managed Care
Agency: Kansas Department of Health and Environment (KDHE),
Kansas Department for Aging and Disability Services (KDADS)
Closing Date: January 05, 2018, 2:00 PM CST

By submission of a bid and the signatures affixed thereto, the bidder certifies all products and services proposed in the bid meet or exceed all requirements of this specification as set forth in the request and that all exceptions are clearly identified.

Legal Name of Person, Firm or Corporation Sunflower Health Plan, Inc.

Mailing Address 8325 Lenexa Drive, Suite 200 City & State Lenexa, KS Zip 66214

Toll Free Telephone 877-644-4623 Local 913-401-4118

Cell Phone 314-704-0947 Fax Number 877-851-3990

Tax Number 45-3276702

CAUTION: If your tax number is the same as your Social Security Number (SSN), you must leave this line blank. DO NOT enter your SSN on this signature sheet. If your SSN is required to process a contract award, including any tax clearance requirements, you will be contacted by an authorized representative of the Office of Procurement and Contracts at a later date.

E-Mail ccoffey@sunflowerhealthplan.com

Signature _____ Date 01/02/2018

Typed Name Chris Coffey Title Plan President & CEO

In the event the **contact for the bidding process** is different from above, indicate contact information below.

Bidding Process Contact Name Same as above (Chris Coffey)

Mailing Address _____ City & State _____ Zip _____

Toll Free Telephone _____ Local _____

Cell Phone _____ Fax Number _____

E-Mail _____

If **awarded a contract and purchase orders** are to be directed to an address other than above, indicate mailing address and telephone number below.

Award Contact Name Same as above (Chris Coffey)

Mailing Address _____ City & State _____ Zip _____

Toll Free Telephone _____ Local _____

Cell Phone _____ Fax Number _____

E-Mail _____

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Tax Clearance Certificates

Kansas Department of Revenue

Sam Brownback, Governor
Samuel M. Williams, Secretary

www.ksrevenue.org

CERTIFICATE OF TAX CLEARANCE

Sunflower State Health Plan, Inc.

DBA as Sunflower Health Plan

ISSUE DATE
12/20/2017

TRANSACTION ID
TPH8-RJ8K-YRBB

CONFIRMATION NUMBER
CRNM-YFDA-DDBH

TAX CLEARANCE VALID THROUGH 03/20/2018

Verification of this certificate can be obtained on our website, www.ksrevenue.org, or by calling the Kansas Department of Revenue at 785-296-3199

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Kansas Department of Revenue

Sam Brownback, Governor
Samuel M. Williams, Secretary

www.ksrevenue.org

CERTIFICATE OF TAX CLEARANCE

Centene Corporation

ISSUE DATE
12/21/2017

TRANSACTION ID
T5RJ-AX7F-YAJK

CONFIRMATION NUMBER
CTAC-5HFM-E2NR

TAX CLEARANCE VALID THROUGH 03/21/2018

Verification of this certificate can be obtained on our website, www.ksrevenue.org, or by calling the Kansas Department of Revenue at 785-296-3199

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Kansas Department of Revenue

Sam Brownback, Governor
Samuel M. Williams, Secretary

www.ksrevenue.org

CERTIFICATE OF TAX CLEARANCE

Envolve Dental, Inc.

ISSUE DATE
12/19/2017

TRANSACTION ID
TD5S-YM8F-5C82

CONFIRMATION NUMBER
C6EB-CDC8-HADJ

TAX CLEARANCE VALID THROUGH 03/19/2018

Verification of this certificate can be obtained on our website, www.ksrevenue.org, or by calling the Kansas Department of Revenue at 785-296-3199

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sunflower health plan

Kansas Department of Revenue

Sam Brownback, Governor
Samuel M. Williams, Secretary
www.ksrevenue.org

CERTIFICATE OF TAX CLEARANCE

Evolve PeopleCare, Inc.

ISSUE DATE
12/27/2017

TRANSACTION ID
TRD3-4NAY-NBNA

CONFIRMATION NUMBER
C684-CGRC-26B6

TAX CLEARANCE VALID THROUGH 03/27/2018

Verification of this certificate can be obtained on our website, www.ksrevenue.org, or by calling the Kansas Department of Revenue at 785-296-3199

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Kansas Department of Revenue

Sam Brownback, Governor
Samuel M. Williams, Secretary

www.ksrevenue.org

CERTIFICATE OF TAX CLEARANCE

Envolve Pharmacy Solutions, Inc.

ISSUE DATE
12/18/2017

TRANSACTION ID
T67F-T7KH-T448

CONFIRMATION NUMBER
CSF7-CJ5R-H7M2

TAX CLEARANCE VALID THROUGH 03/18/2018

Verification of this certificate can be obtained on our website, www.ksrevenue.org, or by calling the Kansas Department of Revenue at 785-296-3199

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Kansas Department of Revenue

Sam Brownback, Governor
Samuel M. Williams, Secretary

www.ksrevenue.org

CERTIFICATE OF TAX CLEARANCE

Envolve Vision, Inc.

ISSUE DATE
12/26/2017

TRANSACTION ID
TMEC-GXB2-ND6H

CONFIRMATION NUMBER
CNAA-TETX-BFHR

TAX CLEARANCE VALID THROUGH 03/26/2018

Verification of this certificate can be obtained on our website, www.ksrevenue.org, or by calling the Kansas Department of Revenue at 785-296-3199

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sunflower health plan

Kansas Department of Revenue

Sam Brownback, Governor
Samuel M. Williams, Secretary
www.ksrevenue.org

CERTIFICATE OF TAX CLEARANCE

LogistiCare Solutions, LLC

ISSUE DATE
12/18/2017

TRANSACTION ID
T5HT-GHEE-XP28

CONFIRMATION NUMBER
C7TE-FS24-PAJT

TAX CLEARANCE VALID THROUGH 03/18/2018

Verification of this certificate can be obtained on our website, www.ksrevenue.org, or by calling the Kansas Department of Revenue at 785-296-3199

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Kansas Department of Revenue

Sam Brownback, Governor
Samuel M. Williams, Secretary

www.ksrevenue.org

CERTIFICATE OF TAX CLEARANCE

National Imaging Associates, Inc.

ISSUE DATE
12/18/2017

TRANSACTION ID
TBRC-XHP5-EYKC

CONFIRMATION NUMBER
CTNK-3HKM-368H

TAX CLEARANCE VALID THROUGH 03/18/2018

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Kansas Department of Revenue

Sam Brownback, Governor
Samuel M. Williams, Secretary

www.ksrevenue.org

CERTIFICATE OF TAX CLEARANCE

Cyracom International, Inc.

DBA as Voiance Language Services, LLC

ISSUE DATE
12/20/2017

TRANSACTION ID
TY6C-KGBD-735G

CONFIRMATION NUMBER
CPC7-2HN4-AFHG

TAX CLEARANCE VALID THROUGH 03/20/2018

Verification of this certificate can be obtained on our website, www.ksrevenue.org, or by calling the Kansas Department of Revenue at 785-296-3199

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Immigration Reform and Control Certification

IMMIGRATION REFORM &
CONTROL CERT.

sunflower health plan

CERTIFICATION REGARDING
IMMIGRATION REFORM & CONTROL

All Contractors are expected to comply with the Immigration and Reform Control Act of 1986 (IRCA), as may be amended from time to time. This Act, with certain limitations, requires the verification of the employment status of all individuals who were hired on or after November 6, 1986, by the Contractor as well as any subcontractor or sub-subcontractor. The usual method of verification is through the Employment Verification (I-9) Form. With the submission of this bid, the Contractor hereby certifies without exception that Contractor has complied with all federal and state laws relating to immigration and reform. Any misrepresentation in this regard or any employment of persons not authorized to work in the United States constitutes a material breach and, at the State's option, may subject the contract to termination and any applicable damages.

Contractor certifies that, should it be awarded a contract by the State, Contractor will comply with all applicable federal and state laws, standards, orders and regulations affecting a person's participation and eligibility in any program or activity undertaken by the Contractor pursuant to this contract. Contractor further certifies that it will remain in compliance throughout the term of the contract.

At the State's request, Contractor is expected to produce to the State any documentation or other such evidence to verify Contractor's compliance with any provision, duty, certification, or the like under the contract.

Contractor agrees to include this Certification in contracts between itself and any subcontractors in connection with the services performed under this contract.

President & CEO
Signature, Title of Contractor

01/02/2018
date

Boycott of Israel Form

sunflower health plan

CERTIFICATION INDIVIDUAL OR COMPANY NOT CURRENTLY ENGAGED IN A BOYCOTT OF ISRAEL

In accordance with HB 2409, 2017 Legislative Session, the State of Kansas shall not enter into a contract with any Individual or Company to acquire or dispose of services, supplies, information technology or construction, unless such Individual or Company submits a written certification that such Individual or Company is not currently engaged in a boycott of Israel.

As an Individual or Contractor entering into a contract with the State of Kansas, it is hereby certified that the Individual or Company listed below is not currently engaged in a boycott of Israel.

President + CEO

Signature, Title of Contractor

01/02/2018

Date

Chris Coffey, Plan President & CEO

Printed

Sunflower Health Plan, Inc.

Name of Company

2. PROPOSAL RESPONSE

2.3 Transmittal Letter

sunflower health plan
8325 Lenexa Drive
Lenexa, KS 66214

January 2, 2018

Aubrey L. Waters
Department of Administration
Procurement and Contracts
900 SW Jackson
Suite 451-South
Topeka KS 66612-1286

Dear Ms. Waters,

Thank you for inviting Sunflower Health Plan, Inc. (Sunflower) to submit a response to the Request for Proposal (RFP) Event ID: 17300-EVT0005464, for the KanCare 2.0 Medicaid and CHIP Capitated Managed Care Services for Kansas Department of Health and Environment (KDHE) and Kansas Department for Aging and Disability Services (KDADS).

Sunflower began serving members in the state of Kansas in 2013. We value our collaborative partnership with the Department of Administration and look forward to continue serving our current membership and expanding our services throughout Kansas.

In accordance with section 2.3 Transmittal Letter of the Proposal Response Requirements, Sunflower has provided responses for (a) through (j) below:

(a) the bidder is the prime contractor and identifying all subcontractors;
A listing of Sunflower's subcontractors and services to be performed are listed in the table on the following page:

Envolve Benefit Options, Inc. ***(Formerly Dental Health & Wellness and OptiCare)***	Dental Benefit Management/Services and Vision Care Benefit Management
Envolve Pharmacy Solutions, Inc. (formerly US Script, Inc.)	Pharmacy services; Pharmacy Benefit Manager
Envolve PeopleCare (formerly Nurtur & NurseWise)	Nurse Advice Line providing 24-hour health care triage and outreach. Disease management Programs
LogistiCare	Non-Emergency Transportation
National Imaging Associates (NIA)	Outpatient Radiology Program Management
Voiance	Phone and language interpretation services

(b) the bidder is a corporation or other legal entity;
Sunflower is a corporation registered to do business in Kansas.

(c) no attempt has been made or will be made to induce any other person or firm to submit or not to submit a proposal;
I, Chris Coffey, Plan President & CEO confirm that no attempt has been made or will be made to induce any other person or firm to submit or not to submit a proposal in response to EVT0005464 issued by the Kansas Department of Administration Procurement and Contracts.

(d) the bidder does not discriminate in employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin or disability;
Sunflower, our parent company, Centene and any of our other subcontractors do not discriminate in employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin or disability. Sunflower is an equal opportunity employer that is committed to diversity, and values the ways in which we are different. All qualified applicants receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, disability, veteran status, or other characteristic protected by applicable law.

(e) no cost or pricing information has been included in the transmittal letter or the Technical Proposal;
Sunflower confirms that no cost or pricing information has been provided in the Transmittal Letter or the Technical Proposal Response.

(f) the bidder presently has no interest, direct or indirect, which would conflict with the performance of services under this contract and shall not employ, in the performance of this contract, any person having a conflict;

Sunflower has no interest, direct or indirect, which would conflict with the performance of services under this contract and will not employ, in the performance of this contract, any person having a conflict.

(g) the person signing the proposal is authorized to make decisions as to pricing quoted and has not participated, and will not participate, in any action contrary to the above statements;

I, Chris Coffey, Plan President & CEO certify that I am the official, authorized representative of Sunflower Health Plan, and, as such, am duly authorized to make decisions regarding price quotes. I further certify that I have not participated in, and shall not participate, in any actions that contradict the statements in this transmittal letter.

(h) whether there is a reasonable probability that the bidder is or will be associated with any parent, affiliate or subsidiary organization, either formally or informally, in supplying any service or furnishing any supplies or equipment to the bidder which would relate to the performance of this contract. If the statement is in the affirmative, the bidder is required to submit with the proposal, written certification and authorization from the parent, affiliate or subsidiary organization granting the State and/or the federal government the right to examine any directly pertinent books, documents, papers and records involving such transactions related to the contract. Further, if at any time after a proposal is submitted, such an association arises, the bidder will obtain a similar certification and authorization and failure to do so will constitute grounds for termination for cause of the contract at the option of the State;

Sunflower affirms its association with parent and affiliate organizations in supplying services related to the performance of this contract. Sunflower has provided attestations from our parent company, Centene Corporation and all of our subcontractors following the transmittal letter. If at any time, after our proposal is submitted, another such association arises, Sunflower will obtain similar certification and authorization. Sunflower understands that failure to do so will constitute grounds for termination of the Contract at the option of the State.

(i) bidder agrees that any lost or reduced federal matching money resulting from unacceptable performance in a contractor task or responsibility defined in the RFP, contract or modification shall be

accompanied by reductions in state payments to Contractor; and
Sunflower acknowledges and agrees to accept reductions in state payments due to the State's loss or reduction in Federal matching money that resulted from unacceptable performance in a task or responsibility defined in the RFP, contract or modification.

(j) the bidder has not been retained, nor has it retained a person to solicit or secure a state contract on an agreement or understanding for a commission, percentage, brokerage or contingent fee, except for retention of bona fide employees or bona fide established commercial selling agencies maintained by the bidder for the purpose of securing business.
Sunflower has not been retained, nor have we retained a person to solicit or secure a state contract on an agreement or understanding for a commission, percentage, brokerage or contingent fee, except for retention of bona fide employees or bona fide established commercial selling agencies maintained by the bidder for the purpose of securing business.

Sunflower Health Plan's experience, local approach, and innovative solutions uniquely positions us to apply our Kansas experience over the past 5 years and continue our commitment to the Department to work collaboratively to enhance and expand our programs to serve KanCare members. We are grateful for the opportunity to continue to serve our fellow Kansans.

Sincerely,

Chris Coffey
Plan President & CEO

sunflower
health plan®

EVENT ID: EVT0005464

8325 Lenexa Drive
Lenexa, KS 66214

CERTIFICATION & AUTHORIZATION
ATTESTATION

The undersigned, Sunflower State Health Plan, Inc. (Sunflower), hereby attests that in the event that Sunflower is awarded a contract for the KanCare 2.0 Medicaid and CHIP Capitated Managed Care Services from the Kansas Department of Health and Environment (KDHE) and Kansas Department for Aging and Disability Services (KDADS), Sunflower hereby grants to the State and/or Federal Government the right to examine any directly pertinent books, documents, papers and records involving such transactions related to the contract.

Date: 12/27/2017

SUNFLOWER HEALTH PLAN

By:

Signature

Plan President & CEO

Title

Chris Coffey

Printed Name

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sunflower health plan
8325 Lenexa Drive
Lenexa, KS 66214

CERTIFICATION & AUTHORIZATION
ATTESTATION

The undersigned, Centene Corporation (Centene), being the parent corporation of Sunflower State Health Plan, Inc. (Sunflower), hereby attests as follows on behalf of itself and its affiliates and subsidiaries.

In the event that Sunflower is awarded a contract for the KanCare 2.0 Medicaid and CHIP Capitated Managed Care Services from the Kansas Department of Health and Environment (KDHE) and Kansas Department for Aging and Disability Services (KDADS), Centene hereby grants to the State and/or Federal Government the right to examine any directly pertinent books, documents, papers and records involving such transactions related to the contract.

Date: 12/18/17

CENTENE CORPORATION

By:

Signature

Secretary
Title

Keith H. Williamson
Printed Name

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sunflower health plan
8325 Lenexa Drive
Lenexa, KS 66214

CERTIFICATION & AUTHORIZATION
ATTESTATION

The undersigned, Envolve Dental, Inc. (*formerly Dental Health and Wellness)*, being an affiliated subcontractor for Sunflower State Health Plan, Inc. (Sunflower), hereby attests as follows:

In the event that Sunflower is awarded a contract for the KanCare 2.0 Medicaid and CHIP Capitated Managed Care Services from the Kansas Department of Health and Environment (KDHE) and Envolve Dental hereby grants to the State and/or Federal Government the right to examine any directly pertinent books, documents, papers and records involving such transactions related to the contract.

Date: 12/19/2017

ENVOLVE DENTAL, INC.

By: _____
Signature

President & CEO
Title

Scott Laihinen
Printed Name

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EVENT ID: EVT0005464

sunflower health plan
8325 Lenexa Drive
Lenexa, KS 66214

CERTIFICATION & AUTHORIZATION
ATTESTATION

The undersigned, Envolve PeopleCare, Inc. (*formerly Nurtur and NurseWise*) being an affiliated subcontractor for Sunflower State Health Plan, Inc. (Sunflower), hereby attests as follows:

In the event that Sunflower is awarded a contract for the KanCare 2.0 Medicaid and CHIP Capitated Managed Care Services from the Kansas Department of Health and Environment (KDHE) and Kansas Department for Aging and Disability Services (KDADS), Envolve PeopleCare, Inc. hereby grants to the State and/or Federal Government the right to examine any directly pertinent books, documents, papers and records involving such transactions related to the contract.

Date: 12/18/17

ENVOLVE PEOPLECARE, INC.

By:

Signature

Plan Chief Financial Officer
Title

George Verrastro
Printed Name

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EVENT ID: EVT0005464

sunflower health plan
8325 Lenexa Drive
Lenexa, KS 66214

CERTIFICATION & AUTHORIZATION
ATTESTATION

The undersigned, Envolve Pharmacy Solutions, Inc. (formerly US Script, Inc.), being an affiliated subcontractor for Sunflower State Health Plan, Inc. (Sunflower), hereby attests as follows:

In the event that Sunflower is awarded a contract for the KanCare 2.0 Medicaid and CHIP Capitated Managed Care Services from the Kansas Department of Health and Environment (KDHE) and Kansas Department for Aging and Disability Services (KDADS), Envolve Pharmacy Solutions, Inc. hereby grants to the State and/or Federal Government the right to examine any directly pertinent books, documents, papers and records involving such transactions related to the contract.

Date: December 18, 2017

ENVOLVE PHARMACY SOLUTIONS, INC.

By: _____
Signature

EVP Sales and Account Management
Title

Carmen Fontanez
Printed Name

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EVENT ID: EVT0005464

sunflower health plan
8325 Lenexa Drive
Lenexa, KS 66214

CERTIFICATION & AUTHORIZATION
ATTESTATION

The undersigned, Envolve Vision (*formerly OptiCare)*, being an affiliated subcontractor for Sunflower State Health Plan, Inc. (Sunflower), hereby attests as follows:

In the event that Sunflower is awarded a contract for the KanCare 2.0 Medicaid and CHIP Capitated Managed Care Services from the Kansas Department of Health and Environment (KDHE) and Envolve Vision hereby grants to the State and/or Federal Government the right to examine any directly pertinent books, documents, papers and records involving such transactions related to the contract.

Date: 12-20-17

ENVOLVE VISION

By:

Signature

COO

Title

Michael Grover II

Printed Name

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EVENT ID: EVT0005464

sunflower health plan
8325 Lenexa Drive
Lenexa, KS 66214

CERTIFICATION & AUTHORIZATION
ATTESTATION

The undersigned, LogistiCare Solutions, LLC being an unaffiliated subcontractor for Sunflower State Health Plan, Inc. (Sunflower), hereby attests as follows:

In the event that Sunflower is awarded a contract for the KanCare 2.0 Medicaid and CHIP Capitated Managed Care Services from the Kansas Department of Health and Environment (KDHE) and Kansas Department for Aging and Disability Services (KDADS), LogistiCare Solutions, LLC hereby grants to the State and/or Federal Government the right to examine any directly pertinent books, documents, papers and records involving such transactions related to the contract.

Date: 12/15/2017

LOGISTICARE SOLUTIONS, LLC

By:

Signature

Chief Administrative Officer
Title

Albert Cortina
Printed Name

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sunflower health plan
8325 Lenexa Drive
Lenexa, KS 66214

CERTIFICATION & AUTHORIZATION

ATTESTATION

The undersigned, National Imaging Associates, Inc. (NIA), being an unaffiliated subcontractor for Sunflower State Health Plan, Inc. (Sunflower), hereby attests as follows:

In the event that Sunflower is awarded a contract for the KanCare 2.0 Medicaid and CHIP Capitated Managed Care Services from the Kansas Department of Health and Environment (KDHE) and Kansas Department for Aging and Disability Services (KDADS), National Imaging Associates, Inc. hereby grants to the State and/or Federal Government the right to examine any directly pertinent books, documents, papers and records involving such transactions related to the contract.

Date: 12/15/17

NATIONAL IMAGING ASSOCIATES, INC. (NIA)

By:

Signature

Assistant Corporate Secretary
Title

John J. DiBernardi Jr.
Printed Name

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EVENT ID: EVT0005464

sunflower health plan

8325 Lenexa Drive
Lenexa, KS 66214

CERTIFICATION & AUTHORIZATION

ATTESTATION

The undersigned, Voiance Language Services, LLC, being an unaffiliated subcontractor for Sunflower State Health Plan, Inc. (Sunflower), hereby attests as follows:

In the event that Sunflower is awarded a contract for the KanCare 2.0 Medicaid and CHIP Capitated Managed Care Services from the Kansas Department of Health and Environment (KDHE) and Kansas Department for Aging and Disability Services (KDADS), Voiance Language Services, LLC hereby grants to the State and/or Federal Government the right to examine any directly pertinent books, documents, papers and records involving such transactions related to the contract.

Date: 12/19/2017

VOIANCE LANGUAGE SERVICES, LLC

By:

Signature

VP Contact Center Operation

Title

Best Iheyborow

Printed Name

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2.4 Bidder Information

2.4 BIDDER INFORMATION

The bidder must include a narrative of the bidder's corporation and each subcontractor if any. The narrative shall include the following:
(a) date established;
(b) ownership (public, partnership, subsidiary, etc.);
(c) number of personnel, full and part time, assigned to this project by function and job title;
(d) resources assigned to this project and the extent they are dedicated to other matters;
(e) organizational chart;
(f) financial statement may be required.

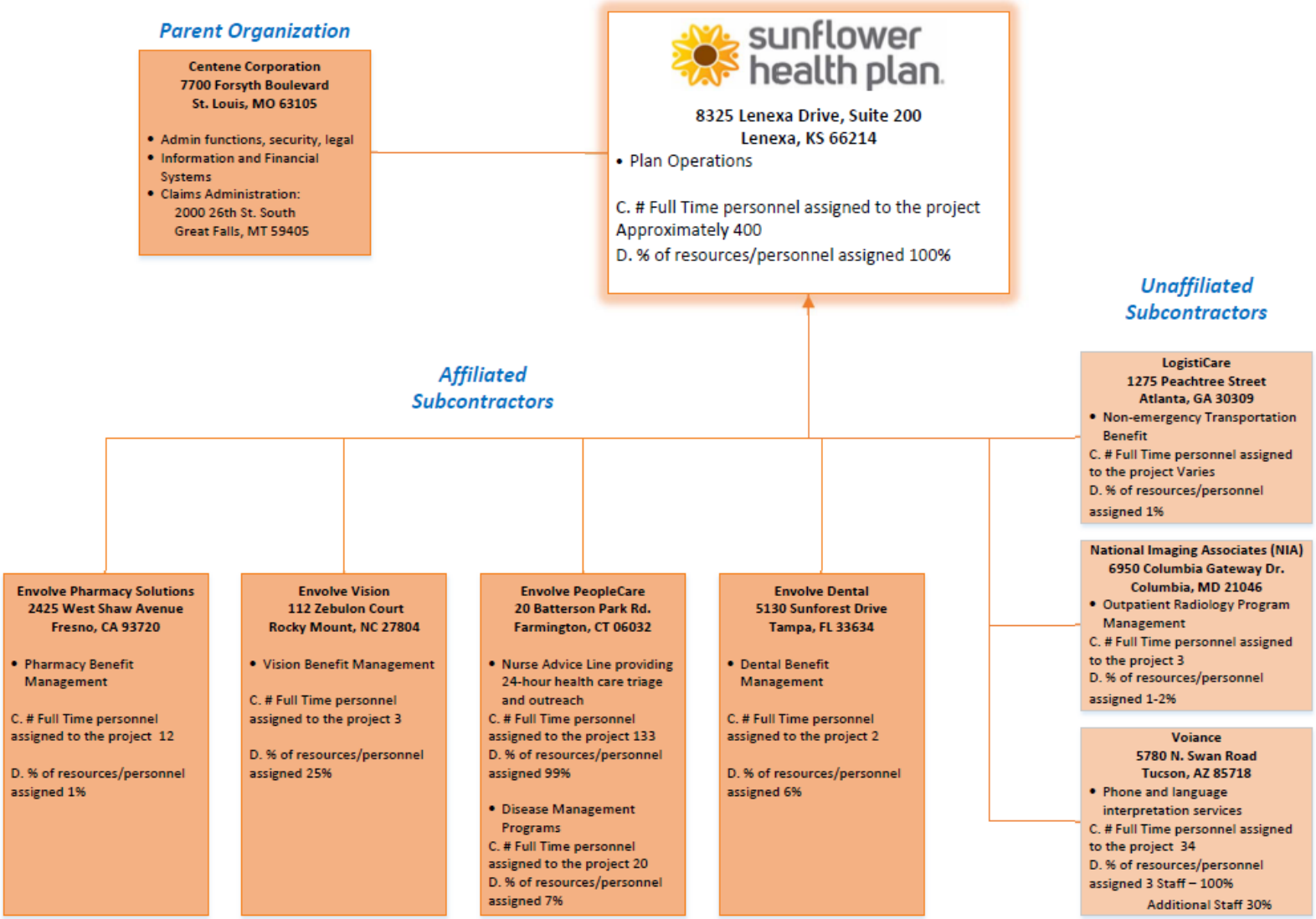
SUNFLOWER HEALTH PLAN OVERVIEW

Sunflower Health Plan (Sunflower) has served our KanCare members since 2013, providing health care services for populations in the KanCare Program including: Temporary Assistance to Needy Families (TANF), Children's Health Insurance Program (CHIP), Aged, Blind and Disabled (ABD) (Duals and Non Duals), Long-term Services and Support (LTSS), Home and Community Based Services (HCBS) Waiver Programs, Foster Care, Intellectually/Developmentally Disabled (I/DD), and Pregnant Women. We currently serve approximately 130,000 members through the KanCare Program. Sunflower has held NCQA Commendable status longer than any other MCO in the state, and our parent company has been providing services within Kansas through affiliates since 2005*.

Sunflower Bidder Information	
A. DATE ESTABLISHED	Sunflower was established in 2011.
B. OWNERSHIP	Sunflower is a wholly owned subsidiary of Centene Corporation (described below), which is a publicly-traded corporation.
C. NUMBER OF PERSONNEL AND **D. RESOURCES ASSIGNED TO THIS PROJECT**	We will have approximately 400 full time personnel assigned to this project. Resources assigned to this project are broken out by functional area below (FTEs are listed in parenthesis). **Senior Executive**—Senior Executive Project Director, Chris Coffey. T**otal Departmental FTEs: (1).** **Operations**—Dr. Jonalan Smith; Systems Director (2); Sharon Traylor; Member Services Director (8); Dr. Angie Zhou, Pharmacy Director (9); Michelle Boller, Claims / Operations Manager (12); Elaine Parker, Provider Appeals Manager (13); Doug Klise, Provider Relations Director (10); Debra Burnham, Network Management and Contracting Director (7); Beau Winfrey, Chief Data Analytics Coordinator (11); Greg Herdlick, KanCare Contract Oversight for Subcontractors and Delegated Entities (14); Chad Benhardt, LTSS and Behavioral Health, Provider Representatives (15); Alana Dotson, LTSS and Behavioral Health Provider Representatives (16); Ian Kuenzi, Member Advocate (17); Jeannette Bass, Member Advocate (18). **Total Department FTEs: 106**. **Medical Affairs**— Dr. Katherine Friedebach, Chief Medical Director (4); **to be hired-**Service Coordination Director (19); Dr. Sosunmolu Shoyinka, Behavioral Health Medical Director (20); Dr. Sandra Berg, Behavioral Health Supports Director (21); Susan Hood, QI Director (22), Terie Beverlin, Health Services Director (23); Mariza Greenwald, EPSDT Coordinator (24); Michelle Collins, Grievance and Appeal Manager

	(25); Audrey Davis-Donovan, Transitions Care Coordinator (26); Brenda Soto, Foster Care Coordinator (27). **Total Departmental FTEs: 260**. **LTSS**—Stephanie Rasmussen, LTSS Director (6); **to be hired-**LTSS Clinical Officer (28); **to be hired**-Housing, Services and Support (29); Cheryl Laaker, Employment Service and Supports Coordinator (30). **Total Departmental FTEs: 20.** **Compliance**—Carmen Mills, Compliance Officer; Neisha Martin, Program Integrity Manager; Jenny Waddle, SIU Investigator; Kelly Poston, Supervisor, Compliance; Marc Shiff, Senior Compliance Analyst; Melinda Shultz, Compliance Coordinator; Tammy Reynolds, Compliance Specialist. **Total Departmental FTEs: 7**. **Finance**— Terry Weathers, Senior Executive Financial Officer; Jennifer King, Senior Director Finance; David Samples, Manager of Finance; Joshua Matthys, Data Analyst IV; Renee Estrada, Finance Analyst III; Dawn Marriot, Finance Analyst II; Donna Benoit ,Finance Analyst II; Richard Zankel, Finance Analyst III. **Total Departmental FTEs: 8.** Sunflower will assign 100% of our personnel/resources to this project (function and titles are listed directly above). Our focus has been, and will continue to be serving Kansas' most vulnerable populations.
E. ORGANIZATIONAL CHART	Please see the following page for ***Figure 2.4.A Sunflower Health Plan's Subcontractor Organizational Chart***
F. FINANCIAL STATEMENT	Please see ***Attachment. 2.4.B_ Sunflower Financial Statement*** In accordance with the Q and A, we are only submitting the financial statements for Sunflower and our parent company, Centene.

Figure 2.4.A Sunflower Health Plan's Subcontractor Organizational Chart



Centene Corporation

Sunflower's parent company, Centene Corporation (Centene), a Fortune 100 company, has over 33 years of experience in managed care. Centene is a diversified, multi-national health care enterprise that provides a portfolio of services to government sponsored and commercial health care programs, focusing on under-insured and uninsured individuals. Centene currently serves over 12.3 million members in health care programs in 29 states primarily through Medicaid, Medicare, TRICARE federal contracts and Health Insurance Marketplace. As the largest Medicaid managed care organization in the nation, Centene serves over 7 million Medicaid beneficiaries in 24 states.

Centene Financial Statement. Please refer to ***Attachment 2.4.C_Centene Financial Statement***. In accordance with the Q and A, we are only submitting the financial statements for Sunflower and our parent company, Centene.

SUBCONTRACTORS

Sunflower incorporates subcontractor expertise to provide a strong suite of capabilities and services. Our subcontractors' extensive experience serving Sunflower members means they understand the challenges faced by these populations, the specific Program requirements, and the tailored approaches we have jointly developed to ensure integrated care for our members. A differentiator for Sunflower is that many of our subcontractors are Sunflower affiliates and operate on the same communication platforms and share resources on many levels such as reporting applications. This ownership strategy removes much of the performance risk inherent in subcontracting by removing the necessity to rely on external data and affords Sunflower the capability for proactive and rapid response.

Sunflower understands that we are ultimately responsible for all products, services, and obligations agreed to by the health plan and the State of Kansas, and that we must certify and warrant all subcontractor work. Our subcontracts include appropriate provisions, certifications and contractual obligations, ensuring the successful fulfillment of all contractual obligations. Below is a listing of the subcontractors we plan to contract with for the purposes of this Agreement.

Affiliated Subcontractors

Integrated Specialty Solutions. In 2015, Centene launched Envolve™, a new brand that brings together its extensive portfolio of specialty health care solutions to achieve a level of integration that is unparalleled in health care. Envolve represents a family of health solutions working together to make health care simpler, more effective, and more accessible for everyone. Envolve leverages its collective expertise in nurse advice line services, life and health management, disease management (DM), pharmacy benefits management, specialty pharmacy, dental benefits management, managed vision, and more, to provide integrated and comprehensive health care for members.

envolve PEOPLE CARE Envolve PeopleCare (EPC). EPC services focus on individual health management through education and empowerment. Through our 24/7/365 nurse advice line and triage services and health, wellness, and disease guidance programs, EPC helps transform lives through nurse triage and nurse advice line support and DM and health coaching services.

Envolve PeopleCare (formerly NurseWise)	
A. DATE ESTABLISHED	NurseWise was established in 1995.
B. OWNERSHIP	NurseWise is a wholly owned subsidiary of a Centene, a publicly-traded corporation.
C. NUMBER OF PERSONNEL	NurseWise will have 133 full time personnel assigned to this project. They are: 58 Registered Nurses and 75 Customer Care Professionals
D. RESOURCES ASSIGNED TO THIS PROJECT	NurseWise will assign 99% of its resources to this project; staff will also be dedicated to any other matters/projects 99.4% of the time.
E. ORGANIZATIONAL CHART	No need to submit per Q&A
F. FINANCIAL STATEMENT	No need to submit per Q&A

Envolve PeopleCare (Formerly Nurtur)	
A. DATE ESTABLISHED	Nurtur was established in 2007.
B. OWNERSHIP	Nurtur is a wholly owned subsidiary of a Centene, a publicly-traded corporation.
C. NUMBER OF PERSONNEL	EPC will have 20 personnel, both full and part time, assigned to this project. They are: 12 DM Coaches and 8 Customer Service Representatives.
D. RESOURCES ASSIGNED TO THIS PROJECT	Nurtur will assign 7% of its resources to this project; staff will also be dedicated to any other matters/projects 80% of the time.
E. ORGANIZATIONAL CHART	No need to submit per Q&A
F. FINANCIAL STATEMENT	No need to submit per Q&A

envolve BENEFIT OPTIONS Envolve Benefit Options (Envolve Benefits). Envolve Benefits provides fully integrated dental and vision services and benefits so that customizable solutions can be created depending on the exact needs of the populations being served. This integration aids in governing costs while offering the highest care to the communities served.

Envolve Dental (formerly Dental Health & Wellness)	
A. DATE ESTABLISHED	Envolve Dental was established in 2013.
B. OWNERSHIP	Envolve Dental is a wholly owned subsidiary of a Centene, a publicly-traded corporation.
C. NUMBER OF PERSONNEL	Envolve Dental will have two full time personnel assigned to this project. They are: one Contract Manager and one Network Professional Representative.
D. RESOURCES ASSIGNED TO THIS PROJECT	Envolve Dental will assign 6% of its resources to this project; staff will also be dedicated to any other matters/projects 50% of the time.
E. ORGANIZATIONAL CHART	No need to submit per Q&A
F. FINANCIAL STATEMENT	No need to submit per Q&A

Envolve Vision (formerly OptiCare)	
A. DATE ESTABLISHED	Envolve Vision was established in 2006.
B. OWNERSHIP	Envolve Vision is a wholly owned subsidiary of a Centene, a publicly-traded corporation.
C. NUMBER OF PERSONNEL	Envolve Vision will have approximately three full time personnel assigned to this project. They are: One and a half Claims staff, one Call Center staff person, a portion of one Account Services staff person, and a portion of one from other areas, such as UM, Network, Finance, Quality, etc.
D. RESOURCES ASSIGNED TO THIS PROJECT	Envolve Vision will assign 25% of its resources to this project; staff will also be dedicated to any other matters/projects 75% of the time.
E. ORGANIZATIONAL CHART	No need to submit per Q&A
F. FINANCIAL STATEMENT	No need to submit per Q&A

envolve PHARMACY SOLUTIONS Envolve Pharmacy Solutions (formerly US Script). Envolve Pharmacy Solutions' analytical approach to managing the pharmacy network results in a robust pharmacy network ensuring compatibility with Sunflower's product offering and strategic initiatives.

Envolve Pharmacy	
A. DATE ESTABLISHED	Envolve Pharmacy Solutions was established in 1999.
B. OWNERSHIP	Envolve Pharmacy Solutions is a wholly owned subsidiary of a Centene, a publicly-traded corporation.
C. NUMBER OF PERSONNEL	Envolve Pharmacy Solutions will have 12 full time personnel assigned to this project; seven Call Center Representatives, three Claims Adjudication staff, one Prior Authorization Representative, and one Date Analytics Representative.
D. RESOURCES ASSIGNED TO THIS PROJECT	Envolve Pharmacy Solutions will assign 1% of its resources to this project; staff will also be dedicated to any other matters/projects 100% of the time.
E. ORGANIZATIONAL CHART	No need to submit per Q&A
F. FINANCIAL STATEMENT	No need to submit per Q&A

Non-Affiliated Subcontractors

LogistiCare. As a transportation manager, LogistiCare works with state agencies, managed care organizations, transportation providers, and health care professionals to provide and coordinate non-emergent transportation needs to our members. They provide compassion, ensuring members get where they need to go in a timely, safe, and cost-effective manner.

LogistiCare-non-emergent medical transportation	
A. DATE ESTABLISHED	LogistiCare Solutions, LLC (LogistiCare) was founded in 1986 as a logistics software solution developer offering data technology to the ambulance industry. In the mid-1990s, focus transitioned to non-emergency medical transportation (NEMT) as the sole line of business.
B. OWNERSHIP	LogistiCare is a wholly owned subsidiary of The Providence Service Corporation.
C. NUMBER OF PERSONNEL	LogistiCare will have 34 full time personnel assigned to this project. They are: Customer Services Representatives; Facility Representatives; Transportation Coordinators; Mass Transit staff person; Grievance, Compliance, and Monitoring staff; Regional Manager; Field Monitors; Vice President and Director of Operations; Contract Center Manager and Supervisor; Healthcare Manager; Transportation Manager; and an Account Manager.
D. RESOURCES ASSIGNED TO THIS PROJECT	LogistiCare will assign 100% of three of its staff resources—a Customer Service Representative, a Facility Representative, and a Transportation Coordinator to this project; LogistiCare will assign additional staff to this project who are listed above approximately 30% of the time; staff not assigned at 100% will also be dedicated to any other matters/projects 70% of the time.
E. ORGANIZATIONAL CHART	No need to submit per Q&A
F. FINANCIAL STATEMENT	No need to submit per Q&A

National Imaging Associates, Inc. (NIA). NIA has provided leadership in managing specialty solutions for 21 years, and grew from being an advanced radiology benefits management (RBM) organization to a specialty solutions organization that focuses on complex and high-cost areas of health care spend, including the management of radiation oncology services. NIA is NCQA accredited and has provided radiology benefits management (RBM) services for Sunflower since 2013.

NIA-high-tech radiological imaging services	
A. DATE ESTABLISHED	National Imaging Associates, Inc. (NIA) was established in 1996. In 2006, Magellan Health acquired NIA.
B. OWNERSHIP	NIA is a privately owned company, and is an indirect, wholly owned subsidiary of Magellan Health, Inc., a publicly-traded company.
C. NUMBER OF PERSONNEL	NIA will have three full time Account Management personnel assigned to this project; however, other staff will also be involved, on an as needed basis, such as: Customer Care Associate (intake/non-clinical) team staff, Care Assist Team staff, Initial Clinical Reviewer team (nurses), Physician Clinical Reviewer who is board-certified in the specialty most relevant to each request, Provider Relations staff, Quality/Compliance staff, Information Technology staff, and Business Analytics staff.
D. RESOURCES ASSIGNED TO THIS PROJECT	NIA will assign 1 to 2% of the above listed staff/resources to this project; staff will also be dedicated to any other matters/projects approximately 98% of the time.
E. ORGANIZATIONAL CHART	No need to submit per Q&A
F. FINANCIAL STATEMENT	No need to submit per Q&A

Voiance. Voiance is a US-based translation company that specializes in providing medical, engineering, and technical translation and localization services in all European, Asian, Middle Eastern, African, and American languages.

Voiance-phone and language interpretation services	
A. DATE ESTABLISHED	Voiance was established in 1995.
B. OWNERSHIP	Private
C. NUMBER OF PERSONNEL	Voiance will have a varying number of full time personnel assigned to this project. Voiance employs 2,400 FTEs, and because they provide on-demand phone interpretation services, dedicated resources would not be assigned specifically to our Kansas members. Instead the number of interpreters and operational staff made available to Kansas members' and will vary based on service requests sent to Voiance.
D. RESOURCES ASSIGNED TO THIS PROJECT	Voiance will assign approximately 1% of its resources to this project; staff will also be dedicated to any other matters/projects approximately 99% of the time.
E. ORGANIZATIONAL CHART	No need to submit per Q&A
F. FINANCIAL STATEMENT	No need to submit per Q&A

**Beginning in 2005, Centene participated in other Kansas programs through affiliates, such as Cenpatico and FirstGuard, Inc.*

sunflower
health plan®

SUNFLOWER STATE HEALTH PLAN, INC.

(A Wholly Owned Subsidiary of Centene Corporation)

Statutory Financial Statements and
Supplemental Information

December 31, 2016 and 2015

(With Independent Auditors' Report Thereon)

SUNFLOWER STATE HEALTH PLAN, INC.
(A Wholly Owned Subsidiary of Centene Corporation)

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KPMG LLP
Suite 900
10 South Broadway
St. Louis, MO 63102-1761

Independent Auditors' Report

The Audit Committee of the Board of Directors
Sunflower State Health Plan, Inc.:

Report on the Financial Statements

We have audited the accompanying financial statements of Sunflower State Health Plan, Inc. (the Company), which comprise the statutory statements of admitted assets, liabilities, and capital and surplus as of December 31, 2016 and 2015, and the related statutory statements of revenue and expenses, changes in capital and surplus, and cash flow for the years then ended, and the related notes to the statutory financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with statutory accounting practices prescribed or permitted by the Kansas Insurance Department. Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles

As described in Note 2 to the financial statements, the financial statements are prepared by the Company using statutory accounting practices prescribed or permitted by the Kansas Insurance Department, which is a basis of accounting other than U.S. generally accepted accounting principles. Accordingly, the financial statements are not intended to be presented in accordance with U.S. generally accepted accounting principles.

KPMG LLP is a Delaware limited liability partnership and the U.S. member firm of the KPMG network of independent member firms affiliated with KPMG International Cooperative ("KPMG International"), a Swiss entity.

The effects on the financial statements of the variances between the statutory accounting practices described in Note 2 and U.S. generally accepted accounting principles, although not reasonably determinable, are presumed to be material.

Adverse Opinion on U.S. Generally Accepted Accounting Principles

In our opinion, because of the significance of the variances between statutory accounting practices and U.S. generally accepted accounting principles discussed in the Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles paragraph, the financial statements referred to above do not present fairly, in accordance with U.S. generally accepted accounting principles, the financial position of the Company as of December 31, 2016 and 2015, or the results of its operations or its cash flows for the years then ended.

Opinion on Statutory Basis of Accounting

In our opinion, the financial statements referred to above present fairly, in all material respects, the admitted assets, liabilities, and capital and surplus of the Company as of December 31, 2016 and 2015, and the results of its operations and its cash flow for the years then ended, in accordance with statutory accounting practices prescribed or permitted by the Kansas Insurance Department described in Note 2.

Other Matter

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplementary information included in the Supplemental Schedule Investment Schedule – December 31, 2016, and Supplemental Investment Risk Interrogatories – December 31, 2016, is presented for purposes of additional analysis and is not a required part of the financial statements but is supplementary information required by the Kansas Insurance Department. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the financial statements as a whole.

KPMG LLP

St. Louis, Missouri
April 21, 2017

SUNFLOWER STATE HEALTH PLAN, INC.
(A Wholly Owned Subsidiary of Centene Corporation)

Statutory Statements of Admitted Assets, Liabilities, and Capital and Surplus

December 31, 2016 and 2015

Admitted Assets		**2016**	**2015**
Bonds	$	57,700,695	23,222,954
Cash, cash equivalents, and short-term investments		59,007,522	51,709,763
Investment income due and accrued		392,003	166,455
Premiums receivable		122,216,420	181,072,255
Reinsurance receivable		284,159	4,395
Amounts due from affiliates		771,183	466,084
Healthcare receivables		3,262,943	8,015,681
State income tax recoverable		1,275,945	983,945
Federal income tax recoverable		7,207,525	—
Net deferred tax asset		1,900,122	—
Total admitted assets	$	254,018,517	265,641,532
Liabilities and Capital and Surplus			
Liabilities:			
Claims payable	$	81,677,559	85,221,428
Unpaid claims adjustment expenses		1,366,000	1,359,000
Accrued medical incentive pool and bonus amounts		—	571,384
General expenses due or accrued		37,038,181	42,769,970
Accrued federal income tax		—	836,901
Ceded reinsurance premiums payable		640,632	94,006
Total liabilities		120,722,372	130,852,689
Capital and surplus:			
Common stock, zero par value		—	—
Gross paid-in and contributed capital		245,000,000	245,000,000
Special surplus funds		—	12,395,549
Unassigned deficit		(111,703,855)	(122,606,706)
Total capital and surplus		133,296,145	134,788,843
Total liabilities and capital and surplus	$	254,018,517	265,641,532

See accompanying notes to statutory financial statements.

SUNFLOWER STATE HEALTH PLAN, INC.
(A Wholly Owned Subsidiary of Centene Corporation)

Statutory Statements of Revenue and Expenses

Years ended December 31, 2016 and 2015

	2016	2015
Revenue:		
Premium income	$ 1,106,721,810	1,114,952,592
Expenses:		
Medical and hospital benefits	679,106,428	717,317,928
Other professional services	130,357,805	130,969,381
Emergency room	20,827,070	21,113,470
Prescription drugs	135,200,679	145,070,238
Incentive pool and bonus amounts	768,122	933,473
Reinsurance recoveries	(5,708,029)	(5,281,547)
Total medical and hospital expenses	960,552,075	1,010,122,943
Claims adjustment expenses	13,639,916	13,882,395
General administrative expenses	110,523,426	109,061,872
Change in premium deficiency reserve	—	(36,968,937)
Total expenses	1,084,715,417	1,096,098,273
Investment income:		
Net investment income	1,083,560	271,778
Income (loss) before federal income taxes	23,089,953	19,126,097
Federal income tax expense (benefit)	13,412,651	(1,664,564)
Net income (loss)	$ 9,677,302	20,790,661

See accompanying notes to statutory financial statements.

SUNFLOWER STATE HEALTH PLAN, INC.
(A Wholly Owned Subsidiary of Centene Corporation)

Statutory Statements of Changes in Capital and Surplus

Years ended December 31, 2016 and 2015

	Common stock	Gross paid-in and contributed surplus	Special Surplus	Unassigned deficit	Total
Balance, December 31, 2014	$ —	245,000,000	13,161,322	(145,390,953)	112,770,369
Net income	—	—	—	20,790,661	20,790,661
Change in special surplus funds	—	—	(765,773)	765,773	—
Change in nonadmitted assets	—	—	—	1,227,813	1,227,813
Balance, December 31, 2015	—	245,000,000	12,395,549	(122,606,706)	134,788,843
Dividends paid	—	—	—	(13,000,000)	(13,000,000)
Net income	—	—	—	9,677,302	9,677,302
Change in special surplus funds	—	—	(12,395,549)	12,395,549	—
Change in net unrealized capital gains	—	—	—	(154)	(154)
Change in nonadmitted assets	—	—	—	(69,964)	(69,964)
Change in net deferred income tax	—	—	—	1,900,122	1,900,122
Balance, December 31, 2016	$ —	245,000,000	—	(111,703,851)	133,296,149

See accompanying notes to statutory financial statements.

SUNFLOWER STATE HEALTH PLAN, INC.
(A Wholly Owned Subsidiary of Centene Corporation)

Statutory Statements of Cash Flow

Years ended December 31, 2016 and 2015

	2016	2015
Cash from operations:		
Premiums collected net of reinsurance	$ 1,166,124,271	1,085,714,310
Net investment income	1,172,341	165,432
Benefits and loss related payments	(960,194,863)	(1,015,003,263)
General administrative and claims adjustment expenses paid	(130,554,696)	(91,033,599)
Federal income taxes recovered (paid)	(21,459,663)	(11,004,831)
Net cash from (used in) operations	55,087,390	(31,161,951)
Cash from investments:		
Proceeds from investments sold, matured, or repaid	2,009,208	325,574
Cost of investments acquired	(36,798,839)	(19,771,741)
Net cash from (used in) investments	(34,789,631)	(19,446,167)
Cash from financing and miscellaneous sources:		
Paid-in surplus	—	45,000,000
Dividends paid	(13,000,000)	—
Net cash from (used in) financing and miscellaneous sources	(13,000,000)	45,000,000
Net change in cash and short-term investments	7,297,759	(5,608,118)
Cash, cash equivalents and short-term investments, beginning of year	51,709,763	57,317,881
Cash, cash equivalents and short-term investments, end of year	$ 59,007,522	51,709,763

See accompanying notes to statutory financial statements.

(1) Organization and Operations

Sunflower State Health Plan, Inc. (the Company) is a wholly owned subsidiary of Centene Corporation (Centene), a Delaware stock corporation. The Company, which is organized as a Health Maintenance Organization, was incorporated on September 15, 2011 for the purposes of providing comprehensive managed healthcare services to the Kansas market. During 2012, the Company entered into a contract with an initial term of January 1, 2013 through December 31, 2015 with the Kansas Department of Health and Environment (KDHE) to provide physical and behavioral health, nursing facility, and home and community based services to Medicaid recipients in the State of Kansas. The original contract contained a provision, which would allow the state to renew their contract for two one-year periods. The state exercised both renewal options on April 7, 2015, extending the contract through December 31, 2017. The Company began operations on January 1, 2013 and its contract with KDHE accounts for 100% of the Company's revenue for the years ended December 31, 2016 and 2015.

(2) Basis of Presentation and Significant Accounting Policies

The statutory financial statements of the Company are presented on the basis of accounting practices prescribed or permitted by the Kansas Insurance Department (KID) for determining and reporting the financial condition and the results of operations of an insurance company and for determining its solvency under Kansas insurance law.

The State of Kansas has adopted accounting policies found in the revised National Association of Insurance Commissioners' (NAIC) *Accounting Practices and Procedures Manual* (NAIC SAP), subject to any deviations prescribed or permitted by the KID (SAP). SAP differs in certain respects from U.S. generally accepted accounting principles (GAAP) followed by other types of enterprises in determining their financial position, results of operations, and cash flow. The most significant variances are as follows:

A. Under SAP, certain assets, designated as "nonadmitted assets" are excluded from the statutory statements of admitted assets, liabilities, and capital and surplus and are charged to unassigned surplus as follows:

		2016	2015
Healthcare receivables	$	661,530	661,015
Prepaid expenses		85,199	15,750
Total nonadmitted assets	$	746,729	676,765

Under GAAP, such assets are included in the balance sheets subject to impairment and allowances.

B. The statutory financial statements reflect certain assets and liabilities net of ceded reinsurance.

C. Under SAP, debt securities are carried at amortized cost. Under GAAP, debt securities are carried at amortized cost only if there is both a positive intent and ability to hold to maturity. Otherwise, they are carried at fair value with unrealized gains and losses recognized within income or accumulated other comprehensive income according to prescribed rules.

D. Under SAP, the statements of cash flow reconciles to changes in cash and short-term investments with original maturities of one year or less. Under GAAP, the statements of cash flow reconciles to changes in cash and cash equivalents with a maturity period of three months or less. The statutory statements of cash flow are presented in a specified format, which differs from the format prescribed by GAAP.

E. Under SAP, net deferred income tax assets are admitted following the application of certain criteria with the resulting change in admitted deferred tax asset amount being credited directly to capital and surplus. Under GAAP, deferred income tax assets and liabilities are recorded for temporary differences between the reported amounts of assets and liabilities and those in the Company's income tax return. Changes to deferred income tax assets and liabilities are recorded in current operations under GAAP and directly to surplus under SAP.

F. Comprehensive income is not determined for statutory reporting purposes, and there is no statement reflecting accumulated other comprehensive income.

The aggregate effect of the foregoing differences between SAP and GAAP has not been determined, but is presumed to be material.

(a) Management's Estimates

The preparation of statutory financial statements in conformity with the accounting practices prescribed or permitted by Kansas Insurance Department requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Future events and their effects cannot be predicted with certainty; accordingly, the accounting estimates require the exercise of judgment. The accounting estimates used in the preparation of the financial statements will change as new events occur, as more experience is acquired, as additional information is obtained and as the operating environment changes. The Company evaluates and updates its assumptions and estimates on an ongoing basis and may employ outside experts to assist in the evaluation, as considered necessary. Actual results could differ from those estimates.

(b) Fair Value Measurements

In the normal course of business, the Company invests in various financial assets and incurs various financial liabilities. Fair values are disclosed for all financial instruments, whether or not such values are recognized in the statutory statements of admitted assets, liabilities, and capital and surplus. Management obtains quoted market prices or other observable inputs for these disclosures. The carrying amounts reported in the statutory statements of admitted assets, liabilities, and capital and surplus for cash and cash equivalents, premium and related receivables, premiums received in advance, general expenses due and accrued, and certain other current liabilities are carried at cost, which approximates fair value because of their short-term nature.

(c) Bonds

Bonds are valued as prescribed by the NAIC and are generally carried at amortized cost with the accretion of discounts and amortization of premiums being computed under the scientific method. Realized gains and losses are calculated using the specific-identification method. Asset-backed securities are revalued using currently estimated cash flow and prepayment assumptions. A prospective adjustment methodology is used for all asset-backed securities.

The Company evaluates all of its bonds for impairment based on current market prices, economic conditions and the financial condition of the issuer. Investments that have declines in NAIC fair value below cost, which are judged to be other-than-temporary, are written down to estimated NAIC fair value. Factors considered in evaluating whether a decline in value is other-than-temporary include: (1) whether the decline is substantial, (2) the Company's ability and intent to retain the investment for a period of time sufficient to allow for an anticipated recovery in value, (3) the duration and extent to which the fair value has been less than cost, and (4) the financial condition and near-term prospects of the issuer in relation to the anticipated recovery period. There were no charges recorded in 2016 or 2015 related to other-than-temporary impairments.

Investment securities are exposed to various risks, such as interest rate, market, and credit. Due to the level of risk associated with certain investment securities and the level of uncertainty related to changes in the value of investment securities, it is at least reasonably possible that changes in risks in the near term would materially affect the amounts reported in the statutory statements of admitted assets, liabilities, and capital and surplus or the statutory statements of revenue and expense.

(d) Restricted Assets

Under the KID regulations, the Company is required to maintain certain insolvency deposits of not less than $300,000 in a custodial account for the protection of enrollees. The Company is entitled to receive interest income on these deposits. At December 31, 2016 and 2015, assets in the amount of $310,028 and $310,061, respectively, were on deposit with government authorities or trustees as required by law and are invested in bonds and money market funds.

(e) Cash and Short Term Investments

Cash and short-term investments consist of cash on deposit and investments with an original maturity of one year or less.

(f) Investment Income Due and Accrued

The Company recognizes investment income when earned. Investment income due and accrued is recorded for investment income earned as of the reporting date but collected in a subsequent period. The Company performs an evaluation of these receivables to determine whether an impairment exists. No impairment charges were recorded during 2016 or 2015.

(g) Premium Income and Receivables

Premium income is recognized in the period in which members are entitled to receive covered services. Premiums due to the Company are recorded as premium receivables and are recorded net of an allowance based on historical trends and management's judgment on the collectability of these accounts.

During 2016 and 2015, the Company earned premium revenue net of ceded reinsurance premiums of $1,106,721,810 and $1,114,952,592, respectively, under its contract with KDHE. The original contract with KDHE was in effect through December 31, 2015 with two one-year options for renewal. During 2015, KDHE exercised its right to both one-year renewal options extending the contract through December 31, 2017. The contract can be terminated by KDHE upon the occurrence of certain events.

Premiums receivable consist primarily of reimbursements receivable from KDHE and includes capitation, delivery, and retrospective premium receivables. Amounts receivable under government insured plans, including amounts over 90 days due that qualify as accident and health contracts are admitted assets under NAIC SAP. Amounts receivable under government insured plans include, but are not limited to, receivables under Medicare, Medicaid, and similarly funded government insured plans. As of December 31, 2016 and 2015, the Company had no receivables greater than 90 days.

The Company estimates retrospective premiums in accordance with the provisions of its contract with KDHE and for the years ended December 31, 2016 and 2015, all of the Company's premiums written are subject to retrospective premium features. Premiums receivable are recorded at net realizable value, adjusted for estimated uncollectible amounts. As of December 31, 2016 and 2015, no allowance for doubtful accounts was deemed necessary based on the Company's evaluation.

(h) Income Taxes

Deferred tax assets and liabilities are recorded for the future tax consequences attributable to differences between the statutory financial statement carrying amounts of existing assets and liabilities and their respective tax bases. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled.

Valuation allowances are provided when it is considered more likely than not that deferred tax assets will not be realized. In determining if a deductible temporary difference or net operating loss can be realized, the Company considers future reversals of existing taxable temporary differences, future taxable income, taxable income in prior carryback periods, and tax planning strategies.

For the years ended December 31, 2016 and 2015, the Company filed a consolidated federal income tax return with Centene and its other subsidiaries. In accordance with the group's tax allocation agreement, the subsidiaries reimburse or recover from Centene their portion of the income taxes as calculated on a separate company basis.

(i) Amounts Due from Affiliates

Amounts due from affiliates generally consist of amounts receivable from related parties under various service agreements as well as surplus contributions receivable from Centene. See note 7 for detailed amounts due from affiliates.

(j) Healthcare Receivables

Healthcare receivables consist primarily of capitation arrangement, risk-sharing receivables, and claims overpayment receivables. The Company records capitation arrangement receivables for advances to providers for future services and admits those receivables recorded up to one month of average capitation payments to the subject provider during the preceding twelve months. The Company records risk sharing receivables, which can be reasonably estimated based on the provisions of the provider contract and through discussions with the provider at least annually. The Company records claims overpayment receivables based upon amounts that are due to be recouped by the Company and are offset by a corresponding payable as of the reporting date.

(k) Claims Payable and Unpaid Claims Adjustment Expenses

Claims payable includes claims reported but not yet paid, or inventory, and estimates for claims incurred but not reported, or IBNR. Unpaid claims adjustment expenses include estimates for the costs necessary to process unpaid claims. The Company estimates its medical claims liability using actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. These actuarial methods consider factors such as historical data for payment patterns, cost trends, product mix, seasonality, utilization of healthcare services, and other relevant factors.

Actuarial Standards of Practice generally require that claims payable estimates be adequate to cover obligations under moderately adverse conditions. Moderately adverse conditions are situations in which the actual claims are expected to be higher than the otherwise estimated value of such claims at the time of estimate. In many situations, the claims amounts ultimately settled will be different than the estimate that satisfies the Actuarial Standards of Practice. The Company includes in its IBNR an estimate for claims payable under moderately adverse conditions, which represents the risk of adverse deviation of the estimates in its actuarial method of reserving.

The Company uses its judgment to determine the assumptions to be used in the calculation of the required estimates. The assumptions it considers when estimating IBNR include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, healthcare service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to fee schedules, and the incidence of high dollar or catastrophic claims.

The Company's development of the medical claims liability estimate is a continuous process, which it monitors and refines on a monthly basis as additional claims receipts and payment information becomes available. As more complete claim information becomes available, the Company adjusts the amount of the estimates, and includes the changes in estimates in medical costs in the period in which the changes are identified. In every reporting period, the operating results include the effects of more completely developed medical claims liability estimates associated with previously reported periods.

The Company consistently applies its reserving methodology from period to period. As additional information becomes known, it adjusts the actuarial model, accordingly, to establish medical claims liability estimates. Management believes the amount of medical claims payable is reasonable and adequate to cover the Company's liability for unpaid claims as of December 31, 2016 and 2015; however, actual claim payments may differ from established estimates.

(l) Premium Deficiency Reserve

Premium deficiency reserves are recognized when expected incurred costs, claims adjustment expenses, and administration costs exceed the premiums to be collected for the remainder of the contract period. Premium deficiency reserves of $0 and $0 were recorded at December 31, 2016 and 2015, respectively, based on the Company's expectations regarding the profitability of the contract in force at December 31, 2016 and 2015. The Company considered anticipated investment income when calculating its premium deficiency reserve. The adequacy of reserve requirements is continually reviewed by management, with any reductions in the reserve being recorded as a beneficial effect in the statutory statements of revenue and expenses.

(m) General Expenses Due or Accrued

The Company records general expenses due or accrued for those direct costs associated with operations incurred as of the reporting date but paid in a subsequent period. General expenses as of December 31, 2016 and 2015 consist primarily of accrued premium taxes.

(n) Premium Taxes

The Company records a premium tax revenue and expense within premium income and general administrative expenses, respectively. During 2016 and 2015, the Company incurred premium taxes of approximately 3.3% and 3.3%, respectively, of its gross premium revenues. The Company recorded premium tax expenses of $36,851,112 and $36,933,154 during 2016 and 2015, respectively, and the associated premium tax payables of these amounts are reported in general expenses due or accrued as of December 31, 2016 and 2015, respectively.

(o) Medical and Hospital Expenses

The Company contracts with various healthcare providers for the provision of certain medical care to its members. Medical claims are submitted by providers and processed in accordance with the terms of the contract. Additionally, the Company compensates some providers on a capitation basis. The amount of the capitation payments and the frequency of the distributions to the provider are based on contractual arrangements.

The cost of other healthcare services provided or contracted for is accrued in the period in which it is provided to a member based in part on estimates, including an accrual for medical services provided but not reported.

(p) Reinsurance

The Company limits its risk of certain catastrophic losses by maintaining reinsurance coverage. Premium income is recorded net of ceded reinsurance premiums. Total medical and hospital expenses are recorded net of reinsurance recoveries.

(q) General Administrative Expenses

The Company has a management services agreement with Centene Management Company, LLC (CMC). Under the agreement, the Company pays CMC a fee on percentage of its monthly revenues for which CMC provides the services necessary to manage the business operations of the Company and assumes responsibility for all associated costs. CMC assumes responsibility for program planning and development, management information systems, financial systems and services, facilities arrangement, claims administration, provider and enrollee services and records, case management, care coordination, utilization and peer review, and quality assurance/quality improvement. In addition, under the agreement, the Company also pays other direct costs associated with the business not covered by the management agreement.

(r) Dividend Restrictions

The amount of dividends that can be paid by the Company to its shareholder is limited by statute and subject to prior approval from the Commissioner of the KID. Ordinary dividends can only be paid out of earned surplus as distinguished from contributed surplus. Before an extraordinary dividend can be paid the Commissioner of the KID must be notified 30 days prior to the proposed dividend and the Commissioner must approve the payment, or not disapprove the payment within the thirty-day period. Extraordinary dividends include, but are not limited to, (a) dividends whose fair market value together with that of other dividends made in the preceding 12 months exceed 10% of the insurer's surplus as of December 31 next preceding or (b) net income not including realized capital gains for the 12-month period ended December 31 next preceding. The company declared and paid dividends in the amount of $13,000,000 and $0 during the years ended December 31, 2016 and 2015, respectively.

(3) Bonds

The amortized cost and estimated statutory fair values of investments in bonds at December 31, 2016 and 2015 are as follows:

	December 31, 2016			
	Amortized cost	Gross unrealized gains	Gross unrealized losses	Statutory fair value
U.S. government obligations	$ 3,659,513	395	8,002	3,651,906
Securities issued by U.S. states and political subdivisions:				
States and subdivisions general obligations	2,593,395	3,995	30,449	2,566,941
Revenue and other obligations	22,330,476	22,089	440,655	21,911,910
Mortgage-backed securities	3,384,167	7,711	58,735	3,333,143
Industrial and miscellaneous	25,733,144	73,772	228,146	25,578,770
Total	$ 57,700,695	107,962	765,987	57,042,670

The above table excludes bonds classified as short-term of $1,010,000.

	December 31, 2015			
	Amortized cost	Gross unrealized gains	Gross unrealized losses	Statutory fair value
U.S. government obligations	$ 3,336,229	—	25,593	3,310,636
Securities issued by U.S. states and political subdivisions:				
Revenue and other obligations	9,563,672	70,923	6,855	9,627,740
Industrial and miscellaneous	10,323,053	7,168	84,006	10,246,215
Total	$ 23,222,954	78,091	116,454	23,184,591

The above table excludes bonds classified as short-term of $508,845.

The fair values of the Company's bonds are evaluated based on NAIC designations set forth by the Securities Valuation Office (SVO). The SVO does not provide fair market values for certain of the Company's bonds. As such, the Company utilizes independent pricing services to estimate fair value for bonds which are not actively traded on the measurement date or for which the SVO does not provide fair market values.

The following tables illustrate the gross unrealized losses included in the Company's investment portfolio aggregated by investment category. The tables also illustrate the length of time the securities have been in an unrealized loss position as of December 31, 2016 and 2015.

	December 31, 2016					
	Decline for less than 12 months			Decline for greater than 12 months		
	Amortized cost	Statutory fair value	Difference	Amortized cost	Statutory fair value	Difference
U.S. government obligations	$ 2,908,633	2,900,631	8,002	—	—	—
Securities issued by U.S. states and political subdivisions:						
States and subdivisions general obligations	1,746,203	1,715,754	30,449	—	—	—
Revenue and other obligations	19,177,432	18,736,777	440,655	—	—	—
Mortgage-backed securities	2,136,413	2,077,678	58,735	—	—	—
Industrial and miscellaneous	15,748,350	15,521,339	227,011	250,000	248,865	1,135
Total	$ 41,717,031	40,952,179	764,852	250,000	248,865	1,135

	December 31, 2015					
	Decline for less than 12 months			Decline for greater than 12 months		
	Amortized cost	Statutory fair value	Difference	Amortized cost	Statutory fair value	Difference
U.S. government obligations	$ 3,336,229	3,310,636	25,593	—	—	—
Securities issued by U.S. states and political subdivisions:						
Revenue and other obligations	2,949,189	2,943,290	5,899	27,461	26,502	959
Industrial and miscellaneous	8,677,583	8,601,722	75,861	139,989	131,844	8,145
Total	$ 14,963,001	14,855,648	107,353	167,450	158,346	9,104

The Company views the decrease in value of all of the securities with unrealized capital losses at December 31, 2016 and 2015 as temporary, expects recovery in fair value, anticipates continued payments under the terms of the securities, and has the intent and ability to hold these securities until maturity or a recovery in fair value occurs. Therefore, no impairment of these securities was recorded during 2016 and 2015, or for the years then ended.

The amortized cost and statutory fair value of debt securities at December 31, 2016, by contractual maturity, are shown below. Actual maturities may differ due to call or prepayment options. Asset-backed securities are included in the due after five years through ten years category.

	Amortized cost	Statutory fair value
Due one year or less	$ 6,058,540	6,056,553
Due after one year through five years	35,962,380	35,624,133
Due after five years through ten years	15,029,775	14,710,312
Due after ten years	650,000	651,672
Total	$ 57,700,695	57,042,670

Proceeds from sales of investments in debt securities during 2016 and 2015 were $1,549,208 and $0, respectively. Proceeds from maturities, repayments and other disposals of investments in debt securities during 2016 and 2015 were $460,000 and $325,574, respectively. Gross realized losses for the years ended December 31, 2016 and 2015 were $0 and $0, respectively. Gross realized gains on the sales of bonds during 2016 and 2015 were $7,389 and $0, respectively.

Net investment income for the years ended December 31, 2016 and 2015 was as follows:

		2016	2015
Interest income:			
Bonds	$	875,452	193,849
Cash, cash equivalents, and short-term investments		256,038	90,004
Investment expenses		(52,733)	(12,075)
Net investment income	$	1,078,757	271,778

(4) Reinsurance

During 2016 and 2015, the Company obtained reinsurance coverage with an affiliated insurance entity equal to 90% of hospital inpatient services in excess of $200,000 per covered person per agreement term to a $4,600,000 and $2,500,000 maximum incurred in 2016 and 2015, respectively. Reimbursement for services provided at hospitals is subject to coinsurance provisions. Eligible hospital expenses are limited to an average daily maximum of $15,000 for 2016 and 2015.

The reinsurance agreements also provide for certain coverage in the event of the insolvency of the Company, as defined in the reinsurance agreements. The reinsurance company agrees to continue benefits to the Company's members who are hospitalized at the time of the insolvency until the earlier of the member's discharge from the hospital or the date the covered person becomes eligible for health insurance coverage or benefit under another group or blanket policy or plan or any federal state or local governmental plan or program. The reinsurance company will also continue benefits for any member for medical services incurred after the date of insolvency provided that premium was received. Coverage for such medical services will continue 30 days after the Company becomes insolvent. The reinsurance company's aggregate maximum liability under this provision of the reinsurance agreement will not exceed $4,600,000 and $2,500,000 in 2016 or 2015, respectively.

Under these agreements, the Company recorded ceded premiums of $7,814,144 and $8,372,796 and reinsurance recoveries of $5,708,030 and $5,281,547 for the years ended December 31, 2016 and 2015, respectively. As of December 31, 2016 and 2015, the Company had reinsurance receivable balances of $284,159 and $4,395, respectively. At December 31, 2016 and 2015, the Company recorded reinsurance ceded of $4,892,649 and $3,245,739, respectively, as a reduction to claims unpaid in the statutory statements of admitted assets, liabilities, and capital and surplus.

(5) Income Taxes

The December 31, 2016 and 2015 balances and related disclosures are calculated and presented pursuant to Statements on Statutory Accounting Principles (SSAP) No. 101. The net deferred tax asset at December 31 and the changes from the prior year are comprised of the following components:

	2016			2015			Change		
	Ordinary	Capital	Total	Ordinary	Capital	Total	Ordinary	Capital	Total
Total gross deferred tax assets	$ 1,906,544	—	1,906,544	489,922	—	489,922	1,416,622	—	1,416,622
Valuation allowance adjustment	—	—	—	(484,079)	—	(484,079)	484,079	—	484,079
Adjusted gross deferred tax assets	1,906,544	—	1,906,544	5,843	—	5,843	1,900,701	—	1,900,701
Total gross deferred tax liabilities	(6,422)	—	(6,422)	(5,843)	—	(5,843)	(579)	—	(579)
Net deferred tax assets (liabilities)	1,900,122	—	1,900,122	—	—	—	1,900,122	—	1,900,122
Total deferred tax assets nonadmitted	—	—	—	—	—	—	—	—	—
Net admitted deferred tax assets (liabilities)	$ 1,900,122	—	1,900,122	—	—	—	1,900,122	—	1,900,122
Net change in total deferred tax assets nonadmitted	$ —	—	—	—	—	—	—	—	—

The amount of adjusted gross deferred tax assets admitted is as follows:

	2016			2015			Change		
	Ordinary	Capital	Total	Ordinary	Capital	Total	Ordinary	Capital	Total
Federal income tax recoverable by loss carryback (11.a.)	$ 1,906,544	—	1,906,544	—	—	—	1,906,544	—	1,906,544
Surplus limitation	19,709,403	—	19,709,403	20,218,326	—	20,218,326	(508,923)	—	(508,923)
Deferred tax liability offset	—	—	—	5,843	—	5,843	(5,843)	—	(5,843)
Total admitted under 11.a.–11.c.	1,906,544	—	1,906,544	5,843	—	5,843	1,900,701	—	1,900,701
Deferred tax liabilities	(6,422)	—	(6,422)	(5,843)	—	(5,843)	(579)	—	(579)
Net admitted deferred tax asset (liability) under 11.a.–11.c.	$ 1,900,122	—	1,900,122	—	—	—	1,900,122	—	1,900,122

The information used in the expected to be realized calculation consists of the following:

	2016	2015
Authorized control level risk-based capital ratio without net deferred tax assets	364%	352%
Adjusted capital and surplus	$ 131,396,023	134,788,843

Tax planning strategies have not been used to admit deferred tax assets. The Company has no temporary differences for which deferred tax liabilities have not been established.

The change in deferred income taxes reported in surplus before consideration of nonadmitted assets is comprised of the following components:

		2016	2015	Change
Total deferred tax assets	$	1,906,544	489,922	1,416,622
Total deferred tax liabilities		(6,422)	(5,843)	(579)
Net deferred tax assets/liabilities		1,900,122	484,079	1,416,043
Statutory valuation allowance adjustment		—	(484,079)	484,079
Net deferred tax assets/ liabilities after statutory valuation allowance	$	1,900,122	—	1,900,122
Change in deferred income tax	$	1,900,122	—	1,900,122

Current income taxes incurred consist of the following major components:

		2016	2015
Current year tax expense (benefit)	$	13,416,215	(1,647,591)
Prior year adjustments		(978)	(16,973)
Current income taxes incurred	$	13,415,237	(1,664,564)

Deferred income tax assets and liabilities consist of the following major components:

	2016			2015			Change		
	Ordinary	Capital	Total	Ordinary	Capital	Total	Ordinary	Capital	Total
Loss reserve discounting	$ 1,524,390	—	1,524,390	253,054	—	253,054	1,271,336	—	1,271,336
Other state deferred tax	120,799	—	120,799	—	—	—	120,799	—	120,799
Nonadmitted assets	261,355	—	261,355	236,868	—	236,868	24,487	—	24,487
Net operating loss carryforward	—	—	—	—	—	—	—	—	—
Total adjusted gross deferred tax assets	1,906,544	—	1,906,544	489,922	—	489,922	1,416,622	—	1,416,622
Valuation allowance adjustment	—	—	—	(484,079)	—	(484,079)	484,079	—	484,079
Total adjusted gross deferred tax assets	1,906,544	—	1,906,544	5,843	—	5,843	1,900,701	—	1,900,701
Nonadmitted deferred tax assets	—	—	—	—	—	—	—	—	—
Admitted deferred tax assets	1,906,544	—	1,906,544	5,843	—	5,843	1,900,701	—	1,900,701
Investments	(908)	—	(908)	(330)	—	(330)	(578)	—	(578)
Prepaid expenses	(5,514)	—	(5,514)	(5,513)	—	(5,513)	(1)	—	(1)
Total deferred tax liabilities	(6,422)	—	(6,422)	(5,843)	—	(5,843)	(579)	—	(579)
Net admitted deferred tax asset	$ 1,900,122	—	1,900,122	—	—	—	1,900,122	—	1,900,122

The valuation allowance adjustment to gross deferred tax assets as of December 31, 2016 and 2015 was $0 and $484,079, respectively. The net change in the total valuation allowance adjustments for the year ended December 31, 2016 was a decrease of $484,079. The net change in the total valuation allowance adjustments for the years ended December 31, 2016 and 2015 was $484,079 and $13,421,127, respectively.

The Company's income tax incurred and change in deferred income tax differs from the amount obtained by applying the federal statutory rate of 35% to income before income taxes as follows:

		2016	2015
Current income taxes incurred	$	13,415,237	(1,664,564)
Change in deferred income tax (without tax on unrealized gains and losses)		(1,900,122)	—
Total income tax reported	$	11,515,115	(1,664,564)
Gain (loss) before taxes	$	23,092,539	19,126,097
		35 %	35 %
Expected income tax benefit at 35% statutory rate		8,082,389	6,694,134
Increase (decrease) in actual tax reported resulting from:			
a. Tax-exempt interest		(85,924)	(22,098)
b. Health insurer fee		4,027,127	4,649,898
c. Meals and entertainment, lobbying expenses, etc.		489	3,057
d. Change in deferred taxes on nonadmittted assets		(24,486)	429,734
e. Statutory valuation allowance adjustment		(484,079)	(13,421,127)
f. Other		(401)	1,838
Total income tax benefit reported	$	11,515,115	(1,664,564)

As of December 31, 2016, the Company had no net operating loss or tax credit carryforwards available for tax purposes.

The Company does not have any tax loss contingencies for which it is reasonably possible that the total liability will significantly increase within 12 months of the reporting date.

The following is income tax expense for 2015 and 2016 that is available for recoupment in the event of future net losses:

Year		Ordinary	Capital	Total
2015	$	—	—	—
2016		13,416,215	—	13,416,215
Total	$	13,416,215	—	13,416,215

The aggregate amount of deposits admitted under Section 6603 of the Internal Revenue Code is $0.

The Company's federal income tax return is consolidated with:

Absolute Total Care, Inc.
Bankers Reserve Life Insurance Company of Wisconsin
Buckeye Community Health Plan, Inc.
California Health & Wellness Plan
CeltiCare Health Plan of Massachusetts, Inc.
Cenpatico of Arizona, Inc.
Coordinated Care Corporation
Coordinated Care of Washington, Inc.
Envolve Vision of Texas, Inc.
Fidelis SecureCare of Michigan, Inc.
Granite State Health Plan, Inc.
Hallmark Life Insurance Co.
Home State Health Plan, Inc.
IlliniCare Health Plan, Inc.
Kentucky Spirit Health Plan, Inc.
Louisiana Healthcare Connections, Inc.
Magnolia Health Plan, Inc.
Managed Health Services Insurance Corp.
Nebraska Total Care, Inc.
Peach State Health Plan, Inc.
Sunshine Health Community Solutions, Inc.
Sunshine State Health Plan, Inc.
Superior Health Plan, Inc.
Trillium Community Health Plan, Inc.

The method of allocation among companies is subject to a written agreement whereby allocation is made primarily on a separate company basis using the percentage method pursuant to provisions of Internal Revenue Code (IRC) Sections 1502 and 1552 and Treasury Regulations 1.1502 and 1.1552. This percentage method allocates a tax asset (i.e., intercompany receivable) for any benefit derived by the consolidated group for the member's losses or credits that offset consolidated taxable income. In accordance with the tax sharing agreement, each member shall pay to Centene or receive from Centene the amount of tax liability or benefit reported on each member's pro forma federal income tax return within 90 days of the date Centene files its consolidated federal income tax return.

(6) Claims Payable

Following is a summary of claims-related expenses and payments during 2016 and 2015:

		2016	2015
Balance at January 1, net of reinsurance ceded of $3,245,739 and $1,801,212, respectively	$	85,792,812	91,649,311
Incurred related to current year		986,853,521	1,023,503,959
Incurred related to prior year		(26,301,446)	(13,381,016)
Total incurred		960,552,075	1,010,122,943
Paid related to current year		906,017,003	939,449,090
Paid related to prior year		58,650,325	76,530,352
Total paid		964,667,328	1,015,979,442
Balance at December 31, net of reinsurance ceded of $4,892,649 and $3,245,739, respectively		81,677,559	85,792,812
Less accrued medical incentive pool and bonus payment		—	571,384
Net balance at December 31	$	81,677,559	85,221,428

The incurred amounts related to prior year represent the variation between the Company's estimated claims and loss adjustment experience for prior year's claims and the actual amounts required to satisfy such claims. During 2016 and 2015, the Company experienced approximately $26,301,446 and $13,381,016 of favorable development on prior year claims, respectively, generally as the result of ongoing analysis of recent loss development trends. Original estimates are increased or decreased as additional information becomes known regarding individual claims.

(7) Related-Party Transactions

In addition to the reinsurance agreement in note 4 to the financial statements, the Company's transactions, amounts due (to), and admitted amounts due from related parties in exchange for services provided for the years ended December 31, 2016 and 2015 are detailed as follows:

Affiliate	Expense 2016	Expense 2015	Amount due from (to) 2016	Amount due from (to) 2015	Services provided
Cenpatico Behavioral Health, LLC	$ 89,681,221	91,472,060	1,369,030	4,182,597	Behavioral health*
Centene Management Company, LLC	86,458,762	86,655,594	483,990	461,979	General management services
Envolve Dental, Inc fka Dental Health and Wellness	24,685,113	23,716,856	287,193	(181,933)	Managed dental*
Envolve PeopleCare, Inc fka NurseWise LP and fka Nurtur Health, Inc.	2,579,992	3,938,378	(212,980)	4,104	Nurse-line triage and Life and health management*
Envolve Vision, Inc fka Opticare Vision Company, Inc.	8,487,952	8,256,031	(753,270)	(660,957)	Managed vision*
Envolve Pharmacy Solutions, Inc fka US Script, Inc.	138,852,575	145,942,872	(110,667)	13,167	Pharmacy benefits management*
Lifeshare Management Group	1,434,220	1,404,973	(602,207)	(2,583)	Specialized care management*
U.S. Medical Management	179,668	135,282	(122,554)	(71,125)	In-home health services*

* Amounts due to affiliates reflected in claims payable on statutory statements of admitted assets, liabilities, and capital and surplus as of December 31, 2016 and 2015.

The Company received no surplus contributions for the years ended December 31, 2016 and 2015, respectively, from its parent company, Centene Corporation. The Company paid dividends totaling $13,000,000 and $0 for the years ended December 31, 2016 and 2015, respectively, to its parent company, Centene Corporation. Amounts due from affiliates includes capital contributions receivable of $0 and $0 at December 31, 2016 and 2015, respectively.

(8) Statutory Net Worth and Risk-Based Capital Requirements

Under the laws of the State of Kansas, the Company is required to maintain a minimum statutory net worth based upon the NAIC Managed Care Organizations Risk-Based Capital (RBC). As of December 31, 2016 and 2015, the Company's adjusted capital and surplus exceeded the thresholds set forth by the NAIC RBC formula. The minimum requirement as of December 31, 2016 and 2015 was $73,175,150 and $76,546,458, respectively, or 200% of the Authorized Control Level RBC, and the Company's actual total adjusted capital was $133,296,145 and $134,788,841, respectively.

(9) Contingencies

From time to time, the Company is involved in litigation arising in the ordinary course of operations. While the results of litigation cannot be predicted with certainty, management is of the opinion, after reviewing these matters with legal counsel, that the final outcome of such litigation, if any, will not have a material adverse effect on the Company's financial position.

(10) Fair Value of Financial Instruments

Assets and liabilities recorded at fair value in statutory statements of admitted assets, liabilities, and capital and surplus are categorized based upon the extent to which the fair value estimates are based upon observable or unobservable inputs. Level inputs are as follows:

Level input	Input definition
Level I	Inputs are unadjusted, quoted prices for identical assets or liabilities in active markets at the measurement date.
Level II	Inputs other than quoted prices included in Level I that are observable for the asset or liability through corroboration with market data at the measurement date
Level III	Unobservable inputs that reflect management's best estimate of what market participants would use in pricing the asset or liability at the measurement date

The carrying values and estimated fair values of the Company's financial instruments at December 31, 2016 and 2015 were as follows:

	December 31, 2016					
Type of financial instrument	Aggregate fair value	Admitted assets	Level I	Level II	Level III	Not practicable (carrying value)
Cash and cash equivalents	$ 57,414,943	57,414,943	57,414,943	—	—	—
Short-term investments – at fair value	1,590,418	1,592,579	—	1,590,418	—	—
Bonds	57,042,670	57,700,695	3,651,906	53,390,764	—	—

	December 31, 2015					
Type of financial instrument	Aggregate fair value	Admitted assets	Level I	Level II	Level III	Not practicable (carrying value)
Cash and cash equivalents	$ 41,200,916	41,200,916	41,200,916	—	—	—
Short-term investments – at fair value	10,513,690	10,508,849	10,000,000	513,690	—	—
Bonds	23,184,591	23,222,954	3,310,636	19,873,955	—	—

(11) Risks and Uncertainties

The Company's profitability depends in large part on accurately predicting and effectively managing medical services costs. The Company continually reviews its premium and benefit structure to reflect its underlying claims experience and revised actuarial data; however, several factors could adversely affect the medical service costs. Certain of these factors, which include changes in healthcare practices, inflation, new technologies, major epidemics, natural disasters, and malpractice litigation, are beyond any health plan's control and could adversely affect the Company's ability to accurately predict and effectively control healthcare costs. Costs in excess of those anticipated could have a material adverse effect on the Company's results of operations.

(12) Subsequent Events

In connection with the preparation of the statutory financial statements, the Company evaluated subsequent events after the statutory statement of admitted assets, liabilities, and capital and surplus date of December 31, 2016 through April 21, 2017, which was the date the statutory statements were issued.

The Company is subject to an annual fee under Section 9010 of the Affordable Care Act (ACA). This annual fee will be allocated to individual health insurers based on the ratio of the amount of the entity's net premiums written during the preceding calendar year to the amount of health insurance for any U.S. health risk that is written during the preceding calendar year. A health insurance entity's portion of the annual fee becomes payable once the entity provides health insurance for any U.S. health risk for each calendar year beginning on or after January 1 of the year the fee is due. During the year ended December 31, 2016, the Company recorded $11,506,076 of nondeductible expense for the ACA annual health insurer fee based on net assessable premium of $645,485,001, which was paid on September 30, 2016. The Consolidated Appropriations Act, 2016 amended the effective date of Section 9010 of the ACA to apply to those calendar years beginning after December 31, 2013 and ending before January 1, 2017, as well as those calendar years beginning after December 31, 2017.

	Current year	Prior year
A. Did the reporting entity write accident and health insurance premium that is subject to Section 9010 of the federal Affordable Care Act?	N/A	Yes
B. ACA fee assessment payable for the upcoming year	$ —	12,395,549
C. ACA fee assessment paid	11,506,076	13,285,424
D. Premium written subject to ACA 9010 assessment	—	645,485,001
E. Total adjusted capital before surplus adjustment	—	134,788,843
F. Total adjusted capital after surplus adjustment	—	122,393,294
G. Authorized control level	—	38,273,229
H. Would reporting the ACA assessment as of December 31, 2015 have triggered an RBC action level?	N/A	No

Schedule 1

SUNFLOWER STATE HEALTH PLAN, INC.
(A Wholly Owned Subsidiary of Centene Corporation)

Supplemental Summary Investment Schedule

December 31, 2016

	Gross investment holdings		Admitted assets	
Bonds:				
U.S. Treasury securities	$ 641,094	0.5%	$ 641,094	0.5%
U.S. government agency obligations	3,018,419	2.6	3,018,419	2.6
Securities issued by states, territories, and possessions and political subdivisions in the U.S.:				
States and territories general obligations	521,578	0.4	521,578	0.4
Political subdivisions general obligations	2,071,817	1.8	2,071,817	1.8
Revenue and assessment obligations	21,424,832	18.4	21,424,832	18.4
Industrial development obligations	905,645	0.8	905,645	0.8
Mortgage-backed securities:				
Issued or guaranteed by FNMA and FHLMC	457,904	0.4	457,904	0.4
All other	2,926,262	2.5	2,926,262	2.5
Other debt and other fixed-income securities:				
Unaffiliated domestic securities	17,861,101	15.3	17,861,101	15.3
Unaffiliated non-U.S. securities	7,872,043	6.7	7,872,043	6.7
Cash and short-term investments	59,007,522	50.6	59,007,522	50.6
Total invested assets	$ 116,708,217	100.0%	$ 116,708,217	100.0%

See accompanying independent auditors' report.

Schedule 2

SUNFLOWER STATE HEALTH PLAN, INC.
(A Wholly Owned Subsidiary of Centene Corporation)

Supplemental Investment Risk Interrogatories

Year ended December 31, 2016

1. The Company's total admitted assets as of December 31, 2016 were: $ 254,018,517

2. The following are the 10 largest exposures to a single issuer, excluding U.S. government, U.S. government agency securities, and U.S. Government money market funds:

1. Protective Life Global Funding – Bonds	$ 2,212,980	0.87 %
2. State of Michigan – Bonds	1,536,366	0.60
3. Gilead Sciences, Inc – Bonds	1,398,896	0.55
4. Pennsylvania Economic Development Financing Authority – Bonds	1,386,463	0.55
5. County of Lee, Florida – Bonds	1,374,196	0.54
6. Avis Budget Rental Car Funding (AESOP) LLC – Bonds	1,202,550	0.47
7. Great Lakes Water Authority – Bonds	1,199,433	0.47
8. HSBC Holdings PLC – Bonds	1,172,255	0.46
9. Cisco Systems, Inc. – Bonds	1,098,893	0.43
10. Illinois Housing Development Authority (Inc) – Bonds	1,010,000	0.40

3. The amounts and percentages of the Company's total admitted assets held in bonds and preferred stocks by NAIC rating is as follows:

	Bonds	
Rating	**Amount**	**Percentage**
NAIC-1	$ 51,627,755	20.32 %
NAIC-2	7,635,669	3.01
NAIC-3	29,850	0.01

4. The amounts and percentages of the Company's total admitted assets held in foreign investments are as follows:

	Foreign investments	
	Amount	**Percentage**
Total	$ 7,837,058	3.09 %

5. The amounts and percentages of the Company's total admitted assets held in foreign investments by NAIC sovereign designation are as follows:

Rating	Amount	Percentage
NAIC-1	7,837,058	3.09 %
NAIC-2	—	—
NAIC-3 or below	—	—

6. The following are the 2 largest investment exposures to a single country by NAIC sovereign designation:
Countries designated NAIC-1

Country	Amount	Percentage
United Kingdom	2,117,606	0.83 %
Japan	1,574,474	0.62

10. The following are the 10 largest investments in foreign issues, excluding governmental:

	Rating	Amount	Percentage
1. HSBC Holdings PLC	NAIC-1	1,172,255	0.46 %
2. Mizuho Financial Group, Inc.	NAIC-1	850,000	0.33
3. Mitsubishi UFJ Financial Group, Inc.	NAIC-1	724,474	0.29
4. Flex Ltd.	NAIC-2	652,004	0.26
5. BMW US Capital, LLC	NAIC-1	600,000	0.24
6. Air Liquide Finance SA	NAIC-1	598,547	0.24
7. BPCE SA	NAIC-1	498,885	0.20
8. B.A.T. International Finance P.L.C.	NAIC-1	480,385	0.19
9. Shell International Finance B.V.	NAIC-1	473,142	0.19
10. ING Bank NV	NAIC-1	400,000	0.16

All other interrogatories in Section 2 of Appendix A-001 to the NAIC *Accounting Practices and Procedures Manual* have not been disclosed as they are not applicable.

See accompanying independent auditors' report.

sunflower
health plan®

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

(Mark One)

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the fiscal year ended December 31, 2016

or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the transition period from to

Commission file number: 001-31826

Centene Corporation

(Exact name of registrant as specified in its charter)

Delaware	**42-1406317**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification Number)
7700 Forsyth Boulevard **St. Louis, Missouri**	**63105**
(Address of principal executive offices)	(Zip Code)

Registrant's telephone number, including area code: (314) 725-4477

Securities registered pursuant to Section 12(b) of the Act:

Common Stock, $0.001 Par Value	**New York Stock Exchange**
Title of Each Class	Name of Each Exchange on Which Registered

Securities registered pursuant to Section 12(g) of the Act:

None

(Title of Each Class)

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was require to submit and post such files). Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☒

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of “large accelerated filer”, “accelerated filer” and “small reporting company” in Rule 12b-2 of the Exchange Act.

☒ Large accelerated filer	☐ Accelerated filer
☐ Non-accelerated filer (do not check if a smaller reporting company)	☐ Smaller reporting company

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). Yes ☐ No ☒

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant, based upon the last reported sale price of the common stock on the New York Stock Exchange on June 30, 2016, was $12.2 billion.

As of February 17, 2017, the registrant had 172,028,161 shares of common stock issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Proxy Statement for the registrant's 2017 annual meeting of stockholders are incorporated by reference in Part III, Items 10, 11, 12, 13 and 14.

CENTENE CORPORATION
ANNUAL REPORT ON FORM 10-K
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CAUTIONARY STATEMENT ON FORWARD-LOOKING STATEMENTS

All statements, other than statements of current or historical fact, contained in this filing or incorporated by reference herein are forward-looking statements. We intend such forward looking statements to be covered by the safe-harbor provisions for forward-looking statements contained in the Private Securities Litigation Reform Act of 1995, and we are including this statement for purposes of complying with these safe-harbor provisions. We have attempted to identify these statements by terminology including "believe," "anticipate," "plan," "expect," "estimate," "intend," "seek," "target," "goal," "may," "will," "would," "could," "should," "can," "continue" and other similar words or expressions (and the negative thereof) in connection with, among other things, any discussion of future operating or financial performance. In particular, these statements include without limitation statements about our market opportunity, our growth strategy, competition, expected activities and future acquisitions, investments and the adequacy of our available cash resources. These statements may be found in the various sections of this filing, such as Part II, Item 7. *"Management's Discussion and Analysis of Financial Condition and Results of Operations,"* Part I, Item 3. *"Legal Proceedings,"* and Part I, Item 1A. *"Risk Factors."* Readers are cautioned that matters subject to forward-looking statements involve known and unknown risks and uncertainties, including economic, regulatory, competitive and other factors that may cause our or our industry's actual results, levels of activity, performance or achievements to be materially different from any future results, levels of activity, performance or achievements expressed or implied by these forward-looking statements. These statements are not guarantees of future performance and are subject to risks, uncertainties and assumptions.

All forward-looking statements included in this filing are based on information available to us on the date of this filing. Except as may be otherwise required by law, we undertake no obligation to update or revise the forward-looking statements included in this filing, whether as a result of new information, future events or otherwise, after the date of this filing. You should not place undue reliance on any forward looking statements, as actual results may differ materially from projections, estimates, or other forward-looking statements due to a variety of important factors, including but not limited to:

- our ability to accurately predict and effectively manage health benefits and other operating expenses and reserves;
- competition;
- membership and revenue declines or unexpected trends;
- changes in healthcare practices, new technologies, and advances in medicine;
- increased health care costs;
- changes in economic, political or market conditions;
- changes in federal or state laws or regulations, including changes with respect to government health care programs as well as changes with respect to the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act and any regulations enacted thereunder that may result from changing political conditions;
- rate cuts or other payment reductions or delays by governmental payors and other risks and uncertainties affecting our government businesses;
- our ability to adequately price products on federally facilitated and state based Health Insurance Marketplaces;
- tax matters;
- disasters or major epidemics;
- the outcome of legal and regulatory proceedings;
- changes in expected contract start dates;
- provider, state, federal and other contract changes and timing of regulatory approval of contracts;
- the expiration, suspension, or termination of our contracts with federal or state governments (including but not limited to Medicaid, Medicare, and TRICARE);
- challenges to our contract awards;
- cyber-attacks or other privacy or data security incidents;
- the possibility that the expected synergies and value creation from acquired businesses, including, without limitation, the acquisition of Health Net, Inc., will not be realized, or will not be realized within the expected time period, including, but not limited to, as a result of conditions, terms, obligations or restrictions imposed by regulators in connection with their approval of, or consent to, the acquisition;
- the exertion of management's time and our resources, and other expenses incurred and business changes required in connection with complying with the undertakings in connection with certain regulatory approvals;
- disruption from the acquisition making it more difficult to maintain business and operational relationships;
- the risk that unexpected costs will be incurred in connection with, among other things, the acquisition and/or the integration;
- changes in expected closing dates, estimated purchase price and accretion for acquisitions;
- the risk that acquired businesses will not be integrated successfully;
- our ability to maintain or achieve improvement in the Centers for Medicare and Medicaid Services (CMS) Star ratings and other quality scores that impact revenue;

- availability of debt and equity financing, on terms that are favorable to us;
- inflation; and
- foreign currency fluctuations.

This list of important factors is not intended to be exhaustive. We discuss certain of these matters more fully, as well as certain other risk factors that may affect our business operations, financial condition and results of operations, in our filings with the Securities and Exchange Commission, including our annual reports on Form 10-K, quarterly reports on Form 10-Q and current reports on Form 8-K. Item 1A. "*Risk Factors*" of Part I of this filing contains a further discussion of these and other important factors that could cause actual results to differ from expectations. Due to these important factors and risks, we cannot give assurances with respect to our future performance, including without limitation our ability to maintain adequate premium levels or our ability to control our future medical costs.

Non-GAAP Financial Presentation

The Company is providing certain non-GAAP financial measures in this report as the Company believes that these figures are helpful in allowing investors to more accurately assess the ongoing nature of the Company's operations and measure the Company's performance more consistently across periods. The Company uses the presented non-GAAP financial measures internally to allow management to focus on period-to-period changes in the Company's core business operations. Therefore, the Company believes that this information is meaningful in addition to the information contained in the GAAP presentation of financial information. The presentation of this additional non-GAAP financial information is not intended to be considered in isolation or as a substitute for the financial information prepared and presented in accordance with GAAP.

Specifically, the Company believes the presentation of non-GAAP financial information that excludes Health Net acquisition related expenses, amortization of acquired intangible assets, as well as other items, allows investors to develop a more meaningful understanding of the Company's performance over time. The tables below provide reconciliations of non-GAAP items ($ in millions, except per share data):

	Year Ended December 31,		
	2016	2015	2014
GAAP net earnings from continuing operations	$ 559	$ 356	$ 268
Health Net acquisition related expenses	234	27	—
Amortization of acquired intangible assets	147	24	16
California minimum medical loss ratio change [1]	(195)	—	—
Charitable contribution [2]	50	—	—
Debt extinguishment [3]	11	—	—
Income tax effects of adjustments [4]	(79)	(20)	(6)
Adjusted net earnings from continuing operations	$ 727	$ 387	$ 278

(1) A favorable impact associated with the retroactive contract amendment received in the fourth quarter of 2016 that changed the minimum medical loss ratio (MLR) calculation under California's Medicaid expansion program, $195 million of which relates to periods prior to 2016 for the legacy Centene business and prior to the acquisition date for the legacy Health Net business.

(2) In connection with the additional revenue associated with the California minimum MLR change, the Company committed to a charitable contribution to its foundation of $50 million in the fourth quarter of 2016.

(3) Additional expense of $11 million associated with the early redemption of the Centene 5.75% Senior Notes due 2017 and the Health Net 6.375% Senior Notes due 2017.

(4) The income tax effects of adjustments are based on the effective income tax rates applicable to adjusted (non-GAAP) results. The amounts are based on the effective income tax rate that would increase or decrease based on the exclusion of these adjustments.

	Year Ended December 31,		
	2016	2015	2014
GAAP diluted earnings per share (EPS)	$ 3.41	$ 2.89	$ 2.23
Health Net acquisition related expenses [1]	0.98	0.14	—
Amortization of acquired intangible assets [2]	0.57	0.11	0.08
California minimum MLR change [3]	(0.76)	—	—
Charitable contribution [4]	0.19	—	—
Debt extinguishment [5]	0.04	—	—
Adjusted Diluted EPS	$ 4.43	$ 3.14	$ 2.31

(1) The Health Net acquisition related expenses per diluted share are net of the income tax benefit of $0.45 and $0.08 for the years ended December 31, 2016 and 2015, respectively.

(2) The amortization of acquired intangible assets per diluted share are net of the income tax benefit of $0.33, $0.08, and $0.05 for the years ended December 31, 2016, 2015 and 2014, respectively.

(3) The impact associated with the retroactive contract amendment received in the fourth quarter of 2016 that changed the minimum MLR calculation per diluted share is net of the income tax expense of $(0.43) for the year ended December 31, 2016.

(4) The charitable contribution per diluted share is net of the income tax benefit of $0.11 for the year ended December 31, 2016.

(5) The debt extinguishment cost per diluted share is net of the income tax benefit of $0.03 for the year ended December 31, 2016.

	Year Ended December 31,		
	2016	2015	2014
GAAP selling, general and administrative expenses	$ 3,676	$ 1,802	$ 1,298
Health Net acquisition related expenses	234	27	—
Selling, general and administrative expenses, excluding Health Net acquisition related expenses	$ 3,442	$ 1,775	$ 1,298

	Year Ended December 31,	
	2016	2015
Net earnings from continuing operations attributable to Centene Corporation	$ 559	$ 356
Income tax expense	599	339
Interest expense	217	43
Depreciation and amortization	281	112
Non-cash stock compensation expense	148	71
Adjusted EBITDA [1]	$ 1,804	$ 921

(1) Adjusted EBITDA represents net earnings attributable to Centene Corporation excluding income tax expense, interest expense, depreciation, amortization (excluding senior note premium amortization) and non-cash stock compensation expense.

PART I
ITEM 1. ***Business***

OVERVIEW

We are a diversified, multi-national healthcare enterprise that provides a portfolio of services to government sponsored healthcare programs, focusing on under-insured and uninsured individuals. We provide member-focused services through locally based staff by assisting in accessing care, coordinating referrals to related health and social services and addressing member concerns and questions. We also provide education and outreach programs to inform and assist members in accessing quality, appropriate healthcare services. We believe our local approach, including member and provider services, enables us to provide accessible, quality, culturally-sensitive healthcare coverage to our communities. Our health management, educational and other initiatives are designed to help members best utilize the healthcare system to ensure they receive appropriate, medically necessary services and effective management of routine, severe and chronic health problems, resulting in better health outcomes. We combine our decentralized local approach for care with a centralized infrastructure of support functions such as finance, information systems and claims processing.

On March 24, 2016, we acquired all of the issued and outstanding shares of Health Net, Inc. (Health Net) a publicly traded managed care organization that delivers healthcare services through health plans and government-sponsored managed care plans. The transaction was valued at approximately $5,990 million, including the assumption of $703 million of outstanding debt. The acquisition allows us to offer a more comprehensive and scalable portfolio of solutions and provides opportunity for additional growth across the combined company's markets.

We operate in two segments: Managed Care and Specialty Services. Our Managed Care segment provides health plan coverage to individuals through government subsidized programs, including Medicaid, that also encompasses the State Children's Health Insurance Program (CHIP), Long Term Care (LTC), Foster Care, dual-eligible individuals (Duals), the Supplemental Security Income Program, also known as the Aged, Blind or Disabled Program (ABD), Medicare, and Health Insurance Marketplace. The Managed Care segment also includes the operations previously included in Health Net's Western Region Operations Segment, with the exception of certain operations of its pharmaceutical services and behavioral health subsidiaries. The portions of Health Net's Western Region Operations segment included in the Managed Care segment consist of the following Health Net operations: commercial, Medicare, Medicaid and dual eligible health plans, primarily in Arizona, California, Oregon and Washington. Our Specialty Services segment consists of our specialty companies offering diversified healthcare services and products to state programs, correctional facilities, healthcare organizations, employer groups and other commercial organizations, as well as to our own subsidiaries. The Specialty Services segment also includes the operations previously included in the Government Contracts segment of Health Net as well as certain operations of its pharmaceutical services and behavioral health subsidiaries, the latter of which Health Net previously included in its Western Region Operations segment. The Government Contracts business includes our government-sponsored managed care support contract with the U.S. Department of Defense (DoD) under the TRICARE program in the North Region, the Military Family and Life Counseling (MFLC) contract with the DoD, and other health care related government contracts, including the Patient Centered Community Care (PC3) with the U.S. Department of Veterans Affairs (VA). For the year ended December 31, 2016, our Managed Care and Specialty Services segments accounted for 92% and 8%, respectively, of our total external revenues.

Our managed care membership totaled 11.4 million as of December 31, 2016. For the year ended December 31, 2016, our total revenues and net earnings from continuing operations attributable to Centene were $40.6 billion and $559 million, respectively, and our total cash flow from operations was $1,851 million.

Our subsidiary, Kentucky Spirit Health Plan (Kentucky Spirit), ceased serving members in Kentucky as of July 6, 2013. Accordingly, the results of operations for Kentucky Spirit are classified as discontinued operations for all periods presented in our consolidated financial statements. The following discussion and analysis, with the exception of cash flow information, is presented in the context of continuing operations unless otherwise identified.

Our initial health plan commenced operations in Wisconsin in 1984. We were organized in Wisconsin in 1993 as a holding company for our initial health plan and reincorporated in Delaware in 2001. Our corporate office is located at 7700 Forsyth Boulevard, St. Louis, Missouri 63105, and our telephone number is (314) 725-4477. Our stock is publicly traded on the New York Stock Exchange under the ticker symbol “CNC.”

INDUSTRY

We provide a full spectrum of managed healthcare products and services, primarily through Medicaid, which includes CHIP, LTC, Foster Care, Duals, and ABD, Medicare, Health Insurance Marketplace, TRICARE, and other state and federal programs, including programs for the uninsured. We also offer a variety of individual, small group, and large group commercial health care products, both to employers and directly to members.

Medicaid

Established in 1965, Medicaid is the largest publicly funded program in the United States, and provides health insurance to low-income families and individuals with disabilities. Authorized by Title XIX of the Social Security Act, Medicaid is an entitlement program funded jointly by the federal and state governments and administered by the states. The majority of funding is provided at the federal level. Each state establishes its own eligibility standards, benefit packages, payment rates and program administration within federal standards. As a result, there are 56 Medicaid programs - one for each U.S. state, each U.S. territory and the District of Columbia. Eligibility is based on a combination of household income and assets, often determined by an income level relative to the federal poverty level. Historically, children have represented the largest eligibility group. Many states have selected Medicaid managed care as a means of delivering quality healthcare and controlling costs. We refer to these states as mandated managed care states.

Established in 1972, and authorized by Title XVI of the Social Security Act of 1935, as amended, ABD covers low-income persons with chronic physical disabilities or behavioral health impairments. ABD beneficiaries represent a growing portion of all Medicaid recipients. In addition, ABD recipients typically utilize more services because of their critical health issues.

The Balanced Budget Act of 1997 created CHIP to help states expand coverage primarily to children whose families earned too much to qualify for Medicaid, yet not enough to afford private health insurance. Some states include the parents of these children in their CHIP programs. Costs related to the largest eligibility group, children, are primarily composed of pediatrics and family care. These costs tend to be more predictable than those associated with other healthcare issues which predominantly affect the adult population.

CMS estimated the total Medicaid market was approximately $545 billion in 2015, and estimate the market will grow to $973 billion by 2025. Medicaid spending increased by 9.7% in 2015 and is projected to increase at an average annual rate of 5.9% between 2016 and 2025.

LTC is a Medicaid product that covers Institutional/Residential Care (Nursing Facilities, Intermediate Care Facilities) and Home and Community Based Services (HCBS) for beneficiaries requiring assistance with their activities of daily living, such as bathing, dressing and transferring. The most common HCBS services include personal care, adult day care, non-emergent transportation, home-delivered meals and personal emergency response systems. LTC services are provided for individuals requiring nursing home level of care, receiving waiver services, or who are entitled to state Medicaid LTC benefits. The largest group receiving LTC, by spending, are older individuals and individuals with physical disabilities ($93 billion in 2014), followed by individuals with intellectual and developmental disabilities ($42 billion in 2014), those with serious mental illness and/or serious emotional disturbance ($9 billion in 2014) and other populations ($8 billion in 2014). States are increasingly turning to managed care as a solution to provide coordinated, holistic care to their LTC beneficiaries. According to the National Association of States United for Aging and Disabilities, 22 states utilize some form of LTC up from eight in 2004.

While Medicaid programs have directed funds to many individuals who cannot afford or otherwise maintain health insurance coverage, they did not initially address the inefficient and costly manner in which the Medicaid population tends to access healthcare. Medicaid recipients in non-managed care programs typically have not sought preventive care or routine treatment for chronic conditions, such as asthma and diabetes. Rather, they have sought healthcare in hospital emergency rooms, which tends to be more expensive. As a result, many states have found that the costs of providing Medicaid benefits have increased while the medical outcomes for the recipients remained unsatisfactory.

We believe recognition of the value of managed care as a means of delivering improved health outcomes for Medicaid beneficiaries and effectively controlling costs will continue to strengthen. A growing number of states have mandated that their Medicaid recipients enroll in managed care plans. Other states are considering moving to a mandated managed care approach. As a result, we believe a significant market opportunity exists for managed care organizations with operations and programs focused on the distinct socio-economic, cultural and healthcare needs of the uninsured population and the Medicaid, CHIP, LTC, Foster Care and ABD populations.

Medicare

We contract with CMS under the Medicare Advantage program to provide Medicare Advantage products directly to Medicare beneficiaries as well as through employer and union groups. We provide or arrange health care benefits for services normally covered by Medicare, plus a broad range of health care benefits for services not covered by traditional Medicare, usually in exchange for a fixed monthly premium per member from CMS that varies based upon the county in which the member resides, demographic factors of the member such as age, gender and institutionalized status, and the health status of the member. Any benefits that are not covered by Medicare may result in an additional monthly premium charged to the enrollee or through portions of payments received from CMS that may be allocated to these benefits, according to CMS regulations and guidance. Many of our Medicare Advantage members pay no monthly premium to us for these additional benefits.

We provide a wide range of Medicare products, including Medicare Advantage plans with and without prescription drug coverage and Medicare supplement products that supplement traditional fee-for-service Medicare coverage. Our subsidiaries have a number of contracts with CMS under the Medicare Advantage program authorized under Title XVIII of the Social Security Act of 1935, as amended.

A portion of Medicaid beneficiaries are dual-eligible, low-income seniors and people with disabilities who are enrolled in both Medicaid and Medicare. According to CMS, there were approximately 10.4 million dual-eligible enrollees in 2016. These dual-eligible members may receive assistance from Medicaid for benefits, such as nursing home care, HCBS, and/or assistance with Medicare premiums and cost sharing. Dual-eligibles also use more services due to their tendency to have more chronic health issues. We serve dual-eligibles through our ABD, LTC, Medicare-Medicaid Plan (MMP) and Medicare Advantage Dual Special Needs Plan lines of business.

CMS developed the Medicare Advantage Star Ratings system to help consumers choose among competing plans, awarding between 1.0 and 5.0 stars to Medicare Advantage plans based on performance in certain measures of quality. The Star Ratings are used by CMS to award quality bonus payments to Medicare Advantage plans. Beginning with the 2014 Star Rating (calculated in 2013), Medicare Advantage plans were required to achieve a minimum of 4.0 Stars to qualify for a quality bonus payment in 2016. The methodology and measures included in the Star Ratings system can be modified by CMS annually and Star Ratings thresholds are based on performance of Medicare Advantage plans nationally.

CMS estimated the total Medicare market was approximately $646 billion in 2015, and estimate the market will grow to $1.3 trillion by 2025. Medicare spending increased 4.5% in fiscal 2015 and is projected to increase at an average annual rate of 7.1% between 2016 and 2025.

Commercial

We offer commercial health care products to individuals and large and small employer groups as well as products to individuals through the Health Insurance Marketplace. Our health maintenance organization (HMO) plans offer comprehensive benefits generally for a fixed fee or premium that does not vary with the extent or frequency of medical services actually received by the member. We offer HMO plans with differing benefit designs and varying levels of co-payments at different premium rates. These plans are offered generally through contracts with participating network physicians, hospitals and other providers. When an individual enrolls in one of our HMO plans, he or she selects a primary care physician (PCP) from among the physicians participating in our network. Our preferred provider organization (PPO) plans offer coverage for services received from any health care provider, with benefits generally paid at a higher level when care is received from a participating network provider. Coverage typically is subject to deductibles and copayments or coinsurance. Our point of service (POS) plans and our elect open access (EOA) plans blend the characteristics of HMO, PPO and indemnity plans. Members can have comprehensive HMO-style benefits for services received from participating network providers with lower copayments (particularly within the medical group), but also have coverage, generally at higher copayment or coinsurance levels or with coverage limitations, for services received outside the network. Our Exclusive Provider Organization (EPO) plans and Healthcare Service Plans (HSPs) similarly blend elements of traditional HMO and PPO plans.

In 2010, the Patient Protection and Affordable Care Act and the accompanying Health Care and Education Affordability Reconciliation Act collectively referred to as the Affordable Care Act (ACA), were enacted. While the constitutionality of the ACA was subsequently challenged in a number of legal actions, in June 2012, the Supreme Court upheld the constitutionality of the ACA, with one limited exception relating to the Medicaid expansion provision (Medicaid Expansion). The Supreme Court held that states could not be required to expand Medicaid and risk losing all federal money for their existing Medicaid programs. Under the ACA, Medicaid coverage was expanded to all individuals under age 65 with incomes up to 138% of the federal poverty level beginning January 1, 2014, subject to the states' elections. The federal government will pay the entire costs for Medicaid Expansion coverage for newly eligible beneficiaries from 2014 through 2016. Assuming that the current program remains in effect unchanged, in 2017 the federal share is scheduled to decline to 95%; in 2018 it would be 94%; in 2019 it would be 93%; and it would be 90% in 2020 and subsequent years.

Health Insurance Marketplaces are a key component of the ACA and provide an opportunity for individuals and small businesses to obtain health insurance. States have the option of operating their own Marketplace or partnering with the federal government. States choosing neither option currently default to a federally-facilitated Marketplace. Premium and cost-sharing subsidies are available to make coverage more affordable and access to Marketplaces is limited to U.S. citizens and legal immigrants. Insurers are required to offer a minimum level of benefits with three levels of coverage that vary based on premiums and out-of-pocket costs. Premium subsidies are provided to families without access to other coverage and with incomes between 100-400% of the federal poverty level to help them purchase insurance through the Marketplaces. These subsidies are offered on a sliding scale basis.

OUR COMPETITIVE STRENGTHS

Our approach is based on the following key attributes:

- *Strong Historic Operating Performance.* We have increased revenues as we have grown in existing markets, expanded into new markets and broadened our product offerings. We entered the Wisconsin market in 1984 as a single health plan and have grown to serve 29 states. Our operating performance has been demonstrated by the following:

	2016	2015	% Change 2015 - 2016
Total membership (in millions)	11.4	5.1	124%
Total revenues ($ in billions)	$ 40.6	$ 22.8	78%
Net earnings from continuing operations attributable to Centene Corporation ($ in millions)	$ 559	$ 356	57%
Diluted earnings per share (EPS)	$ 3.41	$ 2.89	18%
Adjusted Diluted EPS	$ 4.43	$ 3.14	41%
Adjusted EBITDA	$ 1,804	$ 921	96%

  For the year ended December 31, 2016, total revenues of $40.6 billion produced a five year Compound Annual Growth Rate (CAGR) of 51%.

- *Innovative Technology and Scalable Systems.* The ability to access data and translate it into meaningful information is essential to operating across a multi-state service area in a cost-effective manner. Our centralized information systems support our core processing functions under a set of integrated databases and are designed to be both replicable and scalable to accommodate organic growth and growth from acquisitions. We continue to enhance our systems in order to leverage the platform we have developed for our existing states for configuration into new states or health plan acquisitions. We believe our predictive modeling technology enables our medical management operations to proactively case and disease manage specific high risk members. It can recommend medical care opportunities using a mix of company defined algorithms and evidence based medical guidelines. Interventions are determined by the clinical indicators, the ability to improve health outcomes, and the risk profile of members. We believe our integrated approach helps to assure that consistent sources of claim and member information are provided across all of our health plans. Our membership and claims processing system is capable of expanding to support additional members in an efficient manner.

- *Expertise in Government Sponsored Programs.* For more than 30 years, we have developed a specialized government services expertise that has helped us establish and maintain relationships with members, providers and state governments. We have implemented programs developed to achieve savings for state governments and improve medical outcomes for members by reducing inappropriate emergency room use, inpatient days and high cost interventions, as well as by managing care of chronic illnesses. We work with state agencies in order to maximize the effectiveness of their programs. Our approach is to accomplish this while maintaining adequate levels of provider compensation and protecting our profitability.

- *Diversified Business Lines.* We continue to broaden our service offerings to address areas that we believe have been traditionally under-served by Medicaid managed care organizations. In addition to our Medicaid and Medicaid-related managed care services, our service offerings include behavioral health management, care management software, correctional healthcare services, dental benefits management, Commercial, in-home health services, life and health management, managed vision, pharmacy benefits management, specialty pharmacy and telehealth services. With the acquisition of Health Net, we further broadened our service offerings in 2016, which added government-sponsored care under its federal contracts with the Department of Defense and the U.S. Department of Veterans Affairs (VA), as well as Medicare Advantage. Through the utilization of a multi-business line approach, we are able to improve the quality of care, improve outcomes, diversify our revenues and help control our medical costs.

- *Localized Approach with Centralized Support Infrastructure.* We take a localized approach to managing our subsidiaries, including provider and member services. This approach enables us to facilitate access by our members to high quality, culturally sensitive healthcare services. Our systems and procedures have been designed to address these community-specific challenges through outreach, education, transportation and other member support activities. For example, our community outreach programs work with our members and their communities to promote health and self-improvement through education on how best to access care. We complement this localized approach with a centralized infrastructure of support functions such as finance, information systems and claims processing, which allows us to minimize selling, general and administrative (SG&A) expenses and to integrate and realize synergies from acquisitions. We believe this combined approach allows us to efficiently integrate new business opportunities in both Medicaid and specialty services while maintaining our local accountability and improved access.

- *Quality and Innovation.* Our innovative medical management programs focus on improving quality of care in areas that have the greatest impact on our members. We concentrate on serving the whole person to impact outcomes and costs. We recognize the importance of member-focused delivery of quality managed care services and have developed award winning education and outreach programs including the CentAccount program, Start Smart For Your Baby, and MemberConnections.

OUR BUSINESS STRATEGY

Key components of our current business strategy include:

- *Increase Penetration of Existing State Markets.* We seek to continue to increase our Medicaid and Medicare membership in states in which we currently operate through alliances with key providers, outreach efforts, development and implementation of community-specific products and acquisitions. For example, in 2016, we began serving the STAR Kids Medicaid population in seven delivery areas in Texas. In 2017, we expect to expand our Medicare Advantage footprint into four of our existing states.

- *Diversify Business Lines.* We seek to broaden our business lines into areas that complement our existing business to enable us to grow and diversify our revenue. In 2016, we served managed care members in 24 states through over 250 product solutions. We are constantly evaluating new opportunities for expansion both domestically and abroad. For example, in 2016, we acquired Health Net, which broadened our service offerings and added government-sponsored care. We employ a disciplined acquisition strategy that is based on defined criteria including internal rate of return, accretion to earnings per share, market leadership and compatibility with our information systems. We engage our executives in the relevant operational units or functional areas to ensure consistency between the diligence and integration process.

- *Address Emerging State Needs.* We work to assist the states in which we operate in addressing the operating challenges they face. We seek to assist the states in balancing premium rates, benefit levels, member eligibility, policies and practices, provider compensation and minimizing fraud, waste, and abuse. By helping states structure appropriate programs to cover a wide range of populations including Medicaid, CHIP, LTC, ABD, IDD, and specialty services, among others. We seek to ensure that we are able to continue to provide those services on terms that achieve targeted gross margins, provide an acceptable return and grow our business.

- *Develop and Acquire Additional Markets.* We continue to leverage our experience to identify and develop new domestic and international markets by seeking both to acquire existing business and to build our own operations. Domestically, we focus expansion in states where Medicaid recipients are mandated to enroll in managed care organizations because we believe member enrollment levels are more predictable in these states. In addition, we provide solutions to states looking to deliver the highest quality of care within their budgetary constraints. In 2014, we entered the international market with our investment in Ribera Salud, S.A. (Ribera Salud), a Spanish health management group. In 2015, we began managing care for Medicaid members in Oregon and also began managing care for members who are dually eligible for Medicare and Medicaid in Michigan. In 2016, we increased our ownership interest to 75% in The Practice (Group) Limited (TPG), one of the largest provider networks for NHS England.

- *Leverage Established Infrastructure to Enhance Operating Efficiencies*. We intend to continue to invest in infrastructure to further drive efficiencies in operations and to add functionality to improve the service provided to members and other organizations at a low cost. Information technology, or IT, investments complement our overall efficiency goals by increasing the automated processing of transactions and growing the base of decision-making analytical tools. We believe that our centralized functions and common systems enable us to add members and markets quickly and economically.

- *Maintain Operational Discipline.* We seek to operate in markets that allow us to meet our internal metrics including membership growth, plan size, market leadership and operating efficiency. We use multiple techniques to monitor and reduce our medical costs, including on-site hospital review by staff nurses and involvement of medical management in significant cases. Our executive dashboard is utilized to quickly identify cost drivers and medical trends. Our management team regularly evaluates the financial impact of proposed changes in provider relationships, contracts, changes in membership and mix of members, potential state rate changes and cost reduction initiatives. We may divest contracts or health plans in markets where the environment, over a long term basis, does not allow us to meet our targeted performance levels. For example, due to under performance, we exited the Arizona individual PPO business, effective January 1, 2017. In addition, in 2016, we took various rate and product design actions for 2017 to address issues and improve profitability in connection with certain lines of business acquired with the Health Net acquisition.

We have subsidiaries offering healthcare services in each state we serve. The table below provides summary data for the state markets we currently serve:

State	Health Plan Name	First Year of Operations	Managed Care Membership at December 31, 2016 [1]
Arizona			598,300
	Cenpatico Integrated Care	2005	
	Bridgeway Health Solutions	2006	
	Health Net of Arizona, Inc.	1981	
	Health Net Access, Inc.	2013	
	Health Net Life Insurance Company	1987	
Arkansas	Arkansas Health and Wellness	2014	58,600
California			2,973,500
	California Health and Wellness	2013	
	Health Net of California, Inc.	1979	
	Health Net Community Solutions, Inc.	2005	
	Health Net Life Insurance Company	1987	
Florida			716,100
	Sunshine State Health Plan	2009	
	Celtic Insurance Company	2016	
Georgia			488,000
	Peach State Health Plan	2006	
	Ambetter of Peach State Inc.	2016	
Illinois			237,700
	IlliniCare Health	2011	
	Celtic Insurance Company	2016	
Indiana			285,800
	Managed Health Services	1996	
	Celtic Insurance Company	2015	
Kansas	Sunflower Health Plan	2013	139,700
Louisiana	Louisiana Healthcare Connections	2012	472,800

State	Health Plan Name	First Year of Operations	Managed Care Membership at December 31, 2016 [1]
Massachusetts			48,300
	CeltiCare Health	2009	
	Massachusetts Partnership for Correctional Healthcare LLC	2013	
Michigan	Fidelis SecureCare of Michigan, Inc.	2005	2,000
Minnesota	Centurion of Minnesota LLC	2014	9,400
Mississippi			310,200
	Magnolia Health	2011	
	Centurion of Mississippi LLC	2015	
	Ambetter of Magnolia Inc.	2015	
Missouri	Home State Health	2012	105,700
New Hampshire			77,400
	New Hampshire Healthy Families	2013	
	Celtic Insurance Company	2016	
New Mexico	Centurion Correctional Healthcare of New Mexico LLC	2016	7,100
Ohio	Buckeye Health Plan	2004	316,000
Oregon			217,800
	Trillium Community Health Plan	2001	
	Health Net Health Plan of Oregon, Inc.	1989	
	Health Net Life Insurance Company	1987	
South Carolina	Absolute Total Care	2007	122,500
Tennessee	Centurion of Tennessee LLC	2013	21,700
Texas			1,072,400
	Superior HealthPlan	1999	
	Superior HealthPlan Network	2004	
	Celtic Insurance Company	2016	
Vermont	Centurion of Vermont LLC	2015	1,600
Washington	Coordinated Care	2012	238,400
Wisconsin	Managed Health Services Insurance Corp	1984	73,800
Total at-risk membership			8,594,800
TRICARE eligibles		1988	2,847,000
Total			11,441,800

[1] Table includes members served in each of our states through our government sponsored programs, commercial, and correctional healthcare services.

Substantially all of our revenue is derived from operations within the United States and its territories, and all of the Company's long lived assets are based in the United States and its territories. We generally receive a fixed premium per member per month pursuant to our state contracts. Our medical costs have a seasonality component due to cyclical illness, for example cold and flu season, resulting in higher medical expenses beginning in the fourth quarter and continuing throughout the first quarter of the following year. Our managed care subsidiaries in California and Texas had revenues from their respective state governments that each exceeded 10% of our consolidated total revenues in 2016. In addition, the federal government is a significant customer to our Specialty Services segment due to our Federal Services business.

MANAGED CARE

Benefits to Customers

We feel that our ability to establish and maintain a leadership position in the markets we serve results primarily from our demonstrated success in providing quality care while reducing and managing costs, and from our specialized programs in working with state governments. Among the benefits we are able to provide to the states with which we contract are:

- *Significant cost savings and budget predictability compared to state paid reimbursement for services.* We bring experience relating to quality of care improvement methods, utilization management procedures, an efficient claims payment system, and provider performance reporting, as well as managers and staff experienced in using these key elements to improve the quality of and access to care. We generally receive a contracted premium on a per member basis and are responsible for the medical costs and as a result, provide budget predictability.

- *Data-driven approaches to balance cost and verify eligibility.* We seek to ensure effective outreach procedures for new members, then educate them and ensure they receive needed services as quickly as possible. Our IT department has created mapping/translation programs for loading membership and linking membership eligibility status to all of Centene's subsystems. We utilize predictive modeling technology to proactively case and disease manage specific high risk members. In addition, we have developed Centelligence, our enterprise data warehouse system to provide a seamless flow of data across our organization, enabling providers and case managers to access information, apply analytical insight and make informed decisions.

- *Establishment of realistic and meaningful expectations for quality deliverables.* We have collaborated with state agencies in redefining benefits, eligibility requirements and provider fee schedules with the goal of maximizing the number of individuals covered through Medicaid.

- *Managed care expertise in government subsidized programs.* Our expertise in Medicaid has helped us establish and maintain strong relationships with our constituent communities of members, providers and state governments. We provide access to services through local providers and staff that focus on the cultural norms of their individual communities. To that end, systems and procedures have been designed to address community-specific challenges through outreach, education, transportation and other member support activities.

- *Improved quality and medical outcomes.* We have implemented programs to enhance the ability of providers to improve the quality of healthcare delivered to our members including Start Smart for your Baby, Living Well With Sickle Cell and The CentAccount Program.

- *Timely payment of provider claims.* We are committed to ensuring that our information systems and claims payment systems meet or exceed state requirements. We continuously endeavor to update our systems and processes to improve the timeliness of our provider payments.

- *Provider outreach and programs.* Our health plans have adopted a physician-driven approach where network providers are actively engaged in developing and implementing healthcare delivery policies and strategies. We prepare provider comparisons on a severity adjusted basis. This approach is designed to eliminate unnecessary costs, improve services to members and simplify the administrative burdens placed on providers.

- *Care management for complex populations.* Through our experience with Medicaid populations and long-time presence in states with experience in long term care for children and adolescents in the foster care system, we have developed care management, service coordination and crisis prevention/response programs that increase opportunities for successful outcomes for members. This experience has led to partnerships with specialized networks and community advocates as states transition to managed care programs for vulnerable and complex populations.

- *Responsible collection and dissemination of utilization data.* We gather utilization data from multiple sources, allowing for an integrated view of our members' utilization of services. These sources include medical, vision and behavioral health claims and encounter data, pharmacy data, dental vendor claims and authorization data from the authorization and case management system utilized by us to coordinate care.

- *Timely and accurate reporting.* Our information systems have reporting capabilities which have been instrumental in identifying the need for new and/or improved healthcare and specialty programs. For state agencies, our reporting capability is important in demonstrating an auditable program.

- *Fraud, waste and abuse prevention.* We have several systems in place to help identify, detect and investigate potential waste, abuse and fraud including pre and post payment review software. We collaborate with state and federal agencies and assist with investigation requests. We use nationally recognized standards to benchmark our processes.

Member Programs and Services

We recognize the importance of member-focused delivery of quality managed care services. Our locally-based staff assists members in accessing care, coordinating referrals to related health and social services and addressing member concerns and questions. While covered healthcare benefits vary from customer to customer and program to program, our health plans generally provide the following services:

- primary and specialty physician care
- inpatient and outpatient hospital care
- emergency and urgent care
- prenatal care
- laboratory and x-ray services
- home health care
- provision of durable medical equipment
- behavioral health and substance abuse services
- 24-hour nurse advice line
- transportation assistance
- vision care
- dental care
- immunizations
- prescriptions and limited over-the-counter drugs
- specialty pharmacy
- therapies
- social work services
- care coordination

We also provide a comprehensive set of education and outreach programs to inform, assist and incentivize members to access quality, appropriate healthcare services in an efficient manner. Many of these programs have been recognized with awards for their excellence in education, outreach and/or case management techniques including Case In Point, Hermes Awards, U.S. Environmental Protection Agency and National Health Information Awards.

- *Start Smart For Your Baby,* or Start Smart, is our award winning prenatal and infant health program designed to increase the percentage of pregnant women receiving early prenatal care, reduce the incidence of low birth weight babies, identify high-risk pregnancies, increase participation in the federal Women, Infant and Children program, prevent hospital admissions in the first year of life and increase well-child visits.

- *Connections Plus* is a cell phone program developed for high-risk members who have limited or no safe and reliable access to telephone. This program seeks to eliminate lack of safe, reliable access to a telephone as a barrier to coordinating care, thus reducing avoidable adverse events such as inappropriate emergency room utilization, hospital admissions and premature birth.

- *MemberConnections* is a community face-to-face outreach and education program designed to create a link between the member and the provider and help identify potential challenges or risk elements to a member's health, such as nutritional challenges and health education shortcomings.

- *The ScriptAssist for Hepatitis C Adherence Program* seeks to empower patients towards Hepatitis C virus treatment success through a series of telephonic interventions. Goals of the program include preventing premature treatment discontinuation due to medication side effects and access to therapy. NurseWise clinicians and AcariaHealth patient care coordinators collaborate throughout a patient’s treatment course to ensure appropriate therapy management and regimen access.

- *Health Initiatives for Children* is aimed at educating child members on a variety of health topics. In order to empower and educate children, we have partnered with a nationally recognized children's author to develop our own children's book series on topics such as obesity prevention and healthy eating, asthma, diabetes, foster care, the ills of smoking, anti-bullying and heart health.

- *Health Initiatives for Teens* is aimed at empowering, educating and reinforcing life skills with our teenage members. We have developed an educational series that addresses health issues, dealing with chronic diseases including diabetes and asthma, as well as teen pregnancy.

- *Living Well with Sickle Cell* is our innovative program that assists with coordination of care for our sickle cell members. Our program ensures that sickle cell members have established a medical home and work on strategies to reduce unnecessary emergency room visits through proper treatment to control symptoms and chronic complications, as well as promote self-management.

- *My Route for Health* is our adult educational series used with our case management and disease management programs. The topics of this series include how to manage asthma, Chronic Obstructive Pulmonary Disease (COPD), diabetes, heart disease and HIV.

- *The Diabetes Management Program* is an innovative program that is a collaboration with our life and health management subsidiary and our health plans that targets diabetic patients and educates them on their disease state.

- *Community Health Record,* our patient-centric electronic database, collects patient demographic data, clinician visit records, dispensed medications, vital sign history, lab results, allergy charts, and immunization data. Providers can directly input additional or updated patient data and documentation into the database. All information is accessible anywhere, anytime to all authorized users, including health plan staff, greatly facilitating coordinated care among providers.

- *The CentAccount Program* offers members financial incentives for performing certain healthy behaviors. The incentives are delivered through a restricted-use prepaid debit card. This incentive-based approach effectively increases the utilization of preventive services while strengthening the relationships between members and their primary care providers.

- *The Asthma Management Program* integrates a hands-on approach with a flexible outreach methodology that can be customized to suit different age groups and populations affected by asthma. We provide proactive identification of members, stratification into appropriate levels of intervention including home visits, culturally sensitive education, and robust outcome reporting. The program also includes aggressive care coordination to ensure patients have basic services such as transportation to the doctor, electricity to power the nebulizer, and a clean, safe home environment.

- *Fluvention* is an outreach program aimed at educating members on preventing the transmission of the influenza virus by encouraging members to get the seasonal influenza vaccines and take everyday precautions to prevent illness.

- *Preventive Care Programs* are designed to educate our members on the benefits of Early and Periodic Screening, Diagnosis and Treatment, or EPSDT, services. We have a systematic program of communicating, tracking, outreach, reporting and follow-through that promotes state EPSDT programs.

- *Readmission Reduction Program* utilizes a proprietary scoring methodology to evaluate members' risks on preventable readmissions. Members with higher risk scores are identified at the point of admission to an acute care setting, then concurrently managed during the in-patient stay, and followed up with post discharge outreach to provide effective transition of care.

- *Clinical Programs Library (CPL)* is a highly collaborative initiative that empowers partners across the organization to develop evidence based clinical programs to promote best practice information sharing, and to establish measurable outcomes for clinical studies. The CPL also serves as a repository of enterprise pilots and programs intended to improve the member's health outcomes.

- *Promotores Health Network (PHN)* is a volunteer-driven community health network designed to improve the community's health through health education specific to health conditions impacting their community and providing guidance and linkage to healthcare services and local resources. PHN provides face-to-face education to members where they live, shop, worship and congregate.

- *myStrength ("The health club for your mind")* is a web and mobile self-help resource to manage depression, anxiety, substance use, and chronic pain. myStrength empowers members to be active participants in their journey to becoming and staying mentally and physically healthy.

Providers

For each of our service areas, we establish a provider network consisting of primary and specialty care physicians, hospitals and ancillary providers. Our network of primary care physicians is a critical component in care delivery, management of costs and the attraction and retention of new members. Primary care physicians include family and general practitioners, pediatricians, internal medicine physicians and obstetricians and gynecologists. Specialty care physicians provide medical care to members generally upon referral by the primary care physicians. Specialty care physicians include, but are not limited to, orthopedic surgeons, cardiologists and otolaryngologists. We also provide education and outreach programs to inform and assist members in accessing quality, appropriate healthcare services.

Our health plans facilitate access to healthcare services for our members primarily through contracts with our providers. Our contracts with primary and specialty care physicians and hospitals usually are for one to two-year periods and renew automatically for successive one-year terms, but generally are subject to termination by either party upon 90 to 120 days prior written notice. In the absence of a contract, we typically pay providers at applicable state or federal reimbursement levels, depending on the product timeline (e.g., Medicaid or Medicare). We pay providers under a variety of methods, including fee-for-service, capitation arrangements, or risk-sharing performance-based arrangements.

- Under our fee-for-service contracts with providers, we pay a negotiated fee for covered services. This model is characterized as having no financial risk for the provider.

- Under our capitated contracts, providers can be paid a set amount for their services as outlined in their respective provider agreements. A provider group's financial instability or failure to pay secondary providers for services rendered could lead secondary providers to demand payment from us, even though we have made our regular capitated payments to the provider group. Depending on state law and the regulatory environment, it may be necessary for us to pay such claims.

- Under risk-sharing performance-based arrangements, providers are paid under a capitated or fee-for-service arrangement. The arrangement, however, contains provisions for additional payments to the providers or reimbursement from the providers based upon cost and quality measures.

In addition, we maintain a network of qualified physicians, facilities, and ancillary providers in the prime service areas of our T-3 contract for the TRICARE North Region. Services are provided on a fee-for-service basis. We also maintain a provider network in Regions 1, 2, and 4 in support of VA's PC3 program.

We work with physicians to help them operate efficiently by providing financial and utilization information, physician and patient educational programs and disease and medical management programs. Our programs are also designed to help the physicians coordinate care rendered by other providers.

We believe our local and collaborative approach with physicians and other providers gives us a competitive advantage in entering new markets. Our physicians serve on local committees that assist us in implementing preventive care programs, managing costs and improving the overall quality of care delivered to our members, while also simplifying the administrative burdens on our providers. This approach has enabled us to strengthen our provider networks through improved physician recruitment and retention that, in turn, have helped to increase our membership base. The following are among the services we provide to support physicians:

- *Customized Utilization Reports* provide certain of our contracted physicians with information that enables them to run their practices more efficiently and focuses them on specific patient needs. For example, quarterly detail reports update physicians on their status within their risk pools. Equivalency reports provide physicians with financial comparisons of capitated versus fee-for-service arrangements.

- *Case Management Support* helps the physician coordinate specialty care and ancillary services for patients with complex conditions and direct members to appropriate community resources to address both their health and socio-economic needs.

- *Web-based Claims and Eligibility Resources* have been implemented to provide physicians with on-line access to perform claims and eligibility inquiries.

Our contracted physicians also benefit from several of the services offered to our members, including the MemberConnections, EPSDT case management and health management programs. For example, the MemberConnections staff facilitates doctor/patient relationships by connecting members with physicians, the EPSDT programs encourage routine checkups for children with their physicians and the health management programs assist physicians in managing their patients with chronic disease.

Where appropriate, our health plans contract with our specialty services organizations to provide services and programs such as behavioral health management, care management software, dental benefits management, in-home health services, life and health management, managed vision, pharmacy benefits management, specialty pharmacy and telehealth services. When necessary, we also contract with third-party providers on a negotiated fee arrangement for physical therapy, home healthcare, dental, diagnostic laboratory tests, x-ray examinations, transportation, ambulance services and durable medical equipment.

Quality Management

Our medical management programs focus on improving quality of care in areas that have the greatest impact on our members. We employ strategies, including health management and complex case management, which are adjusted for implementation in our individual markets by a system of physician committees chaired by local physician leaders. This process promotes physician participation and support, both critical factors in the success of any clinical quality improvement program.

We have implemented specialized information systems to support our medical quality management activities. Information is drawn from our data warehouse, clinical databases and our membership and claims processing system to identify opportunities to improve care and to track the outcomes of the interventions implemented to achieve those improvements. Some examples of these intervention programs include:

- appropriate leveling of care for neonatal intensive care unit hospital admissions, other inpatient hospital admissions, and observation admissions, in accordance with Interqual or Milliman criteria.

- tightening of our pre-authorization list and more stringent review of durable medical equipment and injectibles.

- Emergency room program designed to collaboratively work with hospitals to steer non-emergency care away from the costly emergency room setting (through patient education, on-site alternative urgent care settings, etc.).

- increase emphasis on case management and clinical rounding where case managers are nurses or social workers who are employed by the health plan to assist selected members with the coordination of healthcare services in order to meet a member's specific healthcare needs.

- incorporation of disease management, which is a comprehensive, multidisciplinary, collaborative approach to chronic illnesses such as asthma and diabetes.

- Start Smart For Your Baby, a prenatal case management program aimed at helping women with high-risk pregnancies deliver full-term, healthy infants.

- Pharmacy treatment compliance programs driven by clinical policy and focused on identifying the appropriate medication in the correct dose, delivered in an efficient format and utilized for the correct duration.

We provide reporting on a regular basis using our data warehouse. State and Health Employer Data and Information Set, or HEDIS, reporting constitutes the core of the information base that drives our clinical quality performance efforts. This reporting is monitored by Plan Quality Improvement Committees and our corporate medical management team.

In an effort to ensure the quality of our provider networks, we undertake to verify the credentials and background of our providers using standards that are supported by the National Committee for Quality Assurance, or NCQA.

It is our objective to provide access to the highest quality of care for our members. As a validation of that objective, we often pursue accreditation by independent organizations that have been established to promote healthcare quality. The NCQA Health Plan Accreditation and URAC Health Plan Accreditation programs provide unbiased, third party reviews to verify and publicly report results on specific quality care metrics. While we have achieved or are pursuing accreditation for all of our plans, accreditation is only one measure of our ability to provide access to quality care for our members. We currently have 19 of 26 eligible health plans with NCQA accreditation.

CMS developed the Medicare Advantage Star Ratings system to help consumers choose among competing plans, awarding between 1.0 and 5.0 stars to Medicare Advantage plans based on performance in certain measures of quality. For the 2017 Star rating (calculated in 2016 for the quality bonus payment in 2018), our Oregon HMO contract received 4.5 out of 5.0 Stars. The Arizona Bridgeway, California HMO, California PPO, Texas Superior and Wisconsin MHS contracts were measured at 4.0 Stars, our Oregon PPO contract was measured at 3.5 Stars and our Arizona HMO, Ohio Buckeye and Oregon Trillium contracts received 3.0 Stars. In addition, we carry a 4 Star parent organization rating.

SPECIALTY SERVICES

Our specialty services are a key component of our healthcare strategy and complement our core Managed Care business. Our provision of specialty services diversifies our revenue stream, enhances the quality of health outcomes for our members and others, and allows Centene to manage costs. In 2015, we launched Envolve, a new brand that brings together our extensive portfolio of specialty healthcare solutions. Envolve leverages our collective expertise in pharmacy solutions; health, triage, wellness and disease management; and vision and dental services, to provide integrated and comprehensive healthcare for members. Our specialty services are provided primarily as follows:

- *Pharmacy Solutions.* Envolve Pharmacy Solutions utilizes innovative, flexible solutions and customized care management. Under the new brand, we will continue to offer traditional pharmacy benefits management as well as comprehensive specialized pharmacy benefit services through our specialty pharmacy, AcariaHealth. Our traditional pharmacy benefits management program offers progressive pharmacy benefits management services that are specifically designed to improve quality of care while containing costs. This is achieved through a low cost strategy that helps optimize clients' pharmacy benefits. Services that we provide include claims processing, pharmacy network management, benefit design consultation, drug utilization review, formulary and rebate management, online drug management tools, mail order pharmacy services, home delivery services, analytics and clinical consulting and patient and physician intervention. AcariaHealth offers specialized care management services for complex diseases and enhances the patient care offering through collaboration with providers and the capture of relevant data to measure patient outcomes. Acquired with the Health Net transaction, Health Net Pharmaceutical Services (HNPS) provides pharmacy benefit management (PBM) services to Medicare and dual eligible members. HNPS manages these benefits in an effort to achieve the highest quality outcomes at the lowest cost for legacy Health Net members. HNPS contracts with national health care providers, vendors, drug manufacturers and pharmacy distribution networks, oversees pharmacy claims and administration, reviews and evaluates new FCA-approved drugs for safety and efficacy and manages data collection efforts to facilitate our health plans' disease management programs.

- *Health, Triage, Wellness, and Disease Management Services*. Envolve PeopleCare brings together our behavioral health, nurse advice, telehealth, and health, wellness and disease guidance programs, allowing for a focus on individual health management through education and empowerment. Our life and health management programs specialize to encourage healthy behaviors, promote healthier workplaces, improve workforce and societal productivity and reduce healthcare costs. Health risk appraisals, biometric screenings, interactive wellness programs, disease management and work-life/employee assistance services are areas of focus. We utilize telephonic health and work/life balance coaching, in-home and online interactions and informatics processes to deliver effective clinical outcomes, enhanced patient-provider satisfaction and lower overall healthcare costs. We offer telehealth services where members engage with bilingual customer service representatives and nursing staff members who provide health education and triage advice and offer continuous access to health plan functions. Our staff can arrange for urgent pharmacy refills, transportation and qualified behavioral health professionals for crisis stabilization assessments. Our behavioral health networks feature a full range of services and levels of care to help people with mental illness reach their recovery and wellness goals. Acquired with the Health Net acquisition, Managed Health Network, Inc. and its subsidiaries (collectively MHN) administers and arranges behavioral health benefits and services. MHN offers behavioral health and substance abuse programs on an insured and self-funded basis to groups in various states. The programs and services are included as a standard part of most of our commercial health plans and are also sold in conjunction with other commercial and Medicare products and on a stand-alone basis to unaffiliated health plans and employer groups.

- *Vision and Dental Services.* Envolve Benefit Options coordinates benefits beyond traditional medical benefits to offer fully integrated vision and dental health services. Our vision benefit program administers routine and medical surgical eye care benefits through a contracted national network of eye care providers. Through the dental benefit, we are dedicated to improving oral health through a contracted network of dental healthcare providers.

- *Care Management Software.* Casenet is a software provider of innovative care management solutions that automate the clinical, administrative and technical components of care management programs, which is used by our health plans and available for sale to third parties.

- *Correctional Healthcare Services.* Centurion, our joint venture subsidiary with MHM Services Inc., provides comprehensive healthcare services to individuals incarcerated in Massachusetts, Minnesota, Mississippi, Tennessee and Vermont state correctional facilities. In 2016, we began providing healthcare services to individuals incarcerated in Florida and New Mexico.

- *In-Home Health Services.* U.S. Medical Management, our majority owned subsidiary acquired in January 2014, provides in-home health services for high acuity populations.

- *Integrated Long-Term Care.* LifeShare provides home and community-based support for people with intellectual and developmental disabilities, children in the child welfare system and people of all ages and abilities, with a focus on those that are often marginalized by society. In addition, LifeShare operates school-based programs that focus on students with special needs.

- *Federal Services*. Health Net Federal Services, which was acquired with the Health Net acquisition, has a Managed Support Contract in the North Region for the DoD TRICARE program. The services that are provided are structured as cost reimbursement arrangements for health care costs plus administrative fees received in the form of fixed prices, fixed unit prices, and contingent fees and payments based on various incentives and penalties. We provide administrative services to Military Health System eligible beneficiaries, which includes eligible active duty service members and their families, retired service members and their families, survivors of retired service members and qualified former spouses. In July 2016, it was announced that the DoD awarded Health Net Federal Services, the TRICARE West Region contract. In connection with this latest generation of TRICARE contracts, the Department of Defense has consolidated the prior North, South and West TRICARE regions into two: the West and East Regions. We expect health care delivery for this new contract to begin in the second half of 2017. Additionally, our wholly owned subsidiary, MHN Government Services, is party to a MFLC contract that was awarded by the DoD to implement, administer and monitor the non-medical counseling MFLC program. The Patient Centered Community Care (PC3) program, acquired with the Health Net acquisition, provides eligible veterans coordinated, timely access to care through a comprehensive network of non-VA providers who meet VA quality standards when a local VA medical center cannot readily provide the care.

We currently have NCQA accreditation and URAC accreditation for several of our specialty companies.

CORPORATE COMPLIANCE

Our Corporate Ethics and Compliance Program provides controls to help us assure that our values are reflected in everything we do, further enhancing operations, improving access to quality care and helping to safeguard against fraud, waste and abuse.

Three standards by which corporate compliance programs in the healthcare industry are measured are the Federal Organizational Sentencing Guidelines, the CMS Chapter Guidance and the Compliance Program Guidance series issued by the Department of Health and Human Services' Office of the Inspector General (OIG). Our program contains each of the seven elements suggested by the Sentencing Guidelines and the OIG guidance. These key components are:

- written standards of conduct
- designation of a corporate compliance officer and compliance committee
- effective training and education
- effective lines for reporting and communication
- enforcement of standards through well publicized disciplinary guidelines and actions
- internal monitoring and auditing
- prompt response to detected offenses and development of corrective action plans

The goal of our program is to build a culture of ethics and compliance, which is assessed periodically to measure the integrity of the organization. Our internal Corporate Compliance intranet site, accessible to all employees, contains our Business Ethics and Conduct Policy (Code of Conduct), Compliance Program description and resources for employees to report concerns or ask questions. If needed, employees have access to the contact information for the members of our Board of Directors' Audit Committee to report concerns. Our Ethics and Compliance Helpline is a toll-free number and web-based reporting tool operated by a third party independent of the Company and allows employees or other persons to report suspected incidents of misconduct, fraud, waste, abuse or other compliance violations anonymously. Furthermore, the Board of Directors has established a Corporate Compliance committee that, among other things, reviews ethics and compliance reports on a quarterly basis.

COMPETITION

We operate in a highly competitive environment in an industry subject to ongoing significant changes resulting from the ACA, business consolidations, new strategic alliances, market pressures, and regulatory and legislative reform including but not limited to the federal and state health care reform legislation described under the heading "Regulation." In addition, changes to the political environment, including recent changes resulting from the 2016 election cycle and related uncertainties, may drive additional changes to the competitive landscape.

In our business, our principal competitors for customers, members, and providers consist of the following types of organizations:

- *Medicaid Managed Care Organizations* focus on providing healthcare services to Medicaid recipients. These organizations consist of national and regional organizations, as well as not-for-profits and smaller organizations that operate in one city or state and are owned by providers, primarily hospitals.

- *National and Regional Commercial Managed Care Organizations* have Medicaid and Medicare members in addition to members in private commercial plans. Some of these organizations offer a range of specialty services including pharmacy benefits management, behavioral health management, health management, and nurse triage call support centers.

- *Primary Care Case Management Programs* are programs established by the states through contracts with primary care providers. Under these programs, physicians provide primary care services to Medicaid recipients, as well as limited medical management oversight.

- *Accountable Care Organizations* are groups of doctors, hospitals, and other health care providers, who come together to give coordinated high quality care to their patients.

We compete with other managed care organizations and specialty companies for state, federal, and commercial contracts. Before granting a contract, state and federal government agencies consider many factors. These factors include quality of care, financial condition, stability and resources and established or scalable infrastructure with a demonstrated ability to deliver services and establish adequate provider networks. Our specialty companies compete with other providers, such as disease management companies, individual health insurance companies, and pharmacy benefits managers for non-governmental contracts.

We also compete to enroll new members and retain existing members. People who wish to enroll in a managed healthcare plan or to change healthcare plans typically choose a plan based on the quality of care and services offered, ease of access to services, a specific provider being part of the network and the availability of supplemental benefits. We believe that the principal competitive features affecting our ability to retain and increase membership include the range and prices of benefit plans offered, size and quality of provider network, quality of service, responsiveness to customer demands, financial stability, comprehensiveness of coverage, diversity of product offerings, market presence and reputation. The relative importance of each of these factors and the identity of our key competitors varies by market and product. We believe that we compete effectively against other health care industry participants.

We also compete with other managed care organizations in establishing provider networks. When contracting with various health plans, we believe that providers consider existing and potential member volume, reimbursement rates, medical management programs, speed of reimbursement and administrative service capabilities. See “Risk Factors - Competition may limit our ability to increase penetration of the markets that we serve.”

The relative importance of each of the aforementioned competitive factors and the identity of our key competitors varies by market, including by geography and by product.

REGULATION

Our operations are comprehensively regulated at both state and federal levels. Government regulation of the provision of healthcare products and services is a changing area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have substantial discretion to issue regulations and interpret and enforce laws and rules. Changes in the regulatory environment and applicable laws and rules also may occur periodically, including in connection with changes in political party or administration at the state, federal or national level. For example, the new administration and certain members of Congress have affirmatively indicated that they will pursue full repeal of or significant amendment to the ACA. Even if the ACA is not amended or repealed, the new administration could propose changes impacting implementation of the ACA. The ultimate content and timing of any legislation enacted under the new administration that would impact the current implementation of the ACA remains uncertain.

The ACA transformed the U.S. health care system through a series of complex initiatives. Some of the ACA's most significant provisions include the imposition of significant fees, assessments and taxes, including the non-deductible tax (technically called a "fee") on health insurers based on prior year net premiums written (the "health insurer fee" or "HIF"); the establishment of federally-facilitated and state-based Health Insurance Marketplaces where individuals and small groups may purchase health coverage; the implementation of certain premium stabilization programs designed to apportion risk amongst insurers; and the optional Medicaid Expansion. State and federal regulators have continued to provide additional guidance and specificity to the ACA, and we continue to monitor this new information and evaluate its potential impact on our business. For a further discussion of the implementation of the ACA, as well as the potential repeal of, or changes to, the ACA, see the risk factor below entitled “The implementation of Health Reform Legislation, as well as potential repeal of or changes to Health Reform Legislation, could materially and adversely affect our results of operations, financial position and cash flows.”

Our regulated subsidiaries are licensed to operate as health maintenance organizations (HMOs), preferred provider organizations (PPOs), third party administrators, utilization review organizations, pharmacies, direct care providers and/or insurance companies in their respective states. In each of the jurisdictions in which we operate, we are regulated by the relevant insurance, health and/or human services departments, departments of insurance, boards of pharmacy and other health care providers, and departments of health that oversee the activities of managed care organizations and health plans providing or arranging to provide services to enrollees.

The process for obtaining authorization to operate as a managed care organization, health insurance plan and provider organizations is complex and requires us to demonstrate to the regulators the adequacy of the health plan's organizational structure, financial resources, utilization review, quality assurance programs, complaint procedures, provider network and procedures for covering emergency medical conditions. Under both state managed care organization statutes and insurance laws, our health plan subsidiaries, as well as our applicable specialty companies, must comply with minimum statutory capital and other financial solvency requirements, such as deposit and surplus requirements. Insurance regulations may also require prior state approval of acquisitions of other managed care organization businesses and the payment of dividends, as well as notice for loans or the transfer of funds. Our subsidiaries are also subject to periodic state and federal reporting requirements. In addition, each health plan and individual health care provider must meet criteria to secure the approval of state regulatory authorities before implementing certain operational changes, including without limitation changes to existing offerings, the development of new product offerings, certain organizational restructurings and, in some states, the expansion of service areas.

States have adopted a number of regulations that may affect our business and results of operations. These regulations in certain states include:

- premium taxes or similar assessments imposed on us;
- stringent prompt payment laws requiring us to pay claims within a specified period of time;
- disclosure requirements regarding provider fee schedules and coding procedures; and
- programs to monitor and supervise the activities and financial solvency of provider groups.

Federal law has also implemented other health programs that are partially funded by the federal government, such as the Medicaid program. Our Medicaid programs are regulated and administered by various state regulatory bodies. Federal funding remains critical to the viability of these programs. Federal law permits the federal government to oversee and, in some cases, to enact, regulations and other requirements that must be followed by states with respect to these programs. Medicaid is administered at the federal level by CMS. Comprehensive legislation, specifically Title XVIII of the Social Security Act of 1935, as amended, governs our Medicare program. In addition, our Medicare contracts are subject to regulation by CMS. CMS has the right to audit Medicare contractors and the health care providers and administrative contractors who provide certain services on their behalf to determine the quality of care being rendered and the degree of compliance with CMS contracts and regulations.

We are regulated as an insurance holding company and are subject to the insurance holding company acts of the states in which our insurance company and HMO subsidiaries are domiciled. These acts contain certain reporting requirements as well as restrictions on transactions between an insurer or HMO and its affiliates. These holding company laws and regulations generally require insurance companies and HMOs within an insurance holding company system to register with the insurance department of each state where they are domiciled and to file with those states' insurance departments reports describing capital structure, ownership, financial condition, intercompany transactions and general business operations. In addition, depending on the size and nature of the transaction, there are various notice and reporting requirements that generally apply to transactions between insurance companies and HMOs and their affiliates within an insurance holding company structure. Some insurance holding company laws and regulations require prior regulatory approval or, in certain circumstances, prior notice of certain material intercompany transfers of assets as well as certain transactions between insurance companies, HMOs, their parent holding companies and affiliates. Among other provisions, state insurance and HMO laws may restrict the ability of our regulated subsidiaries to pay dividends.

Additionally, the holding company acts of the states in which our subsidiaries are domiciled restrict the ability of any person to obtain control of an insurance company or HMO without prior regulatory approval. Under those statutes, without such approval or an exemption, no person may acquire any voting security of an insurance holding company, which controls an insurance company or HMO, or merge with such a holding company, if as a result of such transaction such person would “control” the insurance holding company. “Control” is generally defined as the direct or indirect power to direct or cause the direction of the management and policies of a company and is presumed to exist if a person directly or indirectly owns or controls 10% or more of the voting securities of a company.

PPO regulation also varies by state and covers all or most of the subject area referred to above.

Our pharmacies must be licensed to do business as pharmacies in the states in which they are located. Our pharmacies must also register with the U.S. Drug Enforcement Administration and individual state controlled substance authorities to dispense controlled substances. In many of the states where our pharmacies deliver pharmaceuticals, there are laws and regulations that require out-of-state mail order pharmacies to register with that state’s board of pharmacy or similar regulatory body. These states generally permit the pharmacy to follow the laws of the state in which the mail order pharmacy is located, although some states require that we also comply with certain laws in that state.

Our health care providers must be licensed to practice medicine and do business as care providers in the state in which they are located. In addition, they must be in good standing with the applicable medical board, board of nursing or other applicable entity. Furthermore, they cannot be excluded from participation at both the state and federal levels. Our facilities are periodically reviewed by state departments of health and other regulatory agencies to ensure the environment is safe to provide care.

We must also comply with, and are faceted by, laws and regulations related to the award, administration and performance of U.S. Government contracts. Government contract laws and regulations affect how we do business with our customers and, in some instances, impose added costs on our business. In addition, as a result of our international operations, we are also subject to the U.S. Foreign Corrupt Practices Act (FCPA) and similar worldwide anti-corruption laws, including the U.K. Bribery Act of 2010, which generally prohibit companies and their intermediaries from making improper payments to non-U.S. officials for the purpose of obtaining or retaining business. A violation of specific laws and regulations by us and/or our agents could result in among other things, the imposition of fines and penalties on us, changes to our business practices, the termination of our contracts or debarment from bidding on contracts.

State and Federal Contracts

In addition to being a licensed insurance company or HMO, in order to be a Medicaid managed care organization in each of the states in which we operate, we generally must operate under a contract with the state's Medicaid agency. States generally use either a formal proposal process, reviewing a number of bidders, or award individual contracts to qualified applicants that apply for entry to the program. Under these state Medicaid program contracts, we receive monthly payments based on specified capitation rates determined on an actuarial basis. These rates differ by membership category and by state depending on the specific benefits and policies adopted by each state. In addition, several of our Medicaid contracts require us to maintain Medicare Advantage special needs plans, which are regulated by CMS, for dual eligible individuals within the state. We also contract with states to provide healthcare services to correctional facilities.

We provide Medicare Advantage, Dual Eligible Special Needs Plans (D-SNPs), and Medicare-Medicaid Plans (MMP) which are provided under contracts with CMS and subject to federal regulation regarding the award, administration and performance of such contracts. CMS also has the right to audit our performance to determine our compliance with these contracts, as well as other CMS regulations and the quality of care we provide to Medicare beneficiaries under these contracts. We additionally provide behavioral and other healthcare services to correctional systems under contracts in certain states which are also subject to state regulation.

Our government contracts include government-sponsored managed care and administrative services contracts through the TRICARE program, the Department of Defense Military and Family Life Counseling program, the U.S. Department of Veterans Affairs Patient Centered Community Care program and certain other health care-related government contracts.

Our state and federal contracts and the regulatory provisions applicable to us generally set forth the requirements for operating in the Medicaid and Medicare sectors, including provisions relating to:

- eligibility, enrollment and dis-enrollment processes
- covered services
- eligible providers
- subcontractors
- record-keeping and record retention
- periodic financial and informational reporting
- quality assurance
- accreditation
- health education and wellness and prevention programs
- timeliness of claims payment
- financial standards
- safeguarding of member information
- fraud, waste and abuse detection and reporting
- grievance procedures
- organization and administrative systems

A health plan or individual health insurance provider's compliance with these requirements is subject to monitoring by state regulators and by CMS. A health plan is also subject to periodic comprehensive quality assurance evaluations by a third-party reviewing organization and generally by the insurance department of the jurisdiction that licenses the health plan. A health plan or individual health insurance provider must also submit reports to various regulatory agencies, including quarterly and annual statutory financial statements and utilization reports.

The table below sets forth certain terms of our contracts and provides details regarding related renewal or extension and termination provisions. The contracts generally are subject to termination for cause, an event of default or lack of funding, among other things.

State Contract	Expiration Date	Renewal or Extension
Arizona - Behavioral Health	September 30, 2018	Renewable for two additional two-year terms.
Arizona - LTC	September 30, 2017	RFP following expiration of contract term.
Arizona - Special Needs Plan (Medicare)	December 31, 2017	Renewable annually for successive 12-month periods.
Arizona - Medicaid (Maricopa County)	September 30, 2017	One year option to extend.
Arizona - Medicare Advantage HMO (includes Special Needs Plan)	December 31, 2017	Renewable annually for successive 12-month periods.
Arkansas - Arkansas Works	December 31, 2016*	Program extended until December 31, 2021. The current Arkansas Memorandum of Understanding (MOU) expired December 31, 2016.

State Contract	Expiration Date	Renewal or Extension
California - Correctional Healthcare Services	September 30, 2019	Renewable for up to five additional one-year terms.
California - Medicaid & ABD (Imperial and Northern 18 counties)	October 31, 2018	Renewable up to three additional one-year terms.
California - Medicaid Dental Contract (Los Angeles County)	January 31, 2018	Two 12-month extensions.
California - Medicaid Dental Contract (Sacramento County)	July 31, 2017	Two 12-month extensions.
California - Medicaid (Los Angeles County)	March 31, 2019	Renewable through the state's procurement process.
California - Medicaid (Kern, Stanislaus, San Joaquin, & Tulare Counties)	December 31, 2022	Renewable through the state's procurement process.
California - Medicaid (Sacramento County)	December 31, 2018	Renewable through the state's procurement process.
California - Medicaid (San Diego County)	June 30, 2020	Renewable through the state's procurement process.
California - Dual Eligible Demonstration (Los Angeles and San Diego Counties)	December 31, 2017	May be extended if the Demonstration is funded beyond 2017.
California - Medicare Advantage HMO (includes Special Needs Plan)	December 31, 2017	Renewable annually for successive 12-month periods.
California - Medicare Advantage PPO (Employer Group Health Plan only)	December 31, 2017	Renewable annually for successive 12-month periods.
Florida - Medicaid, ABD, LTC & Foster Care	December 31, 2018	Renewable through the state's recertification process.
Florida - CHIP	December 31, 2017	May be extended for two additional one-year terms.
Florida - Special Needs Plan (Medicare)	December 31, 2017	Renewable annually for successive 12-month periods.
Florida - Special Needs Plan (Medicaid)	December 31, 2017	May be extended for up to three additional years.
Florida - Medicare Advantage	December 31, 2017	Renewable annually for successive 12-month periods.
Florida - Correctional Healthcare Services	January 31, 2018	Renewable for up to three years, or any portion thereof.
Georgia - Medicaid & CHIP	June 30, 2017	RFP awarded for an initial one-year term to begin July 1, 2017 and renewable for five additional one-year terms.
Georgia - Special Needs Plan (Medicare)	December 31, 2017	Renewable annually for successive 12-month periods.
Illinois - ABD & LTC	April 30, 2021	RFP following expiration of the contract term.
Illinois - Duals	December 31, 2019	May be extended based on terms to be determined by CMS and the Illinois Demonstration Project.
Illinois - Medicaid	June 30, 2019	May be extended for up to five additional years.
Illinois - Medicaid Long Term Support Services	December 31, 2019	Renewable for up to six additional years.
Indiana - ABD	March 31, 2019	May be extended for two additional one-year terms.
Indiana - Medicaid, CHIP & Hybrid (Healthy Indiana Plan)	December 31, 2020	Renewable for two additional one-year terms subject to state signature.
Kansas - Medicaid, ABD, CHIP, LTC & Foster Care	December 31, 2018	Renewable through the state's reprocurement process.
Louisiana - Medicaid, CHIP, ABD, Foster Care & Behavioral Health	January 31, 2018	May be extended for up to two additional one-year terms.
Massachusetts - Correctional Healthcare Services	June 30, 2018	Renewable for two additional two-year terms.

State Contract	Expiration Date	Renewal or Extension
Massachusetts - Medicaid	September 30, 2017	Renewable annually for successive 12-month periods.
Michigan - Duals	December 31, 2017	Renewable through the state's reprocurement process.
Minnesota - Correctional Healthcare Services	June 30, 2018	Renewable through the state's reprocurement process.
Mississippi - Medicaid, ABD & Foster Care	June 30, 2017	May be extended for up to two additional one-year terms.
Mississippi - CHIP	June 30, 2017	May be extended for up to two additional one-year terms.
Mississippi - Correctional Healthcare Services	June 30, 2019	Renewable at the discretion of MDOC for two one-year extensions, not to exceed two.
Missouri - Medicaid, CHIP & Foster Care	April 30, 2017	RFP awarded for an initial term of May 1, 2017 through June 30, 2018. Renewable for four additional one-year terms.
Nebraska - Medicaid, ABD, CHIP, Foster Care and LTC	December 31, 2022	Renewable for two additional one-year terms.
New Hampshire - Medicaid, CHIP, Foster Care & ABD	June 30, 2018	Renewable through the state's reprocurement process.
New Hampshire - Premium Assistance Program	December 31, 2018	Memorandum of Understanding with the New Hampshire Department of Health and Human Services has been renewed through 2018.
New Mexico - Correctional Healthcare Services	May 31, 2017	Renewable annually for up to three additional one-year terms.
Ohio - Duals	December 31, 2017	Renewable annually through December 31, 2019.
Ohio - Medicaid, CHIP & ABD	June 30, 2017	Renewable annually for successive 12-month periods.
Ohio - Special Needs Plan (Medicare)	December 31, 2017	Renewable annually for successive 12-month periods.
Oregon - Medicaid, ABD, CHIP & Foster Care	December 31, 2018	Renewable through the state's reprocurement process.
Oregon - Medicare Advantage HMO (Includes Special Needs Plan)	December 31, 2017	Renewable annually for successive 12-month periods.
Oregon - Medicare Advantage PPO	December 31, 2017	Renewable annually for successive 12-month periods.
South Carolina - Medicaid & ABD	June 30, 2018	Renewable through the state's recertification process.
South Carolina - Duals	December 31, 2017	Renewable for one additional one-year term.
Tennessee - Correctional Healthcare Services	February 28, 2017	Renewable through the state’s reprocurement process.
Texas - ABD Dallas Expansion	August 31, 2018	Renewable through the state's reprocurement process.
Texas - ABD MRSA	August 31, 2017	May be extended for up to five additional years.
Texas - CHIP Rural Service Area	August 31, 2018	Renewable through the state's reprocurement process.
Texas - Foster Care	August 31, 2018	May be extended for up to five additional years.
Texas - Medicaid, CHIP & ABD	August 31, 2018	May be extended for up to one and a half additional years.
Texas - Duals	December 31, 2017	Renewable for one-year term.
Texas - Special Needs Plan (Medicare)	December 31, 2017	Renewable annually for successive 12-month periods.
Texas - STAR Kids	August 31, 2019	Renewable for up to five years.

State Contract	Expiration Date	Renewal or Extension
Vermont - Correctional Healthcare Services	January 31, 2018	May be extended for up to two additional one-year terms.
Washington - Medicaid, CHIP & ABD	December 31, 2017	Renewable through the state's recertification process.
Washington - Foster Care	December 31, 2017	Renewable through the state's recertification process.
Wisconsin - Medicaid, CHIP & ABD	December 31, 2017	Renewable through the state's recertification process every two years.
Wisconsin - Network Health Plan Subcontract	December 31, 2020	Renews automatically for successive three-year terms.
Wisconsin - Special Needs Plan (Medicare)	December 31, 2017	Renewable annually for successive 12-month periods.

Federal Contract	Expiration Date	Renewal or Extension
Department of Defense - TRICARE Managed Care Support (North Region)	March 31, 2017	Contract has been extended until TRICARE West Region contract effective date.
Department of Defense - TRICARE Managed Care Support (West Region)	September 30, 2017	Contract currently in base period transition-in status. Renewable for five additional one-year option periods.
Department of Defense - Military & Family Life Counseling	August 14, 2017	We currently expect that the Department of Defense will procure this contract in advance of the August 2017 expiration. If so, we expect to submit a bid.
Department of Veterans Affairs - Patient Centered Community Care / Veterans Choice	September 30, 2017	Although contract is renewable for one additional one-year option period, the Veterans Choice Program modification to the contract is scheduled to end on August 7, 2017.

* We are operating under the same terms of the 2016 MOU until the 2017 MOU is executed.

Marketplace Contracts

We operate in 15 states under federally facilitated and state-based Marketplace contracts with CMS that expire annually. In 2016, we began operating in a federally facilitated Marketplace in New Hampshire, as well as Arizona and California that were added with the Health Net Acquisition.

In addition, we operate under a contract with the Arkansas Department of Human Services Division of Medical Services and the Arkansas Insurance Department to participate in the Medicaid expansion model that Arkansas has adopted (referred to as "Arkansas Works"). In 2016, we started operating under a contract with the New Hampshire Department of Health and Human Services to participate in the Medicaid expansion model that New Hampshire has adopted (referred to as the “Premium Assistance Program”).

Privacy Regulations

We are subject to various federal, state and local laws and rules regarding the use, security and disclosure of protected health information, personal information, and other categories of confidential or legally protected data that our businesses handle. Such laws and rules include, without limitation, the Health Insurance Portability and Accountability Act (HIPAA), the Federal Trade Commission Act, the Gramm-Leach-Bliley Financial Modernization Act of 1999 (Gramm-Leach-Bliley Act), state privacy and security laws such as the California Confidentiality of Medical Information Act and the California Online Privacy Protection Act. Privacy and security laws and regulations often change due to new or amended legislation, regulations or administrative interpretation. A variety of state and federal regulators enforce these laws, including but not limited to the U.S. Department of Health and Human Services (HHS), the Federal Trade Commission, state attorneys general and other state regulators.

HIPAA is designed to improve the portability and continuity of health insurance coverage, simplify the administration of health insurance through standard transactions and ensure the privacy and security of individual health information. Among the requirements of HIPAA are the Administrative Simplification provisions which include: standards for processing health insurance claims and related transactions (Transactions Standards); requirements for protecting the privacy and limiting the use and disclosure of medical records and other personal health information (Privacy Rule); and standards and specifications for safeguarding personal health information which is maintained, stored or transmitted in electronic format (Security Rule). The Health Information Technology for Economic and Clinical Health (HITECH) Act amended certain provisions of HIPAA and enhanced data security obligations for covered entities and their business associates. HITECH also mandated individual notifications in instances of a data breach, provided enhanced penalties for HIPAA violations, and granted enforcement authority to states' Attorneys Generals in addition to the HHS Office for Civil Rights. The HIPAA Omnibus Rule further enhanced the changes under the HITECH Acts and the Genetic Information Nondiscrimination Act of 2008 (GINA) which clarified that genetic information is protected under HIPAA and prohibits most health plans from using or disclosing genetic information for underwriting purposes. This Omnibus rule enhances the privacy protections and strengthens the government's ability to enforce the law. These regulations also establish significant criminal penalties and civil sanctions for non-compliance. The preemption provisions of HIPAA provide that the federal standards will not preempt state laws that are more stringent than the related federal requirements.

The Privacy and Security Rules and HITECH/Omnibus enhancements established requirements to protect the privacy of medical records and safeguard personal health information maintained and used by healthcare providers, health plans, healthcare clearinghouses, and their business associates.

The Security Rule requires healthcare providers, health plans, healthcare clearinghouses, and their business associates to implement administrative, physical and technical safeguards to ensure the privacy and confidentiality of health information electronically stored, maintained or transmitted. The HITECH Act and Omnibus Rule enhanced a federal requirement for notification when the security of protected health information is breached. In addition, there are state laws that have been adopted to provide for, among other things, private rights of action for breaches of data security and mandatory notification to persons whose identifiable information is obtained without authorization.

The requirements of the Transactions Standards apply to certain healthcare related transactions conducted using "electronic media." Since "electronic media" is defined broadly to include "transmissions that are physically moved from one location to another using portable data, magnetic tape, disk or compact disk media," many communications are considered to be electronically transmitted. Under HIPAA, health plans and providers are required to have the capacity to accept and send all covered transactions in a standardized electronic format. Penalties can be imposed for failure to comply with these requirements. The transaction standards were modified on October 1, 2015 with the implementation of the ICD-10 coding system.

In addition, we process and maintain personal card data, particularly in connection with our Marketplace business. As a result, we are subject to the requirements under the Payment Card Industry (PCI) Data Security Standard, which is a multifaceted security standard that is designed to protect credit card account data as mandated by payment card industry entities.

Other Fraud, Waste and Abuse Laws

Investigating and prosecuting healthcare fraud, waste and abuse continues to be a top priority for state and federal law enforcement entities. The focus of these efforts has been directed at participants in public government healthcare programs such as Medicare and Medicaid. The fraud, waste and abuse laws include the federal False Claims Act, which prohibits the known filing of a false claim or the known use of false statements to obtain payment from the federal government. Many states have false claim act statutes that closely resemble the federal False Claims Act. The laws and regulations relating to fraud, waste and abuse and the requirements applicable to health plans and providers participating in these programs are complex and change regularly. Compliance with these laws may require substantial resources. We are constantly looking for ways to improve our waste, fraud and abuse detection methods. While we have both prospective and retrospective processes to identify abusive patterns and fraudulent billing, we continue to increase our capabilities to proactively detect inappropriate billing prior to payment.

EMPLOYEES

As of December 31, 2016, we had approximately 30,500 employees. None of our employees are represented by a union. We believe our relationships with our employees are positive.

EXECUTIVE OFFICERS OF THE REGISTRANT

The following table sets forth information regarding our executive officers, including their ages, at February 17, 2017:

Name	Age	Position
Michael F. Neidorff	74	Chairman, President and Chief Executive Officer
Christopher D. Bowers	61	Executive Vice President, Markets
Cynthia J. Brinkley	57	Executive Vice President, Global Corporate Development
Mark J. Brooks	47	Senior Vice President, Chief Information Officer
Jesse N. Hunter	41	Executive Vice President, Products
Christopher R. Isaak	50	Senior Vice President, Corporate Controller and Chief Accounting Officer
Jeffrey A. Schwaneke	41	Executive Vice President, Chief Financial Officer and Treasurer
Keith H. Williamson	64	Executive Vice President, General Counsel and Secretary

Michael F. Neidorff. Mr. Neidorff has served as our Chairman and Chief Executive Officer since May 2004. From May 1996 to May 2004, Mr. Neidorff served as President, Chief Executive Officer and as a member of our Board of Directors.

Christopher D. Bowers. Mr. Bowers is our Executive Vice President of Markets since November 2016. From March 2007 to November 2016, he served as our Senior Vice President of Health Plans.

Cynthia J. Brinkley. Ms. Brinkley has served as our Executive Vice President, Global Corporate Development since January 2016. From November 2014 to January 2016, she served as Executive Vice President, International Operations and Business Integration. Prior to joining Centene, she served as Vice President of Global Human Resources at General Motors from 2011 to 2013.

Mark J. Brooks. Mr. Brooks is our Senior Vice President and Chief Information Officer since April 2016. Prior to joining Centene, he served as the Chief Information Officer at Health Net from 2012 to 2016. He previously served as Health Net's Chief Technology Officer from 2008 to 2012.

Jesse N. Hunter. Mr. Hunter has served as our Executive Vice President, Products since January 2016. From December 2012 to January 2016, he served as Executive Vice President, Chief Business Development Officer. From February 2012 to December 2012, he served as our Executive Vice President, Operations. He previously served as our Executive Vice President, Corporate Development from April 2008 to February 2012.

Christopher R. Isaak. Mr. Isaak is our Senior Vice President, Corporate Controller and Chief Accounting Officer since April 2016. Prior to joining Centene, he served as Vice President, Corporate Controller at TTM Technologies from 2015 to 2016 and Vice President, Corporate Controller at Viasystems Group, Inc. from 2006 to 2015 and served as Chief Accounting Officer from 2010 to 2015.

Jeffrey A. Schwaneke. Mr. Schwaneke has served as our Executive Vice President, Chief Financial Officer and Treasurer since March 2016. From July 2008 to March 2016, he served as our Senior Vice President, Corporate Controller and served as our Chief Accounting Officer from September 2008 to March 2016.

Keith H. Williamson. Mr. Williamson has served as our Executive Vice President, General Counsel and Secretary since November 2012. He served as Senior Vice President and General Counsel from November 2006 to November 2012.

Available Information

We are subject to the reporting and information requirements of the Securities Exchange Act of 1934, as amended (Exchange Act) and, as a result, we file periodic reports and other information with the Securities and Exchange Commission, or SEC. We make these filings available on our website free of charge, the URL of which is http://www.centene.com, as soon as reasonably practicable after we electronically file such material with, or furnish it to, the SEC. The SEC maintains a website (http://www.sec.gov) that contains our annual, quarterly and current reports and other information we file electronically with the SEC. You can read and copy any materials we file with the SEC at the SEC's Public Reference Room at 100 F Street, N.E., Room 1850, Washington, D.C. 20549. You may obtain information on the operation of the Public Reference Room by calling the SEC at 1-800-SEC-0330. Information on our website does not constitute part of this Annual Report on Form 10-K.

ITEM 1A. ***Risk Factors***

FACTORS THAT MAY AFFECT FUTURE RESULTS AND THE TRADING PRICE OF OUR COMMON STOCK

You should carefully consider the risks described below before making an investment decision. The trading price of our common stock could decline due to any of these risks, in which case you could lose all or part of your investment. You should also refer to the other information in this filing, including our consolidated financial statements and related notes. The risks and uncertainties described below are those that we currently believe may materially affect our Company. Additional risks and uncertainties that we are unaware of or that we currently deem immaterial also may become important factors that affect our Company.

Reductions in funding, changes to eligibility requirements for government sponsored healthcare programs in which we participate and any inability on our part to effectively adapt to changes to these programs could substantially affect our financial position, results of operations and cash flows.

The majority of our revenues come from government subsidized healthcare programs including Medicaid, Medicare, TRICARE, VA, CHIP, LTC, ABD, Foster Care and Health Insurance Marketplace premiums. Under most programs, the base premium rate paid for each program differs, depending on a combination of factors such as defined upper payment limits, a member's health status, age, gender, county or region and benefit mix. Since Medicaid was created in 1965, the federal government and the states have shared the costs for this program, with the federal share currently averaging around 57%. We are therefore exposed to risks associated with U.S. and state government contracting or participating in programs involving a government payor, including but not limited to the general ability of the federal and/or state government to terminate contracts with it, in whole or in part, without prior notice, for convenience or for default based on performance; potential regulatory or legislative action that may materially modify amounts owed; and our dependence upon Congressional or legislative appropriation and allotment of funds and the impact that delays in government payments could have on our operating cash flow and liquidity. For example, future levels of funding and premium rates may be affected by continuing government efforts to contain healthcare costs and may further be affected by state and federal budgetary constraints. Governments periodically consider reducing or reallocating the amount of money they spend for Medicaid, Medicare, TRICARE, VA, CHIP, LTC, ABD and Foster Care. Furthermore, Medicare remains subject to the automatic spending reductions imposed by the Budget Control Act of 2011 and the American Taxpayer Relief Act of 2012 ("sequestration"), subject to a 2% cap. In addition, reductions in defense spending could have an adverse impact on certain government programs in which we currently participate by, among other things, terminating or materially changing such programs, or by decreasing or delaying payments made under such programs. Adverse economic conditions may continue to put pressures on state budgets as tax and other state revenues decrease while the population that is eligible to participate in these programs increases, creating more need for funding. We anticipate this will require government agencies to find funding alternatives, which may result in reductions in funding for programs, contraction of covered benefits, and limited or no premium rate increases or premium rate decreases. A reduction (or less than expected increase), a protracted delay, or a change in allocation methodology in government funding for these programs, as well as termination of the contract for the convenience of the government, may materially and adversely affect our results of operations, financial position and cash flows. In addition, if a federal government shutdown were to occur for a prolonged period of time, federal government payment obligations, including its obligations under Medicaid, Medicare, TRICARE, VA, CHIP, LTC, ABD, Foster Care and the Health Insurance Marketplaces, may be delayed. Similarly, if state government shutdowns were to occur, state payment obligations may be delayed. If the federal or state governments fail to make payments under these programs on a timely basis, our business could suffer, and our financial position, results of operations or cash flows may be materially affected.

There can be no assurance that we will avoid payment delays from government payors in the future, which, if extended for any significant period of time, could have a material adverse effect on our results of operations, financial position, cash flows or liquidity. In addition, delays in obtaining, or failure to obtain or maintain, governmental approvals, or moratoria imposed by regulatory authorities, could adversely affect our revenue or membership, increase costs or adversely affect our ability to bring new products to market as forecasted. Other changes to our government programs could affect our willingness or ability to participate in any of these programs or otherwise have a material adverse effect on our business, financial condition or results of operations.

Finally, changes in these programs could reduce the number of persons enrolled in or eligible for these programs or increase our administrative or healthcare costs under these programs. For example, recent legislation generally requires that eligibility levels be maintained, but this could cause states to reduce reimbursement or reduce benefits in order for states to afford to maintain eligibility levels. If any state in which we operate were to decrease premiums paid to us or pay us less than the amount necessary to keep pace with our cost trends, it could have a material adverse effect on our results of operations, financial position and cash flows.

Our Medicare programs are subject to a variety of risks that could adversely impact our financial results.

If we fail to design and maintain programs that are attractive to Medicare participants; if our Medicare operations are subject to program audits, sanctions or penalties; if we do not submit adequate bids in our existing markets or any expansion markets; if our existing contracts are terminated; or if we fail to maintain or improve our star ratings, our current Medicare business and our ability to expand our Medicare operations could be materially and adversely affected, negatively impacting our financial performance. There are also specific additional risks under Title XVIII, Part D of the Social Security Act associated with our provision of Medicare Part D prescription drug benefits as part of our Medicare Advantage plan offerings. These risks include potential uncollectibility of receivables, inadequacy of pricing assumptions, inability to receive and process information and increased pharmaceutical costs, as well as the underlying seasonality of this business, and extended settlement periods for claims submissions. Our failure to comply with Part D program requirements can result in financial and/or operational sanctions on our Part D products, as well as on our Medicare Advantage products that offer no prescription drug coverage.

Failure to accurately estimate and price our medical expenses or effectively manage our medical costs or related administrative costs could negatively affect our financial position, results of operations or cash flows.

Our profitability, to a significant degree, depends on our ability to estimate and effectively manage expenses related to health benefits through, among other things, our ability to contract favorably with hospitals, physicians and other healthcare providers. For example, our Medicaid revenue is often based on bids submitted before the start of the initial contract year. If our actual medical expense exceeds our estimates, our health benefits ratio (HBR), or our expenses related to medical services as a percentage of premium revenue, would increase and our profits would decline. Because of the narrow margins of our health plan business, relatively small changes in our HBR can create significant changes in our financial results. Changes in healthcare regulations and practices, the level of utilization of healthcare services, hospital and pharmaceutical costs, disasters, the potential effects of climate change, major epidemics, pandemics or newly emergent viruses, including the Zika virus, new medical technologies, new pharmaceutical compounds, increases in provider fraud and other external factors, including general economic conditions such as inflation and unemployment levels, are generally beyond our control and could reduce our ability to accurately predict and effectively control the costs of providing health benefits. In addition, the 2017 marketplace for individual products may be less stable than in 2016 because, among other things, other health plans have changed or stopped offering their Health Insurance Marketplace products in the states we expect to serve in 2017. Also, member behavior could be influenced by uncertainty of potential changes to the Patient Protection and Affordable Care Act and the accompanying Health Care and Education Affordability Reconciliation Act, collectively referred to as the Affordable Care Act (ACA).

Our medical expense includes claims reported but not paid, estimates for claims incurred but not reported, and estimates for the costs necessary to process unpaid claims at the end of each period. Our development of the medical claims liability estimate is a continuous process which we monitor and refine on a monthly basis as claims receipts and payment information as well as inpatient acuity information becomes available. As more complete information becomes available, we adjust the amount of the estimate, and include the changes in estimates in medical expense in the period in which the changes are identified. Given the uncertainties inherent in such estimates, there can be no assurance that our medical claims liability estimate will be adequate, and any adjustments to the estimate may unfavorably impact our results of operations and may be material.

Additionally, when we commence operations in a new state, region or product, we have limited information with which to estimate our medical claims liability. For a period of time after the inception of the new business, we base our estimates on government-provided historical actuarial data and limited actual incurred and received claims and inpatient acuity information. The addition of new categories of eligible individuals as well as evolving Health Insurance Marketplace plans may pose difficulty in estimating our medical claims liability.

From time to time in the past, our actual results have varied from our estimates, particularly in times of significant changes in the number of our members. If it is determined that our estimates are significantly different than actual results, our results of operations and financial position could be adversely affected. In addition, if there is a significant delay in our receipt of premiums, our business operations, cash flows, or earnings could be negatively impacted.

The implementation of Health Reform Legislation, as well as potential repeal of or changes to Health Reform Legislation, could materially and adversely affect our results of operations, financial position and cash flows.

In March 2010, ACA was enacted. While the constitutionality of the ACA was generally upheld by the Supreme Court in 2012, the Court determined that states could elect to opt out of the Medicaid expansion portion of ACA without losing all federal money for their existing Medicaid programs.

Under the ACA, Medicaid coverage was expanded to all individuals under age 65 with incomes up to 138% of the federal poverty level beginning January 1, 2014, subject to each states' election. The federal government pays the entire costs for Medicaid coverage for newly eligible beneficiaries for three years (2014 through 2016). Beginning in 2017, the federal share begins to decline, ending at 90% for 2020 and subsequent years. As of December 31, 2016, 31 states and the District of Columbia have expanded Medicaid eligibility, and additional states continue to discuss expansion. The ACA also maintained CHIP eligibility standards through September 2019.

The ACA required the establishment of Health Insurance Marketplaces for individuals and small employers to purchase health insurance coverage commencing in January 2014. The ACA required insurers participating on the Health Insurance Marketplaces to offer a minimum level of benefits and included guidelines on setting premium rates and coverage limitations.

Any failure to adequately price products offered in the Health Insurance Marketplaces may have a negative impact on our results of operations, financial position and cash flow. Among other things, we may be adversely selected by individuals who have a higher acuity level than the anticipated pool of participants. In addition, the risk corridor, reinsurance and risk adjustment ("three Rs") provisions of the ACA established to apportion risk amongst insurers may not be effective in appropriately mitigating the financial risks related to the Marketplace product. Further, the three Rs may not be adequately funded. Moreover, changes in the competitive marketplace over time may exacerbate the uncertainty in these relatively new markets. For example, competitors seeking to gain a foothold in the changing market may introduce pricing that we may not be able to match, which may adversely affect our ability to compete effectively. Competitors may also choose to exit the market altogether or otherwise suffer financial difficulty, which could adversely impact the pool of potential insured, require us to increase premium rates or result in funding issues under the three Rs. These potential exits and other continued volatility in this market may be further exacerbated by the conclusion of the risk corridor and reinsurance programs as of January 1, 2017. Our continued success in the exchanges is dependent on our ability to successfully respond to these changes in the market over time. Any significant variation from our expectations regarding acuity, enrollment levels, adverse selection, the three Rs, or other assumptions utilized in setting adequate premium rates could have a material adverse effect on our results of operations, financial position and cash flows.

The U.S. Department of Health and Human Services (HHS) has stated that it will consider a limited number of premium assistance demonstration proposals from States that want to privatize Medicaid expansion. States must provide a choice between at least two qualified health plans and offer very similar benefits as those available in the Health Insurance Marketplaces. Arkansas became the first state to obtain federal approval to use Medicaid funding to purchase private insurance for low-income residents and we began operations under the program beginning January 1, 2014.

The ACA imposed an annual insurance industry assessment of $8.0 billion in 2014, and $11.3 billion in each of 2015 and 2016, with increasing annual amounts thereafter. Such assessments are not deductible for federal and most state income tax purposes. The fee is allocated based on health insurers' premium revenues in the previous year. Each health insurer's fee is calculated by multiplying its market share by the annual fee. Market share is based on commercial, Medicare, and Medicaid premium revenue. Not-for-profit insurers may have a competitive advantage since they are exempt from paying the fee if they receive at least 80% of their premium revenue from Medicare, Medicaid, and CHIP, and other not-for-profit insurers are allowed to exclude 50% of their premium revenue from the fee calculation. The health insurer fee payable in 2017 was suspended by the Consolidated Appropriations Act for fiscal year 2016. If we are not reimbursed by the states for the cost of the federal premium assessment (including the associated tax impact), or if we are unable to otherwise adjust our business model to address this new assessment, our results of operations, financial position and cash flows may be materially adversely affected.

There are numerous steps required to implement the ACA, including the promulgation of a substantial number of new and potentially more onerous federal regulations. For example, in April 2016, CMS issued final regulations that revised existing Medicaid managed care rules by establishing a minimum MLR standard for Medicaid of 85% and strengthening provisions related to network adequacy and access to care, enrollment and disenrollment protections, beneficiary support information, continued service during beneficiary appeals, and delivery system and payment reform initiatives, among others. If we fail to effectively implement or appropriately adjust our operational and strategic initiatives with respect to the implementation of healthcare reform, or do not do so as effectively as our competitors, our results of operations may be materially adversely affected.

In addition, the U.S. Court of Appeals for the D.C. circuit has granted a motion to put a lawsuit challenging the ACA's cost-sharing subsidies on hold until the new administration takes over. Now that the U.S. Court of Appeals has stayed the case, the new administration and Congress will decide how they want to proceed, including whether to seek policy changes such as ACA repeal or replacement that affect the issues under review in this case.

Changes to, or repeal of, the ACA, which the new administration and certain members of Congress have affirmatively indicated that they will pursue, could materially and adversely affect our business and financial position, results of operations or cash flows. Even if the ACA is not amended or repealed, the new administration could propose changes impacting implementation of the ACA, which could materially and adversely affect our financial position or operations. However, the ultimate content, timing or effect of any potential future legislation enacted under the new administration cannot be predicted.

Our business activities are highly regulated and new laws or regulations or changes in existing laws or regulations or their enforcement or application could force us to change how we operate and could harm our business.

Our business is extensively regulated by the states in which we operate and by the federal government. In addition, the managed care industry has received negative publicity that has led to increased legislation, regulation, review of industry practices and private litigation in the commercial sector. Such negative publicity may adversely affect our stock price and damage our reputation in various markets.

In each of the jurisdictions in which we operate, we are regulated by the relevant insurance, health and/or human services or government departments that oversee the activities of managed care organizations providing or arranging to provide services to Medicaid, Medicare, Health Insurance Marketplace enrollees or other beneficiaries. For example, our health plan subsidiaries, as well as our applicable specialty companies, must comply with minimum statutory capital and other financial solvency requirements, such as deposit and surplus requirements.

The frequent enactment of, changes to, or interpretations of laws and regulations could, among other things: force us to restructure our relationships with providers within our network; require us to implement additional or different programs and systems; restrict revenue and enrollment growth; increase our healthcare and administrative costs; impose additional capital and surplus requirements; and increase or change our liability to members in the event of malpractice by our contracted providers. In addition, changes in political party or administrations at the state, federal or country level may change the attitude towards healthcare programs and result in changes to the existing legislative or regulatory environment.

Additionally, the taxes and fees paid to federal, state and local governments may increase due to several factors, including: enactment of, changes to, or interpretations of tax laws and regulations, audits by governmental authorities, geographic expansions into higher taxing jurisdictions and the effect of expansions into international markets.

Our contracts with states may require us to maintain a minimum HBR or may require us to share profits in excess of certain levels. In certain circumstances, our plans may be required to return premium back to the state in the event profits exceed established levels or HBR does not meet the minimum requirement. Other states may require us to meet certain performance and quality metrics in order to maintain our contract or receive additional or full contractual revenue.

The governmental healthcare programs in which we participate are subject to the satisfaction of certain regulations and performance standards. For example, under Health Reform Legislation, Congress authorized CMS and the states to implement managed care demonstration programs to serve dually eligible beneficiaries to improve the coordination of their care. Participation in these demonstration programs is subject to CMS approval and the satisfaction of conditions to participation, including meeting certain performance requirements. Our inability to improve or maintain adequate quality scores and star ratings to meet government performance requirements or to match the performance of our competitors could result in limitations to our participation in or exclusion from these or other government programs. Specifically, several of our Medicaid contracts require us to maintain a Medicare health plan. Although we strive to comply with all existing regulations and to meet performance standards applicable to our business, failure to meet these requirements could result in financial fines and penalties. Also, states or other governmental entities may not allow us to continue to participate in their government programs, or we may fail to win procurements to participate in such programs which could materially and adversely affect our results of operations, financial position and cash flows.

In addition, as a result of the expansion of our businesses and operations conducted in foreign countries, we face political, economic, legal, compliance, regulatory, operational and other risks and exposures that are unique and vary by jurisdiction. These foreign regulatory requirements with respect to, among other items, environmental, tax, licensing, intellectual property, privacy, data protection, investment, capital, management control, labor relations, and fraud and corruption regulations are different than those faced by our domestic businesses. In addition, we are subject to U.S. laws that regulate the conduct and activities of U.S.-based businesses operating abroad, such as the Foreign Corrupt Practices Act. Our failure to comply with laws and regulations governing our conduct outside the United States or to successfully navigate international regulatory regimes that apply to us could adversely affect our ability to market our products and services, which may have a material adverse effect on our business, financial condition and results of operations.

Our businesses providing pharmacy benefit management (PBM) and specialty pharmacy services face regulatory and other risks and uncertainties which could materially and adversely affect our results of operations, financial position and cash flows.

We provide PBM and specialty pharmacy services, including through our Envolve Pharmacy Solutions product. These businesses are subject to federal and state laws that govern the relationships of the business with pharmaceutical manufacturers, physicians, pharmacies, customers and consumers. We also conduct business as a mail order pharmacy and specialty pharmacy, which subjects these businesses to extensive federal, state and local laws and regulations. In addition, federal and state legislatures regularly consider new regulations for the industry that could materially and adversely affect current industry practices, including the receipt or disclosure of rebates from pharmaceutical companies, the development and use of formularies, and the use of average wholesale prices.

Our PBM and specialty pharmacy businesses would be materially and adversely affected by an inability to contract on favorable terms with pharmaceutical manufacturers and other suppliers, including with respect to the pricing of new specialty and generic drugs. In addition, our PBM and specialty pharmacy businesses could face potential claims in connection with purported errors by our mail order or specialty pharmacies, including in connection with the risks inherent in the authorization, compounding, packaging and distribution of pharmaceuticals and other healthcare products. Disruptions at any of our mail order or specialty pharmacies due to an event that is beyond our control could affect our ability to process and dispense prescriptions in a timely manner and could materially and adversely affect our results of operations, financial position and cash flows.

If any of our government contracts are terminated or are not renewed on favorable terms or at all, or if we receive an adverse finding or review resulting from an audit or investigation, our business may be adversely affected.

A substantial portion of our business relates to the provision of managed care programs and selected services to individuals receiving benefits under governmental assistance or entitlement programs. We provide these and other healthcare services under contracts with government entities in the areas in which we operate. Our government contracts are generally intended to run for a fixed number of years and may be extended for additional specified number of years if the contracting entity or its agent elects to do so. When our contracts with the government expire, they may be opened for bidding by competing healthcare providers, and there is no guarantee that our contracts will be renewed or extended. Competitors may buy their way into the market by submitting bids with lower pricing. Even if our responsive bids are successful, the bids may be based upon assumptions or other factors which could result in the contracts being less profitable than we had anticipated. Further, our government contracts contain certain provisions regarding eligibility, enrollment and dis-enrollment processes for covered services, eligible providers, periodic financial and informational reporting, quality assurance, timeliness of claims payment and agreement to maintain a Medicare plan in the state and financial standards, among other things, and are subject to cancellation if we fail to perform in accordance with the standards set by regulatory agencies.

We are also subject to various reviews, audits and investigations to verify our compliance with the terms of our contracts with various governmental agencies, as well as compliance with applicable laws and regulations. Any adverse review, audit or investigation could result in, among other things: cancellation of our contracts; refunding of amounts we have been paid pursuant to our contracts; imposition of fines, penalties and other sanctions on us; loss of our right to participate in various programs; increased difficulty in selling our products and services; loss of one or more of our licenses; or require changes to the way we do business. In addition, under government procurement regulations and practices, a negative determination resulting from a government audit of our business practices could result in a contractor being fined, debarred and/or suspended from being able to bid on, or be awarded, new government contracts for a period of time.

If any of our government contracts are terminated, not renewed, renewed on less favorable terms, or not renewed on a timely basis, or if we receive an adverse finding or review resulting from an audit or investigation, our business and reputation may be adversely impacted, our goodwill could be impaired and our financial position, results of operations or cash flows may be materially affected.

We contract with independent third party vendors and service providers who provide services to us and our subsidiaries or to whom we delegate selected functions. Violations of, or noncompliance with, laws and regulations governing our business by such third parties, or governing our dealings with such parties, could, among other things, subject us to additional audits, reviews and investigations and other adverse effects.

Ineffectiveness of state-operated systems and subcontractors could adversely affect our business.

A number of our health plans rely on other state-operated systems or subcontractors to qualify, solicit, educate and assign eligible members into managed care plans. The effectiveness of these state operations and subcontractors can have a material effect on a health plan's enrollment in a particular month or over an extended period. When a state implements new programs to determine eligibility, new processes to assign or enroll eligible members into health plans, or chooses new subcontractors, there is an increased potential for an unanticipated impact on the overall number of members assigned to managed care plans.

Our investment portfolio may suffer losses which could materially and adversely affect our results of operations or liquidity.

We maintain a significant investment portfolio of cash equivalents and short term and long term investments in a variety of securities, which are subject to general credit, liquidity, market and interest rate risks and will decline in value if interest rates increase or one of the issuers' credit ratings is reduced. As a result, we may experience a reduction in value or loss of our investments, which may have a negative adverse effect on our results of operations, liquidity and financial condition.

Execution of our growth strategy may increase costs or liabilities, or create disruptions in our business.

Our growth strategy includes, without limitation, the acquisition of health plans participating in government sponsored healthcare programs and specialty services businesses, contract rights and related assets of other health plans both in our existing service areas and in new markets and start-up operations in new markets or new products in existing markets. Although we review the records of companies or businesses we plan to acquire, it is possible that we could assume unanticipated liabilities or adverse operating conditions, or an acquisition may not perform as well as expected or may not achieve timely profitability. We also face the risk that we will not be able to effectively integrate acquisitions into our existing operations effectively without substantial expense, delay or other operational or financial problems and we may need to divert more management resources to integration than we planned.

In connection with start-up operations, we may incur significant expenses prior to commencement of operations and the receipt of revenue. For example, in order to obtain a certificate of authority in most jurisdictions, we must first establish a provider network, have systems in place and demonstrate our ability to administer a state contract and process claims. We may experience delays in operational start dates. As a result of these factors, start-up operations may decrease our profitability. In addition, we are planning to expand our business internationally and we will be subject to additional risks, including, but not limited to, political risk, an unfamiliar regulatory regime, currency exchange risk and exchange controls, cultural and language differences, foreign tax issues, and different labor laws and practices.

If we are unable to effectively execute our growth strategy, our future growth will suffer and our results of operations could be harmed.

If competing managed care programs are unwilling to purchase specialty services from us, we may not be able to successfully implement our strategy of diversifying our business lines.

We are seeking to diversify our business lines into areas that complement our government sponsored health plan business in order to grow our revenue stream and balance our dependence on risk reimbursement. In order to diversify our business, we must succeed in selling the services of our specialty subsidiaries not only to our managed care plans, but to programs operated by third-parties. Some of these third-party programs may compete with us in some markets, and they therefore may be unwilling to purchase specialty services from us. In any event, the offering of these services will require marketing activities that differ significantly from the manner in which we seek to increase revenues from our government sponsored programs. Our ineffectiveness in marketing specialty services to third-parties may impair our ability to execute our business strategy.

Adverse credit market conditions may have a material adverse effect on our liquidity or our ability to obtain credit on acceptable terms.

In the past, the securities and credit markets have experienced extreme volatility and disruption. The availability of credit, from virtually all types of lenders, has at times been restricted. In the event we need access to additional capital to pay our operating expenses, fund subsidiary surplus requirements, make payments on or refinance our indebtedness, pay capital expenditures, or fund acquisitions, our ability to obtain such capital may be limited and the cost of any such capital may be significant, particularly if we are unable to access our existing credit facility.

Our access to additional financing will depend on a variety of factors such as prevailing economic and credit market conditions, the general availability of credit, the overall availability of credit to our industry, our credit ratings and credit capacity, and perceptions of our financial prospects. Similarly, our access to funds may be impaired if regulatory authorities or rating agencies take negative actions against us. If a combination of these factors were to occur, our internal sources of liquidity may prove to be insufficient, and in such case, we may not be able to successfully obtain sufficient additional financing on favorable terms, within an acceptable time, or at all.

If state regulators do not approve payments of dividends and distributions by our subsidiaries to us, we may not have sufficient funds to implement our business strategy.

We principally operate through our health plan subsidiaries. As part of normal operations, we may make requests for dividends and distributions from our subsidiaries to fund our operations. These subsidiaries are subject to regulations that limit the amount of dividends and distributions that can be paid to us without prior approval of, or notification to, state regulators. If these regulators were to deny our subsidiaries' request to pay dividends, the funds available to us would be limited, which could harm our ability to implement our business strategy.

We derive a majority of our premium revenues from operations in a limited number of states, and our financial position, results of operations or cash flows would be materially affected by a decrease in premium revenues or profitability in any one of those states.

Operations in a limited number of states have accounted for most of our premium revenues to date. If we were unable to continue to operate in any of those states or if our current operations in any portion of one of those states were significantly curtailed, our revenues could decrease materially. Our reliance on operations in a limited number of states could cause our revenue and profitability to change suddenly and unexpectedly depending on legislative or other governmental or regulatory actions and decisions, economic conditions and similar factors in those states. For example, states we currently serve may open the bidding for their Medicaid program to other health insurers through a request for proposal process. Our inability to continue to operate in any of the states in which we operate could harm our business.

Competition may limit our ability to increase penetration of the markets that we serve.

We compete for members principally on the basis of size and quality of provider networks, benefits provided and quality of service. We compete with numerous types of competitors, including other health plans and traditional state Medicaid programs that reimburse providers as care is provided, among others. In addition, the impact of healthcare reform legislation and potential growth in our segment may attract new competitors.

Some of the health plans with which we compete have greater financial and other resources and offer a broader scope of products than we do. In addition, significant merger and acquisition activity has occurred in the managed care industry, as well as complementary industries, such as the hospital, physician, pharmaceutical, medical device and health information systems businesses. To the extent that competition intensifies in any market that we serve, as a result of industry consolidation or otherwise, our ability to retain or increase members and providers, or maintain or increase our revenue growth, pricing flexibility and control over medical cost trends may be adversely affected.

If we are unable to maintain relationships with our provider networks, our profitability may be harmed.

Our profitability depends, in large part, upon our ability to contract at competitive prices with hospitals, physicians and other healthcare providers. Our provider arrangements with our primary care physicians, specialists and hospitals generally may be canceled by either party without cause upon 90 to 120 days prior written notice. We cannot provide any assurance that we will be able to continue to renew our existing contracts or enter into new contracts on a timely basis or under favorable terms enabling us to service our members profitably. Healthcare providers with whom we contract may not properly manage the costs of services, maintain financial solvency or avoid disputes with other providers. Any of these events could have a material adverse effect on the provision of services to our members and our operations.

In any particular market, physicians and other healthcare providers could refuse to contract, demand higher payments, or take other actions that could result in higher medical costs or difficulty in meeting regulatory or accreditation requirements, among other things. In some markets, certain healthcare providers, particularly hospitals, physician/hospital organizations or multi-specialty physician groups, may have significant market positions or near monopolies that could result in diminished bargaining power on our part. In addition, accountable care organizations, practice management companies, which aggregate physician practices for administrative efficiency and marketing leverage, and other organizational structures that physicians, hospitals and other healthcare providers choose may change the way in which these providers interact with us and may change the competitive landscape. Such organizations or groups of healthcare providers may compete directly with us, which could adversely affect our operations, and our results of operations, financial position and cash flows by impacting our relationships with these providers or affecting the way that we price our products and estimate our costs, which might require us to incur costs to change our operations. Provider networks may consolidate, resulting in a reduction in the competitive environment. In addition, if these providers refuse to contract with us, use their market position to negotiate contracts unfavorable to us or place us at a competitive disadvantage, our ability to market products or to be profitable in those areas could be materially and adversely affected.

From time to time healthcare providers assert or threaten to assert claims seeking to terminate non-cancelable agreements due to alleged actions or inactions by us. If we are unable to retain our current provider contract terms or enter into new provider contracts timely or on favorable terms, our profitability may be harmed. In addition, from time to time, we may be subject to class action or other lawsuits by healthcare providers with respect to claim payment procedures or similar matters. For example, the Company's wholly owned subsidiary, Health Net Life Insurance Company ("HNL"), is and may continue to be subject to such disputes with respect to HNL's payment levels in connection with the processing of out-of-network provider reimbursement claims for the provision of certain substance abuse related services. HNL expects to vigorously defend its claims payment practices. Nevertheless, in the event HNL receives an adverse finding in any related legal proceeding or from a regulator, or is otherwise required to reimburse providers for these claims at rates that are higher than expected or for claims HNL otherwise believes are unallowable, the Company's financial condition and results of operations may be materially adversely affected. In addition, regardless of whether any such lawsuits brought against us are successful or have merit, they will still be time-consuming and costly and could distract our management's attention. As a result, under such circumstances we may incur significant expenses and may be unable to operate our business effectively.

We may be unable to attract, retain or effectively manage the succession of key personnel.

We are highly dependent on our ability to attract and retain qualified personnel to operate and expand our business. We would be adversely impacted if we are unable to adequately plan for the succession of our executives and senior management. While we have succession plans in place for members of our executive and senior management team, these plans do not guarantee that the services of our executive and senior management team will continue to be available to us. Our ability to replace any departed members of our executive and senior management or other key employees may be difficult and may take an extended period of time because of the limited number of individuals in the managed care and specialty services industry with the breadth of skills and experience required to operate and successfully expand a business such as ours. Competition to hire from this limited pool is intense, and we may be unable to hire, train, retain or motivate these personnel. If we are unable to attract, retain and effectively manage the succession plans for key personnel, executives and senior management, our business and financial position, results of operations or cash flows could be harmed.

If we are unable to integrate and manage our information systems effectively, our operations could be disrupted.

Our operations depend significantly on effective information systems. The information gathered and processed by our information systems assists us in, among other things, monitoring utilization and other cost factors, processing provider claims, and providing data to our regulators. Our healthcare providers also depend upon our information systems for membership verifications, claims status and other information. Our information systems and applications require continual maintenance, upgrading and enhancement to meet our operational needs and regulatory requirements. We regularly upgrade and expand our information systems' capabilities. If we experience difficulties with the transition to or from information systems or do not appropriately integrate, maintain, enhance or expand our information systems, we could suffer, among other things, operational disruptions, loss of existing members and difficulty in attracting new members, regulatory problems and increases in administrative expenses. In addition, our ability to integrate and manage our information systems may be impaired as the result of events outside our control, including acts of nature, such as earthquakes or fires, or acts of terrorists.

From time to time, we may become involved in costly and time-consuming litigation and other regulatory proceedings, which require significant attention from our management.

From time to time we are a defendant in lawsuits and regulatory actions and are subject to investigations relating to our business, including, without limitation, medical malpractice claims, claims by members alleging failure to pay for or provide health care, claims related to non-payment or insufficient payments for out-of-network services, claims alleging bad faith, investigations regarding our submission of risk adjuster claims, putative securities class actions, and claims related to the imposition of new taxes, including but not limited to claims that may have retroactive application. Due to the inherent uncertainties of litigation and regulatory proceedings, we cannot accurately predict the ultimate outcome of any such proceedings. An unfavorable outcome could have a material adverse impact on our business and financial position, results of operations and/or cash flows and may affect our reputation. In addition, regardless of the outcome of any litigation or regulatory proceedings, such proceedings are costly and time consuming and require significant attention from our management, and could therefore harm our business and financial position, results of operations or cash flows.

An impairment charge with respect to our recorded goodwill and intangible assets could have a material impact on our results of operations.

We periodically evaluate our goodwill and other intangible assets to determine whether all or a portion of their carrying values may be impaired, in which case a charge to earnings may be necessary. Changes in business strategy, government regulations or economic or market conditions have resulted and may result in impairments of our goodwill and other intangible assets at any time in the future. Our judgments regarding the existence of impairment indicators are based on, among other things, legal factors, market conditions, and operational performance. For example, the non-renewal of our health plan contracts with the state in which they operate may be an indicator of impairment. If an event or events occur that would cause us to revise our estimates and assumptions used in analyzing the value of our goodwill and other intangible assets, such revision could result in a non-cash impairment charge that could have a material impact on our results of operations in the period in which the impairment occurs.

If we fail to comply with applicable privacy, security, and data laws, regulations and standards, including with respect to third-party service providers that utilize sensitive personal information on our behalf, our business, reputation, results of operations, financial position and cash flows could be materially and adversely affected.

As part of our normal operations, we collect, process and retain confidential member information. We are subject to various federal and state laws and rules regarding the use and disclosure of confidential member information, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 and the Gramm-Leach-Bliley Act, which require us to protect the privacy of medical records and safeguard personal health information we maintain and use. Certain of our businesses are also subject to the Payment Card Industry Data Security Standard, which is a multifaceted security standard that is designed to protect credit card account data as mandated by payment card industry entities. Despite our best attempts to maintain adherence to information privacy and security best practices as well as compliance with applicable laws, rules and contractual requirements, our facilities and systems, and those of our third party service providers, may be vulnerable to privacy or security breaches, acts of vandalism or theft, malware or other forms of cyber attack, misplaced or lost data including paper or electronic media, programming and/or human errors or other similar events. In the past, we have had data breaches resulting in disclosure of confidential or protected health information that have not resulted in any material financial loss or penalty to date. However, future data breaches could require us to expend significant resources to remediate any damage, interrupt our operations and damage our reputation, subject us to state or federal agency review and could also result in enforcement actions, material fines and penalties, litigation or other actions which could have a material adverse effect on our business, reputation and results of operations, financial position and cash flows.

In addition, HIPAA broadened the scope of fraud and abuse laws applicable to healthcare companies. HIPAA established new enforcement mechanisms to combat fraud and abuse, including civil and, in some instances, criminal penalties for failure to comply with specific standards relating to the privacy, security and electronic transmission of protected health information. The HITECH Act expanded the scope of these provisions by mandating individual notification in instances of breaches of protected health information, providing enhanced penalties for HIPAA violations, and granting enforcement authority to states' Attorneys General in addition to the HHS Office for Civil Rights. It is possible that Congress may enact additional legislation in the future to increase penalties and to create a private right of action under HIPAA, which could entitle patients to seek monetary damages for violations of the privacy rules. Additionally, HHS continued its auditing program in 2016 to assess compliance efforts by covered entities and business associates. Through a second phase of audits, which commenced for covered entities in July 2016, HHS focused on a review of policies and procedures adopted and employed by covered entities and their business associates to meet selected standards and implementation specifications of the HIPAA Privacy, Security, and Breach Notification Rules. An audit resulting in findings or allegations of noncompliance could have a material adverse effect on our results of operations, financial position and cash flows.

If we fail to comply with the extensive federal and state fraud and abuse laws, our business, reputation, results of operations, financial position and cash flows could be materially and adversely affected.

We, along with all other companies involved in public health care programs are the subject of fraud and abuse investigations from time to time. The regulations and contractual requirements applicable to participants in these public sector programs are complex and subject to change. Violations of fraud and abuse laws applicable to us could result in civil monetary penalties, criminal fines and imprisonment, and/or exclusion from participation in Medicaid, Medicare, TRICARE, VA and other federal health care programs and federally funded state health programs. Fraud and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical services, improper marketing and violations of patient privacy rights. These fraud and abuse laws include the federal False Claims Act, which prohibits the known filing of a false claim or the known use of false statements to obtain payment from the federal government. Many states have false claim act statutes that closely resemble the federal False Claims Act. In addition, the Deficit Reduction Act of 2005 encouraged states to enact state-versions of the federal False Claims Act that establish liability to the state for false and fraudulent Medicaid claims and that provide for, among other things, claims to be filed by *qui tam* relators. Federal and state governments have made investigating and prosecuting health care fraud and abuse a priority. In the event we fail to comply with the extensive federal and state fraud and abuse laws, our business, reputation, results of operations, financial position and cash flows could be materially and adversely affected.

A failure in or breach of our operational or security systems or infrastructure, or those of third parties with which we do business, including as a result of cyber attacks, could have an adverse effect on our business.

Information security risks have significantly increased in recent years in part because of the proliferation of new technologies, the use of the internet and telecommunications technologies to conduct our operations, and the increased sophistication and activities of organized crime, hackers, terrorists and other external parties, including foreign state agents. Our operations rely on the secure processing, transmission and storage of confidential, proprietary and other information in our computer systems and networks.

Security breaches may arise from external or internal threats. External breaches include hacking personal information for financial gain, attempting to cause harm or interruption to our operations, or intending to obtain competitive information. We experience attempted external hacking or malicious attacks on a regular basis. We maintain a rigorous system of preventive and detective controls through our security programs; however, our prevention and detection controls may not prevent or identify all such attacks on a timely basis, or at all. Internal breaches may result from inappropriate security access to confidential information by rogue employees, consultants or third party service providers. Any security breach involving the misappropriation, loss or other unauthorized disclosure or use of confidential member information, financial data, competitively sensitive information, or other proprietary data, whether by us or a third party, could have a material adverse effect on our business reputation, financial condition, cash flows, or results of operations.

We may be unable to successfully integrate our business with Health Net and realize the anticipated benefits of the acquisition.

We completed the acquisition of Health Net on March 24, 2016. The success of the acquisition of Health Net will depend, in part, on our ability to successfully combine the businesses of the Company and Health Net and realize the anticipated benefits, including synergies, cost savings, growth in earnings, innovation and operational efficiencies, from the combination. If we are unable to achieve these objectives within the anticipated time frame, or at all, the anticipated benefits may not be realized fully or at all, or may take longer to realize than expected and the value of our common stock may be harmed.

The integration of Health Net's business with our existing business is a complex, costly and time-consuming process. We have not previously completed a transaction comparable in size or scope to the acquisition of Health Net. The integration of the two companies may result in material challenges, including, without limitation:

- the diversion of management's attention from ongoing business concerns and performance shortfalls as a result of the devotion of management's attention to the integration;
- managing a larger combined company;
- maintaining employee morale and retaining key management and other employees;
- the possibility of faulty assumptions underlying expectations regarding the integration process;
- retaining existing business and operational relationships and attracting new business and operational relationships;
- consolidating corporate and administrative infrastructures and eliminating duplicative operations;
- coordinating geographically separate organizations;
- unanticipated issues in integrating information technology, communications and other systems;
- unanticipated changes in federal or state laws or regulations, including the ACA and any regulations enacted thereunder; and
- unforeseen expenses or delays associated with the acquisition and/or integration.

Many of these factors will be outside of our control and any one of them could result in delays, increased costs, decreases in the amount of expected revenues and diversion of management's time and energy, which could materially affect our financial position, results of operations and cash flows.

We have incurred substantial expenses related to the completion of the acquisition of Health Net and are incurring substantial expenses related to the integration of Health Net.

We are in the process of integrating a large number of processes, policies, procedures, operations, technologies and systems, including purchasing, accounting and finance, sales, payroll, pricing, revenue management, marketing and benefits, among other things. In addition, the businesses of Centene and Health Net will continue to maintain a presence in St. Louis, Missouri and Woodland Hills, California, respectively. The substantial majority of these costs will be non-recurring expenses related to the acquisition (including financing of the acquisition), facilities and systems consolidation costs. We may incur additional costs to maintain employee morale and to retain key employees. We are also incurring transaction fees and costs related to formulating integration plans for the combined business, and the execution of these plans may lead to additional unanticipated costs. These incremental transaction and acquisition-related costs may exceed the savings we expect to achieve from the elimination of duplicative costs and the realization of other efficiencies related to the integration of the businesses, particularly in the near term and in the event there are material unanticipated costs.

The market price of our common stock may decline as a result of the acquisition of Health Net.

The market price of our common stock is generally subject to volatility, and there can be no assurances regarding the level or stability of our share price at any time. The market price of our common stock may decline as a result of the acquisition if, among other things, we are unable to achieve the expected growth in earnings, or if the operational cost savings estimates in connection with the integration of Health Net's business with ours are not realized, or if the transaction costs related to the acquisition and integration are greater than expected. The market price also may decline if we do not achieve the perceived benefits of the acquisition as rapidly or to the extent anticipated by financial or industry analysts or if the effect of the acquisition on our financial position, results of operations or cash flows is not consistent with the expectations of financial or industry analysts.

Our future results may be adversely impacted if we do not effectively manage our expanded operations following the completion of our acquisition of Health Net.

The size of our business following the acquisition of Health Net is significantly larger than the size of either Centene's or Health Net's respective businesses prior to the acquisition. Our ability to successfully manage the expanded business will depend, in part, upon management's ability to design and implement strategic initiatives that address the increased scale and scope of the combined business with its associated increased costs and complexity. We will also have to manage our expanded operations in compliance with certain undertakings with regulators that were agreed to in connection with the approval of the acquisition. These undertakings require significant investments by us, may restrict or impose additional material costs on our future operations and strategic initiatives in certain geographies, and subject us to various enforcement mechanisms. There can be no assurances that we will be successful in managing our expanded operations or that we will realize the expected growth in earnings, operating efficiencies, cost savings and other benefits.

We are significantly more leveraged today than we have previously been.

As of December 31, 2016, we had consolidated indebtedness of approximately $4,655 million, which is significantly greater than the indebtedness that we have previously had. This increased indebtedness and higher debt-to-equity ratio will have the effect, among other things, of reducing our flexibility to respond to changing business and economic conditions and increasing borrowing costs.

Among other things, our revolving credit facility requires us to comply with various covenants that impose restrictions on our operations, including our ability to incur additional indebtedness, create liens, pay dividends, make investments or other restricted payments, sell or otherwise dispose of substantially all of our assets and engage in other activities. Our revolving credit facility also requires us to comply with a maximum leverage ratio and a minimum fixed charge coverage ratio. These restrictive covenants could limit our ability to pursue our business strategies. In addition, any failure by us to comply with these restrictive covenants could result in an event of default under the revolving credit facility and, in some circumstances, under the indentures governing our notes, which, in any case, could have a material adverse effect on our financial condition.

Item 1B. ***Unresolved Staff Comments***

None.

Item 2. ***Properties***

We own our corporate office headquarters buildings and land located in St. Louis, Missouri, which is used by each of our reportable segments. We generally lease space in the states where our health plans, specialty companies and claims processing facilities operate. We are required by various insurance and regulatory authorities to have offices in the service areas where we provide benefits. We believe our current facilities and expansion plans are adequate to meet our operational needs for the foreseeable future.

Item 3. ***Legal Proceedings***

A description of the legal proceedings to which the Company and its subsidiaries are a party is contained in Note 18 to the consolidated financial statements included in Part II of this Annual Report on Form 10-K, and is incorporated herein by reference.

Item 4. ***Mine Safety Disclosures***

Not applicable.

PART II

Item 5. ***Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities***

Market for Common Stock; Dividends

Our common stock has been traded and quoted on the New York Stock Exchange under the symbol "CNC" since October 16, 2003. On February 2, 2015, the Board of Directors declared a two-for-one split of Centene's common stock in the form of a 100% stock dividend distributed February 19, 2015 to stockholders of record on February 12, 2015. All share, per share and stock price information presented in this Form 10-K has been adjusted for the two-for-one stock split. The high and low prices, as reported by the NYSE, are set forth below for the periods indicated.

	2017 Stock Price (through February 17, 2017)		2016 Stock Price		2015 Stock Price	
	High	Low	High	Low	High	Low
First Quarter	$ 71.89	$ 56.00	$ 68.42	$ 47.36	$ 71.66	$ 51.73
Second Quarter			71.53	55.60	82.18	61.85
Third Quarter			75.57	63.37	83.00	50.93
Fourth Quarter			67.41	50.00	67.53	51.75

As of February 17, 2017, there were 1,113 holders of record of our common stock.

We have never declared any cash dividends on our capital stock and currently anticipate that we will retain any future earnings for the development, operation and expansion of our business.

Issuer Purchases of Equity Securities

In 2009, the Company's Board of Directors extended the Company's stock repurchase program. The program authorizes the repurchase of up to 8,000,000 shares of the Company's common stock from time to time on the open market or through privately negotiated transactions. We have 3,335,448 available shares remaining under the program for repurchases as of December 31, 2016. No duration has been placed on the repurchase program. The Company reserves the right to discontinue the repurchase program at any time. During the year ended December 31, 2016, we did not repurchase any shares through this publicly announced program.

Issuer Purchases of Equity Securities
Fourth Quarter 2016

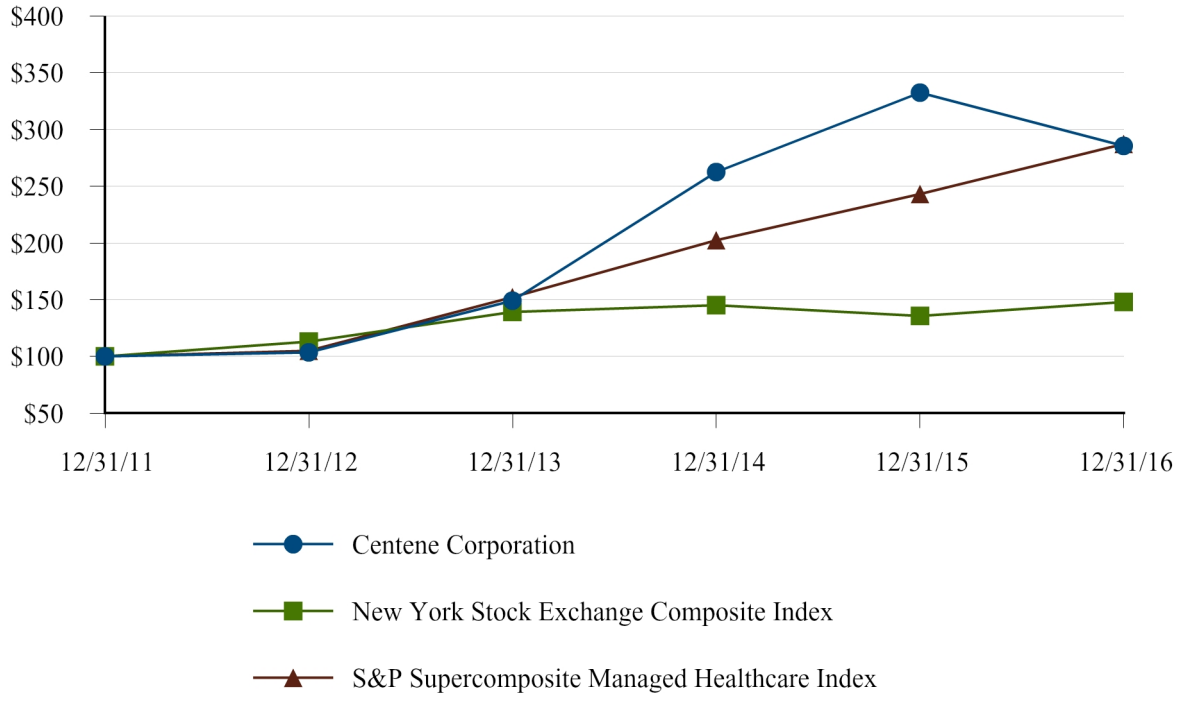
Period	Total Number of Shares Purchased[1]	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number of Shares that May Yet Be Purchased Under the Plans or Programs[2]
October 1 – October 31, 2016	9,589	$ 64.10	—	3,335,448
November 1 – November 30, 2016	9,813	54.14	—	3,335,448
December 1 – December 31, 2016	588,760	56.73	—	3,335,448
Total	608,162	$ 56.80	—	3,335,448

(1) Shares acquired represent shares relinquished to the Company by certain employees for payment of taxes or option cost upon vesting of restricted stock units or option exercise.

(2) Our Board of Directors adopted a stock repurchase program which allows for repurchases of up to a remaining amount of 3,335,448 shares. No duration has been placed on the repurchase program.

Stock Performance Graph

The graph below compares the cumulative total stockholder return on our common stock for the period from December 31, 2011 to December 31, 2016 with the cumulative total return of the New York Stock Exchange Composite Index and the Standard & Poor's Supercomposite Managed Healthcare Index over the same period. The graph assumes an investment of $100 on December 31, 2011 in our common stock (at the last reported sale price on such day), the New York Stock Exchange Composite Index and the Standard & Poor's Supercomposite Managed Healthcare Index and assumes the reinvestment of any dividends.



	December 31,					
	2011	**2012**	**2013**	**2014**	**2015**	**2016**
Centene Corporation	$100.00	$103.54	$148.89	$262.27	$332.37	$285.40
New York Stock Exchange Composite Index	100.00	112.93	139.10	144.97	135.66	147.88
S&P Supercomposite Managed Healthcare Index	100.00	104.85	152.16	202.37	242.93	287.17
Centene Corporation closing stock price	$ 19.80	$ 20.50	$ 29.48	$ 51.93	$ 65.81	$ 56.51
Centene Corporation annual shareholder return	56.3%	3.5%	43.8%	76.2%	26.7%	(14.1)%

In accordance with the rules of the SEC, the information contained in the Stock Performance Graph on this page shall not be deemed to be “soliciting material,” or to be “filed” with the SEC or subject to the SEC’s Regulation 14A, or to the liabilities of Section 18 of the Exchange Act, except to the extent that Centene specifically requests that the information be treated as soliciting material or specifically incorporates it by reference into a document filed under the Securities Act, or the Exchange Act.

Item 6. *Selected Financial Data*

The following selected consolidated financial data should be read in conjunction with the consolidated financial statements and related notes and "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations" included in our Annual Report on Form 10-K. The assets, liabilities and results of operations of Kentucky Spirit have been classified as discontinued operations for all periods presented.

	Year Ended December 31,				
	2016	2015	2014	2013	2012
	(In millions, except share data)				
Revenues:					
Premium	$ 35,399	$ 19,389	$ 14,198	$ 10,153	$ 7,569
Service	2,180	1,876	1,469	373	113
Premium and service revenues	37,579	21,265	15,667	10,526	7,682
Premium tax and health insurer fee	3,028	1,495	893	337	428
Total revenues	40,607	22,760	16,560	10,863	8,110
Expenses:					
Medical costs	30,636	17,242	12,678	8,995	6,781
Cost of services	1,864	1,621	1,280	327	88
Selling, general and administrative expenses	3,676	1,802	1,298	925	700
Amortization of acquired intangible assets	147	24	16	6	5
Premium tax expense	2,563	1,151	698	333	428
Health insurer fee expense	461	215	126	—	—
Total operating expenses	39,347	22,055	16,096	10,586	8,002
Earnings from operations	1,260	705	464	277	108
Other income (expense):					
Investment and other income	114	35	28	19	35
Interest expense	(217)	(43)	(35)	(27)	(20)
Earnings from continuing operations, before income tax expense	1,157	697	457	269	123
Income tax expense	599	339	196	107	47
Earnings from continuing operations, net of income tax expense	558	358	261	162	76
Discontinued operations, net of income tax expense (benefit) of $2, $(1), $1, $2, and $(48), respectively	3	(1)	3	4	(87)
Net earnings (loss)	561	357	264	166	(11)
(Earnings) loss attributable to noncontrolling interests	1	(2)	7	(1)	13
Net earnings attributable to Centene Corporation	$ 562	$ 355	$ 271	$ 165	$ 2
Amounts attributable to Centene Corporation common shareholders:					
Earnings from continuing operations, net of income tax expense	$ 559	$ 356	$ 268	$ 161	$ 89
Discontinued operations, net of income tax expense (benefit)	3	(1)	3	4	(87)
Net earnings	$ 562	$ 355	$ 271	$ 165	$ 2
Net earnings (loss) per common share attributable to Centene Corporation:					
Basic:					
Continuing operations	$ 3.50	$ 2.99	$ 2.30	$ 1.49	$ 0.86
Discontinued operations	0.02	(0.01)	0.03	0.03	(0.84)
Basic earnings per common share	$ 3.52	$ 2.98	$ 2.33	$ 1.52	$ 0.02
Diluted:					
Continuing operations	$ 3.41	$ 2.89	$ 2.23	$ 1.43	$ 0.83
Discontinued operations	0.02	(0.01)	0.02	0.04	(0.81)
Diluted earnings per common share	$ 3.43	$ 2.88	$ 2.25	$ 1.47	$ 0.02
Weighted average number of common shares outstanding:					
Basic	159,567,607	119,100,744	116,345,764	108,253,090	103,018,732
Diluted	163,975,407	123,066,370	120,360,212	112,494,346	107,428,750

	December 31,				
	2016	2015	2014	2013	2012
			(In millions)		
Consolidated Balance Sheet Data:					
Cash and cash equivalents [1]	$ 3,930	$ 1,760	$ 1,610	$ 974	$ 746
Investments and restricted deposits [1]	5,188	2,218	1,557	941	727
Total assets	20,197	7,339	5,824	3,519	2,764
Medical claims liability [1]	3,929	2,298	1,723	1,112	815
Long term debt [1]	4,651	1,216	874	655	526
Total stockholders' equity	5,909	2,168	1,743	1,243	954

(1) From continuing operations.

ITEM 7. Management's Discussion and Analysis of Financial Condition and Results of Operations

The following discussion of our financial condition and results of operations should be read in conjunction with our consolidated financial statements and the related notes included elsewhere in this filing. The discussion contains forward-looking statements that involve known and unknown risks and uncertainties, including those set forth under Part I, Item 1A."Risk Factors" of this Form 10-K.

EXECUTIVE OVERVIEW

General

We are a diversified, multi-national healthcare enterprise that provides services to government sponsored healthcare programs, focusing on under-insured and uninsured individuals. We provide member-focused services through locally based staff by assisting in accessing care, coordinating referrals to related health and social services and addressing member concerns and questions.

Results of operations depend on our ability to manage expenses associated with health benefits (including estimated costs incurred) and SG&A costs. We measure operating performance based upon two key ratios. The HBR represents medical costs as a percentage of premium revenues, excluding premium tax and health insurer fee revenues that are not separately billed, and reflects the direct relationship between the premium received and the medical services provided. The SG&A expense ratio represents SG&A costs as a percentage of premium and service revenues, again excluding premium tax and health insurer fee revenues that are not separately billed.

Health Net Acquisition

On March 24, 2016, the Company acquired all of the issued and outstanding shares of Health Net, a publicly traded managed care organization that delivers healthcare services through health plans and government-sponsored managed care plans. The transaction was valued at approximately $5,990 million, including the assumption of $703 million of outstanding debt. The acquisition allows the Company to offer a more comprehensive and scalable portfolio of solutions and provides opportunity for additional growth across the combined company's markets. 2016 was a transformative year with the acquisition of Health Net. Due to the size of this acquisition, the primary driver of the year over year variances discussed throughout this section are related to the acquisition of Health Net.

Regulatory Trends and Uncertainties

The new U.S. Presidential administration and certain members of Congress have affirmatively indicated that they will pursue full repeal of or significant amendment to the ACA. Even if the ACA is not amended or repealed, the new administration could propose changes impacting implementation of the ACA. The ultimate content and timing of any legislation enacted under the new administration that would impact the current implementation of the ACA remains uncertain. However, we believe we have both the capacity and capability to successfully navigate industry changes to the benefit of our members, customers and shareholders.

For additional information regarding regulatory trends and uncertainties, see Part I, Item 1 *"Business - Regulation"* and Item 1A, "*Risk Factors*."

2016 Highlights

Our financial performance for 2016 is summarized as follows:

- Year-end managed care membership of 11.4 million, an increase of over 6.3 million members, or 124% over 2015.
- Total revenues of $40.6 billion, representing 78% growth year over year.
- HBR of 86.5%, compared to 88.9% in 2015.
- SG&A expense ratio of 9.8% for 2016 compared to 8.5% for 2015. SG&A expense ratio excluding Health Net acquisition related expenses of 9.2% for 2016 compared to 8.3% for 2015.

- Operating cash flows of $1,851 million, or 3.3 times net earnings.
- Diluted EPS for 2016 of $3.41 compared to $2.89 for 2015.
- Adjusted Diluted EPS for 2016 of $4.43 compared to $3.14 for 2015.

Adjusted Diluted EPS is highlighted below and additional detail is provided above under the heading "*Non-GAAP Financial Presentation*":

	Year Ended December 31,	
	2016	**2015**
GAAP diluted EPS	$ 3.41	$ 2.89
Health Net acquisition related expenses	0.98	0.14
Amortization of acquired intangible assets	0.57	0.11
California minimum MLR change [(1)]	(0.76)	—
Charitable contribution [(2)]	0.19	—
Debt extinguishment [(3)]	0.04	—
Adjusted Diluted EPS	$ 4.43	$ 3.14

(1) A favorable impact associated with the retroactive contract amendment received in the fourth quarter of 2016 that changed the minimum MLR calculation under California's Medicaid expansion program, $195 million of which relates to periods prior to 2016 for the legacy Centene business and prior to the acquisition date for the legacy Health Net business.

(2) In connection with the additional revenue associated with the California minimum MLR change, the Company committed to a charitable contribution to its foundation of $50 million in the fourth quarter of 2016.

(3) Additional expense of $11 million associated with the early redemption of the Centene 5.75% Senior Notes due 2017 and the Health Net 6.375% Senior Notes due 2017.

Included in diluted EPS and Adjusted Diluted EPS for the year ended December 31, 2016 is a $0.05 diluted EPS benefit related to the early adoption of the stock-based compensation accounting standard, as well as the incorporation of retirement provisions in our stock-based compensation agreements.

In 2013, we classified the operations for Kentucky Spirit as discontinued operations for all periods presented in our consolidated financial statements. Management's discussion and analysis, with the exception of cash flow information, is presented in the context of continuing operations unless otherwise identified.

The following items contributed to our revenue and membership growth over the last two years:

- *Arizona.* In October 2015, our subsidiary, Cenpatico Integrated Care, in partnership with University of Arizona Health Plan, began operating under a contract with the Arizona Department of Health Services/Division of Behavioral Health Services to be the Regional Behavioral Health Authority for the new southern geographic service area.
- *Centurion.* In February 2015, Centurion began operating under a new contract with the State of Vermont Department of Corrections to provide comprehensive correctional healthcare services. In July 2015, Centurion began operating under a new contract with the Mississippi Department of Corrections to provide comprehensive correctional healthcare services. In April 2016, Centurion began providing correctional healthcare services for the Florida Department of Corrections in Regions 1, 2 and 3. In June 2016, Centurion began operating under two new contracts with the State of New Mexico Corrections Department to provide correctional medical healthcare services and pharmacy services.
- *Florida.* In October 2015, our Florida subsidiary, Sunshine Health began operating under a two-year, statewide contract with the Florida Healthy Kids Corporation to manage healthcare services for children ages five through 18 in all 11 regions of Florida.

- *Health Net.* On March 24, 2016, we acquired all of the issued and outstanding shares of Health Net for approximately $6.0 billion, including the assumption of debt. This strategic acquisition broadened our service offerings, providing expansion in both Medicaid and Medicare programs. This acquisition provided further diversification across our markets and products through the addition of commercial products and government-sponsored care under federal contracts with the Department of Defense (DoD) and the U.S. Department of Veteran's Affairs (VA), as well as Medicare Advantage. Health Net's operations are primarily concentrated in the states of California, Arizona, Oregon, and Washington.

- *Indiana.* In February 2015, our Indiana subsidiary, Managed Health Services, began operating under an expanded contract with the Indiana Family & Social Services Administration to provide Medicaid services under the State's Healthy Indiana Plan 2.0 program. In April 2015, Managed Health Services began operating under an expanded contract with the Indiana Family & Social Services Administration to provide services to its ABD Medicaid enrollees who qualify for the new Hoosier Care Connect Program.

- *Louisiana.* In February 2015, our Louisiana subsidiary, Louisiana Healthcare Connections, began operating under a new contract with the Louisiana Department of Health and Hospitals to serve Healthy Louisiana (Medicaid) beneficiaries. Members previously served under the shared savings program were transitioned to the at-risk program on February 1, 2015. In December 2015, Louisiana Healthcare Connections began operating under an expanded contract to include behavioral health benefits. In July 2016, Louisiana Healthcare Connections began serving Medicaid expansion members.

- *Michigan.* In May 2015, we completed the acquisition of Fidelis SecureCare of Michigan, Inc. (Fidelis). Fidelis began operating under a new contract with the Michigan Department of Community Health and CMS to provide integrated healthcare services to members who are dually eligible for Medicare and Medicaid in Macomb and Wayne counties in May 2015.

- *Mississippi.* In July 2014, our Mississippi subsidiary, Magnolia Health, began operating as one of two contractors under a new statewide managed care contract serving members enrolled in the Mississippi Coordinated Access Network program. Program expansion began in December 2014 and continued through July 2015. In July 2015, Magnolia Health began operating under a two-year CHIP contract with the State of Mississippi. In December 2015, Magnolia Health began operating under an expanded contract to include the inpatient benefit for Medicaid and ABD members.

- *New Hampshire.* In January 2016, we began serving members enrolled in the federally facilitated Health Insurance Marketplace in the State of New Hampshire. In January 2016, we started operating under a contract with the New Hampshire Department of Health and Human Services to participate in the Medicaid expansion model that New Hampshire has adopted (referred to as the “Premium Assistance Program”).

- *Oregon.* In September 2015, we completed the acquisition of Agate Resources, Inc., a diversified holding company, that offers primarily Medicaid and other healthcare products and services to Oregon residents through Trillium Community Health Plan.

- *South Carolina.* In February 2015, our South Carolina subsidiary, Absolute Total Care, began operating under a new contract with the South Carolina Department of Health and Human Services and CMS to serve dual-eligible members as part of the State's dual demonstration program.

- *Texas.* In March 2015, we began operating under an expanded STAR+PLUS contract with the Texas Health and Human Services Commission (HHSC) to include nursing facility benefits. In March 2015, we also began operating under a new contract with the Texas HHSC and CMS to serve dual-eligible members in three counties as part of the State's dual demonstration program. In November 2016, our subsidiary, Superior HealthPlan, Inc., began operating under a new contract with the Texas HHSC to serve STAR Kids Medicaid population in seven delivery areas, more than any other successful bidder.

- *Washington.* In April 2016, our subsidiary, Coordinated Care of Washington, began operating as the sole contractor with the Washington State Health Care Authority to provide foster care services through the Apple Health Foster Care contract.

We expect the following items to contribute to our future growth potential:

- We expect to realize the full year benefit in 2017 from the Health Net acquisition completed on March 24, 2016.

- We expect to realize the full year benefit in 2017 of business commenced during 2016 in Florida, Louisiana, New Mexico, Texas, and Washington as discussed above.

- In January 2017, we signed a joint venture agreement with the North Carolina Medical Society, working in conjunction with the North Carolina Community Health Center, to collaborate on a patient-focused approach to Medicaid under the reform plan enacted in the State of North Carolina. The newly created health plan, Carolina Complete Health, was created to establish, organize and operate a physician-led health plan to provide Medicaid managed care services in North Carolina.

- In January 2017, our Pennsylvania subsidiary, Pennsylvania Health & Wellness, was selected by the Pennsylvania Department of Human Services to serve Medicaid recipients enrolled in the HealthChoices program in three zones. Pending regulatory approval and successful completion of a readiness review, the three-year agreement is expected to commence June 1, 2017.

- In January 2017, our Indiana subsidiary, Managed Health Services, began operating under a contract with the Indiana Family & Social Services Administration to provide risk-based managed care services for enrollees in the Healthy Indiana Plan and Hoosier Healthwise programs.

- In January 2017, our Nebraska subsidiary, Nebraska Total Care, began operating under a contract with the Nebraska Department of Health and Human Services' Division of Medicaid and Long Term Care as one of three managed care organizations to administer its new Heritage Health Program for Medicaid, ABD, CHIP, Foster Care and LTC enrollees.

- In January 2017, we continued our participation as a qualified health plan issuer in the Arizona Health Insurance Marketplace and exited the Health Net preferred provider organization offerings in Arizona.

- In November 2016, our Georgia subsidiary, Peach State Health Plan, was awarded a statewide managed care contract to continue serving members enrolled in the Georgia Families managed care program, including PeachCare for Kids and Planning for Healthy Babies. Through the new contract, Peach State Health Plan will be one of four managed care organizations providing medical, behavioral, dental and vision health benefits for its members. The contract is expected to become effective July 1, 2017.

- In November 2016, our Nevada subsidiary, Silver Summit Health Plan, was selected to serve Medicaid recipients enrolled in Nevada's Medicaid managed care program. The contract is expected to commence on July 1, 2017, pending regulatory approval and successful completion of a readiness review.

- In October 2016, our Missouri subsidiary, Home State Health, was selected to provide managed care services to MO HealthNet Managed Care beneficiaries. Under the new contract, Home State Health expects to serve MO HealthNet Managed Care beneficiaries in each of the state's 114 counties and the City of St. Louis. The contract is expected to commence May 1, 2017.

- In September 2016, the Alabama legislature approved the funding needed to create its regional care organization (RCO) structure. Our subsidiary, AHA Administrative Services, has contracted with five nonprofit RCOs in Alabama to provide management services. Operations are expected to commence October 1, 2017.

- In August 2016, our Pennsylvania subsidiary, Pennsylvania Health & Wellness, was selected by the department of Human Services and Aging to serve enrollees in the Community HealthChoices program statewide. Expected contract commencement dates vary by zone, starting January 2018, and will be fully implemented by January 2019, pending regulatory approval.

- In July 2016, it was announced that the Department of Defense awarded our wholly-owned subsidiary, Health Net Federal Services, the TRICARE West Region contract. We currently administer services for the TRICARE program in the North Region. In connection with this latest generation of TRICARE contracts, the Department of Defense has consolidated the prior North, South and West TRICARE regions into two: the West and East Regions (the East combining the current North and South Regions). We expect health care delivery for this new contract to begin in the second half of 2017.

- In May 2016, our specialty solutions division, Envolve, Inc. was selected by Maryland Care Inc. d/b/a Maryland Physicians Care MCO to provide health plan management services for its Medicaid operations in Maryland effective July 1, 2017.

MEMBERSHIP

From December 31, 2014 to December 31, 2016, we increased our managed care membership by 7.4 million, or 182%. The following table sets forth our membership by state:

	December 31,		
	2016	**2015**	**2014**
Arizona	598,300	440,900	204,000
Arkansas	58,600	41,900	38,400
California	2,973,500	186,000	163,900
Florida	716,100	510,400	425,700
Georgia	488,000	408,600	389,100
Illinois	237,700	207,500	87,800
Indiana	285,800	282,100	197,700
Kansas	139,700	141,000	143,300
Louisiana	472,800	381,900	152,900
Massachusetts	48,300	61,500	48,400
Michigan	2,000	4,800	—
Minnesota	9,400	9,600	9,500
Mississippi	310,200	302,200	108,700
Missouri	105,700	95,100	71,000
New Hampshire	77,400	71,400	62,700
New Mexico	7,100	—	—
Ohio	316,000	302,700	280,100
Oregon	217,800	98,700	—
South Carolina	122,500	104,000	109,700
Tennessee	21,700	20,000	21,000
Texas	1,072,400	983,100	971,000
Vermont	1,600	1,700	—
Washington	238,400	209,400	194,400
Wisconsin	73,800	77,100	83,200
Total at-risk membership	8,594,800	4,941,600	3,762,500
TRICARE eligibles	2,847,000	—	—
Non-risk membership	—	166,300	298,400
Total	11,441,800	5,107,900	4,060,900

The following table sets forth our membership by line of business:

	December 31,		
	2016	**2015**	**2014**
Medicaid:			
TANF, CHIP & Foster Care	5,630,000	3,763,400	2,981,900
ABD & LTC	785,400	478,600	438,700
Behavioral Health	466,600	456,800	197,000
Commercial	1,239,100	146,100	93,500
Medicare & Duals [1]	334,300	37,400	10,400
Correctional	139,400	59,300	41,000
Total at-risk membership	8,594,800	4,941,600	3,762,500
TRICARE eligibles	2,847,000	—	—
Non-risk membership	—	166,300	298,400
Total	11,441,800	5,107,900	4,060,900

(1) Membership includes Medicare Advantage, Medicare Supplement, Special Needs Plans, and Medicare-Medicaid Plans.

At December 31, 2016, we served 1,080,500 members in Medicaid expansion programs in ten states compared to 449,000 members in eight states at December 31, 2015, and 201,300 members in six states at December 31, 2014. At December 31, 2016, we served 372,800 dual-eligible members, compared to 204,800 and 164,600 at December 31, 2015 and 2014, respectively. At December 31, 2016, we served 537,200 members in Health Insurance Marketplaces, compared to 146,100 and 74,500 at December 31, 2015 and 2014, respectively.

From December 31, 2015 to December 31, 2016, our membership increased as a result of:

- the acquisition of Health Net;
- organic growth in many of our states, including Florida, Georgia, Oregon, and Texas;
- product and geographic expansions in Louisiana and Washington;
- market growth and additional penetration in the Health Insurance Marketplace, which included a private option Medicaid expansion in New Hampshire; and
- the commencement of correctional healthcare service contracts in Florida and New Mexico.

From December 31, 2014 to December 31, 2015, our membership increased as a result of:

- product and geographic expansions in Arizona, Florida, Louisiana, Mississippi, and Texas;
- the acquisition of Agate Resources, Inc., our Oregon subsidiary;
- the commencement of HIP 2.0 program in Indiana;
- the commencement of Health Insurance Marketplaces in certain regions of Illinois, and Oregon;
- organic growth in California, Georgia, Illinois, Ohio; and
- the commencement of correctional healthcare service contracts in Mississippi and Vermont.

RESULTS OF OPERATIONS

The following discussion and analysis is based on our consolidated statements of operations, which reflect our results of operations for each of the three years ended December 31, 2016, prepared in accordance with generally accepted accounting principles in the United States ($ in millions, except per share data):

	2016	2015	2014	% Change 2015-2016	% Change 2014-2015
Premium	$ 35,399	$ 19,389	$ 14,198	83 %	37 %
Service	2,180	1,876	1,469	16 %	28 %
Premium and service revenues	37,579	21,265	15,667	77 %	36 %
Premium tax and health insurer fee	3,028	1,495	893	103 %	67 %
Total revenues	40,607	22,760	16,560	78 %	37 %
Medical costs	30,636	17,242	12,678	78 %	36 %
Cost of services	1,864	1,621	1,280	15 %	27 %
Selling, general and administrative expenses	3,676	1,802	1,298	104 %	39 %
Amortization of acquired intangible assets	147	24	16	n.m.	50 %
Premium tax expense	2,563	1,151	698	123 %	65 %
Health insurer fee expense	461	215	126	114 %	71 %
Earnings from operations	1,260	705	464	79 %	52 %
Investment and other income (expense), net	(103)	(8)	(7)	n.m.	(14)%
Earnings from continuing operations, before income tax expense	1,157	697	457	66 %	53 %
Income tax expense	599	339	196	77 %	73 %
Earnings from continuing operations, net of income tax	558	358	261	56 %	37 %
Discontinued operations, net of income tax expense (benefit)	3	(1)	3	n.m.	(133)%
Net earnings	561	357	264	57 %	35 %
(Earnings) loss attributable to noncontrolling interests	1	(2)	7	(150)%	129 %
Net earnings attributable to Centene Corporation	$ 562	$ 355	$ 271	58 %	31 %
Amounts attributable to Centene Corporation common shareholders:					
Earnings from continuing operations, net of income tax expense	$ 559	$ 356	$ 268	57 %	33 %
Discontinued operations, net of income tax expense (benefit)	3	(1)	3	n.m.	(133)%
Net earnings	$ 562	$ 355	$ 271	58 %	31 %
Diluted earnings (loss) per common share attributable to Centene Corporation:					
Continuing operations	$ 3.41	$ 2.89	$ 2.23	18 %	30 %
Discontinued operations	0.02	(0.01)	0.02	n.m.	(150)%
Total diluted earnings per common share	$ 3.43	$ 2.88	$ 2.25	19 %	28 %

n.m.: not meaningful

Year Ended December 31, 2016 Compared to Year Ended December 31, 2015

Total Revenues

Total revenues increased 78% in the year ended December 31, 2016, over the corresponding period in 2015, primarily as a result of the acquisition of Health Net, growth in the Health Insurance Marketplace business, and the impact from expansions, acquisitions or new programs in many of our states in 2016 and 2015. During the year ended December 31, 2016, we received Medicaid premium rate adjustments which yielded a net 1% composite change across all of our markets.

Operating Expenses

Medical Costs

The HBR for the year ended December 31, 2016 was 86.5%, a decrease of 240 basis points over the comparable period in 2015. The decrease compared to last year is primarily attributable to the acquisition of Health Net, membership growth in Medicaid expansion and Health Insurance Marketplace products, and improvement in HBR in the higher acuity populations. Also, in the fourth quarter, we recognized additional revenue relating to the retroactive contract amendment that changed the minimum MLR calculation under California's Medicaid expansion program, which reduced our 2016 HBR by 50 basis points.

Cost of Services

Cost of services increased by $243 million in the year ended December 31, 2016, compared to the corresponding period in 2015. This was primarily due to the acquisition of Health Net and growth in our correctional business, partially offset by lower pharmacy costs to external customers. The cost of service ratio for the year ended December 31, 2016 was 85.5%, compared to 86.4% in 2015. The decrease is primarily due to the acquisition of Health Net, which operates at a lower cost of service ratio.

Selling, General and Administrative Expenses

SG&A increased by $1,874 million in the year ended December 31, 2016, compared to the corresponding period in 2015. This was primarily due to the acquisition of Health Net, acquisition related expenses, restructuring and integration costs, and the impact from expansions, acquisitions, or new programs in many of our states in 2016 and 2015. During the year ended December 31, 2016, we recorded approximately $234 million of Health Net acquisition related expenses, which reduced our diluted earnings per share by $0.98. During the year ended December 31, 2015, we recorded approximately $27 million of Health Net acquisition related expenses, which reduced our diluted earnings per share by $0.14. We also recorded expense of $50 million in 2016 for contribution commitments to our charitable foundation.

The consolidated SG&A expense ratio was 9.8% for the year ended December 31, 2016 compared to 8.5% for the year ended December 31, 2015. The consolidated SG&A expense ratio excluding Health Net acquisition related expenses was 9.2% for the year ended December 31, 2016 compared to 8.3% for the year ended December 31, 2015. The increase in the SG&A expense ratio is primarily attributable to the addition of the Health Net business, which operates at a higher SG&A expense ratio due to a higher mix of commercial and Medicare business.

Other Income (Expense)

The following table summarizes the components of other income (expense) for the year ended December 31, ($ in millions):

	2016	2015
Investment income	$ 109	$ 27
Earnings from equity method investments	5	8
Interest expense	(217)	(43)
Other income (expense), net	$ (103)	$ (8)

The increase in investment income in 2016 reflects an increase in investment balances over 2015, primarily due to the acquisition of Health Net. Interest expense increased during the year ended December 31, 2016 by $174 million primarily reflecting the issuance of an additional $2,400 million in Senior Notes in February 2016 in connection with the financing of the Health Net transaction. Interest expense also increased due to the issuance of an additional $500 million in Senior Notes in June 2016, the assumption of Health Net's $400 million in Senior Notes, and the issuance of the $1,200 million in Senior Notes in November 2016. These increases were partially offset by the redemption of the Centene $425 million 5.75% Senior Notes and the Health Net $400 million 6.375% Senior Notes in November 2016 and December 2016, respectively. In addition, the Company incurred $11 million associated with the early redemption of the Centene 5.75% Senior Notes due 2017 and the Health Net 6.375% Senior Notes due 2017, which was recorded in Interest expense.

Income Tax Expense

Our effective tax rate for the year ended December 31, 2016 was 51.8% compared to 48.6% in 2015. The effective tax rate is higher than the applicable statutory rate primarily as a result of the non-deductibility of the HIF, limitations on the deductibility of compensation, and the non-deductibility of certain acquisition related costs incurred in connection with the acquisition of Health Net.

Segment Results

The following table summarizes our consolidated operating results by segment for the year ended December 31, ($ in millions):

	2016	2015	% Change 2015-2016
Total Revenues			
Managed Care	$ 37,722	$ 20,644	83 %
Specialty Services	9,037	7,080	28 %
Eliminations	(6,152)	(4,964)	(24)%
Consolidated Total	$ 40,607	$ 22,760	78 %
Earnings from Operations			
Managed Care	$ 1,070	$ 513	109 %
Specialty Services	190	192	(1)%
Consolidated Total	$ 1,260	$ 705	79 %

Managed Care

Total revenues increased 83% in the year ended December 31, 2016, compared to the year ended December 31, 2015, primarily as a result of the acquisition of Health Net and expansions or new programs in many of our states, particularly California, Florida, Georgia, Indiana, Louisiana, Mississippi, Oregon, Texas, and Washington. Earnings from operations increased $557 million between years primarily reflecting the acquisition of Health Net and product and geographical expansions in many of our states.

Specialty Services

Total revenues increased 28% in the year ended December 31, 2016, compared to the year ended December 31, 2015, resulting primarily from the acquisition of Health Net, growth in our behavioral health and correctional services businesses, and increased services associated with membership growth in the Managed Care segment. Earnings from operations decreased $2 million in the year ended December 31, 2016, compared to the year ended December 31, 2015, primarily due to lower earnings in our specialty pharmacy, home health, and behavioral health businesses as well as increased utilization in several specialty services businesses, partially offset by an increase in earnings related to our pharmacy benefits management and correctional services businesses, and the Health Net acquisition.

Year Ended December 31, 2015 Compared to Year Ended December 31, 2014

Total Revenues

Total revenues increased 37% in the year ended December 31, 2015, over the corresponding period in 2014, primarily as a result of the impact from expansions or new programs in many of our states, particularly Florida, Illinois, Indiana, Louisiana, Mississippi, Ohio and Texas. During the year ended December 31, 2015, we received Medicaid premium rate adjustments which yielded a net 1% composite change across all of our markets.

Operating Expenses

Medical Costs

The consolidated HBR for the year ended December 31, 2015 of 88.9% was a decrease of 40 basis points over the comparable period in 2014. The decrease compared to the previous year is primarily attributable to improvement in medical expense in the high acuity populations (LTC/MMP) and membership growth in Medicaid expansion programs and Health Insurance Marketplace, which operate at a lower HBR than traditional Medicaid businesses.

Cost of Services

Cost of services increased by $341 million in the year ended December 31, 2015, compared to the corresponding period in 2014. This was primarily due to growth in the AcariaHealth business. The cost of service ratio for the year ended December 31, 2015, was 86.4% compared to 87.1% in 2014.

Selling, General and Administrative Expenses

SG&A increased by $504 million in the year ended December 31, 2015, compared to the corresponding period in 2014. This was primarily due to expenses for additional staff and facilities to support our membership growth. During the year ended December 31, 2015, we recorded approximately $27 million of Health Net acquisition related expenses, which reduced our diluted earnings per share by $0.14.

During the first quarter of 2015, we recorded a gain of $10 million on the settlement of contingent consideration related to the Community Health Solutions (CHS) transaction. We also recorded expense of $10 million for a contribution to our charitable foundation during the first quarter of 2015.

Also during 2015, we experienced higher than anticipated opt-out rates and member attrition in the new Michigan dual demonstration program, resulting in lower than expected membership and lower blended premium rates. As a result, the fair value of estimated contingent consideration was reduced from $50 million to $16 million, and we recorded a gain of $34 million in SG&A. In connection with the lower membership and revenue outlook, we conducted an impairment analysis of the identifiable intangible assets and goodwill, resulting in a reduction of goodwill and intangible assets of $38 million which was recorded in SG&A. The Company's initial allocation of fair value resulted in goodwill and intangible assets of $52 million. At December 31, 2015, the Company had goodwill of $11 million and other identifiable intangible assets of $1 million, net of $2 million of amortization, remaining on the balance sheet.

The consolidated SG&A expense ratio for the years ended December 31, 2015 and 2014 was 8.5% and 8.3%, respectively. The SG&A ratio for the year ended December 31, 2015 was 8.3% excluding the impact of the Health Net acquisition related expenses. The increase over the prior year is primarily related to the expansion of our Health Insurance Marketplace business which operates at a higher SG&A ratio and incurred higher open enrollment costs in the fourth quarter of 2015.

Other Income (Expense)

The following table summarizes the components of other income (expense) for the year ended December 31, ($ in millions):

	2015	2014
Investment income	$ 27	$ 22
Earnings from equity method investments	8	6
Interest expense	(43)	(35)
Other income (expense), net	$ (8)	$ (7)

The increase in investment income in 2015 reflects an increase in investment balances over 2014 and improved performance of certain equity investments. Interest expense increased during the year ended December 31, 2015 by $8 million primarily reflecting the issuance of $300 million of Senior Notes in April 2014 and the issuance of an additional $200 million in Senior Notes in January 2015.

Income Tax Expense

Our effective tax rate for the year ended December 31, 2015 was 48.6%, compared to 42.9% in 2014. The effective tax rate is higher than the applicable statutory rate primarily as a result of the non-deductibility of the health insurer fee expense.

Segment Results

The following table summarizes our consolidated operating results by segment for the year ended December 31, ($ in millions):

	2015	2014	% Change 2014-2015
Total Revenues			
Managed Care	$ 20,644	$ 14,835	39 %
Specialty Services	7,080	4,804	47 %
Eliminations	(4,964)	(3,079)	(61)%
Consolidated Total	$ 22,760	$ 16,560	37 %
Earnings from Operations			
Managed Care	$ 513	$ 353	45 %
Specialty Services	192	111	73 %
Consolidated Total	$ 705	$ 464	52 %

Managed Care

Total revenues increased 39% in the year ended December 31, 2015, primarily as a result of expansions or new programs in many of our states, particularly Florida, Illinois, Indiana, Louisiana, Mississippi, Ohio and Texas. Earnings from operations increased $160 million between years primarily reflecting growth in the business.

Specialty Services

Total revenues increased 47% in the year ended December 31, 2015, resulting primarily from increased services associated with membership growth in the Managed Care segment and growth in our pharmacy businesses. Earnings from operations increased $81 million in the year ended December 31, 2015, primarily reflecting growth in the specialty services provided to our increased Managed Care membership.

LIQUIDITY AND CAPITAL RESOURCES

Shown below is a condensed schedule of cash flows for the years ended December 31, 2016, 2015 and 2014, used in the discussion of liquidity and capital resources ($ in millions).

	Year Ended December 31,		
	2016	2015	2014
Net cash provided by operating activities	$ 1,851	$ 658	$ 1,223
Net cash used in investing activities	(2,397)	(813)	(848)
Net cash provided by financing activities	2,717	305	198
Effect of exchange rate changes on cash and cash equivalents	(1)	—	(1)
Net increase in cash and cash equivalents	$ 2,170	$ 150	$ 572

Cash Flows Provided by Operating Activities

Normal operations are funded primarily through operating cash flows and borrowings under our revolving credit facility. Cash flows from operating activities for 2016 were $1,851 million, or 3.3 times net earnings, compared to $658 million in 2015. The cash provided by operations in 2016 was primarily due to net earnings, an increase in accounts payable and accrued expenses and medical claims liabilities, and a decrease in other assets and premium and related receivables. Additionally, cash provided by operations was increased by approximately $445 million in the fourth quarter due to the finalization of the opening balance sheet and respective cash flows for the eight day period from the March 24, 2016 acquisition date to March 31, 2016.

Cash flows from operating activities for 2015 decreased to $658 million, compared to $1,223 million in 2014. The cash provided by operations in 2015 and 2014 was primarily related to net earnings and an increase in medical claims liabilities resulting from growth in the business, partially offset by increases in premium and related receivables.

Cash flows from operations in each year were impacted by the timing of payments we received from our states. States may prepay the following month premium payment, which we record as unearned revenue, or they may delay our premium payment, which we record as a receivable. We typically receive capitation payments monthly; however, the states in which we operate may decide to adjust their payment schedules which could positively or negatively impact our reported cash flows from operating activities in any given period. Specifically, at December 31, 2016, the State of Illinois was behind in processing capitation for several months. We continue to monitor the receivable balance and work with the state on the timing of payments.

The reimbursement of the HIF from our state customers may be settled as a separate payment or monthly in combination with our other premium payments. The vast majority of our state customers are settling the reimbursement through a separate payment after verification of each state's portion of our HIF, resulting in an increase in Premium and Related Receivables at December 31, 2016. During 2016, we paid the 2016 annual HIF totaling $513 million. This negatively impacted our cash flows as we have not been reimbursed from many of our state customers. Similarly, during 2015, we paid the 2015 annual HIF invoice totaling $220 million. The table below details the impact to cash flows from operations from the timing of payments from our states ($ in millions).

	Year Ended December 31,		
	2016	2015	2014
(Increase) decrease in premium and related receivables	$ 74	$ (360)	$ (463)
Increase (decrease) in unearned revenue	43	(27)	129
Net increase (decrease) in operating cash flow	$ 117	$ (387)	$ (334)

Cash Flows Used in Investing Activities

Investing activities used cash of $2,397 million for the year ended December 31, 2016, and $813 million in the comparable period in 2015. Cash flows used in investing activities in 2016 primarily consisted of our acquisition of Health Net, net additions to the investment portfolio of our regulated subsidiaries, including transfers from cash and cash equivalents to long term investments and capital expenditures.

In March 2016, we acquired Health Net for approximately $5,990 million, including the assumption of $703 million of debt. The total consideration for the acquisition was $5,287 million, consisting of Centene common shares valued at $3,038 million, $2,247 million in cash, and $2 million related to the fair value adjustment to stock based compensation associated with pre-combination service.

We spent $306 million and $150 million in the year ended December 31, 2016 and 2015, respectively, on capital expenditures for system enhancements and market expansions.

As of December 31, 2016, our investment portfolio consisted primarily of fixed-income securities with a weighted average duration of 3.2 years. We had unregulated cash and investments of $264 million at December 31, 2016, compared to $78 million at December 31, 2015. Unregulated cash and investments include cost and equity method investments and company owned life insurance contracts.

Cash flows used in investing activities in 2015 primarily consisted of additions to the investment portfolio of our regulated subsidiaries, including transfers from cash and cash equivalents to long term investments and capital expenditures.

Cash flows used in investing activities in 2014 primarily consisted of additions to the investment portfolio of our regulated subsidiaries, including transfers from cash and cash equivalents to long term investments, the acquisition of U.S. Medical Management and CHS, an equity investment in Ribera Salud and capital expenditures. We completed the acquisition of U.S. Medical Management for $213 million in total consideration. The transaction was financed through a combination of Centene common stock as well as $80 million of cash. We also completed a transaction with CHS for initial cash consideration of $56 million as well as common stock. Additionally, we purchased a noncontrolling interest in Ribera Salud, S.A. (Ribera Salud), a Spanish health management group for $17 million.

Cash Flows Provided by Financing Activities

Our financing activities provided cash of $2,717 million, $305 million and $198 million in 2016, 2015 and 2014, respectively. Financing activities in 2016, 2015 and 2014 are discussed below.

2016

During 2016, our financing activities primarily related to the proceeds from the issuance of Senior Notes in February 2016 associated with the Health Net acquisition, the issuance of additional Senior Notes in June 2016 and November 2016, partially offset by the redemption of our 5.75% Senior Notes due 2017, the redemption of our 6.375% Senior Notes due 2017, and the repayment of amounts outstanding under our Revolving Credit Facility.

In February 2016, our wholly owned unrestricted subsidiary (Escrow Issuer) issued $1,400 million of 5.625% Senior Notes ($1,400 Million Notes) at par due 2021 and $1,000 million of 6.125% Senior Notes ($1,000 Million Notes) at par due 2024. We used the net proceeds of the offering, together with borrowings under the our new $1,000 million revolving credit facility and cash on hand, to fund the cash consideration for the Health Net acquisition and to pay acquisition and offering related fees and expenses. In connection with the February 2016 issuance, we entered into interest rate swap agreements for notional amounts of $600 million and $1,000 million, at floating rates of interest based on the three month LIBOR plus 4.22% and the three month LIBOR plus 4.44%, respectively. Gains and losses due to changes in the fair value of the interest rate swaps completely offset changes in the fair value of the hedged portion of the underlying debt and are recorded as an adjustment to the $1,400 Million Notes and $1,000 Million Notes.

In connection with the closing of the Health Net acquisition on March 24, 2016, our then-existing unsecured $500 million revolving credit facility was terminated and simultaneously replaced with a new $1,000 million unsecured revolving credit facility (Revolving Credit Facility). Borrowings under the agreement bear interest based upon LIBOR rates, the Federal Funds Rate or the Prime Rate. The agreement has a maturity date of March 24, 2021.

In June 2016, we issued an additional $500 million of 4.75% Senior Notes due 2022 at a premium to yield 4.41% ($500 Million Add-on Notes). The $500 Million Add-on Notes were offered as additional debt securities under the indenture governing the $500 million of 4.75% Senior Notes issued April 2014. We used the net proceeds of the offering to repay amounts outstanding under our Revolving Credit Facility and to pay offering related fees and expenses.

In November 2016, we issued an additional $1,200 million of 4.75% Senior Notes due 2025. We used the net proceeds to redeem our $425 million of 5.75% Senior Notes due 2017 and Health Net's $400 million of 6.375% Senior Notes due 2017, to repay amounts outstanding under our Revolving Credit Facility, to pay related fees and expenses and for general purposes.

2015

During 2015, our financing activities primarily related to the proceeds from the issuance of Senior Debt and an additional $150 million of borrowings on our revolving credit facility. In January 2015, we issued an additional $200 million of 4.75% Senior Notes due May 15, 2022 at par (Add on Notes). In connection with the January 2015 issuance, we entered into interest rate swap agreements for a notional amount of $200 million (2015 Swap Agreements) that are scheduled to expire on May 15, 2022. Under the 2015 Swap Agreements, we receive a fixed rate of 4.75% and pay a variable rate of LIBOR plus a spread adjusted quarterly, which allows us to adjust the $200 million Notes to a floating rate. We do not hold or issue any derivative instrument for trading or speculative purposes.

2014

In April 2014, pursuant to a shelf registration statement, we issued $300 million 4.75% Senior Notes due May 15, 2022 at par. Interest is paid semi-annually in May and November. In connection with the issuance, we entered into $300 million notional amount of interest rate swap agreements (2014 Swap Agreements) that are scheduled to expire May 15, 2022. Under the 2014 Swap Agreements, we receive a fixed rate of 4.75% and pay a variable rate of LIBOR plus a spread adjusted quarterly, which allows us to adjust the $300 million Notes to a floating rate. We do not hold or issue any derivative instrument for trading or speculative purposes.

Liquidity Metrics

The credit agreement underlying our Revolving Credit Facility contains non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios and maximum debt-to-EBITDA ratios. We are required to not exceed a maximum debt-to-EBITDA ratio of 3.5 to 1.0 prior to December 31, 2016, and 3.0 to 1.0 on and subsequent to December 31, 2016. As of December 31, 2016, we had $100 million in borrowings outstanding under our revolving credit facility, and we were in compliance with all covenants. As of December 31, 2016, there were no limitations on the availability under the revolving credit agreement as a result of the debt-to-EBITDA ratio.

We had outstanding letters of credit of $71 million as of December 31, 2016, which were not part of our revolving credit facility. We also had letters of credit for $45 million (valued at the December 31, 2016 conversion rate), or €42 million, representing our proportional share of the letters of credit issued to support Ribera Salud's outstanding debt which are a part of the revolving credit facility. Collectively, the letters of credit bore weighted interest of 1.42% as of December 31, 2016. In addition, we had outstanding surety bonds of $365 million as of December 31, 2016.

The indentures governing our various maturities of senior notes contain non-financial and financial covenants of Centene Corporation, including requirements of a minimum fixed charge coverage ratio. As of December 31, 2016, we were in compliance with all covenants.

At December 31, 2016, we had working capital, defined as current assets less current liabilities, of a negative $258 million, compared to a negative $24 million at December 31, 2015. We manage our short term and long term investments with the goal of ensuring that a sufficient portion is held in investments that are highly liquid and can be sold to fund short term requirements as needed.

At December 31, 2016, our debt to capital ratio, defined as total debt divided by the sum of total debt and total equity, was 44.1%, compared to 36.0% at December 31, 2015. Excluding the $64 million non-recourse mortgage note, our debt to capital ratio was 43.7% as of December 31, 2016, compared to 34.7% at December 31, 2015. The increase in the ratio over the prior year is due to the financing associated with the Health Net acquisition. We utilize the debt to capital ratio as a measure, among others, of our leverage and financial flexibility.

We have a stock repurchase program authorizing us to repurchase up to 8 million shares of common stock from time to time on the open market or through privately negotiated transactions. We have 3 million available shares remaining under the program for repurchases as of December 31, 2016. No duration has been placed on the repurchase program. We reserve the right to discontinue the repurchase program at any time. We did not make any repurchases under this plan during 2016, 2015 or 2014.

During the year ended December 31, 2016, 2015 and 2014, we received dividends of $121 million, $11 million, and $50 million, respectively, from our regulated subsidiaries.

2017 Expectations

During 2017, we expect to make net capital contributions to our insurance subsidiaries of approximately $250 million associated with our growth and spend approximately $520 million in additional capital expenditures primarily associated with system integration and enhancements and market expansions. These amounts are expected to be funded by unregulated cash flow generation in 2017 and borrowings on our Revolving Credit Facility. However, from time to time we may elect to raise additional funds for these and other purposes, either through issuance of debt or equity, the sale of investment securities or otherwise, as appropriate. In addition, we may strategically pursue refinancing opportunities to extend maturities and/or improve terms of our indebtedness if we believe such opportunities are favorable to us.

Based on our operating plan, we expect that our available cash, cash equivalents and investments, cash from our operations and cash available under our credit facility will be sufficient to finance our general operations and capital expenditures for at least 12 months from the date of this filing.

CONTRACTUAL OBLIGATIONS

The following table summarizes future contractual obligations. These obligations contain estimates and are subject to revision under a number of circumstances. Our debt consists of borrowings from our senior notes, Revolving Credit Facility, mortgages and capital leases. The purchase obligations consist primarily of software purchases and maintenance contracts. The contractual obligations and estimated period of payment over the next five years and beyond are as follows ($ in millions):

	Payments Due by Period				
	Total	Less Than 1 Year	1-3 Years	3-5 Years	More Than 5 Years
Medical claims liability	$ 3,929	$ 3,929	$ —	$ —	$ —
Debt and interest	6,458	276	564	1,883	3,735
Operating lease obligations	631	133	221	165	112
Purchase obligations	827	446	289	92	—
Other long term liabilities [1]	—	—	—	—	—
Total	$ 11,845	$ 4,784	$ 1,074	$ 2,140	$ 3,847

(1) Our Consolidated Balance Sheet as of December 31, 2016, includes $869 million of other long term liabilities. This consists primarily of long term deferred income taxes, liabilities under our deferred compensation plan, reserves for uncertain tax positions and retirement benefit obligations. These liabilities have been excluded from the table above as the timing and/or amount of any cash payment is uncertain.

Commitments

In addition, in connection with obtaining regulatory approval of the Health Net acquisition from the California Department of Insurance and the California Department of Managed Health Care, we committed to certain undertakings (the Undertakings). The Undertakings included, among other items, operational commitments around premiums, dividend restrictions, minimum Risk Based Capital (RBC) levels, local offices, growth, accreditation, HEDIS scores and other quality measures, network adequacy, certifications, investments and capital expenditures. Specifically, we agreed to, among other things:

- invest an additional $30 million through the California Organized Investment Network over the five years following completion of the acquisition;
- build a service center in an economically distressed community in California, investing $200 million over 10 years and employing at least 300 people;

- contribute $65 million to improve enrollee health outcomes ($10 million over 10 years), support locally-based consumer assistance programs ($5 million over five years) and strengthen the health care delivery system ($50 million over five years), (of which, the present value of $61 million was expensed in the year ended December 31, 2016 and classified as SG&A expenses in the Consolidated Statements of Operations); and
- invest $75 million of its investment portfolio in vehicles supporting California's health care infrastructure.

The undertakings require significant investments by us, may restrict or impose additional material costs on our future obligations and strategic initiatives in certain geographies, and subject us to various enforcement mechanisms.

REGULATORY CAPITAL AND DIVIDEND RESTRICTIONS

Our operations are conducted through our subsidiaries. As managed care organizations, most of our subsidiaries are subject to state regulations and other requirements that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and restrict the timing, payment and amount of dividends and other distributions that may be paid to us. Generally, the amount of dividend distributions that may be paid by a regulated subsidiary without prior approval by state regulatory authorities is limited based on the entity's level of statutory net income and statutory capital and surplus.

Our regulated subsidiaries are required to maintain minimum capital requirements prescribed by various regulatory authorities in each of the states in which we operate. As of December 31, 2016, our subsidiaries had aggregate statutory capital and surplus of $4,529 million, compared with the required minimum aggregate statutory capital and surplus requirements of $2,259 million. During the year ended December 31, 2016, we contributed $467 million of net statutory capital to our subsidiaries. For our subsidiaries that file with the National Association of Insurance Commissioners (NAIC), we estimate our RBC percentage (including Kentucky Spirit) to be in excess of 350% of the Authorized Control Level (excluding the interim impact of the health insurance fee).

Under the California Knox-Keene Health Care Service Plan Act of 1975, as amended ("Knox-Keene"), certain of our California subsidiaries must comply with tangible net equity (TNE) requirements. Under these Knox-Keene TNE requirements, actual net worth less unsecured receivables and intangible assets must be more than the greater of (i) a fixed minimum amount, (ii) a minimum amount based on premiums or (iii) a minimum amount based on health care expenditures, excluding capitated amounts. In addition, certain of our California subsidiaries have made certain undertakings to the DMHC to restrict dividends and loans to affiliates, to the extent that the payment of such would reduce such entities' TNE below the required amount as specified in the undertaking.

The NAIC has adopted rules which set minimum risk-based capital requirements for insurance companies, managed care organizations and other entities bearing risk for healthcare coverage. As of December 31, 2016, each of our health plans was in compliance with the risk-based capital requirements enacted in those states.

As a result of the above requirements and other regulatory requirements, certain of our subsidiaries are subject to restrictions on their ability to make dividend payments, loans or other transfers of cash to their parent companies. Such restrictions, unless amended or waived or unless regulatory approval is granted, limit the use of any cash generated by these subsidiaries to pay our obligations. The maximum amount of dividends that can be paid by our insurance company subsidiaries without prior approval of the applicable state insurance departments is subject to restrictions relating to statutory surplus, statutory income and unassigned surplus. As of December 31, 2016, the amount of capital and surplus or net worth that was unavailable for the payment of dividends or return of capital to us was $2,259 million in the aggregate.

RECENT ACCOUNTING PRONOUNCEMENTS

For this information, refer to Note 2, *Summary of Significant Accounting Policies*, in the Notes to the Consolidated Financial Statements, included herein.

CRITICAL ACCOUNTING POLICIES AND ESTIMATES

Our discussion and analysis of our results of operations and liquidity and capital resources are based on our consolidated financial statements which have been prepared in accordance with GAAP. Our significant accounting policies are more fully described in Note 2, *Summary of Significant Accounting Policies,* to our consolidated financial statements included elsewhere herein. Our accounting policies regarding medical claims liability and intangible assets are particularly important to the portrayal of our financial position and results of operations and require the application of significant judgment by our management. As a result, they are subject to an inherent degree of uncertainty. We have reviewed these critical accounting policies and related disclosures with the Audit Committee of our Board of Directors.

Goodwill and Intangible Assets

We have made several acquisitions that have resulted in our recording of intangible assets. These intangible assets primarily consist of customer relationships, purchased contract rights, provider contracts, trade names and goodwill. We allocate the fair value of purchase consideration to the assets acquired and liabilities assumed based on their fair values at the acquisition date. The excess of the fair value of consideration transferred over the fair value of the net assets acquired is recorded as goodwill. Goodwill is generally attributable to the value of the synergies between the combined companies and the value of the acquired assembled workforce, neither of which qualifies for recognition as an intangible asset. At December 31, 2016, we had $4,712 million of goodwill and $1,545 million of other intangible assets.

Intangible assets are amortized using the straight-line method over the following periods:

Intangible Asset	Amortization Period
Purchased contract rights	5 - 15 years
Provider contracts	4 - 15 years
Customer relationships	3 - 15 years
Trade names	1 - 20 years
Developed technology	5 years

Our management evaluates whether events or circumstances have occurred that may affect the estimated useful life or the recoverability of the remaining balance of goodwill and other identifiable intangible assets. If the events or circumstances indicate that the remaining balance of the intangible asset or goodwill may be impaired, the potential impairment will be measured based upon the difference between the carrying amount of the intangible asset or goodwill and the fair value of such asset. Our management must make assumptions and estimates, such as the discount factor, future utility and other internal and external factors, in determining the estimated fair values. While we believe these assumptions and estimates are appropriate, other assumptions and estimates could be applied and might produce significantly different results.

Goodwill is reviewed annually during the fourth quarter for impairment. In addition, an impairment analysis of intangible assets would be performed based on other factors. These factors include significant changes in membership, state funding, medical contracts and provider networks and contracts.

We first assess qualitative factors to determine whether it is necessary to perform the two-step quantitative goodwill impairment test. We generally do not calculate the fair value of a reporting unit unless we determine, based on a qualitative assessment, that it is more likely than not that its fair value is less than its carrying amount. However, in certain circumstances, such as recent acquisitions, we may elect to perform a quantitative assessment without first assessing qualitative factors. The fair value of all reporting units with material amounts of goodwill was substantially in excess of the carrying value as of our annual impairment testing date, with the exception of reporting units that were recently acquired without excess fair value on the acquisition date and our home health business, which maintains $267 million of goodwill. During 2016, events and circumstances led to unfavorable results in the home health business, which indicated that the goodwill might be impaired. We completed a quantitative analysis, and the estimate of future undiscounted cash flows indicated that such carrying amounts were expected to be recovered. To the extent the undiscounted cash flows are not sufficient in future periods, the reporting unit could be at risk for impairment.

Medical Claims Liability

Our medical claims liability includes claims reported but not yet paid, or inventory, estimates for claims incurred but not reported, or IBNR, and estimates for the costs necessary to process unpaid claims at the end of each period. We estimate our medical claims liability using actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. These actuarial methods consider factors such as historical data for payment patterns, cost trends, product mix, seasonality, utilization of healthcare services and other relevant factors.

Actuarial Standards of Practice generally require that the medical claims liability estimates be adequate to cover obligations under moderately adverse conditions. Moderately adverse conditions are situations in which the actual claims are expected to be higher than the otherwise estimated value of such claims at the time of estimate. In many situations, the claims amounts ultimately settled will be different than the estimate that satisfies the Actuarial Standards of Practice. We include in our IBNR an estimate for medical claims liability under moderately adverse conditions which represents the risk of adverse deviation of the estimates in our actuarial method of reserving.

We use our judgment to determine the assumptions to be used in the calculation of the required estimates. The assumptions we consider when estimating IBNR include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, healthcare service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to fee schedules, and the incidence of high dollar or catastrophic claims.

We apply various estimation methods depending on the claim type and the period for which claims are being estimated. For more recent periods, incurred non-inpatient claims are estimated based on historical per member per month claims experience adjusted for known factors. Incurred hospital inpatient claims are estimated based on known inpatient utilization data and prior claims experience adjusted for known factors. For older periods, we utilize an estimated completion factor based on our historical experience to develop IBNR estimates. The completion factor is an actuarial estimate of the percentage of claims incurred during a given period that have been received or adjudicated as of the reporting period to the estimate of the total ultimate incurred costs. When we commence operations in a new state or region, we have limited information with which to estimate our medical claims liability. See “Risk Factors - Failure to accurately estimate and price our medical expenses or effectively manage our medical costs or related administrative costs could negatively affect our financial position, results of operations or cash flows.” These approaches are consistently applied to each period presented.

Additionally, we contract with independent actuaries to review our estimates on a quarterly basis. The independent actuaries provide us with a review letter that includes the results of their analysis of our medical claims liability. We do not solely rely on their report to adjust our claims liability. We utilize their calculation of our claims liability only as additional information, together with management's judgment, to determine the assumptions to be used in the calculation of our liability for claims.

Our development of the medical claims liability estimate is a continuous process which we monitor and refine on a monthly basis as additional claims receipts and payment information becomes available. As more complete claims information becomes available, we adjust the amount of the estimates, and include the changes in estimates in medical costs in the period in which the changes are identified. In every reporting period, our operating results include the effects of more completely developed medical claims liability estimates associated with previously reported periods. We consistently apply our reserving methodology from period to period. As additional information becomes known to us, we adjust our actuarial models accordingly to establish medical claims liability estimates.

The paid and received completion factors, claims per member per month and per diem cost trend factors are the most significant factors affecting the IBNR estimate. The following table illustrates the sensitivity of these factors and the estimated potential impact on our operating results caused by changes in these factors based on December 31, 2016 data:

Completion Factors: [1]		Cost Trend Factors: [2]	
(Decrease) Increase in Factors	Increase (Decrease) in Medical Claims Liabilities	(Decrease) Increase in Factors	Increase (Decrease) in Medical Claims Liabilities
	(in millions)		(in millions)
(1.00)%	$ 229	(1.00)%	$ (58)
(0.75)	172	(0.75)	(43)
(0.50)	114	(0.50)	(29)
(0.25)	57	(0.25)	(14)
0.25	(57)	0.25	14
0.50	(113)	0.50	29
0.75	(169)	0.75	43
1.00	(225)	1.00	58

(1) Reflects estimated potential changes in medical claims liability caused by changes in completion factors.

(2) Reflects estimated potential changes in medical claims liability caused by changes in cost trend factors for the most recent periods.

While we believe our estimates are appropriate, it is possible future events could require us to make significant adjustments for revisions to these estimates. For example, a 1% increase or decrease in our estimated medical claims liability would have affected net earnings by $25 million for the year ended December 31, 2016, excluding the effect of any return of premium, risk corridor, or minimum MLR programs. The estimates are based on our historical experience, terms of existing contracts, our observance of trends in the industry, information provided by our providers and information available from other outside sources.

The change in medical claims liability is summarized as follows (in millions):

	Year Ended December 31,		
	2016	2015	2014
Balance, January 1, net	$ 2,298	$ 1,723	$ 1,112
Acquisitions	1,482	79	—
Incurred related to:			
Current year	30,946	17,471	12,820
Prior years	(310)	(229)	(142)
Total incurred	30,636	17,242	12,678
Paid related to:			
Current year	28,532	15,279	11,122
Prior years	1,960	1,467	945
Total paid	30,492	16,746	12,067
Balance, December 31, net	3,924	2,298	1,723
Reinsurance recoverable	5	—	—
Balance, December 31,	$ 3,929	$ 2,298	$ 1,723
Days in claims payable [1]	42	44	44

(1) Days in claims payable is a calculation of medical claims liability at the end of the period divided by average expense per calendar day for the fourth quarter of each year.

Medical claims are usually paid within a few months of the member receiving service from the physician or other healthcare provider. As a result, the liability generally is described as having a “short-tail,” which causes less than 5% of our medical claims liability as of the end of any given year to be outstanding the following year. We believe that substantially all the development of the estimate of medical claims liability as of December 31, 2016 will be known by the end of 2017.

Changes in estimates of incurred claims for prior years are primarily attributable to reserving under moderately adverse conditions. Additionally, as a result of minimum HBR and other return of premium programs, approximately $39 million, $47 million and $26 million of the “Incurred related to: Prior years” was recorded as a reduction to premium revenues in 2016, 2015 and 2014, respectively. Further, claims processing initiatives yielded increased claim payment recoveries and coordination of benefits related to prior year dates of service. Changes in medical utilization and cost trends and the effect of medical management initiatives may also contribute to changes in medical claim liability estimates. While we have evidence that medical management initiatives are effective on a case by case basis, medical management initiatives primarily focus on events and behaviors prior to the incurrence of the medical event and generation of a claim. Accordingly, any change in behavior, leveling of care, or coordination of treatment occurs prior to claim generation and as a result, the costs prior to the medical management initiative are not known by us. Additionally, certain medical management initiatives are focused on member and provider education with the intent of influencing behavior to appropriately align the medical services provided with the member's acuity. In these cases, determining whether the medical management initiative changed the behavior cannot be determined. Because of the complexity of our business, the number of states in which we operate, and the volume of claims that we process, we are unable to practically quantify the impact of these initiatives on our changes in estimates of IBNR.

The following are examples of medical management initiatives that may have contributed to the favorable development through lower medical utilization and cost trends:

- Appropriate leveling of care for neonatal intensive care unit hospital admissions, other inpatient hospital admissions, and observation admissions, in accordance with Interqual or other criteria.
- Management of our pre-authorization list and more stringent review of durable medical equipment and injectibles.
- Emergency room program designed to collaboratively work with hospitals to steer non-emergency care away from the costly emergency room setting (through patient education, on-site alternative urgent care settings, etc.)
- Increase emphasis on case management and clinical rounding where case managers are nurses or social workers who are employed by the health plan to assist selected patients with the coordination of healthcare services in order to meet a patient's specific healthcare needs.
- Incorporation of disease management which is a comprehensive, multidisciplinary, collaborative approach to chronic illnesses such as asthma.
- Prenatal and infant health programs utilized in our *Start Smart For Your Baby* outreach service.

Revenue Recognition

Our health plans generate revenues primarily from premiums received from the states in which we operate health plans. We generally receive a fixed premium per member per month pursuant to our state contracts and recognize premium revenues during the period in which we are obligated to provide services to our members at the amount reasonably estimable. In some instances, our base premiums are subject to an adjustment, or risk score, based on the acuity of its membership. Generally, the risk score is determined by the State analyzing submissions of processed claims data to determine the acuity of our membership relative to the entire state's Medicaid membership. We estimate the amount of risk adjustment based upon the processed claims data submitted and expected to be submitted to CMS and record revenues on a risk adjusted basis. Some contracts allow for additional premiums related to certain supplemental services provided such as maternity deliveries.

Our contracts with states may require us to maintain a minimum HBR or may require us to share profits in excess of certain levels. In certain circumstances, our plans may be required to return premium to the state in the event profits exceed established levels. We estimate the effect of these programs and recognize reductions in revenue in the current period. Other states may require us to meet certain performance and quality metrics in order to receive additional or full contractual revenue. For performance-based contracts, we do not recognize revenue subject to refund until data is sufficient to measure performance.

Revenues are recorded based on membership and eligibility data provided by the states, which is adjusted on a monthly basis by the states for retroactive additions or deletions to membership data. These eligibility adjustments are estimated monthly and subsequent adjustments are made in the period known. We continuously review and updates those estimates as new information becomes available. It is possible that new information could require us to make additional adjustments, which could be significant, to these estimates.

Our Medicare Advantage contracts are with CMS. CMS deploys a risk adjustment model which apportions premiums paid to all health plans according to health severity and certain demographic factors. The CMS risk adjustment model pays more for members whose medical history would indicate that they are expected to have higher medical costs. Under this risk adjustment methodology, CMS calculates the risk adjusted premium payment using diagnosis data from hospital inpatient, hospital outpatient, physician treatment settings as well as prescription drug events. We and the health care providers collect, compile and submit the necessary and available diagnosis data to CMS within prescribed deadlines. We estimate risk adjustment revenues based upon the diagnosis data submitted and expected to be submitted to CMS and record revenues on a risk adjusted basis.

Our specialty services generate revenues under contracts with state and federal programs, healthcare organizations and other commercial organizations, as well as from our own subsidiaries. Revenues are recognized when the related services are provided or as ratably earned over the covered period of services. We recognize revenue related to administrative services under the T-3 TRICARE government-sponsored managed care support contract in the North Region for the DoD's TRICARE program (T-3 contract) on a straight-line basis over the option period, when the fees become fixed and determinable. The T-3 contract includes various performance-based incentives and penalties. For each of the incentives or penalties, we adjust revenue accordingly based on the amount that it has earned or incurred at each interim date and are legally entitled to in the event of a contract termination.

Some states enact premium taxes, similar assessments and provider pass-through payments, collectively premium taxes, and these taxes are recorded as a separate component of both revenues and operating expenses. Additionally, our insurance subsidiaries are subject to the Affordable Care Act annual HIF. If we are able to negotiate reimbursement of portions of these premium taxes or the HIF, we recognize revenue associated with the HIF on a straight-line basis when we have binding agreements for such reimbursements, including the “gross-up” to reflect the HIFs non-tax deductible nature. Collectively, this revenue is recorded as premium tax and health insurer fee revenue in the Consolidated Statements of Operations.

ITEM 7A. *Quantitative and Qualitative Disclosures About Market Risk*

INVESTMENTS AND DEBT

As of December 31, 2016, we had short term investments of $505 million and long term investments of $4,683 million, including restricted deposits of $138 million. The short term investments generally consist of highly liquid securities with maturities between three and 12 months. The long term investments consist of municipal, corporate and U.S. Treasury securities, government sponsored obligations, life insurance contracts, asset backed securities and equity securities and have maturities greater than one year. Restricted deposits consist of investments required by various state statutes to be deposited or pledged to state agencies. Due to the nature of the states’ requirements, these investments are classified as long term regardless of the contractual maturity date. Substantially all of our investments are subject to interest rate risk and will decrease in value if market rates increase. Assuming a hypothetical and immediate 1% increase in market interest rates at December 31, 2016, the fair value of our fixed income investments would decrease by approximately $155 million. Declines in interest rates over time will reduce our investment income.

We have interest rate swap agreements for a notional amount of $2,100 million with creditworthy financial institutions to manage the impact of market interest rates on interest expense. Our swap agreements convert a portion of our interest expense from fixed to variable rates to better match the impact of changes in market rates on our variable rate cash equivalent investments. As a result, the fair value of $2,100 million of our long term debt varies with market interest rates. Assuming a hypothetical and immediate 1% increase in market interest rates at December 31, 2016, the fair value of our debt would decrease by approximately $107 million. An increase in interest rates decreases the fair value of the debt and conversely, a decrease in interest rates increases the value.

For a discussion of the interest rate risk that our investments are subject to, see "Risk Factors – Our investment portfolio may suffer losses which could materially and adversely affect our results of operations or liquidity.”

INFLATION

The inflation rate for medical care costs has been higher than the overall inflation rate for all items. We use various strategies to mitigate the negative effects of healthcare cost inflation. Specifically, our health plans try to control medical and hospital costs through our state savings initiatives and contracts with independent providers of healthcare services. Through these contracted care providers, our health plans emphasize preventive healthcare and appropriate use of specialty and hospital services. Additionally, our contracts with states require actuarially sound premiums that include healthcare cost trend.

While we currently believe our strategies to mitigate healthcare cost inflation will continue to be successful, competitive pressures, new healthcare and pharmaceutical product introductions, demands from healthcare providers and customers, applicable regulations, an increase in the expected rate of inflation for healthcare costs or other factors may affect our ability to control the impact of healthcare cost increases.

Item 8. ***Financial Statements and Supplementary Data***

Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders
Centene Corporation:

We have audited the accompanying consolidated balance sheets of Centene Corporation and subsidiaries as of December 31, 2016 and 2015, and the related consolidated statements of operations, comprehensive earnings, stockholders' equity, and cash flows for each of the years in the three-year period ended December 31, 2016. These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Centene Corporation and subsidiaries as of December 31, 2016 and 2015, and the results of their operations and their cash flows for each of the years in the three-year period ended December 31, 2016, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), Centene Corporation's internal control over financial reporting as of December 31, 2016, based on criteria established in *Internal Control - Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO), and our report dated February 20, 2017 expressed an unqualified opinion on the effectiveness of the Company's internal control over financial reporting.

/s/ KPMG LLP

St. Louis, Missouri
February 20, 2017

CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED BALANCE SHEETS
(In millions, except share data)

	December 31, 2016	December 31, 2015
ASSETS		
Current assets:		
Cash and cash equivalents	$ 3,930	$ 1,760
Premium and related receivables	3,098	1,279
Short term investments	505	176
Other current assets	832	390
Total current assets	8,365	3,605
Long term investments	4,545	1,927
Restricted deposits	138	115
Property, software and equipment, net	797	518
Goodwill	4,712	842
Intangible assets, net	1,545	155
Other long term assets	95	177
Total assets	$ 20,197	$ 7,339
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims liability	$ 3,929	$ 2,298
Accounts payable and accrued expenses	3,763	976
Return of premium payable	614	207
Unearned revenue	313	143
Current portion of long term debt	4	5
Total current liabilities	8,623	3,629
Long term debt	4,651	1,216
Other long term liabilities	869	170
Total liabilities	14,143	5,015
Commitments and contingencies		
Redeemable noncontrolling interests	145	156
Stockholders' equity:		
Preferred stock, $.001 par value; authorized 10,000,000 shares; no shares issued or outstanding at December 31, 2016 and December 31, 2015	—	—
Common stock, $.001 par value; authorized 400,000,000 shares; 178,134,306 issued and 171,919,071 outstanding at December 31, 2016, and 126,855,477 issued and 120,342,981 outstanding at December 31, 2015	—	—
Additional paid-in capital	4,190	956
Accumulated other comprehensive loss	(36)	(10)
Retained earnings	1,920	1,358
Treasury stock, at cost (6,215,235 and 6,512,496 shares, respectively)	(179)	(147)
Total Centene stockholders' equity	5,895	2,157
Noncontrolling interest	14	11
Total stockholders' equity	5,909	2,168
Total liabilities and stockholders' equity	$ 20,197	$ 7,339

The accompanying notes to the consolidated financial statements are an integral part of these statements.

CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF OPERATIONS
(In millions, except share data)

	Year Ended December 31,		
	2016	**2015**	**2014**
Revenues:			
Premium	$ 35,399	$ 19,389	$ 14,198
Service	2,180	1,876	1,469
Premium and service revenues	37,579	21,265	15,667
Premium tax and health insurer fee	3,028	1,495	893
Total revenues	40,607	22,760	16,560
Expenses:			
Medical costs	30,636	17,242	12,678
Cost of services	1,864	1,621	1,280
Selling, general and administrative expenses	3,676	1,802	1,298
Amortization of acquired intangible assets	147	24	16
Premium tax expense	2,563	1,151	698
Health insurer fee expense	461	215	126
Total operating expenses	39,347	22,055	16,096
Earnings from operations	1,260	705	464
Other income (expense):			
Investment and other income	114	35	28
Interest expense	(217)	(43)	(35)
Earnings from continuing operations, before income tax expense	1,157	697	457
Income tax expense	599	339	196
Earnings from continuing operations, net of income tax expense	558	358	261
Discontinued operations, net of income tax expense (benefit) of $2, $(1), and $1, respectively	3	(1)	3
Net earnings	561	357	264
(Earnings) loss attributable to noncontrolling interests	1	(2)	7
Net earnings attributable to Centene Corporation	$ 562	$ 355	$ 271
Amounts attributable to Centene Corporation common shareholders:			
Earnings from continuing operations, net of income tax expense	$ 559	$ 356	$ 268
Discontinued operations, net of income tax expense (benefit)	3	(1)	3
Net earnings	$ 562	$ 355	$ 271
Net earnings (loss) per common share attributable to Centene Corporation:			
Basic:			
Continuing operations	$ 3.50	$ 2.99	$ 2.30
Discontinued operations	0.02	(0.01)	0.03
Basic earnings per common share	$ 3.52	$ 2.98	$ 2.33
Diluted:			
Continuing operations	$ 3.41	$ 2.89	$ 2.23
Discontinued operations	0.02	(0.01)	0.02
Diluted earnings per common share	$ 3.43	$ 2.88	$ 2.25
Weighted average number of common shares outstanding:			
Basic	159,567,607	119,100,744	116,345,764
Diluted	163,975,407	123,066,370	120,360,212

The accompanying notes to the consolidated financial statements are an integral part of these statements.

CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF COMPREHENSIVE EARNINGS
(In millions)

	Year Ended December 31,		
	2016	**2015**	**2014**
Net earnings	$ 561	$ 357	$ 264
Reclassification adjustment, net of tax	(2)	—	—
Change in unrealized gain (loss) on investments, net of tax	(22)	(4)	3
Defined benefit pension plan net gain arising during the period, net of tax	1	—	—
Foreign currency translation adjustments, net of tax	(3)	(5)	(1)
Other comprehensive earnings (loss)	(26)	(9)	2
Comprehensive earnings	535	348	266
Comprehensive (earnings) loss attributable to the noncontrolling interests	1	(2)	7
Comprehensive earnings attributable to Centene Corporation	$ 536	$ 346	$ 273

The accompanying notes to the consolidated financial statements are an integral part of these statements.

CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
(In millions, except share data)

	Centene Stockholders' Equity								
	Common Stock					Treasury Stock			
	$.001 Par Value Shares	Amt	Additional Paid-in Capital	Accumulated Other Comprehensive Income (Loss)	Retained Earnings	$.001 Par Value Shares	Amt	Non controlling Interest	Total
Balance, December 31, 2013	117,346,430	$ —	$ 594	$ (3)	$ 732	6,707,952	$ (89)	$ 9	$ 1,243
Net earnings (loss)	—	—	—	—	271	—	—	(1)	270
Other comprehensive earnings, net of $1 tax	—	—	—	2	—	—	—	—	2
Common stock issued for acquisitions	4,486,434	—	170	—	—	(1,492,738)	20	—	190
Common stock issued for employee benefit plans	2,442,000	—	9	—	—	—	—	—	9
Common stock repurchases	—	—	—	—	—	626,234	(29)	—	(29)
Stock compensation expense	—	—	48	—	—	—	—	—	48
Excess tax benefits from stock compensation	—	—	19	—	—	—	—	—	19
Reclassification to redeemable noncontrolling interest	—	—	—	—	—	—	—	(9)	(9)
Balance, December 31, 2014	124,274,864	$ —	$ 840	$ (1)	$ 1,003	5,841,448	$ (98)	$ (1)	$ 1,743
Net earnings	—	—	—	—	355	—	—	—	355
Other comprehensive earnings (loss), net of $3 tax	—	—	—	(9)	—	—	—	—	(9)
Common stock issued for acquisitions	—	—	8	—	—	(247,580)	4	—	12
Common stock issued for employee benefit plans	2,580,613	—	12	—	—	—	—	—	12
Common stock repurchases	—	—	—	—	—	918,628	(53)	—	(53)
Stock compensation expense	—	—	71	—	—	—	—	—	71
Excess tax benefits from stock compensation	—	—	25	—	—	—	—	—	25
Contribution from noncontrolling interest	—	—	—	—	—	—	—	11	11
Reclassification to redeemable noncontrolling interest	—	—	—	—	—	—	—	1	1
Balance, December 31, 2015	126,855,477	$ —	$ 956	$ (10)	$ 1,358	6,512,496	$ (147)	$ 11	$ 2,168
Net earnings	—	—	—	—	562	—	—	1	563
Other comprehensive earnings (loss), net of $(14) tax	—	—	—	(26)	—	—	—	—	(26)
Common stock issued for acquisitions	48,218,310	—	3,074	—	—	(1,375,596)	31	—	3,105
Common stock issued for employee benefit plans	3,060,519	—	12	—	—	—	—	—	12
Common stock repurchases	—	—	—	—	—	1,078,335	(63)	—	(63)
Stock compensation expense	—	—	148	—	—	—	—	—	148
Contribution from noncontrolling interest	—	—	—	—	—	—	—	2	2
Balance, December 31, 2016	178,134,306	$ —	$ 4,190	$ (36)	$ 1,920	6,215,235	$ (179)	$ 14	$ 5,909

The accompanying notes to the consolidated financial statements are an integral part of this statement.

CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CASH FLOWS
(In millions)

	Year Ended December 31,		
	2016	**2015**	**2014**
Cash flows from operating activities:			
Net earnings	$ 561	$ 357	$ 264
Adjustments to reconcile net earnings to net cash provided by operating activities			
Depreciation and amortization	278	111	89
Stock compensation expense	148	71	48
Debt extinguishment costs	(7)	—	—
Deferred income taxes	92	(17)	(42)
Gain on contingent consideration	(5)	(44)	—
Goodwill and intangible adjustment	—	38	—
Changes in assets and liabilities			
Premium and related receivables	74	(360)	(463)
Other assets	167	(102)	(7)
Medical claims liabilities	145	536	609
Unearned revenue	43	(27)	129
Accounts payable and accrued expenses	402	39	506
Other long term liabilities	(61)	51	89
Other operating activities, net	14	5	1
Net cash provided by operating activities	1,851	658	1,223
Cash flows from investing activities:			
Capital expenditures	(306)	(150)	(103)
Purchases of investments	(2,450)	(1,321)	(1,015)
Sales and maturities of investments	1,656	669	406
Investments in acquisitions, net of cash acquired	(1,297)	(18)	(136)
Other investing activities, net	—	7	—
Net cash used in investing activities	(2,397)	(813)	(848)
Cash flows from financing activities:			
Proceeds from borrowings	8,946	1,925	1,875
Payment of long term debt	(6,076)	(1,583)	(1,674)
Common stock repurchases	(63)	(53)	(29)
Debt issuance costs	(76)	(4)	(7)
Other financing activities, net	(14)	20	33
Net cash provided by financing activities	2,717	305	198
Effect of exchange rate changes on cash and cash equivalents	(1)	—	(1)
Net increase in cash and cash equivalents	2,170	150	572
Cash and cash equivalents, beginning of period	1,760	1,610	1,038
Cash and cash equivalents, end of period	$ 3,930	$ 1,760	$ 1,610
Supplemental disclosures of cash flow information:			
Interest paid	$ 165	$ 55	$ 40
Income taxes paid	$ 556	$ 328	$ 237
Equity issued in connection with acquisitions	$ 3,105	$ 12	$ 190

The accompanying notes to the consolidated financial statements are an integral part of these statements.

1. Organization and Operations

Centene Corporation, or the Company, is a diversified, multi-national healthcare enterprise operating in two segments: Managed Care and Specialty Services. The Managed Care segment provides Medicaid and Medicaid-related health plan coverage to individuals through the government subsidized programs, including Medicaid, the State Children's Health Insurance Program (CHIP), Long Term Care (LTC), Foster Care, dual-eligible individuals (Duals) in Medicare Special Needs Plans and the Supplemental Security Income Program, also known as the Aged, Blind or Disabled Program (ABD), Medicare, and the Health Insurance Marketplace. The Company also offers a variety of individual, small group, and large group commercial health care products, both to employers and directly to members in the Managed Care segment. The Specialty Services segment consists of our specialty companies offering auxiliary healthcare services and products to state programs, correctional facilities, healthcare organizations, employer groups and other commercial organizations, as well as to our own subsidiaries. The Specialty Service segment also includes the Government Contracts business which includes the Company's government-sponsored managed care support contract with the U.S. Department of Defense (DoD) under the TRICARE program in the North Region, the Military Family and Life Counseling (MFLC) contract with the DoD, and other health care related government contracts, including the Patient Centered Community Care (PC3) contract with the U.S. Department of Veterans Affairs (VA).

On March 24, 2016, the Company acquired all of the issued and outstanding shares of Health Net, Inc. (Health Net) a publicly traded managed care organization that delivers health care services through health plans and government-sponsored managed care plans. The transaction was valued at approximately $5,990 million, including the assumption of $703 million of outstanding debt. The acquisition allows the Company to offer a more comprehensive and scalable portfolio of solutions and provides opportunity for additional growth across the combined company's markets.

On February 2, 2015, the Board of Directors declared a two-for-one split of Centene's common stock in the form of a 100% stock dividend distributed February 19, 2015 to stockholders of record on February 12, 2015. All share and per share information presented in this Form 10-K has been adjusted for the two-for-one stock split.

2. Summary of Significant Accounting Policies

Basis of Presentation

The accompanying consolidated financial statements include the accounts of Centene Corporation and all majority owned subsidiaries and subsidiaries over which the Company exercises the power and control to direct activities significantly impacting financial performance. All material intercompany balances and transactions have been eliminated. The assets, liabilities and results of operations of Kentucky Spirit Health Plan (Kentucky Spirit) are classified as discontinued operations for all periods presented.

Certain amounts in the consolidated financial statements and notes have been reclassified to conform to the 2016 presentation. These reclassifications have no effect on net earnings or stockholders' equity as previously reported.

Use of Estimates

The preparation of financial statements in conformity with generally accepted accounting principles in the United States, or GAAP, requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Future events and their effects cannot be predicted with certainty; accordingly, the accounting estimates require the exercise of judgment. The accounting estimates used in the preparation of the consolidated financial statements will change as new events occur, as more experience is acquired, as additional information is obtained and as the operating environment changes. The Company evaluates and updates its assumptions and estimates on an ongoing basis and may employ outside experts to assist in our evaluation, as considered necessary. Actual results could differ from those estimates.

Business Combinations

Business combinations are accounted for using the acquisition method of accounting. The Company allocates the fair value of purchase consideration to the assets acquired and liabilities assumed based on their fair values at the acquisition date. The excess of the fair value of consideration transferred over the fair value of the net assets acquired is recorded as goodwill. Goodwill is generally attributable to the value of the synergies between the combined companies and the value of the acquired assembled workforce, neither of which qualifies for recognition as an intangible asset.

The Company uses its best estimates and assumptions to value assets acquired and liabilities assumed at the acquisition date; however, these estimates are sometimes preliminary and in some instances, all information required to value the assets acquired and liabilities assumed may not be available or final as of the end of a reporting period subsequent to the business combination. If the accounting for the business combination is incomplete, provisional amounts are recorded. The provisional amounts are updated during the period determined, up to one year from the acquisition date. The Company includes the results of operations of acquired businesses in the Company's consolidated results prospectively from the date of acquisition.

Acquisition related expenses and post-acquisition restructuring costs are recognized separately from the business combination and are expensed as incurred.

Cash and Cash Equivalents

Investments with original maturities of three months or less are considered to be cash equivalents. Cash equivalents consist of money market funds and bank certificates of deposit and savings accounts.

The Company maintains amounts on deposit with various financial institutions, which may exceed federally insured limits. However, management periodically evaluates the credit-worthiness of those institutions, and the Company has not experienced any losses on such deposits.

Investments

Short term investments include securities with maturities greater than three months to one year. Long term investments include securities with maturities greater than one year.

Short term and long term investments are generally classified as available for sale and are carried at fair value. Certain equity investments are recorded using the cost or equity method. Unrealized gains and losses on investments available for sale are excluded from earnings and reported in accumulated other comprehensive income, a separate component of stockholders' equity, net of income tax effects. Premiums and discounts are amortized or accreted over the life of the related security using the effective interest method. The Company monitors the difference between the cost and fair value of investments. Investments that experience a decline in value that is judged to be other than temporary are written down to fair value and a realized loss is recorded in investment and other income. To calculate realized gains and losses on the sale of investments, the Company uses the specific amortized cost of each investment sold. Realized gains and losses are recorded in investment and other income.

The Company uses the equity method to account for its investments in entities that it does not control but has the ability to exercise significant influence over operating and financial policies. These investments are recorded at the lower of their cost or fair value adjusted for the Company's proportionate share of earnings or losses.

Restricted Deposits

Restricted deposits consist of investments required by various state statutes to be deposited or pledged to state agencies. These investments are classified as long term, regardless of the contractual maturity date, due to the nature of the states' requirements. The Company is required to annually adjust the amount of the deposit pledged to certain states.

Fair Value Measurements

In the normal course of business, the Company invests in various financial assets and incurs various financial liabilities. Fair values are disclosed for all financial instruments, whether or not such values are recognized in the Consolidated Balance Sheets. Management obtains quoted market prices and other observable inputs for these disclosures. The carrying amounts reported in the Consolidated Balance Sheets for cash and cash equivalents, premium and related receivables, medical claims liability, accounts payable and accrued expenses, unearned revenue, and certain other current assets and liabilities are carried at cost, which approximates fair value because of their short term nature.

The following methods and assumptions were used to estimate the fair value of each financial instrument:

- Available for sale investments and restricted deposits: The carrying amount is stated at fair value, based on quoted market prices, where available. For securities not actively traded, fair values were estimated using values obtained from independent pricing services or quoted market prices of comparable instruments.
- Senior unsecured notes: Estimated based on third-party quoted market prices for the same or similar issues.
- Variable rate debt: The carrying amount of our floating rate debt approximates fair value since the interest rates adjust based on market rate adjustments.
- Interest rate swap: Estimated based on third-party market prices based on the forward 3-month LIBOR curve.
- Contingent consideration: Estimated based on expected achievement of metrics included in the acquisition agreement considering circumstances that exist as of the acquisition date.

Property, Software and Equipment

Property, software and equipment are stated at cost less accumulated depreciation. Capitalized software includes certain costs incurred in the development of internal-use software, including external direct costs of materials and services and payroll costs of employees devoted to specific software development. Depreciation is calculated principally by the straight-line method over estimated useful lives. Leasehold improvements are depreciated using the straight-line method over the shorter of the expected useful life or the remaining term of the lease. Property, software and equipment are depreciated over the following periods:

Fixed Asset	Depreciation Period
Buildings and land improvements	5 - 40 years
Computer hardware and software	2 - 7 years
Furniture and equipment	3 - 10 years
Land improvements	3 - 20 years
Leasehold improvements	1 - 20 years

The carrying amounts of all long-lived assets are evaluated to determine if adjustment to the depreciation and amortization period or to the unamortized balance is warranted. Such evaluation is based principally on the expected utilization of the long-lived assets.

The Company retains fully depreciated assets in property and accumulated depreciation accounts until it removes them from service. In the case of sale, retirement, or disposal, the asset cost and related accumulated depreciation balance is removed from the respective account, and the resulting net amount, less any proceeds, is included as a component of earnings from operations in the Consolidated Statements of Operations.

Goodwill and Intangible Assets

Intangible assets represent assets acquired in purchase transactions and consist primarily of purchased contract rights, provider contracts, customer relationships, trade names, developed technologies and goodwill. Intangible assets are amortized using the straight-line method over the following periods:

Intangible Asset	Amortization Period
Purchased contract rights	5 - 15 years
Provider contracts	4 - 15 years
Customer relationships	3 - 15 years
Trade names	1 - 20 years
Developed technology	5 years

The Company tests for impairment of intangible assets as well as long-lived assets whenever events or changes in circumstances indicate that the carrying value of an asset or asset group (hereinafter referred to as “asset group”) may not be recoverable by comparing the sum of the estimated undiscounted future cash flows expected to result from use of the asset group and its eventual disposition to the carrying value. Such factors include, but are not limited to, significant changes in membership, state funding, state contracts and provider networks and contracts. If the sum of the estimated undiscounted future cash flows is less than the carrying value, an impairment determination is required. The amount of impairment is calculated by subtracting the fair value of the asset group from the carrying value of the asset group. An impairment charge, if any, is recognized within earnings from operations.

The Company tests goodwill for impairment using a fair value approach. The Company is required to test for impairment at least annually, absent a triggering event, which could include a significant decline in operating performance that would require an impairment assessment. Absent any impairment indicators, the Company performs its goodwill impairment testing during the fourth quarter of each year. The Company recognizes an impairment charge for any amount by which the carrying amount of goodwill exceeds its implied fair value.

The Company first assesses qualitative factors to determine whether it is necessary to perform the two-step quantitative goodwill impairment test. The Company generally does not calculate the fair value of a reporting unit unless it determines, based on a qualitative assessment, that it is more likely than not that its fair value is less than its carrying amount. However, in certain circumstances, such as recent acquisitions, the Company may elect to perform a quantitative assessment without first assessing qualitative factors.

If the two-step quantitative test is deemed necessary, the Company determines an appropriate valuation technique to estimate a reporting unit's fair value as of the testing date. The Company utilizes either the income approach or the market approach, whichever is most appropriate for the respective reporting unit. The income approach is based on an internally developed discounted cash flow model that includes many assumptions related to future growth rates, discount factors, future tax rates, etc. The market approach is based on financial multiples of comparable companies derived from current market data. Changes in economic and operating conditions impacting assumptions used in our analyses could result in goodwill impairment in future periods.

Medical Claims Liability

Medical claims liability includes claims reported but not yet paid, or inventory, estimates for claims incurred but not reported, or IBNR, and estimates for the costs necessary to process unpaid claims at the end of each period. The Company estimates its medical claims liability using actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. These actuarial methods consider factors such as historical data for payment patterns, cost trends, product mix, seasonality, utilization of healthcare services and other relevant factors.

Actuarial Standards of Practice generally require that the medical claims liability estimates be adequate to cover obligations under moderately adverse conditions. Moderately adverse conditions are situations in which the actual claims are expected to be higher than the otherwise estimated value of such claims at the time of estimate. In many situations, the claims amounts ultimately settled will be different than the estimate that satisfies the Actuarial Standards of Practice. The Company includes in its IBNR an estimate for medical claims liability under moderately adverse conditions which represents the risk of adverse deviation of the estimates in its actuarial method of reserving.

The Company uses its judgment to determine the assumptions to be used in the calculation of the required estimates. The assumptions it considers when estimating IBNR include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, healthcare service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to fee schedules, and the incidence of high dollar or catastrophic claims.

The Company's development of the medical claims liability estimate is a continuous process which it monitors and refines on a monthly basis as additional claims receipts and payment information becomes available. As more complete claims information becomes available, the Company adjusts the amount of the estimates, and includes the changes in estimates in medical costs in the period in which the changes are identified. In every reporting period, the operating results include the effects of more completely developed medical claims liability estimates associated with previously reported periods. The Company consistently applies its reserving methodology from period to period. As additional information becomes known, it adjusts the actuarial model accordingly to establish medical claims liability estimates.

The Company periodically reviews actual and anticipated experience compared to the assumptions used to establish medical costs. The Company establishes premium deficiency reserves if actual and anticipated experience indicates that existing policy liabilities together with the present value of future gross premiums will not be sufficient to cover the present value of future benefits, settlement and maintenance costs.

Revenue Recognition

The Company's health plans generate revenues primarily from premiums received from the states in which it operates health plans. The Company generally receives a fixed premium per member per month pursuant to its state contracts and recognizes premium revenues during the period in which it is obligated to provide services to its members at the amount reasonably estimable. In some instances, the Company's base premiums are subject to an adjustment, or risk score, based on the acuity of its membership. Generally, the risk score is determined by the State analyzing submissions of processed claims data to determine the acuity of the Company's membership relative to the entire state's Medicaid membership. The Company estimates the amount of risk adjustment based upon the processed claims data submitted and expected to be submitted to Centers for Medicare and Medicaid Services (CMS) and records revenues on a risk adjusted basis. Some contracts allow for additional premiums related to certain supplemental services provided such as maternity deliveries.

The Company's contracts with states may require us to maintain a minimum health benefits ratio (HBR) or may require us to share profits excess of certain levels. In certain circumstances, our plans may be required to return premium to the state in the event profits exceed established levels. We estimate the effect of these programs and recognize reductions in revenue in the current period. Other states may require us to meet certain performance and quality metrics in order to receive additional or full contractual revenue. For performance-based contracts, we do not recognize revenue subject to refund until data is sufficient to measure performance.

Revenues are recorded based on membership and eligibility data provided by the states, which is adjusted on a monthly basis by the states for retroactive additions or deletions to membership data. These eligibility adjustments are estimated monthly and subsequent adjustments are made in the period known. The Company continuously reviews and updates those estimates as new information becomes available. It is possible that new information could require us to make additional adjustments, which could be significant, to these estimates.

The Company's Medicare Advantage contracts are with CMS. CMS deploys a risk adjustment model which apportions premiums paid to all health plans according to health severity and certain demographic factors. The CMS risk adjustment model pays more for members whose medical history would indicate that they are expected to have higher medical costs. Under this risk adjustment methodology, CMS calculates the risk adjusted premium payment using diagnosis data from hospital inpatient, hospital outpatient, physician treatment settings as well as prescription drug events. The Company and the health care providers collect, compile and submit the necessary and available diagnosis data to CMS within prescribed deadlines. The Company estimates risk adjustment revenues based upon the diagnosis data submitted and expected to be submitted to CMS and records revenues on a risk adjusted basis.

The Company's specialty services generate revenues under contracts with state and federal programs, healthcare organizations and other commercial organizations, as well as from our own subsidiaries. Revenues are recognized when the related services are provided or as ratably earned over the covered period of services. The Company recognizes revenue related to administrative services under the T-3 TRICARE government-sponsored managed care support contract in the North Region for the DoD's TRICARE program (T-3 contract) on a straight-line basis over the option period, when the fees become fixed and determinable. The T-3 contract includes various performance-based incentives and penalties. For each of the incentives or penalties, the Company adjusts revenue accordingly based on the amount that it has earned or incurred at each interim date and are legally entitled to in the event of a contract termination.

Some states enact premium taxes, similar assessments and provider pass-through payments, collectively premium taxes, and these taxes are recorded as a separate component of both revenues and operating expenses. Additionally, the Company's insurance subsidiaries are subject to the Affordable Care Act annual health insurer fee (HIF). If the Company is able to negotiate reimbursement of portions of these premium taxes or the HIF, it recognizes revenue associated with the HIF on a straight-line basis when we have binding agreements for such reimbursements, including the “gross-up” to reflect the HIFs non-tax deductible nature. Collectively, this revenue is recorded as premium tax and health insurer fee revenue in the Consolidated Statements of Operations.

Affordable Care Act

The Affordable Care Act (ACA) established risk spreading premium stabilization programs effective January 1, 2014. These programs, commonly referred to as the “three Rs”, include a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridor program. Additionally, the ACA established a minimum annual medical loss ratio (MLR) and cost-sharing reductions. Each of the three R programs are taken into consideration to determine if the Company's estimated annual medical costs are less than the minimum loss ratio and require an adjustment to premium revenue to meet the minimum MLR.

During the second quarter of 2016, the Company recognized a $70 million net pre-tax benefit related to the reconciliation of 2015 risk adjustment and reinsurance programs. During the third quarter of 2016, the company received information from CMS, indicating that some of the participants in the Arizona risk adjustment program were unable to pay the amounts owed. As a result, the uncollected portion has been allocated pro-rata to other insurers in the market. Accordingly, the Company reduced the pre-tax earnings by $19 million during the third quarter.

The Company’s accounting policies for the programs are as follows:

Risk Adjustment

The permanent risk adjustment program established by the ACA transfers funds from qualified individual and small group insurance plans with below average risk scores to those plans with above average risk scores within each state. The Company estimates the receivable or payable under the risk adjustment program based on its estimated risk score compared to the state average risk score. The Company may record a receivable or payable as an adjustment to Premium revenue to reflect the year to date impact of the risk adjustment based on its best estimate. The Company expects to refine its estimate as new information becomes available. As of December 31, 2016 and 2015, the Company recorded a payable of $425 million and $108 million, respectively, associated with risk adjustment.

Reinsurance

The ACA established a transitional three-year reinsurance program whereby the Company’s claims costs incurred for qualified members will be reimbursed when they exceed a specific threshold. For the 2016 benefit year, qualified member claims that exceeded $90,000 entitled the Company to reimbursement from the programs at 50% coinsurance. The Company accounts for reinsurance recoveries as a reduction of Medical Costs based on each individual case that exceeds the reinsurance threshold established by the program. As of December 31, 2016 and 2015, the Company recorded a receivable of $122 million and $24 million, respectively, associated with reinsurance.

Risk Corridor

The temporary, three-year risk corridor program established by the ACA applies to qualified individual and small group health plans operating both inside and outside of the Health Insurance Marketplace. The risk corridor program limits the Company's gains and losses in the Health Insurance Marketplace by comparing certain medical and administrative costs to a target amount and sharing the risk for allowable costs with the federal government. Allowable medical costs are adjusted for risk adjustment settlements, transitional reinsurance recoveries, and cost sharing reductions received from the federal government. The Company records a risk corridor receivable or payable as an adjustment to premium revenue on a year to date basis based on where its estimated annual costs fall within the risk corridor range. As of December 31, 2016 and 2015, the Company recorded a payable of $3 million and $4 million, respectively, associated with risk corridor.

Minimum Medical Loss Ratio

Additionally, the ACA established a minimum annual MLR for the Health Insurance Marketplace. Each of the three R programs described above are taken into consideration to determine if the Company's estimated annual medical costs are less than the minimum loss ratio and require an adjustment to premium revenue to meet the minimum MLR. As of December 31, 2016 and 2015, the Company recorded a payable of $18 million and $15 million, respectively, associated with minimum MLR.

Cost-sharing Reductions (CSRs)

The ACA directs issuers to reduce the Company's members' cost sharing for essential health benefits for individuals with Federal Poverty Levels (FPLs) between 100% and 250% who are enrolled in a silver tier product; eliminate cost sharing for Indians/Alaska Natives with an FPL less than 300% and eliminate cost sharing for Indians/Alaska Natives regardless of FPL level when services are provided by an Indian Health Service. In order to compensate issuers for reduced cost sharing provided to enrollees, CMS pays an advance CSR payment to the Company each month based on the Company's certification data provided at the time of the qualified health plan application. After the close of the benefit year, the Company is required to provide CMS with data on the value of the CSRs provided to enrollees based on either a 'simplified' or 'standard' approach. A reconciliation will occur in order to calculate the difference between the Company's CSR advance payments received and the value of CSRs provided to enrollees. This reconciliation will produce either a payable or receivable to/from CMS. The Company has elected the standard methodology approach. As of December 31, 2016 and 2015, the Company recorded a payable of $147 million and $40 million, respectively, associated with CSRs.

Premium and Related Receivables and Unearned Revenue

Premium and service revenues collected in advance are recorded as unearned revenue. For performance-based contracts the Company does not recognize revenue subject to refund until data is sufficient to measure performance. Premiums and service revenues due to the Company are recorded as premium and related receivables and are recorded net of an allowance based on historical trends and management's judgment on the collectibility of these accounts. As the Company generally receives payments during the month in which services are provided, the allowance is typically not significant in comparison to total revenues and does not have a material impact on the presentation of the financial condition or results of operations. Amounts receivable under federal contracts are comprised primarily of contractually defined billings, accrued contract incentives under the terms of the contract and amounts related to change orders for services not originally specified in the contract.

Activity in the allowance for uncollectible accounts for the years ended December 31, is summarized below ($ in millions):

	2016	2015	2014
Allowances, beginning of year	$ 10	$ 5	$ 1
Amounts charged to expense	33	12	8
Write-offs of uncollectible receivables	(14)	(7)	(4)
Allowances, end of year	$ 29	$ 10	$ 5

Significant Customers

Centene receives the majority of its revenues under contracts or subcontracts with state Medicaid managed care programs. The current contracts expire on various dates between February 28, 2017 and December 31, 2022. Customers where the aggregate annual contract revenues exceeded 10% of total annual revenues included the state of California, where the percentage of the Company's total revenue was 21%, 3% and 2% for the years ended December 31, 2016, 2015 and 2014, respectively; the state of Florida, where the percentage of the Company's total revenue was 14% for the years ended December 31, 2015 and 2014; and the state of Texas, where the percentage of the Company's total revenue was 13%, 22% and 25% for the years ended December 31, 2016, 2015 and 2014, respectively. The decrease in the revenue percentage for the state of Texas compared to prior periods is attributable to the overall growth in the Company's revenues as a result of the Health Net acquisition.

Other Income (Expense)

Other income (expense) consists principally of investment income, interest expense and equity method earnings from investments. Investment income is derived from the Company's cash, cash equivalents, restricted deposits and investments. Interest expense relates to borrowings under the senior notes, interest rate swap, credit facilities, interest on capital leases and credit facility fees.

Income Taxes

Deferred tax assets and liabilities are recorded for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax law or tax rates is recognized in income in the period that includes the enactment date.

Valuation allowances are provided when it is considered more likely than not that deferred tax assets will not be realized. In determining if a deductible temporary difference or net operating loss can be realized, the Company considers future reversals of existing taxable temporary differences, future taxable income, taxable income in prior carryback periods and tax planning strategies.

Contingencies

The Company accrues for loss contingencies associated with outstanding litigation, claims and assessments for which it has determined it is probable that a loss contingency exists and the amount of loss can be reasonably estimated. The Company expenses professional fees associated with litigation claims and assessments as incurred.

Stock Based Compensation

The fair value of the Company's employee share options and similar instruments are estimated using the Black-Scholes option-pricing model. That cost is recognized over the period during which an employee is required to provide service in exchange for the award. Excess tax benefits related to stock compensation are presented as a cash inflow from financing activities for the years ended December 31, 2015 and 2014 and as a cash inflow from operating activities for the year ended December 31, 2016 due to the prospective adoption of employee share-based payment guidance in 2016. The Company accounts for forfeitures when they occur.

Foreign Currency Translation

The Company is exposed to foreign currency exchange risk through its equity method investment in Ribera Salud S.A. (Ribera Salud), a Spanish health management group whose functional currency is the Euro. The assets and liabilities of the Company's investment are translated into United States dollars at the balance sheet date. The Company translates its proportionate share of earnings using average rates during the year. The resulting foreign currency translation adjustments are recorded as a separate component of accumulated other comprehensive income.

Recently Adopted Accounting Pronouncements

In March 2016, the Financial Accounting Standards Board (FASB) issued an Accounting Standards Update (ASU) which simplifies several aspects of the accounting for employee share-based payment transactions, including the accounting for income taxes, forfeitures, and statutory tax withholding requirements, as well as classification in the statement of cash flows. Under the new guidance, an entity recognizes all excess tax benefits and tax deficiencies as income tax expense or benefit in the income statement. The ASU also allows an entity to elect as an accounting policy either to continue to estimate the total number of awards for which the requisite service period will not be rendered, as currently required, or to account for forfeitures when they occur. Finally, the ASU modifies the current exception to liability classification of an award when an employer uses a net-settlement feature to withhold shares to meet the employee's minimum statutory tax withholding requirement. The new standard is effective for annual periods beginning after December 15, 2016, including interim periods within those annual reporting periods. Early adoption is permitted. The Company elected to early adopt this guidance in the fourth quarter of 2016. The adoption of this ASU decreased the Company's income tax expense by $14 million in 2016 and increased diluted shares outstanding by approximately one million shares. Excess tax benefits related to stock compensation are now presented as cash flows from operating activities rather than as cash flows from financing activities, this aspect of the guidance has been adopted prospectively. In connection with the adoption, the Company has elected to account for forfeitures as they occur.

In May 2015, the FASB issued an ASU which expands the disclosure requirements for insurance companies that issue short-duration contracts. The new standard will increase the level of disclosure around the Company's Medical Claims Liability to include the following: claims development by year; claim frequency; a rollforward of the claims liability; and a description of methods and assumptions used for determining the liability. It is effective for annual periods beginning after December 15, 2015 and interim periods beginning after December 15, 2016. The Company has adopted this guidance in the current fiscal year.

Recent Accounting Guidance Not Yet Adopted

In January 2017, the FASB issued an ASU simplifying the test for goodwill impairment. The amendments in this ASU eliminate Step 2 from the goodwill impairment test. Thus, an entity will no longer be required to compare the implied fair value of a reporting unit’s goodwill to its carrying amount. Instead, under the new guidance, an entity should perform the goodwill impairment test by comparing the fair value of a reporting unit with its carrying amount and should recognize an impairment charge for the amount by which the carrying amount exceeds the fair value. The impairment charge should be limited to the total amount of goodwill allocated to that reporting unit. Under the new guidance, an entity still has the option to first perform the qualitative assessment for a reporting unit to determine if the quantitative impairment test is necessary. The new standard is effective for an entity’s annual or interim goodwill impairment tests in fiscal years beginning after December 15, 2019. Early adoption is permitted, including adoption in an interim period. The Company is currently evaluating the effect of the new goodwill impairment guidance.

In November 2016, the FASB issued an ASU clarifying the classification and presentation of changes in restricted cash on the statement of cash flows. The amendments in this ASU require that a statement of cash flows explain the change during the period in the total of cash, cash equivalents, and restricted cash. Therefore, amounts generally described as restricted cash should be included with cash and cash equivalents when reconciling the beginning-of-period and end-of-period total amounts shown on the statement of cash flows. The new standard is effective for annual periods beginning after December 15, 2017, including interim periods within those annual reporting periods. Early adoption is permitted, including adoption in an interim period. The Company is currently evaluating the effect of the new statement of cash flows guidance.

In August 2016, the FASB issued an ASU which clarifies how entities should classify certain cash receipts and cash payments on the statement of cash flows. The new guidance also clarifies how the predominance principle should be applied when cash receipts and cash payments have aspects of more than one class of cash flows. The new standard is effective for annual periods beginning after December 15, 2017, including interim periods within those annual reporting periods. Early adoption is permitted. The Company is currently evaluating the effect of the new statement of cash flows guidance.

In February 2016, the FASB issued an ASU which introduces a lessee model that requires the majority of leases to be recognized on the balance sheet. The new standard also aligns many of the underlying principles of the new lessor model with those in Accounting Standards Codification 606, the FASB's new revenue recognition standard, and addresses other concerns related to the current lessee model. The standard also requires lessors to increase the transparency of their exposure to changes in value of their residual assets and how they manage that exposure. It is effective for annual and interim periods beginning after December 15, 2018. Early adoption is permitted. The Company is currently evaluating the effect of the new lease guidance.

In May 2014, the FASB issued an ASU which supersedes existing revenue recognition standards with a single model unless those contracts are within the scope of other standards (e.g., an insurance entity's insurance contracts). Under the new standard, recognition of revenue occurs when a customer obtains control of promised goods or services in an amount that reflects the consideration which the entity expects to receive in exchange for those goods or services. In addition, the standard requires disclosure of the nature, amount, timing and uncertainty of revenue and cash flows arising from contracts with customers. The new effective date is for annual and interim periods beginning after December 15, 2017. Early adoption is permitted. The Company is currently evaluating the effect of the new revenue recognition guidance. The majority of the Company's revenues are derived from insurance contracts and are excluded from the new standard, therefore the new guidance is not expected to have a material impact on the Company's consolidated financial position, results of operations or cash flows.

The Company has determined that there are no other recently issued accounting pronouncements that will have a material impact on its consolidated financial position, results of operations or cash flows.

3. Health Net

On March 24, 2016, the Company acquired all of the issued and outstanding shares of Health Net, a publicly traded managed care organization that delivers health care services through health plans and government-sponsored managed care plans. The transaction was valued at approximately $5,990 million, including the assumption of $703 million of outstanding debt. The acquisition allows the Company to offer a more comprehensive and scalable portfolio of solutions and provides opportunity for additional growth across the combined company's markets.

The total consideration for the acquisition was $5,287 million, consisting of Centene common shares valued at $3,038 million (based on Centene's stock price of $62.70), $2,247 million in cash, and $2 million related to the fair value adjustment to stock based compensation associated with pre-combination service. Each Health Net share was converted into 0.622 of a validly issued, fully paid, non-assessable share of Centene common stock and $28.25 in cash. In total, 48,449,444 shares of Centene common stock were issued in connection with the transaction. The cash portion of the acquisition consideration was funded through the issuance of long-term debt as further discussed in Note 11, *Debt*. For the year ended December 31, 2016, the Company also recognized acquisition related expenses of $234 million that were recorded in selling, general and administrative (SG&A) expense in the Consolidated Statements of Operations.

The acquisition of Health Net has been accounted for as a business combination using the acquisition method of accounting which requires assets acquired and liabilities assumed to be recognized at fair value as of the acquisition date. The valuation of all the assets acquired and liabilities assumed was finalized in the fourth quarter of 2016.

Since the initial allocation of purchase price, the Company made adjustments and reclassifications to the fair value of certain assets and liabilities acquired, including the premium and related receivables, medical claims liability, accrued liabilities, return of premium payable and deferred taxes, resulting in a net increase of $258 million to goodwill. The Company's allocation of the fair value of assets acquired and liabilities assumed as of the acquisition date of March 24, 2016, is as follows ($ in millions):

Assets Acquired and Liabilities Assumed		
Cash and cash equivalents	$	956
Premium and related receivables [(a)]		1,890
Short term investments		74
Other current assets		524
Long term investments		2,037
Restricted deposits		30
Property, software and equipment, net		41
Intangible assets [(b)]		1,530
Other long term assets		136
Total assets acquired		7,218
Medical claims liability [(c)]		1,482
Borrowings under revolving credit facility		285
Accounts payable and accrued expenses [(c)] [(d)]		2,297
Return of premium payable		435
Unearned revenue		130
Long term deferred tax liabilities [(e)]		311
Long term debt [(f)]		418
Other long term liabilities		432
Total liabilities assumed		5,790
Total identifiable net assets		1,428
Goodwill [(g)]		3,859
Total assets acquired and liabilities assumed	$	5,287

Significant fair value adjustments are noted as follows:

(a) The fair value of premium and related receivables approximated their historical cost, with the exception of the risk corridor receivable associated with the Health Insurance Marketplace. The fair value of the risk corridor receivable was estimated at $9 million.

(b) The identifiable intangible assets acquired are to be measured at fair value as of the completion of the acquisition. The fair value of intangible assets is determined primarily using variations of the "income approach," which is based on the present value of the future after tax cash flows attributable to each identified intangible asset. Other valuation methods, including the market approach and cost approach, were also utilized in estimating the fair value of certain intangible assets. The Company has finalized its fair value of intangibles to be $1,530 million with a weighted average life of 12 years. This final fair value of intangibles is approximately $30 million higher than the preliminary fair value of intangibles and the weighted average life increased by two years, which resulted in an immaterial true-up of intangible amortization recorded during the fourth quarter of 2016. The Company identified intangible assets including purchased contract rights, provider contracts, trade names and developed technology.

(c) Medical claims liability and accounts payable and accrued expenses include $160 million of reserves associated with substance abuse rehabilitation claims primarily related to periods prior to the acquisition date.

(d) Accounts payable and accrued expenses include approximately $253 million related to premium deficiency reserves based on cost trends existing prior to the acquisition date. The premium deficiency reserves are primarily associated with losses in the individual commercial business, largely in California, unfavorable performance in the Arizona commercial business as well as unfavorable performance in the Medicare business primarily in Oregon and Arizona.

(e) The deferred tax liabilities are presented net of $365 million of deferred tax assets.

(f) Debt is required to be measured at fair value under the acquisition method of accounting. The fair value of Health Net's $400 million Senior Notes assumed in the acquisition was $418 million. The $18 million increase will be amortized as a reduction to interest expense over the remaining life of the debt. In November 2016, this debt was redeemed as discussed in Note 11, *Debt.*

(g) The acquisition resulted in $3,859 million of goodwill related primarily to buyer specific synergies expected from the acquisition and the assembled workforce of Health Net. This goodwill is not deductible for income tax purposes. The Company assigned $3,317 million of goodwill to the Managed Care segment and $542 million of goodwill to the Specialty Services segment.

The fair values and weighted average useful lives for identifiable intangible assets acquired are as follows:

	Fair Value	Weighted Average Useful Life (in years)
Purchased contract rights	$ 1,095	13
Provider contracts	181	11
Trade names	150	10
Developed technology	104	5
Total intangible assets acquired	$ 1,530	12

Statement of Operations

From the acquisition date through December 31, 2016, the Company's Consolidated Statements of Operations include total Health Net revenues of $13,454 million. It is impracticable to determine the effect on net income resulting from the Health Net acquisition for the year ended December 31, 2016, as the Company immediately integrated Health Net into its ongoing operations.

Unaudited Pro Forma Financial Information

The unaudited pro forma total revenues for the year ended December 31, 2016 were $44,280 million. The following table presents supplemental pro forma information for the year ended December 31, 2015 ($ in millions, except per share data).

	December 31, 2015
Total revenues	$ 38,826
Net earnings attributable to Centene Corporation	$ 245
Diluted earnings per share	$ 1.43

The pro forma results do not reflect any anticipated synergies, efficiencies, or other cost savings of the acquisition. Accordingly, the unaudited pro forma financial information is not indicative of the results if the acquisition had been completed on January 1, 2015 and is not a projection of future results. It is impracticable for the Company to determine the pro forma earnings information for the year ended December 31, 2016 due to the nature of obtaining that information as the Company immediately integrated Health Net into its ongoing operations.

The unaudited pro forma financial information reflects the historical results of Centene and Health Net adjusted as if the acquisition had occurred on January 1, 2015, primarily for the following:

- Additional interest income associated with adjusting the amortized cost of Health Net's investment portfolio to fair value.
- Elimination of historical Health Net intangible asset amortization expense and addition of amortization expense based on the current values of identifiable intangible assets.
- Adjustments to premium revenue related to the risk corridor receivables associated with the Health Insurance Marketplace to align with Centene's accounting policies.

- Interest expense associated with financing the acquisition and amortization of the fair value adjustment to Health Net's debt.
- Additional stock compensation expense related to the amortization of the fair value increase to Health Net rollover stock awards.
- Increased tax expense due to the assumption that Centene would be subject to the IRS Regulation 162(m)(6) beginning in 2015.
- Elimination of acquisition related costs.

Restructuring Related Charges

In connection with the Health Net acquisition, the Company undertook a restructuring plan as a result of the integration of Health Net's operations into its business, resulting in a reduction in workforce beginning in 2016 and expected to continue through early 2017. The restructuring related costs are classified as SG&A expenses in the Consolidated Statements of Operations. Changes in the restructuring liability for the year ended December 31, 2016 were as follows ($ in millions):

	December 31, 2016		
	Employee Termination Costs	Stock Based Compensation	Total
Total accrued restructuring costs as of December 31, 2015	$ —	$ —	$ —
Charges incurred	46	43	89
Paid/settled	(28)	(43)	(71)
Total accrued restructuring costs as of December 31, 2016	$ 18	$ —	$ 18

For the year ended December 31, 2016, the Company recorded employee termination costs of $46 million and stock based compensation of $43 million in the Managed Care Segment. The Company expects to record a total of approximately $51 million of employee termination costs and $45 million of stock based compensation in connection with the acquisition, the majority of which was expensed in 2016. The remainder is to be incurred in early 2017.

Commitments

In connection with obtaining regulatory approval of the Health Net acquisition from the California Department of Insurance and the California Department of Managed Health Care, the Company committed to certain undertakings (the Undertakings). The Undertakings included, among other items, operational commitments around premiums, dividend restrictions, minimum Risk Based Capital (RBC) levels, local offices, growth, accreditation, HEDIS scores and other quality measures, network adequacy, certifications, investments and capital expenditures. Specifically, the Company agreed to, among other things:

- invest an additional $30 million through the California Organized Investment Network over the five years following completion of the acquisition;
- build a service center in an economically distressed community in California, investing $200 million over 10 years and employing at least 300 people;
- contribute $65 million to improve enrollee health outcomes ($10 million over 10 years), support locally based consumer assistance programs ($5 million over five years) and strengthen the health care delivery system ($50 million over five years), (of which, the present value of $61 million was expensed in the year ended December 31, 2016, and classified as SG&A expenses in the Consolidated Statements of Operations); and
- invest $75 million of its investment portfolio in vehicles supporting California's health care infrastructure.

4. Acquisitions and Noncontrolling Interest

Acquisitions

Health Net. On March 24, 2016, the Company acquired all of the issued and outstanding shares of Health Net, a publicly traded managed care organization that delivers health care services through health plans and government-sponsored managed care plans. See Note 3, *Health Net,* for further discussion on the acquisition.

Agate Resources, Inc. In September 2015, the Company completed the acquisition of Agate Resources, Inc. (Agate) for $114 million. Agate is a diversified holding company that offers primarily Medicaid and other healthcare products and services to Oregon residents. The fair value of consideration of $114 million consists of initial cash consideration of $93 million, the present value of future cash payments of $12 million to be paid out over a three year period, and the fair value of estimated contingent consideration of $9 million. A portion of the contingent consideration is based on the achievement of underwriting targets and is being paid in cash over a three year period; the remainder is based on the net proceeds of a retrospective rate adjustment, which was settled in 2016.

The Company's allocation of fair value resulted in goodwill of $42 million and other identifiable intangible assets of $39 million. The goodwill is not deductible for income tax purposes. The acquisition is recorded in the Managed Care segment.

Noncontrolling Interest

The Company has consolidated subsidiaries where it maintains less than 100% ownership. The Company's ownership interest for each subsidiary as of December 31, are as follows:

	2016	2015	2014
Celtic Insurance Company	100%	75%	100%
Cenpatico Integrated Care	80%	80%	80%
Centurion	51%	51%	51%
Home State Health Plan	95%	95%	95%
The Practice (Group) Limited (TPG) [1]	75%	49%	49%
U.S. Medical Management	68%	68%	68%

(1) In 2016, the Company purchased a controlling interest in TPG for $8 million.

Net income attributable to Centene Corporation and transfers from (to) noncontrolling interest entities are as follows ($ in millions):

	Year Ended December 31,		
	2016	2015	2014
Net earnings attributable to Centene Corporation	$ 559	$ 356	$ 268
Transfers from (to) the noncontrolling interest:			
Increase in equity for distributions from and consolidation of noncontrolling interest	2	11	—
Reclassification to redeemable noncontrolling interest	—	1	(9)
Net transfers from (to) noncontrolling interest	2	12	(9)
Changes from net earnings attributable to Centene Corporation and net transfers from (to) the noncontrolling interest	$ 561	$ 368	$ 259

Redeemable Noncontrolling Interest

As a result of put option agreements, noncontrolling interest is considered redeemable and is classified in the Redeemable Noncontrolling Interest section of the Consolidated Balance Sheets. Noncontrolling interest is initially measured at fair value using the binomial lattice model as of the acquisition date. The Company has elected to accrete changes in the redemption value through additional paid-in capital over the period from the date of issuance to the earliest redemption date following the effective interest method.

A reconciliation of the changes in the Redeemable Noncontrolling Interest is as follows ($ in millions):

Balance, December 31, 2015	$ 156
Noncontrolling interest related to TPG acquisition	3
Noncontrolling interest repurchased related to Celtic Insurance Company	(12)
Net losses attributable to noncontrolling interest	(2)
Balance, December 31, 2016	$ 145

Pro forma disclosures related to the acquisitions other than Health Net (see Note 3, *Health Net*) have been excluded as they were deemed to be immaterial.

5. Short term and Long term Investments, Restricted Deposits

Short term and long term investments and restricted deposits by investment type consist of the following ($ in millions):

	December 31, 2016				December 31, 2015			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ 364	$ —	$ (1)	$ 363	$ 431	$ —	$ (2)	$ 429
Corporate securities	1,933	12	(13)	1,932	859	2	(8)	853
Restricted certificates of deposit	5	—	—	5	5	—	—	5
Restricted cash equivalents	6	—	—	6	78	—	—	78
Municipal securities	1,767	1	(35)	1,733	496	2	(1)	497
Asset backed securities	317	1	(1)	317	163	—	(1)	162
Residential mortgage backed securities	219	1	(5)	215	66	1	—	67
Commercial mortgage backed securities	343	—	(5)	338	40	—	—	40
Cost and equity method investments	163	—	—	163	71	—	—	71
Life insurance contracts	116	—	—	116	16	—	—	16
Total	$ 5,233	$ 15	$ (60)	$ 5,188	$ 2,225	$ 5	$ (12)	$ 2,218

The Company’s investments are classified as available-for-sale with the exception of life insurance contracts and certain cost and equity method investments. The Company’s investment policies are designed to provide liquidity, preserve capital and maximize total return on invested assets with the focus on high credit quality securities. The Company limits the size of investment in any single issuer other than U.S. treasury securities and obligations of U.S. government corporations and agencies. As of December 31, 2016, 95% of the Company’s investments in rated securities carry an investment grade rating by S&P and Moody’s. At December 31, 2016, the Company held certificates of deposit, life insurance contracts and cost and equity method investments which did not carry a credit rating.

The Company's residential mortgage-backed securities are primarily issued by the Federal National Mortgage Association, Government National Mortgage Association or Federal Home Loan Mortgage Corporation, which carry implicit or explicit guarantees of the U.S. government. The Company's commercial mortgage-backed securities are primarily senior tranches with a weighted average rating of AA+ and a weighted average duration of 3.7 years at December 31, 2016.

In January 2016, the Company completed a 19% investment in a data analytics business, and as a result, issued the selling stockholders 1.1 million shares of Centene common stock, valued at $68 million. The investment is being accounted for using the equity method of accounting due to the Company's significant influence of the business.

The fair value of available-for-sale investments with gross unrealized losses by investment type and length of time that individual securities have been in a continuous unrealized loss position were as follows ($ in millions):

	December 31, 2016				December 31, 2015			
	Less Than 12 Months		12 Months or More		Less Than 12 Months		12 Months or More	
	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ (1)	$ 215	$ —	$ 2	$ (2)	$ 294	$ —	$ 14
Corporate securities	(12)	1,020	(1)	39	(6)	561	(2)	41
Municipal securities	(35)	1,423	—	30	(1)	208	—	5
Asset backed securities	(1)	101	—	18	(1)	121	—	8
Residential mortgage backed securities	(5)	188	—	—	—	30	—	—
Commercial mortgage backed securities	(5)	271	—	—	—	34	—	—
Total	$ (59)	$ 3,218	$ (1)	$ 89	$ (10)	$ 1,248	$ (2)	$ 68

As of December 31, 2016, the gross unrealized losses were generated from 1,881 positions out of a total of 2,845 positions. The change in fair value of fixed income securities is primarily a result of movement in interest rates subsequent to the purchase of the security.

For each security in an unrealized loss position, the Company assesses whether it intends to sell the security or if it is more likely than not the Company will be required to sell the security before recovery of the amortized cost basis for reasons such as liquidity, contractual or regulatory purposes. If the security meets this criterion, the decline in fair value is other-than-temporary and is recorded in earnings. The Company does not intend to sell these securities prior to maturity and it is not likely that the Company will be required to sell these securities prior to maturity; therefore, there is no indication of other-than-temporary impairment for these securities.

During the years ended December 31, 2016, 2015 and 2014, the company recognized $5 million, $8 million and $6 million, respectively, of income from equity method investments.

The contractual maturities of short term and long term investments and restricted deposits are as follows ($ in millions):

	December 31, 2016				December 31, 2015			
	Investments		Restricted Deposits		Investments		Restricted Deposits	
	Amortized Cost	Fair Value	Amortized Cost	Fair Value	Amortized Cost	Fair Value	Amortized Cost	Fair Value
One year or less	$ 500	$ 500	$ 91	$ 91	$ 176	$ 176	$ 93	$ 93
One year through five years	1,982	1,974	47	47	1,662	1,654	22	22
Five years through ten years	1,101	1,089	—	—	267	268	—	—
Greater than ten years	633	617	—	—	5	5	—	—
Asset-backed securities	879	870	—	—	—	—	—	—
Total	$ 5,095	$ 5,050	$ 138	$ 138	$ 2,110	$ 2,103	$ 115	$ 115

Actual maturities may differ from contractual maturities due to call or prepayment options. Cost and equity method investments and life insurance contracts are included in the five years through ten years category. The Company has an option to redeem at amortized cost substantially all of the securities included in the greater than ten years category listed above.

The Company continuously monitors investments for other-than-temporary impairment. Certain investments have experienced a decline in fair value due to changes in credit quality, market interest rates and/or general economic conditions. The Company recognizes an impairment loss for cost and equity method investments when evidence demonstrates that it is other-than-temporarily impaired. Evidence of a loss in value that is other-than-temporary may include the absence of an ability to recover the carrying amount of the investment or the inability of the investee to sustain a level of earnings that would justify the carrying amount of the investment.

6. Fair Value Measurements

Assets and liabilities recorded at fair value in the Consolidated Balance Sheets are categorized based upon observable or unobservable inputs used to estimate fair value. Level inputs are as follows:

Level Input:	Input Definition:
Level I	Inputs are unadjusted, quoted prices for identical assets or liabilities in active markets at the measurement date.
Level II	Inputs other than quoted prices included in Level I that are observable for the asset or liability through corroboration with market data at the measurement date.
Level III	Unobservable inputs that reflect management's best estimate of what market participants would use in pricing the asset or liability at the measurement date.

The following table summarizes fair value measurements by level at December 31, 2016, for assets and liabilities measured at fair value on a recurring basis ($ in millions):

	Level I	Level II	Level III	Total
Assets				
Cash and cash equivalents	$ 3,930	$ —	$ —	$ 3,930
Investments available for sale:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ 221	$ 15	$ —	$ 236
Corporate securities	—	1,932	—	1,932
Municipal securities	—	1,733	—	1,733
Asset backed securities	—	317	—	317
Residential mortgage backed securities	—	215	—	215
Commercial mortgage backed securities	—	338	—	338
Total investments	$ 221	$ 4,550	$ —	$ 4,771
Restricted deposits available for sale:				
Cash and cash equivalents	$ 6	$ —	$ —	$ 6
Certificates of deposit	5	—	—	5
U.S. Treasury securities and obligations of U.S. government corporations and agencies	127	—	—	127
Total restricted deposits	$ 138	$ —	$ —	$ 138
Other long term assets:				
Interest rate swap agreements	$ —	$ 4	$ —	$ 4
Total assets at fair value	$ 4,289	$ 4,554	$ —	$ 8,843
Liabilities				
Other long term liabilities:				
Interest rate swap agreements	$ —	$ 62	$ —	$ 62
Total liabilities at fair value	$ —	$ 62	$ —	$ 62

The following table summarizes fair value measurements by level at December 31, 2015, for assets and liabilities measured at fair value on a recurring basis ($ in millions):

	Level I	Level II	Level III	Total
Assets				
Cash and cash equivalents	$ 1,760	$ —	$ —	$ 1,760
Investments available for sale:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ 325	$ 72	$ —	$ 397
Corporate securities	—	853	—	853
Municipal securities	—	497	—	497
Asset backed securities	—	162	—	162
Residential mortgage backed securities	—	67	—	67
Commercial mortgage backed securities	—	40	—	40
Total investments	$ 325	$ 1,691	$ —	$ 2,016
Restricted deposits available for sale:				
Cash and cash equivalents	$ 78	$ —	$ —	$ 78
Certificates of deposit	5	—	—	5
U.S. Treasury securities and obligations of U.S. government corporations and agencies	32	—	—	32
Total restricted deposits	$ 115	$ —	$ —	$ 115
Other long term assets:				
Interest rate swap agreements	$ —	$ 11	$ —	$ 11
Total assets at fair value	$ 2,200	$ 1,702	$ —	$ 3,902
Liabilities				
Other long term liabilities:				
Interest rate swap agreements	$ —	$ 2	$ —	$ 2
Total liabilities at fair value	$ —	$ 2	$ —	$ 2

The Company periodically transfers U.S. Treasury securities and obligations of U.S. government corporations and agencies between Level I and Level II fair value measurements dependent upon the level of trading activity for the specific securities at the measurement date. The Company's policy regarding the timing of transfers between Level I and Level II is to measure and record the transfers at the end of the reporting period. At December 31, 2016, there were $1 million of transfers from Level I to Level II and $45 million of transfers from Level II to Level I. The Company utilizes matrix pricing services to estimate fair value for securities which are not actively traded on the measurement date. The Company designates these securities as Level II fair value measurements. The aggregate carrying amount of the Company's life insurance contracts and other non-majority owned investments, which approximates fair value, was $279 million and $87 million as of December 31, 2016 and December 31, 2015, respectively.

7. Property, Software and Equipment

Property, software and equipment consist of the following as of December 31 ($ in millions):

	2016	2015
Land	$ 113	$ 104
Building	271	223
Computer software	377	237
Computer hardware	179	105
Furniture and office equipment	126	92
Leasehold improvements	173	108
	1,239	869
Less accumulated depreciation	(442)	(351)
Property, software and equipment, net	$ 797	$ 518

As of December 31, 2016 and 2015, the Company had assets acquired under capital leases included above of $5 million and $6 million, net of accumulated amortization of $4 million and $4 million, respectively. Amortization on assets under capital leases charged to expense is included in depreciation expense. Depreciation expense for the years ended December 31, 2016, 2015 and 2014 was $101 million, $78 million and $65 million, respectively.

8. Goodwill and Intangible Assets

The following table summarizes the changes in goodwill by operating segment ($ in millions):

	Managed Care	Specialty Services	Total
Balance as of December 31, 2014	$ 276	$ 478	$ 754
Acquisitions and purchase accounting adjustments	103	3	106
Impairment	(18)	—	(18)
Balance as of December 31, 2015	361	481	842
Acquisitions and purchase accounting adjustments	3,331	542	3,873
Translation impact	(3)	—	(3)
Balance as of December 31, 2016	$ 3,689	$ 1,023	$ 4,712

Goodwill was related to the acquisitions and finalization of fair value allocations discussed in Note 3, *Health Net* and Note 4, *Acquisitions and Noncontrolling Interest*.

Intangible assets at December 31, consist of the following ($ in millions):

			Weighted Average Life in Years	
	2016	2015	2016	2015
Purchased contract rights	$ 1,171	$ 71	12.6	8.8
Provider contracts	285	103	10.7	11.1
Customer relationships	22	26	8.2	8.1
Trade names	163	12	9.6	7.3
Developed technology	110	5	5.0	5.0
Intangible assets	1,751	217	11.5	9.8
Less accumulated amortization:				
Purchased contract rights	(95)	(21)		
Provider contracts	(55)	(24)		
Customer relationships	(21)	(14)		
Trade names	(17)	(2)		
Developed technology	(18)	(1)		
Total accumulated amortization	(206)	(62)		
Intangible assets, net	$ 1,545	$ 155		

Amortization expense was $147 million, $24 million and $16 million for the years ended December 31, 2016, 2015 and 2014, respectively. Estimated total amortization expense related to intangible assets for each of the five succeeding fiscal years is as follows ($ in millions):

Year	Expense
2017	$ 155
2018	152
2019	152
2020	150
2021	133

9. Medical Claims Liability

The following table summarizes the change in medical claims liability by operating segment ($ in millions):

	Managed Care	Specialty Services	Consolidated Total
Balance, January 1, 2014, net	$ 1,101	$ 11	$ 1,112
Incurred related to:			
Current year	12,468	352	12,820
Prior years	(141)	(1)	(142)
Total incurred	12,327	351	12,678
Paid related to:			
Current year	10,796	326	11,122
Prior years	936	9	945
Total paid	11,732	335	12,067
Balance, December 31, 2014, net	$ 1,696	$ 27	$ 1,723
Acquisitions	79	—	79
Incurred related to:			
Current year	16,974	497	17,471
Prior years	(223)	(6)	(229)
Total incurred	16,751	491	17,242
Paid related to:			
Current year	14,826	453	15,279
Prior years	1,448	19	1,467
Total paid	16,274	472	16,746
Balance at December 31, 2015, net	$ 2,252	$ 46	$ 2,298
Acquisitions	1,482	—	1,482
Incurred related to:			
Current year	30,073	873	30,946
Prior years	(303)	(7)	(310)
Total incurred	29,770	866	30,636
Paid related to:			
Current year	27,714	818	28,532
Prior years	1,921	39	1,960
Total paid	29,635	857	30,492
Balance at December 31, 2016, net	$ 3,869	$ 55	$ 3,924
Reinsurance recoverable	5	—	5
Balance, December 31, 2016	$ 3,874	$ 55	$ 3,929

Reinsurance recoverables related to medical claims are included in premium and related receivables. Changes in estimates of incurred claims for prior years are primarily attributable to reserving under moderately adverse conditions. Additionally, as a result of minimum HBR and other return of premium programs, approximately $39 million, $47 million, and $26 million of the "Incurred related to: Prior years" was recorded as a reduction to premium revenues in 2016, 2015 and 2014, respectively. Further, claims processing initiatives yielded increased claim payment recoveries and coordination of benefits related to prior year dates of service. Changes in medical utilization and cost trends and the effect of medical management initiatives may also contribute to changes in medical claim liability estimates. While the Company has evidence that medical management initiatives are effective on a case by case basis, medical management initiatives primarily focus on events and behaviors prior to the incurrence of the medical event and generation of a claim. Accordingly, any change in behavior, leveling of care, or coordination of treatment occurs prior to claim generation and as a result, the costs prior to the medical management initiative are not known by the Company. Additionally, certain medical management initiatives are focused on member and provider education with the intent of influencing behavior to appropriately align the medical services provided with the member's acuity. In these cases, determining whether the medical management initiative changed the behavior cannot be determined. Because of the complexity of its business, the number of states in which it operates, and the volume of claims that it processes, the Company is unable to practically quantify the impact of these initiatives on its changes in estimates of IBNR.

The Company periodically reviews actual and anticipated experience compared to the assumptions used to establish medical costs. The Company establishes premium deficiency reserves if actual and anticipated experience indicates that existing policy liabilities together with the present value of future gross premiums will not be sufficient to cover the present value of future benefits, settlement and maintenance costs.

Information about incurred and paid claims development as of December 31, 2016 is included in the table below and is inclusive of claims incurred and paid related to the Health Net business prior and subsequent to the acquisition date. The claims development information for all periods preceding the most recent reporting period is considered required supplementary information. Incurred and paid claims development as of December 31, 2016 is as follows ($ in millions):

Cumulative Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance			
For the Years Ended December 31,			
Claim Year	2014 (unaudited)	2015 (unaudited)	2016
Managed Care:			
2014	$ 23,790	$ 23,472	$ 23,468
2015		30,122	29,833
2016			33,782
		Total incurred claims	$ 87,083
Specialty Services:			
2014	$ 352	$ 348	$ 346
2015		497	492
2016			873
		Total incurred claims	$ 1,711

Cumulative Paid Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance			
For the Years Ended December 31,			
Claim Year	2014 (unaudited)	2015 (unaudited)	2016
Managed Care:			
2014	$ 20,415	$ 22,895	$ 23,450
2015		27,211	29,539
2016			30,225
		Total payment of incurred claims	$ 83,214
		Managed Care medical claims liability	$ 3,869
Specialty Services:			
2014	$ 326	$ 346	$ 346
2015		453	492
2016			818
		Total payment of incurred claims	$ 1,656
		Specialty Services medical claims liability	$ 55
		Consolidated total, net of reinsurance	$ 3,924

Incurred claims and allocated claim adjustment expenses, net of reinsurance, IBNR plus expected development on reported claims and cumulative claims data as of December 31, 2016 are included in the following table and are inclusive of the acquired Health Net business. For claims frequency information summarized below, a claim is defined as the financial settlement of a single medical event in which remuneration was paid to the servicing provider. Total IBNR plus expected development on reported claims represents estimates for claims incurred but not reported, development on reported claims, and estimates for the costs necessary to process unpaid claims at the end of each period. We estimate our liability using actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. These actuarial methods consider factors such as historical data for payment patterns, cost trends, product mix, seasonality, utilization of healthcare services and other relevant factors. Information is summarized as follows (in millions):

	December 31, 2016		
	Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance	Total IBNR Plus Expected Development on Reported Claims	Cumulative Paid Claims
Managed Care:			
2014	$ 23,468	$ 2	121.0
2015	29,833	52	153.4
2016	33,782	3,001	164.9
Specialty Services:			
2014	$ 346	$ —	2.7
2015	492	—	3.1
2016	873	49	6.3

10. Affordable Care Act

The Affordable Care Act (ACA) established risk spreading premium stabilization programs effective January 1, 2014. These programs, commonly referred to as the “three Rs,” include a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridor program. Additionally, the ACA established a minimum annual MLR and cost sharing reductions. Each of the three R programs are taken into consideration to determine if the Company’s estimated annual medical costs are less than the minimum loss ratio and require an adjustment to Premium revenue to meet the minimum MLR.

During 2016, the Company recognized a $51 million net pre-tax benefit related to the reconciliation of 2015 risk adjustment and reinsurance programs.

The Company's receivables (payables) for each of these programs are as follows at each year ended ($ in millions):

	December 31, 2016	**December 31, 2015**
Risk adjustment	$ (425)	$ (108)
Reinsurance	122	24
Risk corridor	(3)	(4)
Minimum MLR	(18)	(15)
Cost sharing reductions	(147)	(40)

11. Debt

Debt consists of the following ($ in millions):

	December 31, 2016	December 31, 2015
$425 million 5.75% Senior notes, due June 1, 2017	$ —	$ 428
$1,400 million 5.625% Senior notes, due February 15, 2021	1,400	—
$1,000 million 4.75% Senior notes, due May 15, 2022	1,008	500
$1,000 million 6.125% Senior notes, due February 15, 2024	1,000	—
$1,200 million 4.75% Senior notes, due January 15, 2025	1,200	—
Fair value of interest rate swap agreements	(58)	9
Senior notes	4,550	937
Revolving credit agreement	100	225
Mortgage notes payable	64	67
Capital leases and other	18	6
Debt issuance costs	(77)	(14)
Total debt	4,655	1,221
Less current portion	(4)	(5)
Long term debt	$ 4,651	$ 1,216

Senior Notes

In December 2016, the Company redeemed the outstanding principal balance on the $400 million 6.375% Senior Notes, due June 1, 2017, plus applicable premium for early redemption and accrued and unpaid interest to the redemption date, for cash totaling $411 million. The Company recognized a loss on extinguishment of debt of $3 million on the redemption of these notes.

In November 2016, the Company redeemed the outstanding principal balance on the $425 million 5.75% Senior Notes due June 1, 2017, plus applicable premium for early redemption and accrued and unpaid interest to the redemption date, for cash totaling $447 million. The Company recognized a loss on extinguishment of debt of $10 million on the redemption of these notes. The Company also recognized a gain of $2 million on the termination of the $250 million interest rate swap agreement associated with these notes.

In November 2016, the Company issued $1,200 million in aggregate principal amount of 4.75% Senior Notes due 2025 ($1,200 million Notes). The Company used the net proceeds of the offering to redeem its 5.75% Senior Notes due 2017 and Health Net Inc.'s 6.375% Senior Notes due 2017, to repay amounts outstanding under its Revolving Credit Facility, to pay related fees and expenses and for general corporate purposes.

In June 2016, the Company issued an additional $500 million in aggregate principal amount of 4.75% Senior Notes due 2022 ($500 Million Add-on Notes) at a premium to yield of 4.41%. The $500 Million Add-on Notes were offered as additional debt securities under the indenture governing the $500 million in aggregate principal amount of 4.75% Senior Notes issued in April 2014. The Company used the net proceeds of the offering to repay amounts outstanding under its Revolving Credit Facility and to pay offering related fees and expenses.

In February 2016, a wholly owned unrestricted subsidiary of the Company (Escrow Issuer) issued $1,400 million in aggregate principal amount of 5.625% Senior Notes ($1,400 Million Notes) at par due 2021 and $1,000 million in aggregate principal amount of 6.125% Senior Notes ($1,000 Million Notes) at par due 2024. In July 2016, the Company completed an exchange offer, whereby it offered to exchange all of the outstanding $1,400 Million Notes and the $1,000 Million Notes for identical securities that have been registered under the Securities Act of 1933. The Company used the net proceeds of the offering, together with borrowings under the Company's new $1,000 million revolving credit facility and cash on hand, primarily to fund the cash consideration for the Health Net acquisition, and to pay acquisition and offering related fees and expenses.

In connection with the February 2016 issuance, the Company entered into interest rate swap agreements for notional amounts of $600 million and $1,000 million, at floating rates of interest based on the three month LIBOR plus 4.22% and the three month LIBOR plus 4.44%, respectively. Gains and losses due to changes in the fair value of the interest rate swaps completely offset changes in the fair value of the hedged portion of the underlying debt and are recorded as an adjustment to the $1,400 Million Notes and $1,000 Million Notes.

In connection with the closing of the Health Net acquisition, the Company assumed the $400 million in aggregate principal amount of Health Net's 6.375% Senior Notes due 2017, recorded at acquisition date fair value of $418 million. These Senior Notes were redeemed in December 2016.

In January 2015, the Company issued an additional $200 million of 4.75% Senior Notes ($200 Million Add-on Notes) at par. The $200 Million Add-on Notes were offered as additional debt securities under the indenture governing the $300 million of 4.75% Senior Notes issued in April 2014. In connection with the January 2015 issuance, the Company entered into interest rate swap agreements for a notional amount of $200 million at a floating rate of interest based on the three month LIBOR plus 2.88%. Gains and losses due to changes in the fair value of the interest rate swap completely offset changes in the fair value of the hedged portion of the underlying debt and are recorded as an adjustment to the $200 Million Add-on Notes.

The indentures governing the $1,400 Million Notes, the $1,000 million of 4.75% Senior Notes due 2022, the $1,000 Million Notes and the $1,200 Million Notes contain non-financial and financial covenants of Centene Corporation, including requirements of a minimum fixed charge coverage ratio. At December 31, 2016, the Company was in compliance with all covenants.

Interest Rate Swaps

The Company uses interest rate swap agreements to convert a portion of its interest rate exposure from fixed rates to floating rates to more closely align interest expense with interest income received on its cash equivalent and variable rate investment balances. The Company has $2,100 million of notional amount of interest rate swap agreements consisting of:

- $600 million expiring on February 15, 2021;
- $500 million expiring on May 15, 2022; and,
- $1,000 million expiring on February 15, 2024.

Under the Swap Agreements, the Company receives a fixed rate of interest and pays an average variable rate of the three month LIBOR plus 3.92% adjusted quarterly. At December 31, 2016, the weighted average rate was 4.83%.

The Swap Agreements are formally designated and qualify as fair value hedges and are recorded at fair value in the Consolidated Balance Sheets in other assets and/or other liabilities. Gains and losses due to changes in fair value of the interest rate swap agreements completely offset changes in the fair value of the hedged portion of the underlying debt. Therefore, no gain or loss has been recognized due to hedge ineffectiveness. Offsetting changes in fair value of both the interest rate swaps and the hedged portion of the underlying debt both were recognized in interest expense in the Consolidated Statement of Operations. The Company does not hold or issue any derivative instrument for trading or speculative purposes.

The fair values of the Swap Agreements as of December 31, 2016 were assets of $4 million and liabilities of $62 million, and are included in other long term assets and other long term liabilities, respectively in the Consolidated Balance Sheet. The fair value of the Swap Agreements as of December 31, 2015 were assets of $11 million and liabilities of $2 million, and are included in other long term assets and other long term liabilities, respectively in the Consolidated Balance Sheet. The fair value of the Swap Agreements excludes accrued interest and takes into consideration current interest rates and current likelihood of the swap counterparties' compliance with its contractual obligations.

Revolving Credit Agreement

In connection with the closing of the Health Net acquisition in March 2016, the Company's existing unsecured $500 million revolving credit facility was terminated and simultaneously replaced with a new $1,000 million unsecured revolving credit facility. Borrowings under the agreement bear interest based upon LIBOR rates, the Federal Funds Rate or the Prime Rate. The agreement has a maturity date of March 24, 2021. As of December 31, 2016, the Company had $100 million of borrowings outstanding under the agreement with a weighted average interest rate of 4.5%, and the Company was in compliance with all covenants.

The revolving credit facility contains both non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios and maximum debt-to-EBITDA ratios. The Company is required to not exceed a maximum debt-to-EBITDA ratio of 3.5 to 1.0 prior to December 31, 2016 and 3.0 to 1.0 on and subsequent to December 31, 2016. As of December 31, 2016, there were no limitations on the availability under the revolving credit agreement as a result of the debt-to-EBITDA ratio.

Also, upon the closing of the Health Net acquisition, the Company assumed, fully repaid $285 million in outstanding borrowings under, and terminated the existing Health Net revolving credit facility.

Mortgage Notes Payable

The Company has a non-recourse mortgage note of $64 million at December 31, 2016 collateralized by its corporate headquarters building. The mortgage note is due January 1, 2021 and bears a 5.14% interest rate. The collateralized property had a net book value of $173 million at December 31, 2016.

Letters of Credit & Surety Bonds

The Company had outstanding letters of credit of $71 million as of December 31, 2016, which were not part of the revolving credit facility. The Company also had letters of credit for $45 million (valued at December 31, 2016 conversion rate), or €42 million, representing its proportional share of the letters of credit issued to support Ribera Salud's outstanding debt, which are a part of the revolving credit facility. Collectively, the letters of credit bore interest at 1.42% as of December 31, 2016. The Company had outstanding surety bonds of $365 million as of December 31, 2016.

Aggregate maturities for the Company's debt are as follows ($ in millions):

2017	$	4
2018		4
2019		16
2020		4
2021		1,404
Thereafter		3,350
Total	$	4,782

The fair value of outstanding debt was approximately $4,676 million and $1,239 million at December 31, 2016 and 2015, respectively.

12. Stockholders' Equity

The Company has 10,000,000 authorized shares of preferred stock at $.001 par value. At December 31, 2016, there were no preferred shares outstanding.

The Company's Board of Directors has authorized a stock repurchase program for up to 8,000,000 shares of the Company's common stock from time to time on the open market or through privately negotiated transactions. No duration has been placed on the repurchase program. The Company has 3,335,448 available shares remaining under the program for repurchases as of December 31, 2016. The Company reserves the right to discontinue the repurchase program at any time. During the year ended December 31, 2016, the Company did not repurchase any shares through this publicly announced program.

As a component of the employee stock compensation plan, employees can use shares of stock which have vested to satisfy statutory tax withholding obligations. As part of this plan, the Company repurchased 1,078,335 shares at an aggregate cost of $63 million in 2016 and 918,628 shares at an aggregate cost of $53 million in 2015. These shares are included in the Company's treasury stock.

In March 2016, the Company issued 48,449,444 shares of Centene stock, with a fair value of approximately $3,038 million.

In January 2016, the Company completed a 19% investment in a data analytics business and issued 1,144,462 shares of Centene common stock to the selling stockholders. The investment is being accounted for using the equity method of accounting, due to the Company's significant influence on the business.

13. Statutory Capital Requirements and Dividend Restrictions

Various state laws require Centene's regulated subsidiaries to maintain minimum capital levels specified by each state and restrict the amount of dividends that may be paid without prior regulatory approval. At December 31, 2016 and 2015, Centene's subsidiaries, including Kentucky Spirit, had aggregate statutory capital and surplus of $4,529 million and $2,284 million, respectively, compared with the required minimum aggregate statutory capital and surplus of $2,259 million and $1,195 million, respectively. As of December 31, 2016, the amount of capital and surplus or net worth that was unavailable for the payment of dividends or return of capital to the Company was $2,259 million in the aggregate.

14. Income Taxes

The consolidated income tax expense consists of the following for the years ended December 31 ($ in millions):

	2016	2015	2014
Current provision			
Federal	$ 485	$ 332	$ 225
State and local	22	26	13
Total current provision	507	358	238
Deferred provision	92	(19)	(42)
Total income tax expense	$ 599	$ 339	$ 196

The reconciliation of the tax provision at the U.S. federal statutory rate to income tax expense for the years ended December 31 is as follows ($ in millions):

	2016	2015	2014
Earnings from continuing operations, before income tax expense	$ 1,157	$ 697	$ 457
(Earnings) loss attributable to flow through noncontrolling interest	(8)	1	4
Earnings from continuing operations, less noncontrolling interest, before income tax expense	1,149	698	461
Tax provision at the U.S. federal statutory rate	402	244	162
State income taxes, net of federal income tax benefit	10	15	6
Nondeductible compensation	23	2	(13)
ACA Health Insurer Fee	162	75	44
Other, net	2	3	(3)
Income tax expense	$ 599	$ 339	$ 196

The tax effects of temporary differences which give rise to deferred tax assets and liabilities are presented below for the years ended December 31 ($ in millions):

	2016	2015
Deferred tax assets:		
Medical claims liability	$ 66	$ 27
Nondeductible liabilities	39	14
Net operating loss and tax credit carryforwards	101	22
Compensation accruals	156	73
Acquisition costs	—	10
Premium and related receivables	79	36
Other	14	9
Deferred tax assets	455	191
Valuation allowance	(86)	(11)
Net deferred tax assets	$ 369	$ 180
Deferred tax liabilities:		
Intangible assets	$ 577	$ 46
Prepaid assets	17	8
Fixed assets and intangibles	65	31
Investments in joint ventures	11	6
Other	2	2
Deferred tax liabilities	672	93
Net deferred tax assets (liabilities)	$ (303)	$ 87

Valuation allowances are provided when it is considered more likely than not that deferred tax assets will not be realized. The valuation allowances primarily relate to future tax benefits on certain federal, state and foreign net operating loss and tax credit carryforwards. The $75 million increase in valuation allowance primarily relates to acquired federal and state net operating loss carryforwards from the Health Net transaction.

Federal net operating loss carryforwards of $59 million expire beginning in 2020 through 2036; state net operating loss and tax credit carryforwards of $37 million expire beginning in 2017 through 2036. Substantially all of the non-U.S. tax loss carryforwards have indefinite carryforward periods.

The Company maintains a reserve for uncertain tax positions that may be challenged by a tax authority. A rollforward of the beginning and ending amount of uncertain tax positions, exclusive of related interest and penalties, is as follows:

	Year Ended December 31,	
	2016	2015
Gross unrecognized tax benefits, beginning of period	$ 5	$ 4
Gross increases:		
Current year tax positions	6	1
Acquired reserves	93	—
Gross decreases:		
Prior year tax positions	(1)	—
Statute of limitation lapses	(1)	—
Gross unrecognized tax benefits, end of period	$ 102	$ 5

Uncertain tax positions increased $93 million due to the acquisition of Health Net. As of December 31, 2016, $87 million of unrecognized tax benefits could impact our effective tax rate in future periods, if recognized. The Company believes it is reasonably possible that its liability for unrecognized tax benefits will decrease in the next twelve months by $5 million as a result of audit settlements and the expiration of statutes of limitations in certain major jurisdictions.

The table above excludes interest, net of related tax benefits, which is treated as income tax expense (benefit) under our accounting policy. For the year ended December 31, 2016, the Company recognized net interest expense and penalties related

to uncertain positions of $1 million. The Company had $5 million and $1 million of accrued interest and penalties for uncertain tax positions as of December 31, 2016 and 2015, respectively.

The company files tax returns for federal as well as numerous state tax jurisdictions. As of December 31, 2016, Health Net is under federal examination for tax years 2011 through 2013. Additionally, tax years subject to federal examination for both Centene and Health Net are 2014 through 2016.

In September 2014, the Internal Revenue Service issued final regulations related to the compensation deduction limitation applicable to certain health insurance issuers. The new regulations provided additional information regarding the definition of a health insurance issuer. As a result of this change in regulation, tax benefits of $14 million related to 2013 were recorded during the 2014 period. The Company finalized the 2013 federal audit in the third quarter of 2016 and sustained its compensation deduction limitation position.

As of December 31, 2016 and 2015, the Company had $12 million and $8 million, respectively, of undistributed earnings from non-U.S. subsidiaries that are intended to be reinvested in non-U.S. operations. Because these earnings are considered permanently reinvested, no U.S. tax provision has been accrued related to the repatriation of these earnings. The amount of U.S. tax that would be payable on the eventual remittance of such earnings is not material to the Company's financial statements.

15. Stock Incentive Plans

The Company's stock incentive plans allow for the granting of restricted stock or restricted stock unit awards and options to purchase common stock. Both incentive stock options and nonqualified stock options can be awarded under the plans. No option will be exercisable for longer than ten years after the date of grant. The plans have 6,224,268 shares available for future awards. However, 5,376,101 are legacy Health Net shares and based on the terms of the Health Net acquisition, these shares are only available for awards to legacy Health Net employees and new Centene employees. Compensation expense for stock options and restricted stock unit awards is recognized on a straight-line basis over the vesting period, generally three to five years for stock options and one to 10 years for restricted stock or restricted stock unit awards. Certain restricted stock unit awards contain performance-based as well as service-based provisions. Certain awards provide for accelerated vesting if there is a change in control as defined in the plans. In addition, the Company incorporated retirement provisions in our stock-based compensation agreements beginning in 2016. The total compensation cost that has been charged against income for the stock incentive plans was $148 million, $71 million and $48 million for the years ended December 31, 2016, 2015 and 2014, respectively. The Company adopted ASU 2016-09 during the fourth quarter of 2016, effective prospectively as of the beginning of the 2016 fiscal year. As a result, excess tax benefits are now recorded in income tax expense in the period in which the exercise or vesting occurs. The total income tax benefit recognized in the income statement for stock-based compensation arrangements was $67 million, $24 million and $17 million for the years ended December 31, 2016, 2015 and 2014, respectively. In connection with the adoption of the new standard, we have also elected to recognize forfeitures as they occur.

Option activity for the year ended December 31, 2016 is summarized below:

	Shares	Weighted Average Exercise Price	Aggregate Intrinsic Value ($ in millions)	Weighted Average Remaining Contractual Term
Outstanding as of December 31, 2015	677,408	$ 11.88		
Granted	40,000	59.94		
Exercised	(397,040)	12.25		
Forfeited	—	—		
Outstanding as of December 31, 2016	320,368	$ 17.44	$ 13	2.9
Exercisable as of December 31, 2016	280,368	$ 11.37	$ 13	1.9

The fair value of each option grant is estimated on the date of the grant using the Black-Scholes option-pricing model with the following weighted-average assumptions:

	Year Ended December 31,		
	2016	2015 [1]	2014 [1]
Expected life (in years)	4.8	—	—
Risk-free interest rate	1.6%	—	—
Expected volatility	39.0%	—	—
Expected dividend yield	—	—	—

(1) No options were awarded in the years ended December 31, 2015 and 2014.

For options granted in the year ended December 31, 2016, the Company used a projected expected life for each award granted based on historical experience of employees' exercise behavior. The expected volatility is primarily based on historical volatility levels. The risk-free interest rates are based on the implied yield currently available on U.S. Treasury instruments with a remaining term equal to the expected life.

Other information pertaining to option activity is as follows:

	Year Ended December 31,		
	2016	2015 [1]	2014 [1]
Weighted-average fair value of options granted	$ 59.94	$ —	$ —
Total intrinsic value of stock options exercised ($ in millions)	$ 19	$ 28	$ 17

(1) No options were awarded in the years ended December 31, 2015 and 2014.

A summary of the Company's non-vested restricted stock and restricted stock unit shares as of December 31, 2016, and changes during the year ended December 31, 2016, is presented below:

	Shares	Weighted Average Grant Date Fair Value
Non-vested balance as of December 31, 2015	4,122,003	$ 48.65
Granted	2,120,101	57.71
Converted [1]	1,285,674	62.70
Vested	(2,546,543)	50.00
Forfeited	(190,894)	47.65
Non-vested balance as of December 31, 2016	4,790,341	$ 55.75

[1] Health Net awards converted in connection with the acquisition.

The total fair value of restricted stock and restricted stock units vested during the years ended December 31, 2016, 2015 and 2014, was $147 million, $112 million and $82 million, respectively.

As of December 31, 2016, there was $233 million of total unrecognized compensation cost related to non-vested share-based compensation arrangements granted under the plans; that cost is expected to be recognized over a weighted-average period of 2.4 years.

The Company maintains an employee stock purchase plan and issued 118,293 shares, 86,819 shares, and 76,088 shares in 2016, 2015 and 2014, respectively.

16. Retirement Plan

Centene has a defined contribution plan which covers substantially all employees who are at least twenty-one years of age. Under the plan, eligible employees may contribute a percentage of their base salary, subject to certain limitations. Centene may elect to match a portion of the employee's contribution. Company expense related to matching contributions to the plan was $37 million, $19 million and $12 million during the years ended December 31, 2016, 2015 and 2014, respectively.

17. Commitments

Centene and its subsidiaries lease office facilities and various equipment under non-cancelable operating leases which may contain escalation provisions. The rental expense related to these leases is recorded on a straight-line basis over the lease term, including rent holidays. Tenant improvement allowances are recorded as a liability and amortized against rent expense over the term of the lease. Rent expense was $137 million, $64 million and $46 million for the years ended December 31, 2016, 2015 and 2014, respectively. Annual non-cancelable minimum lease payments over the next five years and thereafter are as follows ($ in millions):

2017	$ 128
2018	117
2019	105
2020	92
2021	75
Thereafter	114
	$ 631

In connection with obtaining regulatory approval of the Health Net acquisition from the California Department of Insurance and the California Department of Managed Health Care, the Company committed to certain undertakings. See Note 3, *Health Net* for further details.

18. Contingencies

Overview

The Company records reserves and accrues costs for certain legal proceedings and regulatory matters to the extent that it determines an unfavorable outcome is probable and the amount of the loss can be reasonably estimated. While such reserves and accrued costs reflect the Company's best estimate of the probable loss for such matters, the recorded amounts may differ materially from the actual amount of any such losses. In some cases, no estimate of the possible loss or range of loss in excess of amounts accrued, if any, can be made because of the inherently unpredictable nature of legal and regulatory proceedings, which may be exacerbated by various factors, including but not limited to, they may involve indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or legal uncertainties; involve disputed facts; represent a shift in regulatory policy; involve a large number of parties, claimants or regulatory bodies; are in the early stages of the proceedings; involve a number of separate proceedings and/or a wide range of potential outcomes; or result in a change of business practices.

As of the date of this report, amounts accrued for legal proceedings and regulatory matters were not material. However, it is possible that in a particular quarter or annual period the Company’s financial condition, results of operations, cash flow and/or liquidity could be materially adversely affected by an ultimate unfavorable resolution of or development in legal and/or regulatory proceedings, including as described below. Except for the proceedings discussed below, the Company believes that the ultimate outcome of any of the regulatory and legal proceedings that are currently pending against it should not have a material adverse effect on financial condition, results of operations, cash flow or liquidity.

Kentucky

On July 5, 2013, the Company's subsidiary, Kentucky Spirit, terminated its contract with the Commonwealth of Kentucky (the Commonwealth). Kentucky Spirit believed it had a contractual right to terminate the contract and filed a lawsuit in Franklin Circuit Court seeking a declaration of this right. In response, the Commonwealth alleged that Kentucky Spirit's exit constituted a material breach of contract. The Commonwealth sought to recover substantial damages and to enforce its rights under Kentucky Spirit's $25 million performance bond. The Commonwealth asserted that the Commonwealth's expenditures due to Kentucky Spirit's departure range from $28 million to $40 million plus interest, and that the associated CMS expenditures range from $92 million to $134 million. Kentucky Spirit disputed the Commonwealth's alleged damages on several grounds. Prior to terminating the contract, Kentucky Spirit filed a legal complaint in April 2013, amended in October 2014, in Franklin Circuit Court seeking damages against the Commonwealth for losses sustained due to the Commonwealth's alleged breaches.

On May 26, 2015, the Commonwealth issued a demand for indemnification to its actuarial firm, for "all defense costs, and any resultant monetary awards in favor of Kentucky Spirit, arising from or related to Kentucky Spirit's claims which are predicated upon the alleged omissions and errors in the Data Book and the certified actuarially sound rates." The actuarial firm moved to intervene in the litigation and the Franklin Circuit Court granted that motion on September 8, 2015. Also, on August 19, 2015, the actuarial firm filed a petition seeking a declaratory judgment that it is not liable to the Commonwealth for indemnification related to the claims asserted by Kentucky Spirit against the Commonwealth. On October 5, 2015, the Commonwealth filed an answer to the actuarial firm's petition and asserted counterclaims/cross-claims against the firm.

On November 3, 2016, all parties entered into a settlement agreement with respect to all lawsuits and complaints associated with the aforementioned contract termination. Under the terms of the settlement agreement, Kentucky Spirit received an immaterial cash payment from the Commonwealth's actuarial firm and each party dismissed all claims related to the litigation with prejudice. In addition, the Commonwealth and Kentucky Spirit have agreed that neither party acted in bad faith; that the parties took reasonable positions in light of the applicable contractual language; and that the parties acted in good faith in attempting to address a difficult situation.

California

The Company's California subsidiary, Health Net of California, Inc. (Health Net California), has been named as a defendant in a California taxpayer action filed in Los Angeles County Superior Court, captioned as Michael D. Myers v. State Board of Equalization, et al., Los Angeles Superior Court Case No. BS158655. This action is brought under a California statute that permits an individual taxpayer to sue a governmental agency when the taxpayer believes the agency has failed to enforce governing law. Plaintiff contends that Health Net California, a California licensed Health Care Service Plan (HCSP), is an “insurer” for purposes of taxation despite acknowledging it is not an “insurer” under regulatory law. Under California law, “insurers” must pay a gross premiums tax (GPT), calculated as 2.35% on gross premiums. As a licensed HCSP, Health Net California has paid the California Corporate Franchise Tax (CFT), the tax generally paid by California businesses. Plaintiff contends that Health Net California must pay the GPT rather than the CFT. Plaintiff seeks a writ of mandate directing the California taxing agencies to collect the GPT, and seeks an order requiring Health Net California to pay GPT, interest and penalties for a period dating to eight years prior to the October 20, 2015 filing of the complaint. This lawsuit is being coordinated with similar lawsuits filed against other entities. The Company expects an initial status conference shortly. The Company intends to vigorously defend itself against these claims; however, this matter is subject to many uncertainties, and an adverse outcome in this matter could potentially have a materially adverse impact on our financial position and results of operations.

Federal Securities Class Action

On November 14, 2016, a putative federal securities class action was filed against the Company and certain of its executives in the U.S. District Court for the Central District of California. The plaintiffs in the lawsuit allege that the Company's accounting and related disclosures for certain liabilities acquired in the acquisition of Health Net violated federal securities laws. The Company denies any wrongdoing and is vigorously defending itself against these claims. Nevertheless, this matter is subject to many uncertainties and the Company cannot predict how long this litigation will last or what the ultimate outcome will be, and an adverse outcome in this matter could potentially have a materially adverse impact on our financial position and results of operations.

Civil Investigative Demand

On December 15, 2016, a Civil Investigative Demand (CID) was issued to Health Net by the United States Department of Justice regarding Health Net’s submission of risk adjustment claims to the CMS under Parts C and D of Medicare. The CID may be related to a federal qui tam lawsuit filed under seal in 2011 naming more than a dozen health insurers including Health Net. The lawsuit was recently unsealed when the Department of Justice intervened in the case with respect to one of the insurers (not Health Net). The Company is complying with the CID and will vigorously defend any lawsuits. At this point, it is not possible to determine what level of liability, if any, the Company may face as a result of this matter.

Miscellaneous Proceedings

Excluding the matters discussed above, the Company is also routinely subjected to legal and regulatory proceedings in the normal course of business. These matters can include, without limitation:

- periodic compliance and other reviews and investigations by various federal and state regulatory agencies with respect to requirements applicable to the Company's business, including, without limitation, those related to payment of out-of-network claims, submissions to CMS for risk adjustment payments or the False Claims Act, pre-authorization penalties, timely review of grievances and appeals, timely and accurate payment of claims, and the Health Insurance Portability and Accountability Act of 1996;

- litigation arising out of general business activities, such as tax matters, disputes related to health care benefits coverage or reimbursement, putative securities class actions and medical malpractice, privacy, real estate, intellectual property and employment-related claims;

- disputes regarding reinsurance arrangements, claims arising out of the acquisition or divestiture of various assets, class actions and claims relating to the performance of contractual and non-contractual obligations to providers, members, employer groups and others, including, but not limited to, the alleged failure to properly pay claims and challenges to the manner in which the Company processes claims, and claims alleging that the Company has engaged in unfair business practices.

Among other things, these matters may result in awards of damages, fines or penalties, which could be substantial, and/or could require changes to the Company’s business. The Company intends to vigorously defend itself against the miscellaneous legal and regulatory proceedings to which it is currently a party; however, these proceedings are subject to many uncertainties. In some of the cases pending against the Company, substantial non-economic or punitive damages are being sought.

19. Earnings Per Share

The following table sets forth the calculation of basic and diluted net earnings per common share for the years ended December 31 ($ in millions, except per share data):

	2016	2015	2014
Earnings (loss) attributable to Centene Corporation:			
Earnings from continuing operations, net of tax	$ 559	$ 356	$ 268
Discontinued operations, net of tax	3	(1)	3
Net earnings	$ 562	$ 355	$ 271
Shares used in computing per share amounts:			
Weighted average number of common shares outstanding	159,567,607	119,100,744	116,345,764
Common stock equivalents (as determined by applying the treasury stock method)	4,407,800	3,965,626	4,014,448
Weighted average number of common shares and potential dilutive common shares outstanding	163,975,407	123,066,370	120,360,212
Net earnings (loss) per common share attributable to Centene Corporation:			
Basic:			
Continuing operations	$ 3.50	$ 2.99	$ 2.30
Discontinued operations	0.02	(0.01)	0.03
Basic earnings per common share	$ 3.52	$ 2.98	$ 2.33
Diluted:			
Continuing operations	$ 3.41	$ 2.89	$ 2.23
Discontinued operations	0.02	(0.01)	0.02
Diluted earnings per common share	$ 3.43	$ 2.88	$ 2.25

The calculation of diluted earnings (loss) per common share for 2016, 2015 and 2014 excludes the impact of 126,212 shares, 7,247 shares and 207,980 shares, respectively, related to anti-dilutive stock options, restricted stock and restricted stock units.

20. Segment Information

Centene operates in two segments: Managed Care and Specialty Services.

The Managed Care segment consists of Centene's health plans including all of the functions needed to operate them. The Managed Care segment also includes the operations previously included in Health Net's Western Region Operations Segment, with the exception of certain operations of its pharmaceutical services and behavioral health subsidiaries. The portions of Health Net's Western Region Operations segment included in the Managed Care segment consist of the following Health Net operations: commercial, Medicare, Medicaid and dual eligible health plans, primarily in Arizona, California, Oregon and Washington.

The Specialty Services segment consists of Centene's specialty companies offering auxiliary healthcare services and products. The Specialty Services segment also includes the operations previously included in the Government Contracts segment of Health Net as well as certain operations of its pharmaceutical services and behavioral health subsidiaries, the latter of which Health Net previously included in its Western Region Operations segment. The Government Contracts business includes the Company's government-sponsored managed care support contract with the DoD under the TRICARE program in the North Region, the MFLC contract with the DoD, and other health care related government contracts, including PC3/Choice with the VA.

Segment information as of and for the year ended December 31, 2016, follows ($ in millions):

	Managed Care	Specialty Services	Eliminations	Consolidated Total
Total revenues from external customers	$ 37,523	$ 3,084	$ —	$ 40,607
Total revenues internal customers	199	5,953	(6,152)	—
Total revenues	37,722	9,037	(6,152)	40,607
Earnings from operations	1,070	190	—	1,260
Total assets	17,962	2,235	—	20,197

Segment information as of and for the year ended December 31, 2015, follows ($ in millions):

	Managed Care	Specialty Services	Eliminations	Consolidated Total
Total revenues from external customers	$ 20,544	$ 2,216	$ —	$ 22,760
Total revenues internal customers	100	4,864	(4,964)	—
Total revenues	20,644	7,080	(4,964)	22,760
Earnings from operations	513	192	—	705
Total assets	6,202	1,137	—	7,339

Segment information as of and for the year ended December 31, 2014, follows ($ in millions):

	Managed Care	Specialty Services	Eliminations	Consolidated Total
Total revenues from external customers	$ 14,775	$ 1,785	$ —	$ 16,560
Total revenues internal customers	60	3,019	(3,079)	—
Total revenues	14,835	4,804	(3,079)	16,560
Earnings from operations	353	111	—	464
Total assets	4,706	1,118	—	5,824

21. Quarterly Selected Financial Information

(In millions, except share data)
(Unaudited)

	For the Quarter Ended [1]			
	March 31, 2016	June 30, 2016	September 30, 2016	December 31, 2016
Total revenues	$ 6,953	$ 10,897	$ 10,846	$ 11,911
Amounts attributable to Centene Corporation common shareholders:				
Earnings (loss) from continuing operations, net of income tax expense	(15)	171	148	255
Discontinued operations, net of income tax expense (benefit)	(1)	(1)	(1)	6
Net earnings (loss)	$ (16)	$ 170	$ 147	$ 261
Net earnings (loss) per common share attributable to Centene Corporation:				
Basic:				
Continuing operations	$ (0.12)	$ 1.00	$ 0.87	$ 1.49
Discontinued operations	(0.01)	—	(0.01)	0.04
Basic earnings per common share	$ (0.13)	$ 1.00	$ 0.86	$ 1.53
Diluted:				
Continuing operations	$ (0.12)	$ 0.98	$ 0.84	$ 1.45
Discontinued operations	(0.01)	(0.01)	—	0.04
Diluted earnings per common share	$ (0.13)	$ 0.97	$ 0.84	$ 1.49
Weighted average number of common shares outstanding:				
Basic	125,543,076	170,558,778	170,774,587	171,143,624
Diluted	125,543,076	174,848,996	175,495,339	175,511,179

[1] The Company early adopted ASU 2016-09 during the fourth quarter of 2016. The ASU requires adjustments be reflected as of the beginning of the fiscal year of adoption and as a result, prior periods have been restated accordingly. Refer to Note 2, *Summary of Significant Accounting Policies*.

	For the Quarter Ended			
	March 31, 2015	June 30, 2015	September 30, 2015	December 31, 2015
Total revenues	$ 5,131	$ 5,506	$ 5,821	$ 6,302
Amounts attributable to Centene Corporation common shareholders:				
Earnings from continuing operations, net of income tax expense	64	88	92	112
Discontinued operations, net of income tax expense (benefit)	(1)	—	1	(1)
Net earnings	$ 63	$ 88	$ 93	$ 111
Net earnings (loss) per common share attributable to Centene Corporation:				
Basic:				
Continuing operations	$ 0.54	$ 0.74	$ 0.77	$ 0.94
Discontinued operations	(0.01)	—	0.01	(0.01)
Basic earnings per common share	$ 0.53	$ 0.74	$ 0.78	$ 0.93
Diluted:				
Continuing operations	$ 0.52	$ 0.72	$ 0.75	$ 0.91
Discontinued operations	(0.01)	—	0.01	(0.01)
Diluted earnings per common share	$ 0.51	$ 0.72	$ 0.76	$ 0.90

22. Condensed Financial Information of Registrant

Centene Corporation (Parent Company Only)
Condensed Balance Sheets
(In millions, except share data)

	December 31,	
	2016	**2015**
ASSETS		
Current assets:		
Cash and cash equivalents	$ 5	$ 4
Short term investments, at fair value (amortized cost $1 and $5, respectively)	1	5
Other current assets	29	25
Total current assets	35	34
Long term investments, at fair value (amortized cost $19 and $6, respectively)	19	6
Investment in subsidiaries	10,674	3,435
Other long term assets	52	35
Total assets	$ 10,780	$ 3,510
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities	$ 78	$ 13
Long term debt	4,573	1,147
Other long term liabilities	75	26
Total liabilities	4,726	1,186
Redeemable noncontrolling interest	145	156
Stockholders' equity:		
Preferred stock, $.001 par value; authorized 10,000,000 shares; no shares issued or outstanding at December 31, 2016 and December 31, 2015	—	—
Common stock, $.001 par value; authorized 400,000,000 shares; 178,134,306 issued and 171,919,071 outstanding at December 31, 2016, and 126,855,477 issued and 120,342,981 outstanding at December 31, 2015	—	—
Additional paid-in capital	4,190	956
Accumulated other comprehensive loss	(36)	(10)
Retained earnings	1,920	1,358
Treasury stock, at cost (6,215,235 and 6,512,496 shares, respectively)	(179)	(147)
Total Centene stockholders' equity	5,895	2,157
Noncontrolling interest	14	11
Total stockholders' equity	5,909	2,168
Total liabilities and stockholders' equity	$ 10,780	$ 3,510

See notes to condensed financial information of registrant.

Centene Corporation (Parent Company Only)
Condensed Statements of Operations
(In millions, except share data)

	Year Ended December 31,		
	2016	**2015**	**2014**
Expenses:			
Selling, general and administrative expenses	$ 10	$ 9	$ 3
Gain on contingent consideration	(5)	(44)	—
Other income (expense):			
Investment and other income	2	(5)	1
Interest expense	(201)	(39)	(30)
Earnings (loss) before income taxes	(204)	(9)	(32)
Income tax benefit	(76)	(26)	(8)
Net earnings (loss) before equity in subsidiaries	(128)	17	(24)
Equity in earnings from subsidiaries	686	341	285
Net earnings	558	358	261
(Earnings) loss attributable to noncontrolling interests	1	(2)	7
Net earnings attributable to Centene	$ 559	$ 356	$ 268
Net earnings per share from continuing operations:			
Basic earnings per common share	$ 3.50	$ 2.99	$ 2.30
Diluted earnings per common share	$ 3.41	$ 2.89	$ 2.23
Weighted average number of shares outstanding:			
Basic	159,567,607	119,100,744	116,345,764
Diluted	163,975,407	123,066,370	120,360,212

See notes to condensed financial information of registrant.

Centene Corporation (Parent Company Only)
Condensed Statements of Cash Flows
(In millions)

	Year Ended December 31,		
	2016	**2015**	**2014**
Cash flows from operating activities:			
Cash provided by (used in) operating activities	$ (646)	$ 462	$ 317
Cash flows from investing activities:			
Capital contributions to subsidiaries, net of dividends	(566)	(660)	(384)
Purchases of investments	(112)	(17)	(32)
Sales and maturities of investments	169	9	14
Investments in acquisitions	(2,248)	(113)	(137)
Other investing activities, net	—	7	—
Net cash used in investing activities	(2,757)	(774)	(539)
Cash flows from financing activities:			
Proceeds from borrowings	8,934	1,925	1,875
Payment of long term debt	(5,377)	(1,575)	(1,650)
Common stock repurchases	(63)	(53)	(29)
Debt issuance costs	(76)	(4)	(7)
Other financing activities, net	(14)	20	33
Net cash provided by financing activities	3,404	313	222
Net increase in cash and cash equivalents	1	1	—
Cash and cash equivalents, beginning of period	4	3	3
Cash and cash equivalents, end of period	$ 5	$ 4	$ 3

See notes to condensed financial information of registrant.

Notes to Condensed Financial Information of Registrant

Note A - Basis of Presentation and Significant Accounting Policies

The parent company only financial statements should be read in conjunction with Centene Corporation's audited consolidated financial statements and the notes to consolidated financial statements included in this Form 10-K.

The parent company's investment in subsidiaries is stated at cost plus equity in undistributed earnings of the subsidiaries. The parent company's share of net income of its unconsolidated subsidiaries is included in income using the equity method of accounting. Certain unrestricted subsidiaries receive monthly management fees from our restricted subsidiaries. The management and service fees received by our unrestricted subsidiaries are associated with all of the functions required to manage the restricted subsidiaries including but not limited to salaries and wages for all personnel, rent, utilities, medical management, provider contracting, compliance, member services, claims processing, information technology, cash management, finance and accounting, and other services. The management fees are based on a percentage of the restricted subsidiaries revenue.

Due to our centralized cash management function, cash flows generated by our unrestricted subsidiaries are transferred to the parent company to the extent required, primarily to repay borrowings on the parent company's revolving credit facility, make acquisitions, fund capital contributions to subsidiaries and fund its operations. During the year ended December 31, 2016, operating cash flows were negatively impacted by the funding of the Health Net acquisition related expenses as well as refinancing the $400 million of Health Net Senior Notes. These Senior Notes were redeemed in December 2016. During the years ended December 31, 2015 and 2014, cash flows received by the parent from unrestricted subsidiaries were $445 million and $341 million, respectively, and were included in cash flows from operating activities.

Certain amounts presented in the parent company only financial statements are eliminated in the consolidated financial statements of Centene Corporation. Certain amounts in the parent company only financial statements have been reclassified to conform to the 2016 presentation. These reclassifications have no effect on net earnings or stockholders' equity as previously reported.

Note B - Dividends

During 2016, 2015 and 2014, the Registrant received dividends from its regulated subsidiaries totaling $121 million, $11 million and $50 million, respectively, reflected as investing cash flows.

Item 9. ***Changes in and Disagreements With Accountants on Accounting and Financial Disclosure***

None.

Item 9A. ***Controls and Procedures***

Evaluation of Disclosure Controls and Procedures - Our management, with the participation of our Chief Executive Officer and Chief Financial Officer, evaluated the effectiveness of our disclosure controls and procedures as of December 31, 2016. The term “disclosure controls and procedures,” as defined in Rules 13a-15(e) and 15d-15(e) under the Exchange Act, means controls and other procedures of a company that are designed to ensure that information required to be disclosed by a company in the reports that it files or submits under the Exchange Act is recorded, processed, summarized and reported, within the time periods specified in the SEC's rules and forms. Disclosure controls and procedures include, without limitation, controls and procedures designed to ensure that information required to be disclosed by a company in the reports that it files or submits under the Exchange Act is accumulated and communicated to the company's management, including its principal executive and principal financial officers, as appropriate to allow timely decisions regarding required disclosure. Management recognizes that any controls and procedures, no matter how well designed and operated, can provide only reasonable assurance of achieving their objectives and management necessarily applies its judgment in evaluating the cost-benefit relationship of possible controls and procedures. Based on the evaluation of our disclosure controls and procedures as of December 31, 2016, our Chief Executive Officer and Chief Financial Officer concluded that, as of such date, our disclosure controls and procedures were effective at the reasonable assurance level.

Management's Report on Internal Control Over Financial Reporting - Our management is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Exchange Act Rules 13a-15(f) and 15d-15(f). Under the supervision and with the participation of our management, including our principal executive officer and principal financial officer, we conducted an evaluation of the effectiveness of our internal control over financial reporting based on the framework in *Internal Control - Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission. Based on our evaluation under the framework in *Internal Control - Integrated Framework (2013)*, our management concluded that our internal control over financial reporting was effective at the reasonable assurance level as of December 31, 2016. Our management's assessment of the effectiveness of our internal control over financial reporting as of December 31, 2016 has been audited by KPMG LLP, an independent registered public accounting firm, as stated in their report which is included herein.

Changes in Internal Control Over Financial Reporting - On March 24, 2016, we acquired Health Net, Inc. Management has finalized our evaluation of the internal controls and has integrated Health Net's internal controls over financial reporting with our existing internal controls over financial reporting. This integration has led to changes in the internal controls over financial reporting for us and the acquired Health Net business.

Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders
Centene Corporation:

We have audited Centene Corporation's internal control over financial reporting as of December 31, 2016, based on criteria established in *Internal Control - Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). Centene Corporation's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Management's Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audit also included performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, Centene Corporation maintained, in all material respects, effective internal control over financial reporting as of December 31, 2016, based on criteria established in *Internal Control - Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of Centene Corporation and subsidiaries as of December 31, 2016 and 2015, and the related consolidated statements of operations, comprehensive earnings, stockholders' equity, and cash flows for each of the years in the three-year period ended December 31, 2016, and our report dated February 20, 2017 expressed an unqualified opinion on those consolidated financial statements.

/s/ KPMG LLP

St. Louis, Missouri
February 20, 2017

Item 9B. ***Other Information***

None.

PART III

Item 10. ***Directors, Executive Officers and Corporate Governance***

(a) Directors of the Registrant

Information concerning our directors will appear in our Proxy Statement for our 2017 annual meeting of stockholders under “Proposal One: Election of Directors.” This portion of the Proxy Statement is incorporated herein by reference.

(b) Executive Officers of the Registrant

Pursuant to General Instruction G(3) to Form 10-K and Instruction 3 to Item 401(b) of Regulation S-K, information regarding our executive officers is provided in Item 1 of Part I of this Annual Report on Form 10-K under the caption “Executive Officers of the Registrant.”

Information concerning our executive officers' compliance with Section 16(a) of the Exchange Act will appear in our Proxy Statement for our 2017 annual meeting of stockholders under “Section 16(a) Beneficial Ownership Reporting Compliance.” Information concerning our audit committee financial expert and identification of our audit committee will appear in our Proxy Statement for our 2017 annual meeting of stockholders under “Board of Directors Committees.” Information concerning our code of ethics will appear in our Proxy Statement for our 2017 annual meeting of stockholders under “Corporate Governance and Risk Management.” These portions of our Proxy Statement are incorporated herein by reference.

(c) Corporate Governance

Information concerning certain corporate governance matters will appear in our Proxy Statement for our 2017 annual meeting of stockholders under “Corporate Governance and Risk Management.” These portions of our Proxy Statement are incorporated herein by reference.

Item 11. ***Executive Compensation***

Information concerning executive compensation will appear in our Proxy Statement for our 2017 Annual Meeting of Stockholders under “Information About Executive Compensation.” Information concerning Compensation Committee interlocks and insider participation will appear in the Proxy Statement for our 2017 Annual Meeting of Stockholders under “Compensation Committee Interlocks and Insider Participation.” These portions of the Proxy Statement are incorporated herein by reference.

Item 12. ***Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters***

Information concerning the security ownership of certain beneficial owners and management and our equity compensation plans will appear in our Proxy Statement for our 2017 annual meeting of stockholders under “Information About Stock Ownership” and “Equity Compensation Plan Information.” These portions of the Proxy Statement are incorporated herein by reference.

Item 13. ***Certain Relationships and Related Transactions, and Director Independence***

Information concerning director independence, certain relationships and related transactions will appear in our Proxy Statement for our 2017 annual meeting of stockholders under “Corporate Governance and Risk Management” and “Related Party Transactions.” These portions of our Proxy Statement are incorporated herein by reference.

Item 14. ***Principal Accountant Fees and Services***

Information concerning principal accountant fees and services will appear in our Proxy Statement for our 2017 annual meeting of stockholders under “Proposal Two: Ratification of Appointment of Independent Registered Public Accounting Firm.” This portion of our Proxy Statement is incorporated herein by reference.

PART IV

Item 15. ***Exhibits and Financial Statement Schedules***

(a) **Financial Statements and Schedules**

The following documents are filed under Item 8 of this report:

1. Financial Statements:

   Report of Independent Registered Public Accounting Firm
   Consolidated Balance Sheets as of December 31, 2016 and 2015
   Consolidated Statements of Operations for the years ended December 31, 2016, 2015 and 2014
   Consolidated Statements of Comprehensive Earnings for the years ended December 31, 2016, 2015 and 2014
   Consolidated Statements of Stockholders' Equity for the years ended December 31, 2016, 2015 and 2014
   Consolidated Statements of Cash Flows for the years ended December 31, 2016, 2015 and 2014
   Notes to Consolidated Financial Statements

2. Financial Statement Schedules:

   None.

3. The exhibits listed in the accompanying Exhibit Index are filed or incorporated by reference as part of this filing.

EXHIBIT INDEX

EXHIBIT NUMBER	DESCRIPTION	FILED WITH THIS FORM 10-K	INCORPORATED BY REFERENCE [1] FORM	FILING DATE WITH SEC	EXHIBIT NUMBER
2.1	Agreement and Plan of Merger, dated as of July 2, 2015, by and among Centene Corporation, Health Net, Inc. Chopin Merger Sub I, Inc., and Chopin Merger Sub II, Inc.		8-K	July 7, 2015	2.1
3.1	Certificate of Incorporation of Centene Corporation		S-1	October 9, 2001	3.2
3.1a	Certificate of Amendment to Certificate of Incorporation of Centene Corporation, dated November 8, 2001		S-1/A	November 13, 2001	3.2a
3.1b	Certificate of Amendment to Certificate of Incorporation of Centene Corporation as filed with the Secretary of State of the State of Delaware		10-Q	July 26, 2004	3.1b
3.1c	Certificate of Amendment to Certificate of Incorporation of Centene Corporation as filed with the Secretary of State of the State of Delaware		S-3ASR	May 16, 2014	3.1c
3.1d	Certificate of Amendment to Certificate of Incorporation of Centene Corporation as filed with the Secretary of State of the State of Delaware		8-K	October 26, 2015	3.1
3.2	By-laws of Centene Corporation, as amended effective as of October 25, 2016		8-K	October 27, 2016	3.2
4.1	Indenture, dated April 29, 2014, among the Company and The Bank of New York Mellon Trust Company, N.A., relating to the Company's 4.75% Senior Notes due 2022 (including Form of Global Note as Exhibit A thereto)		8-K	April 29, 2014	4.1
4.2	Indenture, dated February 11, 2016, among Centene Escrow Corporation and The Bank of New York Mellon Trust Company, N.A., relating to the Company's 5.625% Senior Notes due 2021 (including Form of Global Note as Exhibit A thereto)		8-K	February 11, 2016	4.1
4.3	Indenture, dated February 11, 2016, among Centene Escrow Corporation and The Bank of New York Mellon Trust Company, N.A., relating to the Company's 6.125% Senior Notes due 2024 (including Form of Global Note as Exhibit A thereto)		8-K	February 11, 2016	4.2
4.4	Indenture, dated June 14, 2016, among Centene Escrow Corporation and The Bank of New York Mellon Trust Company, N.A., relating to the Company's 4.75% Senior Notes due 2022 (including Form of Global Note as Exhibit A thereto)		8-K	June 14, 2016	4.1
4.5	Indenture, dated November 9, 2016, among Centene Escrow Corporation and The Bank of New York Mellon Trust Company, N.A., relating to the Company's 4.75% Senior Notes due 2025 (including Form of Global Note as Exhibit A thereto)		8-K	November 9, 2016	4.1
10.1 *	1998 Stock Plan of Centene Corporation		S-1	October 9, 2001	10.10
10.2 *	1999 Stock Plan of Centene Corporation		S-1	October 9, 2001	10.11
10.3 *	2000 Stock Plan of Centene Corporation		S-1	October 9, 2001	10.12

10.4	*	2002 Employee Stock Purchase Plan, As Amended and Restated		10-K	February 22, 2016	10.4
10.5	*	Centene Corporation Amended and Restated 2003 Stock Incentive Plan		8-K	April 30, 2010	10.1
10.6	*	Amended and Restated 2012 Stock Incentive Plan		8-K	April 22, 2014	10.1
10.7	*	Amended and Restated Non-Employee Directors Deferred Stock Compensation Plan		10-Q	July 28, 2015	10.1
10.8	*	Centene Corporation Employee Deferred Compensation Plan		10-K	February 22, 2010	10.10
10.9	*	Centene Corporation 2007 Long-Term Incentive Plan		8-K	April 26, 2007	10.2
10.10	*	Centene Corporation Short-Term Executive Compensation Plan		10-K	February 22, 2011	10.12
10.11	*	Executive Employment Agreement between Centene Corporation and Michael F. Neidorff, dated November 8, 2004		8-K	November 9, 2004	10.1
10.11a	*	Amendment No. 1 to Executive Employment Agreement between Centene Corporation and Michael F. Neidorff		10-Q	October 28, 2008	10.2
10.11b	*	Amendment No. 2 to Executive Employment Agreement between Centene Corporation and Michael F. Neidorff		10-Q	April 28, 2009	10.2
10.11c	*	Amendment No. 3 to Executive Employment Agreement between Centene Corporation and Michael F. Neidorff		10-Q	October 23, 2012	10.2
10.11d	*	Amendment No. 4 to Executive Employment Agreement between Centene Corporation and Michael F. Neidorff		8-K	May 16, 2013	10.1
10.11e	*	Amendment No. 5 to Executive Employment Agreement between Centene Corporation and Michael F. Neidorff		8-K	December 14, 2016	10.1
10.12	*	Form of Executive Severance and Change in Control Agreement		10-Q	October 28, 2008	10.3
10.12a	*	Amendment No. 1 to Form of Executive Severance and Change in Control Agreement		10-Q	October 23, 2012	10.3
10.12b	*	Amendment No. 2 to Form of Executive Severance and Change in Control Agreement		10-Q	April 28, 2015	10.1
10.13	*	Form of Non-statutory Stock Option Agreement (Non-Employees)		8-K	July 28, 2005	10.3
10.14	*	Form of Non-statutory Stock Option Agreement (Employees)		10-Q	October 28, 2008	10.5
10.15	*	Form of Non-statutory Stock Option Agreement (Directors)		10-K	February 23, 2009	10.18
10.16	*	Form of Incentive Stock Option Agreement		10-Q	October 28, 2008	10.6
10.17	*	Form of Stock Appreciation Right Agreement		8-K	July 28, 2005	10.6
10.18	*	Form of Restricted Stock Agreement		10-Q	October 25, 2005	10.8
10.19	*	Form of Restricted Stock Unit Agreement #1		10-K	February 22, 2016	10.13
10.20	*	Form of Restricted Stock Unit Agreement #2	X			

10.21	*	Form of Performance Based Restricted Stock Unit Agreement #1		10-K	February 22, 2016	10.20
10.22	*	Form of Performance Based Restricted Stock Unit Agreement #2		10-K	February 22, 2016	10.21
10.23	*	Form of Performance Based Restricted Stock Unit Agreement #3	X		
10.24	*	Form of Long-Term Incentive Plan Agreement #1		8-K	February 7, 2008	10.1
10.25	*	Form of Long-Term Incentive Plan Agreement #2	X		
10.26		Credit Agreement dated as of May 21, 2013 among Centene Corporation, the various financial institutions party hereto and Barclays Bank PLC		8-K	May 22, 2013	10.1
10.26a		Amended No. 1 to Amended and Restated Credit Agreement dated as of July 15, 2014 among Centene Corporation, the various financial institutions party hereto and Barclays Bank PLC		10-Q	October 28, 2014	10.3
10.26b		Amended No. 2 to Amended and Restated Credit Agreement dated as of July 20, 2015 among Centene Corporation, the various financial institutions party hereto and Barclays Bank PLC		10-K	February 22, 2016	10.23b
10.27		Voting Agreement, dated as of July 2, 2015, by and between Centene Corporation and Jay M. Gellert		8-K	July 7, 2015	10.1
10.28		Registration Rights Agreement, dated February 11, 2016, by and among Centene Escrow Corporation, Wells Fargo Securities, LLC, Barclays Capital Inc., Citigroup Global Markets Inc., and SunTrust Robinson Humphrey, Inc., as representatives of the initial purchasers, relating to the Company's 5.625% Senior Notes due 2021		8-K	February 11, 2016	10.1
10.29		Registration Rights Agreement, dated February 11, 2016, by and among Centene Escrow Corporation, Wells Fargo Securities, LLC, Barclays Capital Inc., Citigroup Global Markets Inc., and SunTrust Robinson Humphrey, Inc., as representatives of the initial purchasers, relating to the Company's 6.125% Senior Notes due 2024		8-K	February 11, 2016	10.2
12.1		Computation of ratio of earnings to fixed charges	X		
21		List of subsidiaries	X		
23		Consent of Independent Registered Public Accounting Firm incorporated by reference in each prospectus constituting part of the Registration Statements on Form S-3 (File Numbers 333-197213, 333-196037, 333-193205, 333-187741 and 333-209252) and on Form S-8 (File Numbers 333-210376, 333-197737, 333-180976, 333-108467, 333-90976, 333-83190)	X		
31.1		Certification Pursuant to Rule 13a-14(a) and 15d-14 (a) of the Exchange Act, as Adopted Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002 (Chief Executive Officer)	X		
31.2		Certification Pursuant to Rule 13a-14(a) and 15d-14 (a) of the Exchange Act, as Adopted Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002 (Chief Financial Officer)	X		
32.1		Certification Pursuant to 18 U.S.C. Section 1350 (Chief Executive Officer)	X		

32.2	Certification Pursuant to 18 U.S.C. Section 1350 (Chief Financial Officer)	X
101.1	XBRL Taxonomy Instance Document	X
101.2	XBRL Taxonomy Extension Schema Document	X
101.3	XBRL Taxonomy Extension Calculation Linkbase Document	X
101.4	XBRL Taxonomy Extension Definition Linkbase Document	X
101.5	XBRL Taxonomy Extension Label Linkbase Document	X
101.6	XBRL Taxonomy Extension Presentation Linkbase Document	X

1 SEC File No. 001-31826 (for filings prior to October 14, 2003, the Registrant's SEC File No. was 000-33395).
* Indicates a management contract or compensatory plan or arrangement.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized, as of February 21, 2017.

CENTENE CORPORATION

By: /s/ Michael F. Neidorff

Michael F. Neidorff
Chairman and Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities as indicated, as of February 21, 2017.

Signature	Title
/s/ Michael F. Neidorff **Michael F. Neidorff**	Chairman and Chief Executive Officer (principal executive officer)
/s/ Jeffrey A. Schwaneke **Jeffrey A. Schwaneke**	Executive Vice President and Chief Financial Officer (principal financial officer)
/s/ Christopher R. Isaak **Christopher R. Isaak**	Senior Vice President, Corporate Controller and Chief Accounting Officer (principal accounting officer)
/s/ Orlando Ayala **Orlando Ayala**	Director
/s/ Robert K. Ditmore **Robert K. Ditmore**	Director
/s/ Fred H. Eppinger **Fred H. Eppinger**	Director
/s/ Vicki B. Escarra **Vicki B. Escarra**	Director
/s/ Richard A. Gephardt **Richard A. Gephardt**	Director
/s/ John R. Roberts **John R. Roberts**	Director
/s/ David L. Steward **David L. Steward**	Director
/s/ Tommy G. Thompson **Tommy G. Thompson**	Director

Exhibit 10.20

CENTENE CORPORATION

Restricted Stock Unit Agreement Granted Under

2012 Stock Incentive Plan

THIS AGREEMENT is entered into by Centene Corporation, a Delaware corporation (hereinafter the "Company"), and the undersigned employee of the Company (hereinafter the "Participant").

WHEREAS, the Participant renders important services to the Company and acquires access to Confidential Information (as defined below) of the Company in connection with the Participant's relationship with the Company; and

WHEREAS, the Company desires to align the long-term interests of its valued employees with those of the Company by providing the ownership interest granted herein and to prevent former employees whose interest may become adverse to the Company from maintaining an ownership interest in the Company;

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements herein contained, the parties hereto hereby agree as follows:

1. Grant of RSUs.

This Agreement evidences the grant by the Company on the Issue Date (or the "Grant Date") to the Participant of restricted stock units (each an "RSU," and collectively the "RSUs") pursuant to the Company's 2012 Stock Incentive Plan (the "Plan"). Each RSU represents the right to receive one share of the common stock, $.001 par value per share, of the Company ("Common Stock") as provided in this Agreement. The shares of Common Stock that are issuable upon vesting of the RSUs are referred to in this Agreement as "Shares."

2. Vesting.

Subject to Section 3 of this Agreement, the RSUs shall vest as to ____% of the original number of RSUs on the ____ anniversary of the Grant Date and as to an additional ____% of the original number of RSUs at the end of each successive ____ period following the ____ anniversary of the Grant Date until the ____ anniversary of the Grant Date. The Participant must hold vested shares for one year from the vesting date, less shares valued at an amount equivalent to the Participant's tax liability applicable to the vested shares at the Participant's marginal tax rate. The Participant's tax liability may exceed the minimum statutory withholding.

3. Reorganization Event.

Upon the occurrence of a "Change in Control," all of the RSUs that (but for the application of this clause) are not vested at the time of the occurrence of such Change in Control event shall vest. The shares represented by the RSUs so vested shall not be subject to the one-year additional holding requirement under Section 2. A "Change in Control" shall be deemed to have occurred if any of the events set forth in any one of the following clauses shall occur: (i) any Person (as defined in section 3(a)(9) of the Securities Exchange Act of 1934, as amended (the "Exchange Act"), and as such term is modified in sections 13(d) and 14(d) of the Exchange Act), excluding a group of persons including the Participant, is or becomes the "beneficial owner" (as defined in Rule 13(d)(3) under the Exchange Act), directly or indirectly, of securities of the Company representing forty percent or more of the combined voting power of the Company's then-outstanding securities; (ii) individuals who, as of the Grant Date, constitute the Board of Directors of the Company (the "Incumbent Board"), cease for any reason to constitute a majority thereof (*provided, however,* that an individual becoming a director subsequent to the Grant Date whose election, or nomination for election by the Company's stockholders, was approved by at least a majority of the directors then comprising the Incumbent Board shall be included within the definition of Incumbent Board, but excluding, for this purpose, any such individual whose initial assumption of office occurs as a result of either an actual election contest (or such terms used in Rule 14a-11 of Regulation 14A promulgated under the Exchange Act) or other actual or threatened solicitation of proxies or consents by or on behalf of a person other than the Board of Directors of the Company); or (iii) the stockholders of the Company consummate a merger or consolidation of the Company with any other corporation, other than a merger or consolidation that would result in the voting securities of the Company outstanding immediately prior thereto continuing to represent (either by remaining outstanding or by being converted into voting securities of the surviving entity) at least fifty percent of the combined voting power of the voting securities of the Company or such surviving entity outstanding immediately after such merger or consolidation.

4. Distribution of Shares.

(a) Timing of Distribution. The Company will distribute to the Participant (or to the Participant's estate in the event of the death of the Participant occurring after a vesting date but before distribution of the corresponding Shares), as soon as administratively practicable after each vesting date, the Shares represented by RSUs that vested on such vesting date.

(b) No Fractional Shares. No fractional Shares shall be issuable pursuant to any RSU. In lieu of any fractional shares to which the Participant would otherwise be entitled, the Company shall pay cash in an amount equal to such fraction multiplied by the Fair Market Value (as defined in the Plan) of a share of Common Stock.

(c) Termination of Employment. In the event that the Participant's employment with the Company (and any parent or subsidiary thereof) is terminated for any reason by the Company or by the Participant other than by reason of death, disability (within the meaning of Section 22(e)(3) of the Internal Revenue Code of 1986, as amended (the "Code")) or Qualified Retirement (as defined below), the RSUs shall cease vesting as of the date of termination. In the event the Participant's employment with the Company (and any parent or subsidiary thereof) is terminated by reason of death or disability (as defined previously in this Section 4.(c)), the pro-rata amount of RSUs, attributable to the number of completed months employed between the grant date and the termination date shall immediately vest, and fractional shares will be rounded down to the nearest full share and will not be distributed or paid in cash. In the event the Participant's employment with the Company (and any parent or subsidiary thereof) is terminated by reason of a Qualified Retirement, the RSUs shall cease vesting one year following the date of termination. Any RSUs which vest during such one year period will not be subject to additional holding periods hereunder. A Qualified Retirement is a retirement made pursuant to a bona-fide notice of retirement made 90 Days in advance, by a Participant who is at least 55 years old and has been employed at the Company for at least 10 years.

(d) Compliance Restrictions. The Company shall not be obligated to issue to the Participant the Shares upon the vesting of any RSU (or otherwise) unless (i) the Participant has complied with covenants set forth in Section 10 of this Agreement and (ii) the issuance and delivery of such Shares shall comply with all relevant provisions of law and other legal requirements including any applicable federal or state securities laws and the requirements of any stock exchange or quotation system upon which Common Stock may then be listed or quoted.

5. Restrictions on Transfer.

The RSUs may not be sold, assigned, transferred, pledged or otherwise encumbered by the Participant, either voluntarily or by operation of law, except by will or the laws of descent and distribution.

6. No Rights as Stockholder.

Except as set forth in the Plan, neither the Participant nor any person claiming under or through the Participant shall be, or shall have any rights or privileges of, a stockholder of the Company in respect of any Share issuable pursuant to the RSUs granted hereunder until such Share has been delivered to the Participant.

7. Withholding Taxes; Section 83(b) Election.

(a) No Shares will be delivered pursuant to the vesting of an RSU unless and until the Participant pays to the Company, or makes provision satisfactory to the Company for payment of, the amount (with respect to such vesting, the "Withholding Amount") of the Company's minimum statutory withholding obligations with respect to the income recognized by the Participant upon such vesting, based on minimum statutory withholding rates for all tax purposes, including payroll and social security taxes, that are applicable to such income.

(b) The Participant acknowledges that no election under Section 83(b) of the Code may be filed with respect to the RSUs.

8. Automatic Sale Upon Vesting.

(a) Upon any vesting of RSUs pursuant to Section 2 hereof, the Company may sell, or arrange for the sale of, such number of the Shares issuable pursuant to such vested RSU under Section 2 as is sufficient to generate net proceeds to satisfy the Company's minimum statutory withholding obligations with respect to the income recognized by the Participant upon vesting (based on minimum statutory withholding rates for all tax purposes, including payroll and social security taxes, that are applicable to such income), and the Company shall retain such net proceeds in satisfaction of such tax withholding obligations.

(b) The Participant hereby appoints the Company's Secretary as his or her attorney-in-fact to sell the Shares in accordance with this Section 8. The Participant agrees to execute and deliver such documents, instruments and certificates as may reasonably be required in connection with the sale of the Shares pursuant to this Section 8.

(c) It is understood that the Participant and the Company may agree from time to time, subject to compliance with applicable laws, to procedures to be implemented, in lieu of the procedures set forth in paragraphs (a) and (b) of this Section 8, to fund the Withholding Amount.

9. Provisions of the Plan.

The RSUs are subject to the provisions of the Plan, a copy of which is being furnished to the Participant with this Agreement.

10. Participant's Covenants.

For and in consideration of the delivery of this Agreement, the Participant agrees to the provisions of this Section 10.

(a) Confidential Information. As used in this Agreement, "Confidential Information" shall mean the Company's trade secrets and other non-public proprietary information relating to the Company or the business of the Company, including information relating to financial statements, customer lists and identities, potential customers, customer contacts, employee skills and compensation, employee data, suppliers, acquisition targets, servicing methods, equipment, programs, strategies and information, analyses, marketing plans and strategies, profit margins, financial, promotional, marketing, training or operational information, and other information developed or used by the Company that is not known generally to the public or the industry. Confidential Information shall not include any information that is in the public domain or becomes known in the public domain through no wrongful act on the part of the Participant.

(b) Non-Disclosure. The Participant agrees that the Confidential Information is a valuable, special and unique asset of the Company's business, that such Confidential Information is important to the Company and the effective operation of the Company's business, and that during employment with the Company and at all times thereafter, the Participant shall not, directly or indirectly, disclose to any competitor or other person or entity (other than current employees of the Company) any Confidential Information that the Participant obtains while performing services for the Company, except as may be required in the Participant's reasonable judgment to fulfill his duties hereunder or to comply with any applicable legal obligation.

(c) Non-Competition; Non-Solicitation.

(i) During Participant's employment with the Company and for the period of six (6) months immediately after the termination of Participant's employment with the Company (including any parent, subsidiary, affiliate or division of the Company) for any reason whatsoever, and whether voluntary or involuntary, Participant shall not invest in (other than in a publicly traded company with a maximum investment of no more than 1% of outstanding shares), counsel, advise, consult, be employed or otherwise engaged by or with any entity or enterprise ("Competitor") that competes with (A) the Company's business of providing Medicaid managed care services, Medicaid-related services, behavioral health, nurse triage or pharmacy compliance specialty services or (B) any other business in which, after the date of this Agreement, the Company (or any parent, subsidiary, affiliate or division of the Company) becomes engaged (or has taken substantial steps in which to become engaged) on or prior to the date of termination of Participant's employment. For purposes of paragraph 10, Participant agrees that this agreement not to compete applies to any Competitor that does business within the state of Missouri or and any other state in which Centene does business, and that such geographical limitation is reasonable.

(ii) During the Participant's employment with the Company (or any parent, subsidiary, affiliate or division of the Company) and for the period of twelve months immediately after the termination of the Participant's employment with the Company (or any parent, subsidiary, affiliate or division of the Company) for any cause whatsoever, and whether voluntary or involuntary ("Restricted Period"), the Participant will not, either directly or indirectly, either for himself or for any other person, firm, company or corporation, call upon, solicit, divert, or take away, or attempt to solicit, divert or take away any of the customers, prospective customers, business, vendors or suppliers of the Company that the Participant had dealings with, or responsibility for, or as to which the Participant had access to confidential information.

(iii) The Participant shall not, at any time during the Restricted Period, without the prior written consent of the Company, (i) directly or indirectly, solicit, recruit or employ (whether as an employee, officer, director, agent, consultant or independent contractor) any person who was or is at any time during the previous six months an employee, representative, officer or director of the Company (or any parent, subsidiary, affiliate or division of the Company); or (ii) take any action to encourage or induce any employee, representative, officer or director of the Company (or any parent, subsidiary, affiliate or division of the Company) to cease their relationship with the Company (or any parent, subsidiary, affiliate or division of the Company) for any reason.

(iv) This Section 10(c) shall not apply if a "Change in Control" (as defined in Section 3) occurs under Section 3(ii) thereof, or if such Change in Control occurs under Section 3(i) or 3(iii) thereof without the prior approval, recommendation or consent of the Board of Directors of the Corporation.

(d) Enforcement. If any of the provisions or subparts of this Section 10 shall be held to be invalid or unenforceable by a court of competent jurisdiction, the remaining provisions or subparts thereof shall nevertheless continue to be valid and enforceable according to their terms. Further, if any restriction contained in the provisions or subparts of this Section 10 is held to be overbroad or unreasonable as written, the parties agree that the applicable provision should be considered to be amended to reflect the maximum period, scope or geographical area deemed reasonable and enforceable by the court and enforced as amended.

(e) Remedy for Breach.

(i) Because the Participant's services are unique and because the Participant has access to the Company's Confidential Information, the parties agree that any breach or threatened breach of this Section 10 will cause irreparable harm to the Company and that money damages alone would be an inadequate remedy. The parties therefore agree that, in the event of any breach or threatened breach of this Section 10, and in addition to all other rights and remedies available to it, the Company may

apply to any court of competent jurisdiction for specific performance and/or injunctive or other relief, without a bond, in order to enforce or prevent any violations of the provisions of this Section 10.

(ii) The Participant shall immediately repay to the Company a cash sum in the principal amount equal to all gross proceeds (before-tax) realized by Participant upon the sale or other disposition of the Shares occurring at any time during the period commencing on the date that is three years before the date of termination of the Participant's employment with the Company and all Subsidiaries of the Company and ending on the date of the Participant's breach or threatened breach of this Section 10 (the "Refund Period"), together with interest accrued thereon, from the date of such breach or threatened breach, at the prime rate (compounded calendar monthly) as published from time to time in The Wall Street Journal, electronic edition ("Interest"); and

(iii) The Participant shall repay to the Company a cash sum equal to the fair market value of all of the Shares transferred by the Participant as a gift or gifts at any time during the Refund Period, together with Interest, and for which purpose, "fair market value" shall be the Fair Market Value of one share of Common Stock on the date such gift occurs.

(iv) The Participant acknowledges and agrees that nothing contained herein shall be construed to be an excessive remedy to prohibit the Company from pursuing any other remedies available to it for such actual or threatened breach, including the recovery of money damages, proximately caused by the Participant's breach of this Section 10.

(f) Survival. The provisions of this Section 10 shall survive and continue in full force in accordance with their terms notwithstanding any forfeiture, termination or expiration of this Agreement in accordance with its terms or any termination of the Participant's employment for any reason (whether voluntary or involuntary).

11. Miscellaneous.

(a) Severability. The invalidity or unenforceability of any provision of this Agreement shall not affect the validity or enforceability of any other provision of this Agreement, and each other provision of this Agreement shall be severable and enforceable to the extent permitted by law.

(b) Waiver. Any provision for the benefit of the Company contained in this Agreement may be waived, either generally or in any particular instance, by the Board of Directors of the Company.

(c) Binding Effect. This Agreement shall be binding upon and inure to the benefit of the Company and the Participant and their respective heirs, executors, administrators, legal representatives, successors and assigns, subject to the restrictions on transfer set forth in Section 5 of this Agreement.

(d) Notice. All notices required or permitted hereunder shall be in writing and deemed effectively given upon personal delivery or five days after delivery to a United States Post Office, by registered or certified mail, postage prepaid, addressed to the other party hereto at the address shown beneath his or its respective signature to this Agreement, or at such other address or addresses as either party shall designate to the other in accordance with this paragraph (d).

(e) Entire Agreement. This Agreement and the Plan constitute the entire agreement between the parties, and supersede all prior agreements and understandings, relating to the RSUs.

(f) Participant's Acknowledgments. The Participant acknowledges that he or she: (i) has read this Agreement; (ii) has been represented in the preparation, negotiation, and execution of this Agreement by legal counsel of the Participant's own choice or has voluntarily declined to seek such counsel; (iii) understands the terms and consequences of this Agreement; (iv) is fully aware of the legal and binding effect of this Agreement; and (v) understands that the law firm of Bryan Cave LLP, is acting as counsel to the Company in connection with the transactions contemplated by the agreement, and is not acting as counsel for the Participant.

(g) Unfunded Rights. The right of the Participant to receive Common Stock pursuant to this Agreement is an unfunded and unsecured obligation of the Company. The Participant shall have no rights under this Agreement other than those of an unsecured general creditor of the Company.

(h) Deferral. Neither the Company nor the Participant may defer delivery of any Shares issuable under unvested RSUs except to the extent that such deferral complies with the provisions of Section 409A of the Code.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement.

CENTENE CORPORATION

Exhibit 10.23

CENTENE CORPORATION

Restricted Stock Unit Agreement Granted Under
2012 Stock Incentive Plan

THIS AGREEMENT is entered into by Centene Corporation, a Delaware corporation (hereinafter the "Company"), and the undersigned employee of the Company (hereinafter the "Participant").

WHEREAS, the Participant renders important services to the Company and acquires access to Confidential Information (as defined below) of the Company in connection with the Participant's relationship with the Company; and

WHEREAS, the Company desires to align the long-term interests of its valued employees with those of the Company by providing the ownership interest granted herein and to prevent former employees whose interest may become adverse to the Company from maintaining an ownership interest in the Company;

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements herein contained, the parties hereto hereby agree as follows:

1. Grant of RSUs.

This Agreement evidences the grant by the Company on the Issue Date (or the "Grant Date") to the Participant of restricted stock units (each an "RSU," and collectively the "RSUs") pursuant to the Company's 2012 Stock Incentive Plan (the "Plan"). Each RSU represents the right to receive one share of the common stock, $.001 par value per share, of the Company ("Common Stock") as provided in this Agreement. The shares of Common Stock that are issuable upon vesting of the RSUs are referred to in this Agreement as "Shares."

2. Performance Condition and Vesting.

(a) The grant of RSUs provided for in Section 1 shall be contingent on the Company meeting a **cumulative three year pre-tax margin target of ____ and a three year annualized compounded revenue growth rate (excluding GAAP premium tax revenue and health insurer fee revenue) of ____.** The number of RSUs may be increased or decreased based on the Company's performance compared to these metrics as described in Exhibit A.

(b) If the requirements of paragraph (a) are satisfied in accordance with the terms of Exhibit A, then the RSUs shall vest as to **100%** of the number of shares granted on the **first trading day following the ____ year end earnings release**. The Participant must hold vested shares for one year from the vesting date, less shares valued at an amount equivalent to the Participant's tax liability applicable to the vested shares at the Participant's marginal tax rate. The Participant's tax liability may exceed the minimum statutory withholding.

3. Reorganization Event.

Upon the occurrence of a "Change in Control," all of the RSUs that (but for the application of this clause) are not vested at the time of the occurrence of such Change in Control event shall vest at the greater of the actual performance level at the time of the Change in Control or the target level as set forth in Exhibit A. The shares represented by the RSUs so vested shall not be subject to the one-year additional holding requirement under Section 2(b). A "Change in Control" shall be deemed to have occurred if any of the events set forth in any one of the following clauses shall occur: (i) any Person (as defined in section 3(a)(9) of the Securities Exchange Act of 1934, as amended (the "Exchange Act"), and as such term is modified in sections 13(d) and 14(d) of the Exchange Act), excluding a group of persons including the Participant, is or becomes the "beneficial owner" (as defined in Rule 13(d)(3) under the Exchange Act), directly or indirectly, of securities of the Company representing forty percent or more of the combined voting power of the Company's then-outstanding securities; (ii) individuals who, as of the Grant Date, constitute the Board of Directors of the Company (the "Incumbent Board"), cease for any reason to constitute a majority thereof (*provided, however,* that an individual becoming a director subsequent to the Grant Date whose election, or nomination for election by the Company's stockholders, was approved by at least a majority of the directors then comprising the Incumbent Board shall be included within the definition of Incumbent Board, but excluding, for this purpose, any such individual whose initial assumption of office occurs as a result of either an actual election contest (or such terms used in Rule 14a-11 of Regulation 14A promulgated under the Exchange Act) or other actual or threatened solicitation of proxies or consents by or on behalf of a person other than the Board of Directors of the Company); or (iii) the stockholders of the Company consummate a merger or consolidation of the Company with any other corporation, other than a merger or consolidation that would result in the voting securities of the Company outstanding immediately prior thereto continuing to represent (either by remaining outstanding or by being converted into voting

securities of the surviving entity) at least fifty percent of the combined voting power of the voting securities of the Company or such surviving entity outstanding immediately after such merger or consolidation.

4. Distribution of Shares.

(a) Timing of Distribution. The Company will distribute to the Participant (or to the Participant's estate in the event of the death of the Participant occurring after a vesting date but before distribution of the corresponding Shares), as soon as administratively practicable after the vesting date, the Shares represented by RSUs that vested on such vesting date.

(b) No Fractional Shares. No fractional Shares shall be issuable pursuant to any RSU. In lieu of any fractional shares to which the Participant would otherwise be entitled, the Company shall pay cash in an amount equal to such fraction multiplied by the Fair Market Value (as defined in the Plan) of a share of Common Stock.

(c) Termination of Employment. In the event that the Participant's employment with the Company (and any parent or subsidiary thereof) is terminated for any reason by the Company or by the Participant other than by reason of death or disability (within the meaning of Section 22(e)(3) of the Internal Revenue Code of 1986, as amended (the "Code")) or Qualified Retirement (as defined below), the RSUs shall cease vesting as of the date of termination. In the event the Participant's employment with the Company (and any parent or subsidiary thereof) is terminated by reason of death or disability (as defined previously in this Section 4.(c)), the pro-rata amount of RSUs, based on the number of full months employed with the Company during the performance period (as described in Exhibit A), shall immediately vest, and fractional shares will be rounded down to the nearest full share and will not be distributed or paid in cash. In the event the Participant's employment with the Company (and any parent or subsidiary thereof) is terminated by reason of a Qualified Retirement, the pro-rata amount of RSUs, based on the number of full months employed with the Company during the performance period, shall remain eligible to vest, but shall otherwise remain subject to increase or decrease based on the Company's performance compared to the metrics as described in Exhibit A. Any such RSUs which are earned shall be distributed in stock as soon as practicable following the termination of the performance period and shall not be subject to the one-year additional holding requirement under Section 2(b). A Qualified Retirement is a retirement made pursuant to a bona-fide notice of retirement made 90 days in advance by a Participant who is at least 55 years old and has been employed at the Company for at least 10 years.

(d) Compliance Restrictions. The Company shall not be obligated to issue to the Participant the Shares upon the vesting of any RSU (or otherwise) unless (i) the Participant has complied with covenants set forth in Section 10 of this Agreement and (ii) the issuance and delivery of such Shares shall comply with all relevant provisions of law and other legal requirements including any applicable federal or state securities laws and the requirements of any stock exchange or quotation system upon which Common Stock may then be listed or quoted.

5. Restrictions on Transfer.

The RSUs may not be sold, assigned, transferred, pledged or otherwise encumbered by the Participant, either voluntarily or by operation of law, except by will or the laws of descent and distribution.

6. No Rights as Stockholder.

Except as set forth in the Plan, neither the Participant nor any person claiming under or through the Participant shall be, or shall have any rights or privileges of, a stockholder of the Company in respect of any Share issuable pursuant to the RSUs granted hereunder until such Share has been delivered to the Participant.

7. Withholding Taxes; Section 83(b) Election.

(a) No Shares will be delivered pursuant to the vesting of an RSU unless and until the Participant pays to the Company, or makes provision satisfactory to the Company for payment of, the amount (with respect to such vesting, the "Withholding Amount") of the Company's minimum statutory withholding obligations with respect to the income recognized by the Participant upon such vesting, based on minimum statutory withholding rates for all tax purposes, including payroll and social security taxes, that are applicable to such income.

(b) The Participant acknowledges that no election under Section 83(b) of the Code may be filed with respect to the RSUs.

8. Automatic Sale Upon Vesting.

(a) Upon any vesting of RSUs pursuant to Section 2 hereof, the Company may sell, or arrange for the sale of, such number of the Shares issuable pursuant to such vested RSU under Section 2 as is sufficient to generate net proceeds to satisfy the Company's minimum statutory withholding obligations with respect to the income recognized by the Participant upon vesting (based on minimum statutory withholding rates for all tax purposes, including payroll and social security taxes, that are applicable to such income), and the Company shall retain such net proceeds in satisfaction of such tax withholding obligations.

(b) The Participant hereby appoints the Company's Secretary as his or her attorney-in-fact to sell the Shares in accordance with this Section 8. The Participant agrees to execute and deliver such documents, instruments and certificates as may reasonably be required in connection with the sale of the Shares pursuant to this Section 8.

(c) It is understood that the Participant and the Company may agree from time to time, subject to compliance with applicable laws, to procedures to be implemented, in lieu of the procedures set forth in paragraphs (a) and (b) of this Section 8, to fund the Withholding Amount.

9. Provisions of the Plan.

The RSUs are subject to the provisions of the Plan, a copy of which is being furnished to the Participant with this Agreement.

10. Participant's Covenants.

For and in consideration of the delivery of this Agreement, the Participant agrees to the provisions of this Section 10.

(a) Confidential Information. As used in this Agreement, "Confidential Information" shall mean the Company's trade secrets and other non-public proprietary information relating to the Company or the business of the Company, including information relating to financial statements, customer lists and identities, potential customers, customer contacts, employee skills and compensation, employee data, suppliers, acquisition targets, servicing methods, equipment, programs, strategies and information, analyses, marketing plans and strategies, profit margins, financial, promotional, marketing, training or operational information, and other information developed or used by the Company that is not known generally to the public or the industry. Confidential Information shall not include any information that is in the public domain or becomes known in the public domain through no wrongful act on the part of the Participant.

(b) Non-Disclosure. The Participant agrees that the Confidential Information is a valuable, special and unique asset of the Company's business, that such Confidential Information is important to the Company and the effective operation of the Company's business, and that during employment with the Company and at all times thereafter, the Participant shall not, directly or indirectly, disclose to any competitor or other person or entity (other than current employees of the Company) any Confidential Information that the Participant obtains while performing services for the Company, except as may be required in the Participant's reasonable judgment to fulfill his duties hereunder or to comply with any applicable legal obligation.

(c) Non-Competition; Non-Solicitation.

(i) During Participant's employment with the Company and for the period of six (6) months immediately after the termination of Participant's employment with the Company (including any parent, subsidiary, affiliate or division of the Company) for any reason whatsoever, and whether voluntary or involuntary, Participant shall not invest in (other than in a publicly traded company with a maximum investment of no more than 1% of outstanding shares), counsel, advise, consult, be employed or otherwise engaged by or with any entity or enterprise ("Competitor") that competes with (A) the Company's business of providing Medicaid managed care services, Medicaid-related services, behavioral health, nurse triage or pharmacy compliance specialty services or (B) any other business in which, after the date of this Agreement, the Company (or any parent, subsidiary, affiliate or division of the Company) becomes engaged (or has taken substantial steps in which to become engaged) on or prior to the date of termination of Participant's employment. For purposes of paragraph 10, Participant agrees that this agreement not to compete applies to any Competitor that does business within the state of Missouri or and any other state in which Centene does business, and that such geographical limitation is reasonable.

(ii) During the Participant's employment with the Company (or any parent, subsidiary, affiliate or division of the Company) and for the period of twelve months immediately after the termination of the Participant's employment with the Company (or any parent, subsidiary, affiliate or division of the Company) for any cause whatsoever, and whether

voluntary or involuntary ("Restricted Period"), the Participant will not, either directly or indirectly, either for himself or for any other person, firm, company or corporation, call upon, solicit, divert, or take away, or attempt to solicit, divert or take away any of the customers, prospective customers, business, vendors or suppliers of the Company that the Participant had dealings with, or responsibility for, or as to which the Participant had access to confidential information.

(iii) The Participant shall not, at any time during the Restricted Period, without the prior written consent of the Company, (i) directly or indirectly, solicit, recruit or employ (whether as an employee, officer, director, agent, consultant or independent contractor) any person who was or is at any time during the previous six months an employee, representative, officer or director of the Company (or any parent, subsidiary, affiliate or division of the Company); or (ii) take any action to encourage or induce any employee, representative, officer or director of the Company (or any parent, subsidiary, affiliate or division of the Company) to cease their relationship with the Company (or any parent, subsidiary, affiliate or division of the Company) for any reason.

(iv) If the participant's employment ends by reason of a Qualified Retirement, the post-employment restrictions set forth in subsections 10(c)(i), (ii) and (iii) above shall continue until the later of (x) the date set forth in 10(c)(i), (ii) and (iii), as applicable, or (y) the expiration of the last performance period for which the Participant is receiving pro-rata vesting; provided that after the date set forth in subsection 10(c)(i), (ii) or (iii), as applicable, the sole remedies for the Company relating to a violation of the applicable post-employment restrictions shall be those set forth in subsections 10(e)(ii) and (iii) below.

(v) This Section 10(c) shall not apply if a "Change in Control" (as defined in Section 3) occurs.

(d) Enforcement. If any of the provisions or subparts of this Section 10 shall be held to be invalid or unenforceable by a court of competent jurisdiction, the remaining provisions or subparts thereof shall nevertheless continue to be valid and enforceable according to their terms. Further, if any restriction contained in the provisions or subparts of this Section 10 is held to be overbroad or unreasonable as written, the parties agree that the applicable provision should be considered to be amended to reflect the maximum period, scope or geographical area deemed reasonable and enforceable by the court and enforced as amended.

(e) Remedy for Breach.

(i) Because the Participant's services are unique and because the Participant has access to the Company's Confidential Information, the parties agree that any breach or threatened breach of this Section 10 will cause irreparable harm to the Company and that money damages alone would be an inadequate remedy. The parties therefore agree that, in the event of any breach or threatened breach of this Section 10, and in addition to all other rights and remedies available to it, the Company may apply to any court of competent jurisdiction for specific performance and/or injunctive or other relief, without a bond, in order to enforce or prevent any violations of the provisions of this Section 10.

(ii) The Participant shall immediately repay to the Company a cash sum in the principal amount equal to all gross proceeds (before-tax) realized by Participant upon the sale or other disposition of the Shares occurring at any time during the period commencing on the date that is three years before the date of termination of the Participant's employment with the Company and all Subsidiaries of the Company and ending on the date of the Participant's breach or threatened breach of this Section 10 (the "Refund Period"), together with interest accrued thereon, from the date of such breach or threatened breach, at the prime rate (compounded calendar monthly) as published from time to time in The Wall Street Journal, electronic edition ("Interest"); and

(iii) The Participant shall repay to the Company a cash sum equal to the fair market value of all of the Shares transferred by the Participant as a gift or gifts at any time during the Refund Period, together with Interest, and for which purpose, "fair market value" shall be the Fair Market Value of one share of Common Stock on the date such gift occurs.

(iv) The Participant acknowledges and agrees that nothing contained herein shall be construed to be an excessive remedy to prohibit the Company from pursuing any other remedies available to it for such actual or threatened breach, including the recovery of money damages, proximately caused by the Participant's breach of this Section 10.

(f) Survival. The provisions of this Section 10 shall survive and continue in full force in accordance with their terms notwithstanding any forfeiture, termination or expiration of this Agreement in accordance with its terms or any termination of the Participant's employment for any reason (whether voluntary or involuntary).

11. Miscellaneous.

(a) Severability. The invalidity or unenforceability of any provision of this Agreement shall not affect the validity or enforceability of any other provision of this Agreement, and each other provision of this Agreement shall be severable and enforceable to the extent permitted by law.

(b) Waiver. Any provision for the benefit of the Company contained in this Agreement may be waived, either generally or in any particular instance, by the Board of Directors of the Company.

(c) Binding Effect. This Agreement shall be binding upon and inure to the benefit of the Company and the Participant and their respective heirs, executors, administrators, legal representatives, successors and assigns, subject to the restrictions on transfer set forth in Section 5 of this Agreement.

(d) Notice. All notices required or permitted hereunder shall be in writing and deemed effectively given upon personal delivery or five days after delivery to a United States Post Office, by registered or certified mail, postage prepaid, addressed to the other party hereto at the address shown beneath his or its respective signature to this Agreement, or at such other address or addresses as either party shall designate to the other in accordance with this paragraph (d).

(e) Entire Agreement. This Agreement and the Plan constitute the entire agreement between the parties, and supersede all prior agreements and understandings, relating to the RSUs.

(f) Participant's Acknowledgments. The Participant acknowledges that he or she: (i) has read this Agreement; (ii) has been represented in the preparation, negotiation, and execution of this Agreement by legal counsel of the Participant's own choice or has voluntarily declined to seek such counsel; (iii) understands the terms and consequences of this Agreement; (iv) is fully aware of the legal and binding effect of this Agreement; and (v) understands that the law firm of Bryan Cave LLP, is acting as counsel to the Company in connection with the transactions contemplated by the agreement, and is not acting as counsel for the Participant.

(g) Unfunded Rights. The right of the Participant to receive Common Stock pursuant to this Agreement is an unfunded and unsecured obligation of the Company. The Participant shall have no rights under this Agreement other than those of an unsecured general creditor of the Company.

(h) Deferral. Neither the Company nor the Participant may defer delivery of any Shares issuable under unvested RSUs except to the extent that such deferral complies with the provisions of Section 409A of the Code.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement.

CENTENE CORPORATION

Exhibit 10.25

Centene Corporation
2007 Long-Term Incentive Plan

Cash-Based Award Agreement ("Award Agreement")

Participant Name:	
Type of Award:	Cash-Based Award
Target Incentive Award:	
Performance Goals:	3-Year Annualized Compounded Revenue Growth Rate, 3-Year Cumulative Pre-Tax Margins & 3-Year Cumulative Total Shareholder Return Relative to Centene's Healthcare Peer Group
Performance Period:	January 1, 2___ to December 31, 2___
End of Performance Period:	December 31, 2___

Relationship to Plan. This Award is granted pursuant to the Centene Corporation (the "Company") 2007 Long-Term Incentive Plan (the "Plan") and is in all respects subject to the terms, conditions, and definitions of the Plan (including, but not limited to, provisions concerning restrictions on Awards, termination, non-transferability, and any adjustment to the Award). The Participant hereby accepts this Award subject to all the terms and provisions of the Plan. The Participant further agrees that all decisions under and interpretations of the Plan by the Committee shall be final, binding, and conclusive upon the Participant and his or her heirs. All capitalized terms used herein and not otherwise defined herein shall have the same meanings ascribed to them in the Plan. If there is any inconsistency between the terms of this Award Agreement and the terms of the Plan, the Plan's terms shall completely supersede and replace the conflicting terms of this Award Agreement.

Performance Period. The Performance Period commences on January 1, 2___, and ends on December 31, 2___.

Performance Goals. The Performance Goals are expressed as follows:

1. 3-Year Annualized Compounded Revenue Growth Rate of the Company as identified in Exhibit A ("3-Year Annualized Compounded Revenue Growth Rate"), with a weight of __% as shown in Exhibit B
2. 3-Year Cumulative Pre-Tax Margins of the Company as identified in Exhibit A ("3-Year Cumulative Pre-Tax Margins"), with a weight of __% as shown in Exhibit B
3. 3-Year Cumulative Total Shareholder Return Relative to Centene's Healthcare Peer Group, with a weight of __% as shown in Exhibit B

Determination of Award Amount. Upon conclusion of the Performance Period, the Committee shall determine the level of achievement of the Performance Goals for the Performance Period. The Committee shall determine the percentage level of achievement of each the 3-Year Annualized Compounded Revenue Growth Rate of the Company, the 3-Year Cumulative Pre-Tax Margins of the Company and the 3-Year Cumulative Total Shareholder Return of the Company relative to Centene's Healthcare Peer Group. Once determined, the Participant's Award Amount shall be determined by multiplying the Participant's Target Incentive Award, stated above, by the Performance Goal Weight (in Exhibit B) and by the percentage level of achievement for each of the three Performance Goals. Then, the sum of these three products equals the award amount.

Award Payment. The Participant shall be entitled to receive an Award Payment, as determined under this Award Agreement, from the Company in the form of cash, in one lump sum, within sixty (60) days after the end of the stated Performance Period.

The Company shall maintain a record of all information pertaining to the Participant's rights under this Award Agreement, including the date of payment.

Change in Control. Upon a Change in Control, the payment of the Award shall be accelerated as of the effective date of the Change in Control, and there shall be paid out in cash to the Participant within thirty (30) days following the effective date of the Change in Control an amount equal to the greater of the actual performance level at the time of the Change in Control or the target level as set forth in Exhibit B.

Withholding of Taxes. The Company shall have the power and the right to deduct or withhold, or require a Participant to remit to the Company, the minimum statutory amount to satisfy federal, state, and local taxes, domestic or foreign, required by law or regulation to be withheld with respect to any taxable event arising as a result of this Plan (the "Withholding Taxes"). As the Participant is entitled to receive cash under the terms of this Award Agreement, the Participant shall pay the Withholding Taxes to the Company in cash or have the Company withhold from payments otherwise due to the Participant any Award amounts necessary to pay the Withholding Taxes.

Termination of Employment. The Participant's Termination of Employment shall affect any Award under this Award Agreement in the following manner:

(i) In the event of a Participant's termination of employment for Cause by the Company or Subsidiary all of the Participant's rights to this Award shall be forfeited.

(ii) In the event a Participant's employment with the Company (and any parent or subsidiary thereof) is terminated by reason of death, disability or Qualified Retirement, the Participant is eligible for a pro-rata Award Payment, based on the number of full months employed with the Company during the performance period, but shall otherwise remain subject to increase or decrease based on the Company's performance compared to the metrics as described in Exhibit A and B. Pro-rata Award Payment shall be paid within (60) days following the end of the performance period. In the case of a Participant's Disability, the employment termination shall be deemed to have occurred on the date that the Committee determines the Participant has incurred a Disability, as defined below.

(iii) In the event of a Participant's termination of employment with the Company or Subsidiary is on account of any reason other than a Change in Control or those specified in subparagraphs (i) and (ii) above, the Committee, in its sole discretion, may pay a prorated award for the portion of the Performance Period that the Participant was employed by the Company, computed as determined by the Committee.

For the purpose of this Agreement, Disability means, subject to a medical examination as specified by the Committee, the Participant: (a) is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or can be expected to last for a continuous period of not less than twelve (12) months, or (b) is, by reason of any medically determinable physical or mental impairment which could be expected to result in death or can be expected to last for a continuous period or not less than twelve (12) months, receiving income replacement benefits for a period of not less than three (3) months under an accident and health plan covering employees of the Company.

For the purpose of this Agreement, Qualified Retirement is a retirement made pursuant to a bona-fide notice of retirement made 90 days in advance by a Participant who is at least 55 years old and has been employed at the Company for at least 10 years.

Transferability. The Award granted hereunder shall not be transferable other than by will or by the laws of descent and distribution. During the lifetime of the Participant, the Award shall be paid only to the Participant. Any portion of the Award payable at the date of the Participant's death and transferred by will or by the laws of descent shall be payable in accordance with the terms of the Award to the Participant's estate for the period provided herein with respect to termination of employment as a result of the Participant's death.

No Employment or Service Contract. Nothing in this Award Agreement or in the Plan shall confer upon the Participant any right to continue such Participant's relationship with the Company or Subsidiary thereof, nor shall it give any Participant the right to be retained in the employ of the Company or a subsidiary or interfere with or otherwise restrict in any way the rights of the Company or Subsidiary, which rights are hereby expressly reserved, to terminate any Participant's employment or relationship at any time for any reason, except as may be set forth in an employment agreement between the Participant and the Company or Subsidiary of the Company.

Modification of Award Agreement. This Agreement may be modified, amended, suspended, or terminated, and any terms or conditions may be waived, but only by a written instrument executed by the parties hereto.

Severability. Should any provision of this Agreement be held by a court of competent jurisdiction to be unenforceable or invalid for any reason, the remaining provisions of this Agreement shall not be affected by such holding and shall continue in full force in accordance with their terms.

Special Provisions Relating to Section 409A of the Code. This Award, in form and/or operation, is not intended to constitute "deferred compensation" within the meaning of section 409A of the Code and therefore, the Award is intended to be exempt from the requirements applicable to deferred compensation under section 409A of the Code and the regulations thereunder.

(i) **Modifications required to maintaining Award's exempt status under Section 409A of the Code**. To the extent necessary and permitted under Section 409A of the Code, the Company is authorized to amend this Award Agreement or to substitute this Award with another Award of comparable economic value so that the Award as modified or substituted, remains exempt from the requirements applicable to deferred compensation under Section 409A of the Code and (ii) the Committee shall take no action otherwise permitted under the Plan or this Award Agreement to the extent such action shall cause the Award to be treated as deferred compensation within the meaning of Section 409A of the Code. The Committee, in its sole discretion, shall determine to what extent if any, this Award Agreement shall be required to be so modified or substituted. Notwithstanding any provision to the contrary, such modification or substitution shall be made without prior notice to or consent of Participant.

(ii) **Modifications required if Award considered deferred compensation**. If the Committee determines that this Award, in form or operation, constitutes deferred compensation under Section 409A of the Code, then (i) to the extent necessary, the Company is authorized to modify this Award Agreement or to substitute this Award with another Award of comparable economic value so that the Award as modified or substituted, complies with the requirements applicable to deferred compensation under Section 409A of the Code, and (ii) the Committee shall take no action otherwise permitted under the Plan or the Award Agreement to the extent such action shall cause the Award to no longer comply with the requirements applicable to deferred compensation under Section 409A of the Code. The Committee, in its sole discretion, shall determine to what extent if any, this Award Agreement shall be required to be so modified or substituted. Notwithstanding any provision to the contrary, such modification or substitution shall be made without prior notice to or consent of the Participant.

Governing Law. The validity, interpretation, construction and performance of this Award Agreement shall be governed by the laws of the Missouri without giving effect to the conflicts of laws principles thereof.

IN WITNESS WHEREOF, the parties hereto have executed this Award Agreement as of the date indicated below.

Centene Corporation

Accepted: _____

Dated: _____

Exhibit 12.1

Centene Corporation
Computation of ratio of earnings to fixed charges
($ in millions)

	Year Ended December 31,				
	2016	**2015**	**2014**	**2013**	**2012**
Earnings:					
Pre-tax earnings from continuing operations	$ 1,157	$ 697	$ 457	$ 269	$ 123
Addback:					
Fixed charges	262	65	50	37	29
Add (Subtract):					
Noncontrolling interest	1	(2)	7	(1)	13
Interest capitalized	—	—	—	—	—
Total earnings	$ 1,420	$ 760	$ 514	$ 305	$ 165
Fixed Charges:					
Interest expensed and capitalized	$ 217	$ 43	$ 35	$ 27	$ 20
Interest component of rental payments (1)	45	22	15	10	9
Total fixed charges	$ 262	$ 65	$ 50	$ 37	$ 29
Ratio of earnings to fixed charges	5.4	11.7	10.3	8.2	5.7

(1) Estimated at 33% of rental expense as a reasonable approximation of the interest factor.

Exhibit 21

List of Subsidiaries

Absolute Total Care, Inc., a South Carolina corporation
AcariaHealth Pharmacy #11, Inc., a Texas corporation
AcariaHealth Pharmacy #12, Inc., a New York corporation
AcariaHealth Pharmacy #13, Inc., a California corporation
AcariaHealth Pharmacy #14, Inc., a California corporation
AcariaHealth Pharmacy, Inc., a California corporation
AcariaHealth, Inc., a Delaware corporation
Access Health Solutions, LLC, a Florida LLC
Agate Resources, Inc., an Oregon corporation
AHA Administrative Services, LLC, an Alabama LLC
Ambetter of Magnolia, Inc., a Mississippi corporation
Ambetter of Peach State Inc., a Georgia corporation
ANJ, LLC, a Texas LLC
Bankers Reserve Life Insurance Company of Wisconsin, a Wisconsin corporation
Bridgeway Health Solutions of Arizona, Inc., an Arizona corporation
Buckeye Community Health Plan, Inc., an Ohio corporation
California Health and Wellness Plan, a California corporation
Cantina Laredo Clayton, LP, a Delaware limited partnership
Casenet S.R.O., a Czech Republic S.R.O.
Casenet, LLC, a Delaware LLC
Catalina Behavioral Health Services, Inc., an Arizona corporation
CBHSP Arizona, Inc., an Arizona corporation
Celtic Group, Inc., a Delaware corporation
Celtic Insurance Company, an Illinois corporation
CeltiCare Health Plan of Massachusetts, Inc., a Massachusetts corporation
Cenpatico Behavioral Health of Arizona, LLC, an Arizona LLC
Cenpatico Behavioral Health, LLC, a California LLC
Cenpatico of Arizona Inc., an Arizona corporation
Cenpatico of Louisiana, Inc., a Louisiana corporation
Centene Center II, LLC, a Delaware LLC
Centene Center, LLC, a Delaware LLC
Centene Company of Texas, LP, a Texas limited partnership
Centene Corporation, a Delaware corporation
Centene Management Company, LLC, a Wisconsin LLC
Centene UK Limited, an English and Welsh private company
Centurion Group, Inc., a Delaware corporation
Centurion of Florida, LLC, a Florida LLC
Centurion of Minnesota, LLC, a Minnesota LLC
Centurion of Mississippi, LLC, a Mississippi LLC
Centurion of Tennessee, LLC, a Tennessee LLC
Centurion of Vermont, LLC, a Vermont LLC
Centurion, LLC, a Delaware LLC
Clayton Property Investment, LLC, a Delaware LLC
CMC Hanley, LLC, a Missouri LLC
CMC Real Estate Company, LLC, a Delaware LLC
Comfort Hospice of Missouri, LLC, a Michigan LLC

Comfort Hospice of Texas, LLC, a Michigan LLC
ComfortBrook Hospice, LLC, an Ohio LLC
Coordinated Care Corporation, an Indiana corporation
Coordinated Care of Washington, Inc., a Washington corporation
Country Style Health Care, LLC, a Texas LLC
Drummonds Medical Limited, an English and Welsh private company
Envolve Captive Insurance Company, Inc., a South Carolina corporation
Envolve Dental, Inc., a Delaware corporation
Envolve Dental of Florida, Inc., a Florida corporation
Envolve Dental of Texas, Inc., a Texas corporation
Envolve Holdings, Inc., a Delaware corporation
Envolve, Inc., a Delaware corporation
Envolve - New York, Inc., a New York corporation
Envolve PeopleCare, Inc., a Delaware corporation
Envolve Pharmacy Solutions, Inc., a Delaware corporation
Envolve Total Vision, Inc., a Delaware corporation
Envolve Vision Benefits, Inc., a Delaware corporation
Envolve Vision, Inc, a Delaware corporation
Envolve Vision of Florida, Inc, a Florida corporation
Envolve Vision of Texas, Inc., a Texas corporation
Family Nurse Care II, LLC, a Michigan LLC
Family Nurse Care of Ohio, LLC, a Michigan LLC
Family Nurse Care, LLC, a Michigan LLC
FH Assurance Company, a Cayman Islands corporation
FH Surgery Centers Inc., a California corporation
FH Surgery Limited, Inc., a California corporation
Fidelis SecureCare of Michigan, Inc., a Michigan corporation
Foundation Health Facilities, Inc., a California corporation
GPT Acquisition, LLC, a Delaware LLC
Grace Hospice of Austin, LLC, a Michigan LLC
Grace Hospice of Colorado, LLC, a Michigan LLC
Grace Hospice of Grand Rapids, LLC, a Michigan LLC
Grace Hospice of Indiana, LLC, a Michigan LLC
Grace Hospice of San Antonio, LLC, a Michigan LLC
Grace Hospice of Virginia, LLC, a Michigan LLC
Grace Hospice of Wisconsin, LLC, a Michigan LLC
Granite State Health Plan, Inc., a New Hampshire corporation
Greater Sacramento Surgery Center LP, a California limited partnership
Hallmark Life Insurance Company, an Arizona corporation
Health Care Enterprises, LLC, a Delaware LLC
Health Net Access, Inc., an Arizona corporation
Health Net Community Solutions, Inc., a California corporation
Health Net Community Solutions of Arizona, Inc., an Arizona corporation
Health Net Federal Services, LLC, a Delaware LLC
Health Net Health Plan of Oregon, Inc., an Oregon corporation
Health Net, Inc., a Delaware corporation
Health Net Life Insurance Company, a California corporation
Health Net Life Reinsurance Company, a Cayman Islands corporation
Health Net of Arizona Administrative Services, Inc., an Arizona corporation
Health Net of Arizona, Inc., an Arizona corporation

Health Net of California, Inc., a California corporation
Health Net of California Real Estate Holdings, Inc., a California corporation
Health Net of Pennsylvania, LLC, a Pennsylvania LLC
Health Net of the Northeast, LLC, a Delaware LLC
Health Net One Payment Services, Inc., a Delaware corporation
Health Net Pharmaceutical Services, a California corporation
Health Net Preferred Providers, LLC, a Delaware LLC
Health Net Services Inc., a Delaware corporation
Health Net Veterans, LLC, a Delaware LLC
Health Plan Real Estate Holdings, Inc., a Missouri corporation
Healthy Louisiana Holdings, LLC, a Delaware LLC
Healthy Missouri Holdings, Inc., a Missouri corporation
Heritage Home Hospice, LLC, a Michigan LLC
Home State Health Plan, Inc., a Missouri corporation
HomeScripts.com, LLC, a Michigan LLC
Hospice DME Company, LLC, a Michigan LLC
HSI Advantage Health Holdings, Inc., a Delaware corporation
IAH of Florida, LLC, a Florida LLC
IlliniCare Health Plan, Inc., an Illinois corporation
Independent Professional Services, LLC, an Oregon LLC
Integrated Mental Health Services, a Texas corporation
Integrated Pharmacy Systems, Inc., a Pennsylvania corporation
Kentucky Spirit Health Plan, Inc., a Kentucky corporation
Lane Individual Practice Association, Inc., an Oregon corporation
LBB Industries, Inc., a Texas corporation
LifeShare Management Group, LLC, a New Hampshire LLC
LiveHealthier, Inc., a Delaware corporation
Louisiana Healthcare Connections, Inc., a Louisiana corporation
LSM Holdco, Inc., a Delaware corporation
Magnolia Health Plan, Inc., a Mississippi corporation
Managed Health Network, a California corporation
Managed Health Network, LLC, a California LLC
Managed Health Services Insurance Corporation, a Wisconsin corporation
Massachusetts Partnership of Correctional Healthcare, LLC, a Massachusetts LLC
MHN Global Services, Inc., a Delaware corporation
MHN Government Services LLC, a Delaware LLC
MHN Services IPA, Inc., a New York corporation
MHN Government Services-Belgium, Inc., a Delaware corporation
MHN Government Services-Djibouti, Inc., a Delaware corporation
MHN Government Services-Germany, Inc., a Delaware corporation
MHN Government Services-Guam, Inc., a Delaware corporation
MHN Government Services-International, Inc., a Delaware corporation
MHN Government Services-Italy, Inc., a Delaware corporation
MHN Government Services-Japan, Inc., a Delaware corporation
MHN Government Services-Puerto Rico, Inc., a Delaware corporation
MHN Government Services-Turkey, Inc., a Delaware corporation
MHN Government Services-United Kingdom, Inc., a Delaware corporation
MHN Services, LLC, a California LLC
MHS Consulting International, Inc., a Delaware corporation
MHS Travel & Charter, Inc., a Wisconsin corporation

National Pharmacy Services Inc., a Delaware corporation
Nebraska Total Care, Inc., a Nebraska corporation
Network Providers, LLC, a Delaware corporation
North Florida Health Services, Inc., a Florida corporation
Novasys Health, Inc., a Delaware corporation
Peach State Health Plan, Inc., a Georgia corporation
Pennsylvania Health Care Plan, Inc., a Pennsylvania corporation
Phoenix Home Health Care, LLC, a Delaware LLC
Pinnacle Home Care, LLC, a Texas LLC
Pinnacle Senior Care of Indiana, LLC, a Michigan LLC
Pinnacle Senior Care of Kalamazoo, LLC, a Michigan LLC
Pinnacle Senior Care of Missouri, LLC, a Michigan LLC
Pinnacle Senior Care of Wisconsin, LLC, a Wisconsin LLC
PrimeroSalud, S.L., a Spanish Sociedad Limitada
QualMed, Inc., a Delaware corporation
QualMed Plans for Health of Colorado, Inc., a Colorado corporation
QualMed Plans for Health of Pennsylvania, Inc., a Pennsylvania corporation
QualMed Plans for Health of Western Pennsylvania, Inc., a Pennsylvania corporation
R&C Healthcare, LLC, a Texas LLC
Rapid Respiratory Services, LLC, a Delaware LLC
RMED, LLC, a Florida LLC
RX Direct, Inc., a Texas corporation
Seniorcorps Penninsula, LLC, a Virginia LLC
Specialty Therapeutic Care Holdings, LLC, a Delaware LLC
Specialty Therapeutic Care, GP, LLC, a Texas LLC
Specialty Therapeutic Care, LP, a Texas limited partnership
Sunflower State Health Plan, Inc., a Kansas corporation
Sunshine Health Holding, LLC, a Florida LLC
Sunshine State Health Plan, Inc., a Florida corporation
Superior HealthPlan, Inc., a Texas corporation
The Practice (Group) Limited, an English and Welsh private company
The Practice Health Division Limited , an English and Welsh private company
The Practice Properties Limited, an English and Welsh private company
The Practice Services Limited, an English and Welsh private company
Traditional Home Health Services, LLC, a Texas LLC
Trillium Community Health Plan, Inc., an Oregon corporation
U.S. Medical Management Holdings, Inc., a Delaware corporation
U.S. Medical Management, LLC, a Delaware LLC
U.S. Script IPA, LLC, a New York LLC
USMM Accountable Care Network, LLC, a Delaware LLC
USMM Accountable Care Partners, LLC, a Delaware LLC
USMM Accountable Care Solutions, LLC, a Delaware LLC

Exhibit 23

Consent of Independent Registered Public Accounting Firm

The Board of Directors
Centene Corporation:

We consent to the incorporation by reference in the registration statements on Form S-8 (Nos. 333-210376, 333-197737, 333-180976, 333-108467, 333-90976, and 333-83190) and in the registration statements on Form S-3 (Nos. 333-197213, 333-196037, 333-193205, 333-187741, and 333-209252) of Centene Corporation of our reports, dated February 20, 2017, with respect to the consolidated balance sheets of Centene Corporation and subsidiaries as of December 31, 2016 and 2015, and the related consolidated statements of operations, comprehensive earnings, stockholders' equity, and cash flows for each of the years in the three-year period ended December 31, 2016, and the effectiveness of internal control over financial reporting as of December 31, 2016, which reports appear in the December 31, 2016 annual report on Form 10-K of Centene Corporation.

/s/ KPMG LLP

St. Louis, Missouri
February 20, 2017

EXHIBIT 31.1

CERTIFICATION

I, Michael F. Neidorff, certify that:

1. I have reviewed this Annual Report on Form 10-K of Centene Corporation;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a. Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b. Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   c. Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d. Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   a. All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b. Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: February 21, 2017

/s/ MICHAEL F. NEIDORFF

Chairman, President and Chief Executive Officer
(principal executive officer)

EXHIBIT 31.2

CERTIFICATION

I, Jeffrey A. Schwaneke, certify that:

1. I have reviewed this Annual Report on Form 10-K of Centene Corporation;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a. Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b. Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   c. Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d. Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting;

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   a. All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b. Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: February 21, 2017

/s/ JEFFREY A. SCHWANEKE

Executive Vice President and Chief Financial Officer
(principal financial officer)

EXHIBIT 32.1

CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Annual Report on Form 10-K of Centene Corporation (the Company) for the period ended December 31, 2016, as filed with the Securities and Exchange Commission on the date hereof (the Report), the undersigned, Michael F. Neidorff, Chairman, President and Chief Executive Officer of the Company, hereby certifies, pursuant to 18 U.S.C. Section 1350, that:

(1) the Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: February 21, 2017

/s/ MICHAEL F. NEIDORFF

Chairman, President and Chief Executive Officer
(principal executive officer)

EXHIBIT 32.2

CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Annual Report on Form 10-K of Centene Corporation (the Company) for the period ended December 31, 2016, as filed with the Securities and Exchange Commission on the date hereof (the Report), the undersigned, Jeffrey A. Schwaneke, Executive Vice President and Chief Financial Officer of the Company, hereby certifies, pursuant to 18 U.S.C. Section 1350, that:

(1) the Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: February 21, 2017

/s/ JEFFREY A. SCHWANEKE

Executive Vice President and Chief Financial Officer
(principal financial officer)

2.5 Qualifications

2.5 QUALIFICATIONS

A description of the bidder's qualifications and experience providing the requested or similar service shall be submitted with the Technical Proposal. The bidder must be an established firm recognized for its capacity to perform. The bidder must have sufficient personnel to meet the deadlines specified in the bid event.

SUNFLOWER DEMONSTRATED SUCCESS

Sunflower Health Plan (Sunflower) has served Medicaid members in Kansas as a participant in the KanCare program since 2013. We work closely with KDHE in a trusted, established relationship to support our members. Our current success is demonstrated by:

- Our local approach and Kansas healthcare expertise
- Our established provider network and value-based purchasing strategies
- Our integrated, coordinated commitment to whole-health
- Our qualifications and experience providing requested services
- Our ability to leverage national best practices
- Our quality, network, clinical, and social performance results

Sunflower is excited for the opportunity to continue as a trusted partner to KDHE and actively engage in the KanCare 2.0 goal to help Kansans achieve healthier, more independent lives by providing services and supports for Social Determinants of Health and Independence, in addition to traditional Medicaid and CHIP benefits. Below, we describe how Sunflower is qualified to meet the RFP aims detailed in section 5.1:

- Improve integration and coordination of care for HCBS and other vulnerable populations
- Utilize the existing service coordination and case management structures at the local level
- Contract with local providers for outcomes based coordination services
- Measurably improve healthcare outcomes for members
- Promote wellness and healthy lifestyles
- Lower the overall cost of healthcare

POSITIONED FOR CONTINUED SUCCESS

Commitment to Kansas

Through a local operations approach, Sunflower has served as one of three MCOs in the KanCare program since January 2013. For the past five years, Sunflower has been a trusted partner to KDHE in the transition of enrollees into managed care. We continue to build upon our commitment to serving our members in the KanCare program, improving access and member engagement through innovative collaborations with community partners and finding new ways to align with our provider partners.

KEY SUNFLOWER LEADERSHIP, EXPERIENCED WORKING WITH KDHE

Our President & CEO, Chris Coffey, is accessible to State officials and engages in regular, open dialogue to promote effective management of the KanCare program. At the monthly Joint MCO and 1:1 (KDHE : Health Plan) meetings, Sunflower submits agenda items and delivers background information that is both timely and essential to the successful operation of KanCare. Sunflower presents health plan updates and responds to stakeholder concerns at the quarterly hearings of the Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight. As the most tenured CEO amongst the MCOs in Kansas, Chris has cultivated relationships with officials from the Kansas Department of Health & Environment and the Kansas Department for Aging & Disability Services to the benefit of KanCare beneficiaries and the Kansas taxpayers.

Our Chief Medical Director, Dr. Katherine Friedebach, is a Board-Certified Family Physician who has served as the Chief Medical Officer at Sunflower for nearly five years. As the CMO, Dr. Friedebach is responsible for clinical oversight of all health plan activities, including utilization management, quality improvement, clinical practice guidelines and clinical policies and procedures. Dr. Friedebach also serves as the health plan's liaison to the Kansas clinical community, including our network providers and clinical leaders at KDHE. Through her work, Dr. Friedebach ensures that our Members receive all covered services in an appropriate manner supporting initiatives that focus on the delivery of the right services, at the right time, and in the right setting.

Our Director of LTSS, Stephanie Rasmussen, brings more than 28 years of experience working with members receiving LTSS, primarily with persons with I/DD. Stephanie currently serves on the Centene LTSS Policy Committee making sure that corporate policies meet the needs of persons in LTSS in Kansas, and leads the Sunflower LTSS Advisory Committee. She has been key in the participation of several initiatives including the Long Term Quality Alliance study of integrated care management for persons in MLTSS, a related video they produced, and providing presentations at the annual NASUAD conference on employment and Person Centered Planning for persons in MLTSS. Stephanie also recently participated in a targeted workgroup facilitated by the National Association of Dual Diagnosis to recommend best practice supports for persons with I/DD and mental illness. Stephanie serves on the Alumni Board of the Kansas Association for Youth, a leadership program for junior high and high school students sponsored by the Kansas State High School Activities Association.

Sunflower's reputation as a trusted partner to KDHE will be instrumental as we move to the Integrated Service Coordination Model. Through dynamic feedback, we will share expertise on community healthcare and population health trends and provide feedback on policy changes at the State level and communicate potential impact to members and providers. Working collaboratively to reduce administrative burdens for providers, partnering to bend the cost curve through data-informed innovation and high quality care, Sunflower is committed to Kansas and will continue to go beyond a mere contractual relationship to working collaboratively with KDHE to meet State goals.

Local Approach- Kansans Serving Kansans

Our local and dedicated approach is the driving force behind Sunflower's success in KanCare 2.0. Sunflower is headquartered in Lenexa, Kansas, with additional office locations in Topeka and Wichita. Our local approach enables us to:

- Provide accessible, high quality, and culturally sensitive healthcare services for our members
- Form strong, collaborative relationships with the provider community
- Be responsive to KDHE and other agencies while sharing expertise best practices in State policy design from affiliate markets
- Create flexibility in our operating model to meet the unique needs of Kansas

To further support the goals of KanCare 2.0, Sunflower is implementing its Social Determinants of Health and Independence (SDOHI) Center of Excellence (COE) Team comprised of the Director of SDOHI, Transitions Specialists, Housing Specialists and Employment Supports Specialists and Member Advocates. These Specialists will promote community integration and independence and provide technical assistance and supports for our members, and our members' assigned Service Coordinator (SC)/Community Service Coordinator (CSC) and integrated care team (IC Team).

Sunflower was presented with the 2016 DisAbility Champion Award by the Greater Kansas City Business Leadership Network for our demonstrated commitment to creating and fostering a culture that includes employment of people of all abilities.

Established Team with Kansas-specific Expertise

Sunflower brings an established team that is currently supporting the KanCare program. This team is made up of over 400 staff members, living across the state of Kansas. The Kansas-specific knowledge, experience serving KanCare populations, local experience and tenure of our staff are what set Sunflower apart from our competitors. Under current leadership, Sunflower Health Plan's turnover has been reduced by nearly half resulting in a total turnover of less than 11% with the majority of Sunflower's leadership being in their role, if not since inception of KanCare, shortly afterwards. We acknowledge that our ongoing success is directly attributed to our ability to attract and retain talented, high-performing staff members. Successful programs such as our enriched employee benefit program, cross-training, succession planning, and job family development motivate our employees and encourage the development of innovative ideas and collegial relationships – both of which are vital in establishing a culture where our delivery of quality-focused care is maximized. We are particularly proud of the tenure, experience and low turnover rates of our Integrated Care Team members, which was well below industry average at 9.12% in 2017.

Sunflower believes that the strongest teams are diverse teams and we actively recruit team members who are representative of the communities we serve. This includes employment of individuals with disabilities in a variety of capacities across the organization. Sunflower has already achieved the State's goals for hiring individuals with disabilities. According to employee

self-reported information, 5.8% of our current, Kansas-based staff are living with disabilities, exceeding the State's goal of 5% by the end of the first year of KanCare 2.0 operations.

Our local leadership actively participates in their communities by giving back through participation in local public schools, non-profit Boards, charitable contributions, and advisory boards. This includes groups such as the American Diabetes Association, Kansas Association for Youth, Kansas Interagency Council for Homelessness, Mother & Child Health Coalition and the Kansas Public Health Association. Sunflower staff participate in community health fairs, food drives and volunteer their time for organizations such as: The American Heart Association, The Ronald McDonald House, Special Olympics and Project Eagle (winter clothing drive).

RFP AIM

Contract with local providers for outcomes based service coordination services

Established Provider Network and VBP Strategies

Sunflower's existing provider network and operational processes are established and prepared to seamlessly support the KanCare 2.0 Contract from day one. Our provider network includes more than 23,000 providers with more than 3,400 PCPs, 7,300 specialists and 225 hospitals. Sunflower is committed to a continued partnership with KDHE to improve access, quality of care, and cost effectiveness within the KanCare 2.0 program. Sunflower's Network Development Plan employs innovative approaches to contracting, payment, and incentives.

Over the past five years, Sunflower has designed and implemented a robust portfolio of meaningful Value Based Purchasing (VBP) Strategies that support KDHE's objectives and align with provider capabilities. As of November 2017, 48% of Sunflower's membership was assigned to a provider participating in a VBP arrangement. We will build upon our existing portfolio of innovative, successful VBP arrangements to further empower our provider community to impact outcomes for the KanCare 2.0 population.

Leveraging Established Provider Partnerships to Increase Capacity and Quality

As an incumbent, Sunflower has developed relationships over the past five years with many of the community agencies and advocacy groups that help create our service coordination model. Our provider partnerships and collaborations have led to improved access and quality health outcomes for our members. We realize that our providers are at the forefront of improving our members' health and well-being. In addition to our provider association partnerships, such as Kansas Association for the Medically Underserved (KAMU), HCBS provider associations, Kansas Health Care Association (KHCA), Kansas Medical Society, Disability Rights Center, LeadingAge Kansas, and Kansas Hospital Association (KHA), Sunflower has sound provider partnerships that improve the quality of care provided to members. ***Table 2.5 Strategic Provider Partnerships*** below illustrates some of our strategic provider partnerships designed to increase access, support integration and improve quality in service delivery.

Table 2.5 Strategic Provider Partnerships

Providers	Partnering with the Provider
Association of Community Mental Health Centers of Kansas	Sunflower has an arrangement with the association to provide supplementary payments to CMHCs for quality metrics attained throughout the year. The five metrics used in this VBP agreement will improve the coordination of services for Sunflower members and allow the CMHCs to draw bonus payments from Sunflower. Additionally, Sunflower committed one FTE for onsite support at two CMHCs to assist staff and clients/families, which is also an asset to helping these CMHCs exceed the metrics that are part of the new bonus arrangement.
Center for Counseling and Consultation (The Center) and the Pawnee County Public Health Department	We arranged for a 3-year grant from the Centene Foundation for Quality Healthcare to employ technology solutions to raise awareness, utilization and health literacy for Behavioral Health services across four counties.
GraceMed Health and Dental Clinic	Sunflower supported GraceMed and other providers in the Wichita area to build the capacity to serve patients with disabilities who needed sedation during their dental visits. Additionally, Sunflower invested $300,000 in a community collaborative aimed at improving access to services in what had been labeled a healthcare desert area in south central Kansas. GraceMed health clinic partnered with Via Christi Health and the Greater Wichita YMCA to establish a "hub and spoke" clinic model of care for addressing obesity and diabetes, mental illness and oral health. Project Oasis called for a centralized 'hub' clinic and four 'spokes' – four new satellite school-based clinics. Sunflower's involvement helped the partners bring much-needed services to a community working to eliminate barriers to services while improving the health and wellbeing of our KanCare members.
HealthCore Clinic	Collaboration with HealthCore Clinic to conduct member outreach on increasing immunization rates, conducting health screenings at community events and office sites to provide members with answers to their questions about benefits or access to social support services.
Topeka Independent Living Resource Center (TILRC) and Minds Matter	Partnership to sustain transitional housing supports after Money Follows the Person (MFP) ended in June 2017. The organizations qualify for incentive payments for facilitating successful home placements after a member's stay in a nursing facility.
Indian Health Services	Participation in health fairs held by Indian Health Services as well as health strategy meetings to explore other strategic opportunities.
Sedgwick and Johnson County Health Departments	Agreement with these county health departments to close care gaps. These health departments outreach to their patients (Sunflower's members) who need preventive services to assist with scheduling to receive the service(s) through their local health department.
ExamOne World Wide, Inc.	Arrangement with Exam*One*, for Quest to conduct outreach to targeted members to schedule and conduct home visits to complete the necessary lab work.
I/DD Targeted Case Management (TCM) Providers	Collaboration with six TCM providers and the other Medicaid MCOs to develop a proposal to the State for reducing/eliminating the duplication between the I/DD TCM and Care Coordinator Roles.

Providers	Partnering with the Provider
County Health Departments and Maternal & Child Health Initiatives	Sunflower provided funding to enhance and support the continued implementation of a maternal and child health educational program called Becoming a Mom (BaM)/Comenzando bien, with curriculum in English and Spanish from the March of Dimes. BaM in Kansas is coordinated through KDHE's Bureau of Family Health and administered at the local level through approximately a dozen sites statewide, including County Health Departments. Sunflower aims to engage pregnant women early for preventive services with their obstetrician and promote collaboration among community providers.

RFP AIM

Improve integration and coordination of care for HCBS and other vulnerable populations

Positioned to Support Integration and Coordination

Sunflower has the experience, infrastructure, and capabilities to effectively support integration and coordination, including our Integrated Service Coordination (ISC) model framework grounded in whole-person health; an Integrated Care Management (ICM) approach supported by experienced staff; comprehensive provider, staff and community training; newly designed programs to support delivery system integration; and technology to support information sharing across the continuum of care.

Our Commitment to Whole Person Health. Our ISC framework fosters a whole person health focus. Through this whole person health focus, we look beyond the presenting concern to work with the individual in their environment, including addressing the needs of families and communities. With this as our guiding model, our culture and organizational systems are primed to work collaboratively with KDHE to increase the integration of behavioral and physical health.

Sunflower has been successfully working with our PCPs and BH providers to actively promote coordination and communication across these two disciplines since 2013. This integration is operationalized through our integrated care planning process, led by SCs who facilitate sharing of information through appropriate release of information and timely exchange of clinical notes and information as appropriate. We have also designed our technology solutions to share an integrated Plan of Service/Person-Centered Service Plan (PoS/PCSP).

Sunflower currently has 19 Community Health Workers who have recently received CHW certification and are trained in engagement skills, trauma-informed care, Person Centered Thinking and cultural, disability and poverty sensitivity. Their new skillset helps enhance integration within the health plan and across external organizations with the goals of addressing SDOHI, increasing health literacy, giving members more confidence in their healthcare system, and increasing preventive care visits/reducing ED utilization.

Innovative Strategies to Promote Integration. As we move into KanCare 2.0, our activities will directly impact network design, practice transformation, and evolution of the delivery system. Our VBP strategies, including bi-directional integration, and our Practice Transformation Program are the foundation for our movement toward more innovative network designs and structures to promote integration. Sunflower strategies further described throughout our response include:

- P4P for HEDIS measures in all 26 CMHCs, impacting more than 20,000 members across the state
- Co-location arrangement with Horizons Mental Health in Hutchinson, which has a BH professional embedded in the local primary care clinic
- Community Health Workers assigned to two hospitals and two CMHCs to coordinate care and address members SDOHI
- Sunflower SDOHI Center of Excellence (COE) Team comprised of the Director of SDOHI, Director of LTSS, Transition of Care Coordinator, Housing Specialists and Employment Supports Specialists and Member Advocates. These Specialists promote community integration and independence and provide technical assistance and supports to the member, the member's assigned SCs/CSCs and Integrated Care Team
- Initiation of a workgroup with the Association of CMHCs to help inform our design of an integrated collaborative care model
- Increasing BH Screenings in Home Settings through our affiliate USMM
- Enhanced provider, clinical and support staff training to include education on the integrated model of care and the importance of early identification and assessment of potential co-existing PH and BH needs
- Our Foster Care Center of Excellence focusing on the whole child and bringing our skills in trauma-informed care, care coordination and integration to address PH, BH and social factors, which leads to improved care and outcomes

Stakeholder Engagement

Sunflower is committed to transforming the health of the communities we serve and being a trusted partner for providers, families, and communities. As an experienced Kansas MCO we know that achieving this transformation requires broad stakeholder engagement that includes individual members and families, public advocates, state and local agencies, professional societies, providers, and community organizations. Sunflower consistently works to engage all of these stakeholders, and we do this by being transparent, regularly soliciting input, offering multiple channels for communication with no wrong door, closing the feedback loop, and engaging stakeholders in our operations and program design and development through participation in quality committees and advisory committees.

QUALIFICATIONS AND EXPERIENCE PROVIDING SIMILAR SERVICE

Sunflower has provided healthcare services for our members including TANF, CHIP, Pregnant Women, ABD (dual and Medicaid only), LTSS, Foster Care, and Disabled Children since 2013,

and HCBS for our I/DD population since 2014. We currently serve approximately 130,000 members within the KanCare Program.

LTSS Experience

With a thorough understanding of the system of care for our members with complex care needs, Sunflower provides person-centered care management for our members receiving LTSS including the elderly, physically disabled and persons with I/DD; leveraging existing community relationships and providing our members enhanced community connections to help them meet their goals. We understand the importance of engaging advocates and providers in ongoing systems transformation, and fully realize that our success is dependent on our keen ability to support our members to pave their own path, including in assessing need, developing plans, and defining quality.

Sunflower also leverages Centene's corporate LTSS Product Team which provides program-wide, infrastructural support to all Centene health plans which serve LTSS participants; collectively, this team possesses decades of combined experience serving LTSS populations. Sunflower and our affiliate health plans support 233,000 members receiving LTSS through MLTSS and Medicare-Medicaid Plans (MMPs) across 8 states, the largest membership number by an MCO. As of October 2017, Sunflower supports 46% of the I/DD HCBS population and 67% of persons with I/DD that are in an ICF/ID facility in Kansas. Centene actively participates in national initiatives around LTSS quality measurement. For example, Centene co-chaired the National Quality Forum Measure Application Partnership (MAP) Dual Eligible Beneficiaries Workgroup (which provides recommendations to CMS on quality and performance measures for dual eligibles, including for LTSS). Centene also has national partnerships with organizations such as the National Caregiver Alliance, National Council on Independent Living, and Leaders Engaged on Alzheimer's Disease ("LEAD Coalition").

Children with Complex Care Needs

Sunflower takes an active role in collaboration with Kansas' Department for Children and Families and the 2 Lead Agencies to improve its Foster Care outcomes. By participating in State workgroups, and sharing data with Foster Care Contractors, KVC and St. Francis, we develop trusted relationships with Foster Care entities statewide, and are a known resource for questions surrounding the Foster Care population.

100% of Sunflower's Foster Care Team is annually trained in Trauma-Informed Care, and as of 2017, 248 Sunflower network providers have been trained in Trauma Focused Cognitive Behavioral Therapy (TF-CBT).

Sunflower's PMUR program includes prescribing parameters to ensure members receive medications appropriately, such as the absence of a DSM-5 diagnosis, member claims for 4 or more psychotropic medications, 2 or more psychotropic medications in the same class, and the age of the child being prescribed the medications. Reviews are triggered by automated reports, care management, court orders, and/or external requests. The process includes information

gathering (clinical history and treatment records), psychiatrist review (desk review and peer-to-peer consult), and action steps (report to prescriber and 60- and 90-day follow-up). Since 2013, our PMUR program has shown a decrease in members in Foster Care taking psychotropic medications by 16%.

Sunflower also leverages Centene's Foster Care expertise for program-wide, infrastructural support to all Centene health plans serving members in Foster Care. Sunflower and our affiliate health plans support 135,000 children in Foster Care across 11 states, including three sole-source Foster Care contracts with Medicaid state agencies. Sunflower and our affiliate plans support roughly a third of the nearly 430,000 children in Foster Care programs nationwide.

National Expertise Informing Best Practices and Innovation

Sunflower's parent company, Centene, is a veteran leader in providing managed care services to and improving health outcomes for Medicaid and public sector populations, such as children and adults with complex/special needs and children/youth in Foster Care or receiving adoption assistance. Centene's core business is Medicaid and government sponsored healthcare programs, allowing us to bring a full compendium of Medicaid best practices to every new and existing market we serve. Centene is a trusted provider of government-sponsored healthcare in 29 states. Most relevant to Kansas, Centene affiliates serve over 5.8 million members in TANF, CHIP and Foster Care programs; 850,300 ABD members including LTSS; and over 22,000 members with I/DD. We have built and maintain partnerships with more than 332,000 providers (including BH and LTSS providers) and 2,700 hospitals (many of them academic institutions) nationwide.

Centene operates the largest Managed LTSS program in the country, with over 233,000 members receiving LTSS through MLTSS and Medicare-Medicaid Plans (MMPs) across 8 states. This includes approximately 178,000 HCBS members and 55,000 members living in institutions. In addition, Centene will begin operating a Managed LTSS program in Southwest Pennsylvania on January 1st with nearly 7,000 additional members.

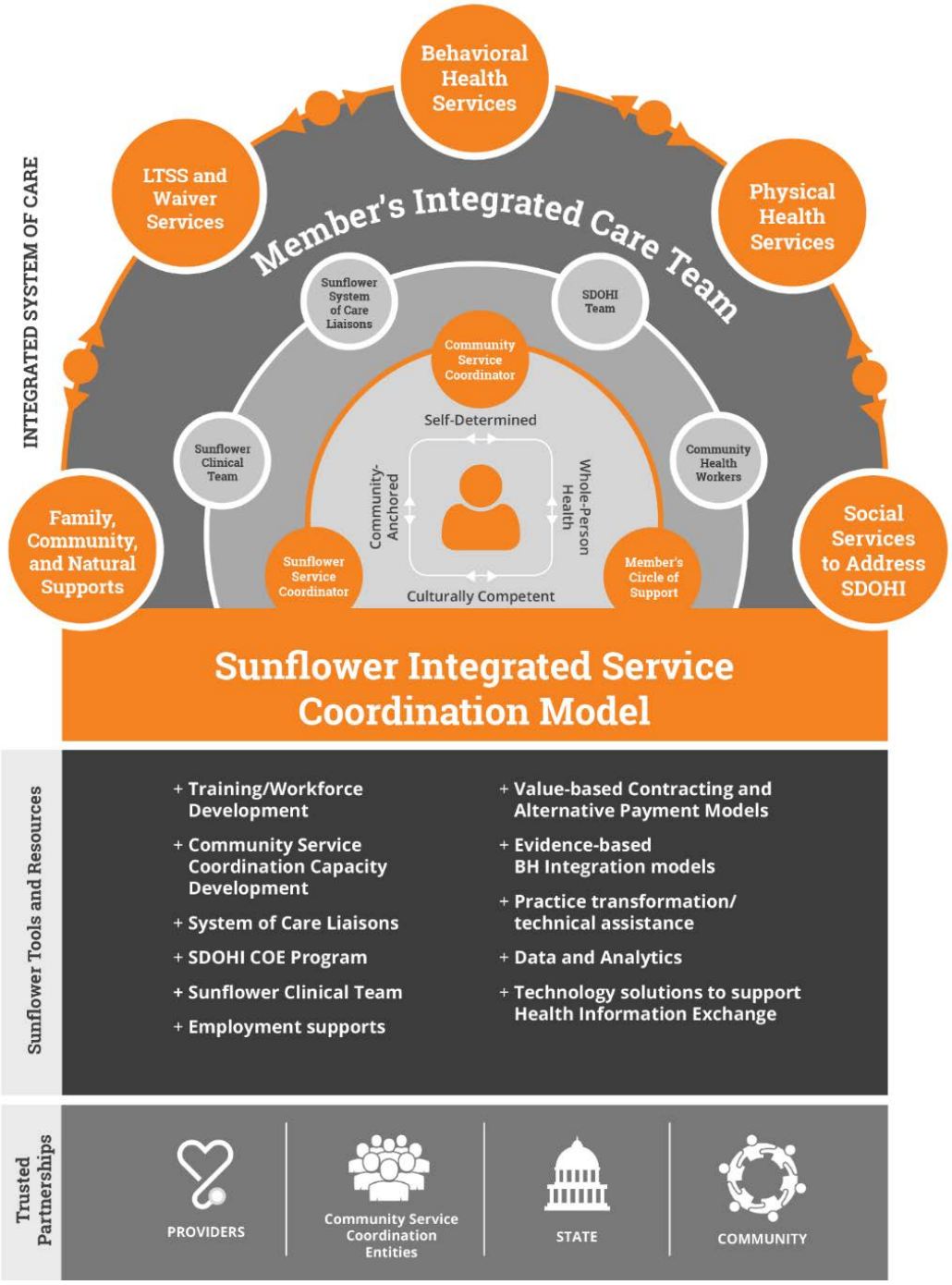
Centene is a national leader in serving high-needs children including children in Foster Care. We manage and coordinate care for almost 697,000 members in 14 states, including 581,300 SSI non-dual eligible/SSI children and 115,000 children and youth in Foster Care and adoption support in 8 states. Our high-needs children live with chronic conditions; functional or cognitive limitations; physical disabilities, I/DD, and brain injuries; serious emotional disturbance (SED); and potential trauma. There are currently only five sole-source, statewide managed care programs for Foster Care in the nation; Sunflower's affiliate health plans hold the sole-source contracts for four of them – Texas, Florida, Washington and Illinois (to go live July 2018). In addition, our affiliate health plan in Mississippi is the state health plan of choice for their fully integrated, statewide Foster Care managed care program.

Building upon this experience, we will continue our work building healthy communities through collaboration, innovation and the pursuit of excellence. As depicted in ***Figure 2.5 Integrated***

Model, our Integrated Service Coordination (ISC) Model is member-centric, grounded in continuous quality improvement (CQI) and supports the State's Hypotheses in:

- Expanding Service Coordination to include assisting Members with accessing affordable housing, food security, employment, and other Social Determinants of Health and Independence will increase independence and stability and improve health Outcomes.
- Increasing employment and independent living supports for Members with Behavioral Health needs, or who have intellectual, developmental or physical disabilities or traumatic brain injuries will increase independence and improve health Outcomes.
- Providing Service Coordination for all youth in Foster Care will decrease the number of placements, reduce psychotropic medication use, and improve health Outcomes for these youth.

Figure 2.5 Integrated Model



RFP AIM

Utilize the existing service coordination and case management structures at the local level

Our ISC model incorporates the evidence-based Integrated Care Management approach promoted by the Case Management Society of America. Founded on Continuous Quality Improvement, the program is designed to achieve the Quadruple Aim of improving the experience of care, improving the health of populations, reducing the per capita cost of healthcare, and improving the work life of our network providers and their staff. We accomplish this by treating the whole-person and integrating all PH, BH, LTSS, social and other services the member receives to create a system of care around that individual. Creating this integrated, community-anchored, culturally competent system, that is provided at the point of care whenever possible, allows us to effectively address not only the clinical needs of the member, but also the member's person-centered goals including social determinants of health and independence (SDOHI) such as transportation, housing, food, employment, and other non-clinical needs that have an impact on health outcomes and quality of life.

Sunflower also partners with several community based organizations, such as Heartland Regional Alcohol and Drug Assessment Center (Heartland RADAC) to reach hard to locate and difficult to engage members. Heartland RADAC utilizes a myriad of strategies and best practice to find and engage members who have chronic or high-risk SUD issues and assist these difficult to engage members with locating affordable housing, employment and recovery services.

COMMUNITY RELATIONS AND SOCIAL RESPONSIBILITY

At Sunflower, our staff value the communities we serve. We contribute to the betterment of Kansas through participation in events and causes that support Sunflower's mission to transform the health of the community one person at a time. With employees at the heart of our mission, they share the company's desire for a local presence by supporting charities throughout the year with their personal time and resources. These charities supported by Sunflower staff include the American Heart Association fundraisers, Christmas in October home improvement for the disabled, Harvesters food drives, Christmas Bureau, Ronald McDonald House home-cooked meals, Happy Bottoms diaper drive, Special Olympics event volunteering and team coaching, Giving the Basics toiletry drive, Suicide Prevention Coalition community event volunteering, United Way fundraisers, Parkinson's Foundation fundraisers, Arthritis Foundation fundraisers, among many others.

82% of Sunflower's workforce participated in the 2017 United Way campaign, with more than $50,000 of personal donations pledged to local charities across Kansas.

Sunflower believes that quality healthcare is best delivered locally, and this local approach enables us to provide accessible, high quality and culturally sensitive services to our members. Further, we engage in meaningful partnerships with organizations across Kansas that jointly

support our purpose to transform the health of the community. Sunflower appreciates the diversity across Kansas in terms of our population density as well as race and ethnicity. Between frontier and urban areas, we are keenly familiar with the varying environments, including the challenges and barriers, experienced by Kansans across the different regions and within different ethnic or social communities because we live there, too. Sunflower's leadership team frequently studies the population characteristics of our state to assess the indicators that help us address location- and community-specific Social Determinants of Health and Independence, including access to healthcare, education, employment, and housing. Sunflower places great emphasis on understanding the public health system and how Social Determinants of Health and Independence play a role in the health of a specific population.

Sunflower spends time with its Members outside of our service coordination activities, for instance, hosting Member Appreciation Day events at community health clinics, holding health-focused events at our Adopt-a-Schools, and inviting members to their local Farmers Market for product vouchers. These events allow members to become familiar with their Sunflower and KanCare resources while allowing Sunflower staff to listen and learn more about the needs of the community during one-on-one conversations with attendees. Each year, Sunflower attends, sponsors or helps facilitate approximately 200 community and provider events delivering education and outreach services to KanCare stakeholders. The following lists are not all inclusive and offer a few examples of Sunflower's participation in each event category:

Health Fairs and Youth Events

Kidzfest (El Dorado), Safe Kids Kansas Day at the Topeka Zoo, Franklin Elementary Health Fair, Back-to-School Fairs (multiple locations statewide), Armourdale Health Fair, Community Baby Showers statewide, Capital City Wellness, Victory Electric Health Fair (Dodge City), Kansas Youth Advisory Council, Latino Health for All Coalition health fair, Head Start

Provider Conferences

InterHab, Kansas Association for the Medically Underserved, LeadingAge Kansas, Kansas Pharmacists Association, Kansas Hospital Association, Kansas Medical Society, Kansas Health Care Association, Kansas Academy of Family Physicians, Association of Community Mental Health Centers of Kansas, Summit on Maternal and Infant Health, multiple events of Independent Living Resource Centers, Kansas Medical Society, Kansas Chapter of the American Academy of Pediatrics, Oral Health Kansas, Kansas Adult Care Executives, Kansas Governor & Attorney General's Crime Victims' Rights Conference

Community Support Events

American Diabetes Association, American Heart Associations, Point-in-Time Homeless Count, Mental Health Advocacy Day at the Capitol, Families Together, Special Olympics Summer Games, Self-Advocates Coalition of Kansas (SACK), Kansas Conference on Poverty, Midwest Ability Expo, National Alliance on Mental Illness (NAMI), Disability Mentoring Day events statewide, Convoy of Hope, KDADS Operation Red File events, Brain Injury Association of Kansas family and survivor seminars

It has been our pleasure to support the events and initiatives for many other partner organizations. Since 2013, **Sunflower has contributed over $1 million in sponsorships to Kansas-based organizations facilitating local events or initiatives that reach our Members and Providers.** Annually, Sunflower is the highest level sponsor at the InterHab annual conference and the Kansas Association for the Medically Underserved annual conference.

Safe Sleep

Sunflower staff are actively engaged in the Fetal and Infant Mortality Review (FIMR) community action teams in Kansas City, Wichita and Topeka. Community partners representing a diverse group of providers, agencies and advocates attend these monthly meetings and hold separate workgroups to examine the factors and issues that influence fetal and infant mortality in a community. Sunflower's involvement in the FIMR community action teams is for the joint purpose of inspiring community changes that result in more women being healthy when they become pregnant, therefore increasing their chance of having positive pregnancy outcomes. To support maternal and child health, Sunflower aligns its community sponsorships with the same goals. For instance, Sunflower funded the work of the Safe Sleep Task Force in Kansas City to expand and recruit new agency partners in Wyandotte County to educate pregnant women and families and to distribute safe-sleep items, such as cribs, to eligible clients who would not otherwise have a bed for their infant. The sponsorship to help purchase the cribs and other items totaled $7,000, and Sunflower plans to continue providing this annual sponsorship.

Prenatal Education and Resources

Sunflower provided funding in the amount of $8,800 to support a separate maternal and child health educational program called Becoming a Mom (BaM)/Comenzando bien, with curriculum in English and Spanish from the March of Dimes. BaM in Kansas is coordinated through KDHE's Bureau of Family Health and administered at the local level through approximately a dozen sites, including County Health Departments. Sunflower is proud of its continued support of multiple programs addressing maternal and child health, as well as the direct care coordination with our members, to help reduce infant mortality.

Double Up Food Bucks

Sunflower has a responsibility to all communities in Kansas, and we work to find opportunities to impact a large portion of the population through our corporate social responsibility initiatives. In 2018, Sunflower Health Plan will be the exclusive corporate sponsor of the Double Up Food Bucks (DUFB) program in Wichita, with the intent and option to sponsor the program in subsequent years based on outcomes from the first program year. The Greater Wichita YMCA is the fiscal agent for the DUFB program in Wichita where farmers market managers and growers, as well as other community partners, are committed to implementing DUFB in service to beneficiaries of the Supplemental Nutrition Assistance Program (SNAP). Nearly 500,000 Kansans experience food insecurity, or inconsistent access to enough food. The DUFB program allows SNAP beneficiaries to receive a match of $1 for every $1 (up to $25, for a total of $50 with the match) redeemed from their Kansas Benefits card at a participating farmers market.

Matched dollars are required to be used exclusively on fresh fruits and vegetables. **DUFB aligns well with Sunflower's statewide farmers market voucher program we operate as part of our value-added benefits.** In multiple cities across the state, Sunflower partners with a local farmers market to invite health plan members to each receive $10 worth of produce. By underwriting the Greater Wichita DUFB program, Sunflower helps local health leaders serve a larger population within the so-called food desert and further demonstrates our commitment to a healthier Kansas.

Employment for People with Disabilities

In addition to our role as statewide coordinator for Project SEARCH and providing the technical assistance for enhanced system capacity, Sunflower sponsored the travel and registration of more than a dozen community leaders at the 2017 national Project SEARCH Conference where they exchanged research and best practices that will improve program operations and outcomes locally. Project SEARCH is a one-year, school-to-work program for young adults with I/DD.Kansas has 12 local Project SEARCH programs, and more than 200 businesses in Kansas have permanently hired Project SEARCH interns. Kansas has achieved a success rate of 74% of interns securing competitive employment, which is above the national average for persons with I/DD. Kansas representatives at the national conference in Pennsylvania included program coordinators, steering committee members, business liaisons, job coaches and instructors from various agencies who are responsible for helping local Project SEARCH interns grow in their selected career field. Sunflower is also an internship host site for the Johnson County program, having permanently hired two former Project SEARCH interns to-date.

REPUTATION

Sunflower has a reputation as a leader within managed care throughout Kansas for:

- Being a collaborative and innovative partner as evidenced by its relationship with KDHE and ability to execute Value Based Strategies with provider partners
- Providing excellent service resulting in high level of member satisfaction received through external surveys
- Addressing member's SDOHI through innovative programs such as our CentAccount Member Incentive Program, Double Up Food Bucks Program, Sunflower Transitions to Employment Program (STEP), member assessment tools, community resource database, and partnerships with key providers and community organizations
- Expertise in providing complex care and training to support all members including children in Foster Care, members needing LTSS and children with special healthcare needs, such as Person-Centered Thinking training, implementation of the LifeCourse Model and Quality of Life Assessment Training
- Increasing employment through Project SEARCH
- Commitment to employing individuals with disabilities as well as noteworthy programs and initiatives supporting employment practices as evidenced by receiving the *2016 DisAbility Champion Award*

Please see the following ***Letters of Support*** following this section demonstrating the support from some of our key partners:

- Senator David Haley, District 4
- Senator Jim Denning, District 8
- Senator Oletha Faust-Goudeau, District 29
- Association of Community Mental Health Centers of Kansas, Inc.
- Shawnee Mission Health
- Kansas Pharmacists Association
- KVC Kansas
- Behavioral Health Association of Kansas
- Central Kansas Foundation
- Community Living Opportunities
- Valeo Behavioral Health Care
- Mosaic
- Kansas Association for the Medically Underserved (KAMU)

RFP AIM

Measurably improve health care outcomes for members
Promote wellness and healthy lifestyles
Lower the overall cost of healthcare

PERFORMANCE RESULTS

Continuous Quality Improvement

Sunflower is a quality-driven organization that has adopted Continuous Quality Improvement as a core business strategy for the health plan, not simply a stand-alone QAPI program. This approach is driven by our Executive and Senior leadership team, who are our Quality Improvement Champions, and extends down to each of our staff-level employees. We take pride in our many quality improvement accomplishments benefitting our members and the State of Kansas including, in part, the following:

- Sunflower was the first KanCare MCO to achieve NCQA "Commendable" status
- Sunflower was named an "exemplar" managed LTSS plan by Long Term Quality Alliance (LTQA)
- We have achieved consistent year-over-year improvement in both Member Experience and Provider Satisfaction
- Sunflower's experience monitoring and impacting quality outcomes in special populations has resulted in improved HEDIS® quality outcomes in our home and community-based services (HCBS) population and exceptional member satisfaction with long term services and supports (LTSS) Service Coordination: in our 2017 LTSS member satisfaction survey, over 95% of members receiving HCBS reported satisfaction with the help they receive from

their Sunflower Service Coordinator and 99% indicated their Service Coordinator respects their beliefs and preferences

- Year-over-year improvement in NCQA accreditation HEDIS® measures (15.6% increase in 2016 compared to 2015)
- Improved member experience with year-over-year improvement in NCQA accreditation score in both Adult and Child-CCC CAHPS® surveys.
- Sunflower has set the national standard for access to behavioral health (BH) services and appropriate treatment of BH conditions exceeding the NCQA Quality Compass 90th percentile in follow up after hospitalization for mental illness and 75th percentile in BH services and screening in our pediatric population.
- Our experienced quality professionals work closely with the state to consistently safeguard member and provider rights while ensuring member safety and a high-quality provider network

Provider Network Achievements

Provider Network Successes. Sunflower's provider network successes are a culmination of diverse and focused strategies to enhance access, pursue evidence based practices, innovate, develop and sustain meaningful provider relationships built on a shared goal of quality outcomes. Our 2017 Provider Satisfaction survey revealed that Sunflower received the highest score of all Medicaid managed care payers in Kansas for overall provider satisfaction. Sunflower also negotiates enhanced reimbursement rates for providers to address rural access. For example, Sunflower enhanced reimbursement for providers to serve members with autism in rural/frontier areas.

Innovative Improvements. Sunflower applies innovative improvements to better serve Kansas' most vulnerable populations. For example, we have multiple telehealth programs underway such as our contract with the University of Kansas Medical Center, Center for Child Health and Development to provide eight telemedicine video tutorials with BH providers about disruptive behavior and behavior analytic techniques for children. Sunflower is working with Topeka Independent Living Resource Center and Minds Matter, LLC to enhance support for members during transition to the community from a nursing facility.

Clinical, Functional and Social Improvement Successes. Sunflower's person-centered, whole-health approach to Service Coordination is well-tested and tailored to meet the individual needs of KanCare beneficiaries. We integrate physical health (PH), behavioral health (BH), long-term services and supports (LTSS), functional, social, and other services the member receives to create a system of care responsive to each individual. Through this model we have demonstrated the following successes:

- Reduced total expenditures in the first 10 months of 2017 (compared to the first 10 months of 2016) by 30.2% for 450 high cost members with inappropriate utilization or poorly controlled chronic conditions

- Successfully transitioned 513 individuals out of institutional settings to community settings since 2014
- Start Smart For Your Baby Program Successes
  - Reduced risk-adjusted C-section rates from 16.0% to 11.5 %
  - Increased 17P utilization to reduce risk of pre-term delivery from 29.8% in 2013 to 43% in 2017
- Quality of Life metrics including:
  - Over 90% of our members on the physical disability (PD) waiver stated they decide on their daily routine in 2017
  - Over 98% of Sunflower's members receiving HCBS services have stated they feel safe in their home in 2017
  - Over 96% of Sunflower's members receiving HCBS services have stated they are satisfied where they live in 2017, including 100% of children (and parents) participating in the Technology Assistance (TA) waiver
  - Over 90% of our members on the PD waiver stated they get to see family and friends when they want

Over 95% of members receiving HCBS reported satisfaction with the help they receive from their Sunflower Service Coordinator.
99% indicated their Service Coordinator respects their beliefs and preferences.

Supporting Self-direction. Our Integrated Service Coordination program and person-centered planning also ***supports the member's ability to choose self-direction*** and provides the flexibility members need to ***manage their lifestyles and the opportunity to make informed choices about their care and services***. We provide members with the option to have decision making authority over LTSS and take direct responsibility to manage their services. Sunflower has played an important role and has been successful in expanding members' access to self-direction under the current KanCare program. Our parent organization's long-standing partnership with National Resource Center for Participant Directed Services/Applied Self Direction has informed our development of tools and resources to expand high quality self-direction across our health plans, including the development of member self-screening tools, FAQs, and videos to educate about self-directed benefits that we will continue to utilize for KanCare 2.0. Centene nationally has almost 65,000 members who self-direct their services (including Sunflower members).

We have successfully supported member self-direction - as evidenced by the percent of our LTSS members that self-direct one or more of their services out of total number of members in the waiver program:

Frail/Elderly waiver- 36%
PD waiver- 73%
IDD waiver- 28%
TBI waiver- 51%
TA waiver- 55%

sunflower
health plan®

State of Kansas
Senate Chamber

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David Haley
State Senate District 4

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Ethics, Elections and Local Government
Interstate Cooperation
Joint Committee on State-Tribal Relations
Joint Committee on Special Claims Aginst the State

Home:
936 Cleveland Avenue
Kansas City, KS 66101

December 29, 2017

Chris Coffey
Sunflower Health Plan
8325 Lenexa Drive
Lenexa, KS 66214

Dear Mr. Coffey:

As a 23 year member of the Kansas Legislature, I continue to work to ensure Kansans (especially those disabled, elderly and/or of low-income) are receiving the care they need through KanCare. As a member of the minority party (often dedicated more to the concept of government service driven by the needs of people and not, necessarily, corporate profits), when KanCare was implemented, I was exceptionally skeptical of for-profit entities being able to deliver par value to the needs of a fragile Kansas constituency.

After several on-going years with this managed care experiment, I have honestly heard both good and bad about KanCare. However, of the three providers, I have most appreciated Sunflower Health Plan's (SHP) willingness to answer Kansans' questions and concerns in a timely, professional yet easy to comprehend manner. Personal member outreach and support to people receiving care, and their advocates (like me) in helping to understand, and utilize, has been helpful. Sunflower excels in plan members' understanding their benefits and does a good job of providing most of these services as well.

Although the system yet struggles with an untenable waiting list (which, in fairness, predated Kansas' for-profit managed care experiment), I also appreciate value-added benefits, such as dental and vision, that SHP offers so that once a constituent *is* connected a more comprehensive healthcare access plan is established and afforded.

This letter serves to acknowledge, with a modicum of gratitude, the informational access and services provided my constituents and many other deserving Kansans by Sunflower Health Plan. Education and quality of care continues to be of prime importance to me and I appreciate, Mr. Coffey, the level of service that Sunflower has achieved on both levels. Feel free to utilize this letter in whichever manner you see fit and if I, or my office, might be of any further insight or assistance, do not hesitate to call.

Season's Greetings,
David Haley
David Haley, J.D.
Senator / Kansas

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State of Kansas
Senate Chamber

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JIM DENNING
STATE SENATE DISTRICT 8

December 28, 2017

Chris Coffey
Sunflower Health Plan
8325 Lenexa Dr.
Lenexa, KS 66214

Dear Mr. Coffey;

As a member of the Kansas Senate and a health care administrator I work hard to ensure Kansans, especially those who are disabled, have low-incomes, or are elderly, are receiving the care they need. Sunflower Health Plan does a good job of not only providing these services, but helping their members understand what services are available to them.

As a health care administrator and Senator, I hear about KanCare on a daily basis. One of the things that stands out about Sunflower Health Plan is your willingness to help answer Kansans' questions and concerns in a timely and understandable manner. When appearing before committees Sunflower addresses any raised concerns head on as well as follows up on any resolutions needed. On the direct consumer side the personal member outreach and support done through MemberConnections helps parents, families, and people receiving care understand their benefits and how they can best utilize the benefits offered to them. Sunflower truly cares that their plan members understand their benefits.

In addition, I appreciate the value-added benefits Sunflower offers. Dental and vision benefits are crucial in making sure all of someone's health care needs are met. Both dental and vision care can lead to so many other issues, so it is essential that those benefits are available to those who need them the most.

Thank you for providing good customer service to my constituents. Medical issues and insurance coverage can be difficult to understand. Sunflower has done a good job in educating my constituents and answering the questions they have.

Sincerely,

Jim Denning

Jim Denning
Kansas Senate Majority Leader

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State of Kansas
Senate Chamber

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Committee Assignments
Federal and State Affiars, Ranking Minority
Ethics, Elections and Local Government, Ranking Minority
Joint Committee on Corrections and Juvenile Justice Oversight
Joint Committee on Administrative Rules and Regulations
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oletha29th@aol.com

December 28, 2017

Chris Coffey
Sunflower Health Plan
8325 Lenexa Dr.
Lenexa, KS 66214

Dear Mr. Coffey;

As a member of the Kansas Legislature for the last 15 years, I have heard the good and bad about Medicaid in Kansas. I work tirelessly every day to ensure my constituents, especially those who are disabled, have low-incomes, or are elderly, are receiving the care they need through KanCare. I have found that Sunflower Health Plan does a good job of not only providing these services, but helping their members understand what services they are entitled to and making sure members get the services they need.

I hear about KanCare regularly, both good and bad things. However, one of the things that stands out about Sunflower Health Plan is the willingness to answer Kansans' questions and concerns in a timely and understandable manner. The personal member outreach and support to people receiving care to help them understand their benefits and how they can best utilize the benefits offered to them is very helpful. Sunflower truly cares that their plan members understand their benefits.

I also appreciate the value-added benefits Sunflower offers, which were not offered to my constituents prior to KanCare. Dental and vision benefits are critically important in making sure all of someone's health care needs are met. Both dental and vision problems can lead to so many other health and safety issues therefore, it is essential that those benefits are available to those who need them the most.

Thank you for providing good customer service to my constituents. Medical issues and insurance coverage can be difficult to understand, but Sunflower has done a good job educating my constituents and answering the questions they have.

Respectfully,

Oletha

Oletha Faust-Goudeau
Kansas Senate

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Association of Community Mental Health Centers of Kansas, Inc.
534 S. Kansas, Suite 330, Topeka, KS 66603
Telephone (785) 234-4773 Fax (785) 234-3189
www.acmhck.org

December 18, 2017

To KanCare RFP Procurement Team:

The Association of Community Mental Health Centers of Kansas, Inc. represents all twenty-six Community Mental Health Centers (CMHCs) across the state providing treatment and services to over 130,000 Kansans each year. The CMHCs functionally serve as the State's safety net for the public mental health system. Furthermore, CMHCs have a vision for collaborating with Managed Care Organizations (MCOs) on strong care coordination services.

The Association appreciates the collaborative relationship that Sunflower has developed with the CMHCs. Sunflower worked with our stakeholders on the "Pay for Performance for CMHCs" incentive program and implemented this in March of 2017.

We believe that Sunflower appreciates and supports the role of the CMHCs in the health care delivery system. They have worked collaboratively with our members on Level of Care guidelines and have continued the conversations around health homes programs.

Sunflower is in support of protecting the integrity of the mental health system by advocating to protect the rehabilitation codes from being used by independent providers. By limiting the usage to the CMHCs and their contractors, as it currently stands, the fidelity of the therapeutic approaches is not in jeopardy of being compromised.

For the aforementioned reasons, the Association strongly supports the response of Sunflower to the request for proposal by the Kansas Department of health and Environment (KDHE) to continue their current roll as an MCO with the State of Kansas.

Please do not hesitate to let me know as you have questions.

Most Sincerely,

Kyle Kessler
Executive Director
Association of Community Mental Health Centers of Kansas, Inc.

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December 18, 2017

Chris Coffey, President and CEO
Sunflower Health Plan
8325 Lenexa Drive, Suite 200
Lenexa, KS 66214

Mr. Coffey,

At Shawnee Mission Medical Center, we are proud of our accomplishments in improving health outcomes for all patient populations, including Kansas Medicaid beneficiaries. We appreciate the partnership we've had with Sunflower Health Plan over the past five years to engage your members, our patients, in their personal healthcare. KanCare makes up 6.45% of our payor mix, and the outcomes we've worked to achieve with Sunflower Health Plan have positively impacted the quality of life for these patients and their families.

Access to quality healthcare services and the continuity of that care are of utmost importance to us; therefore, we would like to provide our support for Sunflower Health Plan to provide care coordination services for KanCare 2.0 members.

We have an interest in continuing to work collaboratively with your team at Sunflower to promote and improve health for all populations served by your plan.

Sincerely,

Ken Bacon
President/CEO
Shawnee Mission Health

T 913-676-2000

9100 W. 74th Street
Shawnee Mission, KS 66204
ShawneeMission.org

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Chris Coffey, President and CEO
Sunflower Health Plan
8325 Lenexa Dr
Lenexa, KS 66214

Dear Chris,

On behalf of the Kansas Pharmacists Association, and its 1,600 members statewide, I am pleased to provide this letter of support for Sunflower Health Plan's application to the State of Kansas Request for Proposal (RFP) to obtain efficient and effective services for the KanCare population currently covered by Medicaid and the Children's Health Insurance Program in Kansas, as well as ensure coordination of care and integration of physical and Behavioral Health services with each other and with home- and community-based services. This program will require member-focused solutions and is dedicated to integrated care of the whole person.

Our working relationship with Sunflower began in 2012, when it awarded the original KanCare contract. Since that time the relationship between Sunflower and Kansas pharmacists has experienced a few growing pains, as will always be expected, but over the last few years that relationship has developed into a productive, patient-centered partnership. Sunflower staff has been responsive and, in many cases, proactive in working with KPhA and its members on identifying problems and finding solutions.

The Association and its members look forward to the opportunity to continue to grow our relationship with Sunflower. We are pleased to collaborate with Sunflower to provide the best possible member support while achieving the goals of better member health, lower overall program costs, and higher member satisfaction.

Sincerely,

Emily Prohaska, PharmD, BCACP, BCGP
President of the Board
Kansas Pharmacists Association

Cc: Aaron Dunkel, Executive Director, KPhA
KPhA Board Members

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Chief Operations Officer
Marilyn L. Jacobson, J.D.
Chief Financial Officer and General Counsel
Chad E. Anderson, L.S.C.S.W.
Chief Clinical Officer
Anne M. Roberts, M.S.
Chief of Staff

December 13, 2017

To whom it may concern:

KVC Kansas has had the pleasure of working alongside Sunflower State Health plan for the past several years. Our agencies have worked closely to improve the health and well-being of children in Kansas. We have appreciated Sunflower's ongoing participation and advocacy for the most vulnerable populations including their participation in several workgroups focused on enhancing service array, improving service coordination and focus on reducing use of psychotropic medication in the foster care population.

Sunflower has a team of well-trained, dedicated staff who understand the complex needs of children involved in the foster care system. They work collaboratively to remove barriers and improve access to timely, comprehensive care.

We look forward to a continued partnership with Sunflower and our ongoing service to children and families in Kansas.

Please do not hesitate to contact me if you need any additional information; lbbass@kvc.org 913-915-7156.

LBass

Linda B. Bass, PhD LCMFT
Vice President of Clinical Services, KVC Kansas

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BEHAVIORAL HEALTH ASSOCIATION OF KANSAS

December 19, 2017

Chris Coffey
State Plan Director
Sunflower Health Plan
8325 Lenexa Dr., Ste. 200
Lenexa, KS 66214

Mr. Coffey,

I appreciate the opportunity to meet with you and your behavioral health leadership team along with some Behavioral Health Association of Kansas members during the KanCare 2.0 process. The Behavioral Health Association of Kansas is the professional association of substance use disorder (SUD) treatment providers in Kansas who are working to expand the capacity of and access to mental health services for our patients and to enhance the state safety net system.

Substance use disorder and behavioral health providers believe the key components of integrated and coordinated behavioral health services in KanCare 2.0 will provide greater access to services and increase the overall capacity to serve Kansans in need. We support managed care companies who seek and support systems change that funds providers for integrated SUD and mental health treatment Based on our conversations, Sunflower's vision and goals correspond with our objectives to serve behavioral health needs where they are treated in an integrated manner. Network adequacy for behavioral health services will require some combination of changes in current payment limitations, thoughtful use of value based purchasing, and fully integrated behavioral health systems. Substance use disorder treatment providers are willing partners ready to fully serve those we treat who also require mental health services.

We believe integrated behavioral health transcends funding mechanisms that protect and isolate treatment to a limited number of providers and does not serve the needs of Kansas. The State of Kansas has sought integration of services in its wavier application and request for proposal and we urge your support to make the necessary changes. We support Sunflower's efforts as conveyed to us, to build and managed a truly integrated network for behavioral health care.

Please feel free to contact me if you have questions.

Sincerely,

Stuart J. Little, Ph. D, President
Behavioral Health Association of Kansas

800 SW Jackson St., Suite 1100 • Topeka, KS 66612
(p) 785.730.3209 • (e) bhakansas1@gmail.com

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December 21, 2017

Chris Coffey
State Plan Director
Sunflower Health Plan
8325 Lenexa Dr., Ste. 200
Lenexa, KS 66214

RE: Letter of Support

Dear Mr. Coffey:

Please allow this letter to serve as a demonstration of our agency's strong support of Sunflower Health Plan's KanCare 2.0 application. As a provider who offers quality behavioral health services statewide, the Central Kansas Foundation values the dynamic working relationship we have developed with Sunflower Health Plan since the inception of KanCare.

From our perspective, Sunflower Health Plan has functioned as a clear leader in the development of innovative practices targeted to improve member health. Your organization has also consistently demonstrated a sincere commitment to efficiently resolve the inevitable operational barriers that are inherent with a project as complex as KanCare.

As Kansas pursues improvements in the administration of KanCare 2.0, we are confident that your desire to develop a broad and robust provider network that offers immediate access to innovative and quality care will result in better health outcomes for Kansans.

We look forward to collaborating with you in the future.

Cordially,

Les Sperling
CEO

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CLO

In Johnson County:

11627 West 79th Street
Lenexa, KS 66214
phone: 913-341-9316
fax: 877-246-2566

In Douglas County:

2113 Delaware Street
Lawrence, KS 66046
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December 2017

Chris Coffey
President & CEO
Sunflower Health Plan
8325 Lenexa Drive
Lenexa, KS 66214

Dear Mr. Coffey,

Across the nation a perfect storm is brewing. Waiting lists for services are growing exponentially, driven by increases in autism and intellectual and developmental disabilities (I/DD) populations, baby boom retirees are seeking services, and people have longer life expectancies. Labor costs are already high and rising at an unprecedented rate, fueled by historically low unemployment, a dramatically shrinking direct care workforce, and increases in both minimum wage and insurance costs. Despite the growth in need and expense, funding for services adjusted for inflation is in decline.

Traditional service strategies such as group homes, assisted living, and in-home staffing services are not the solution. They are far too costly, promote increased dependence (leading to even greater costs), and often do not provide the type of services most families want. For these reasons, more than 65 million people, 29% of the U.S. population, provide an average of 20 hours of care per week for their aging, chronically ill, or intellectually disabled family members.

CLO and its KU/Communiversity faculty partners from the University of Kansas Department of Applied Behavioral Science are working tirelessly to develop next generation solutions for this problem. The result is CLO's Neighborhood Network (NN) at StoneBriar Woods in Overland Park, Kansas. The StoneBriar Woods neighborhood is home to persons of all abilities, some of whom need help to live independently. This is a nationally recognized neighborhood support model permanently and organically woven into the fabric of this unique community.

Our team at CLO has been in discussions with Sunflower Health Plan, and our collaborative efforts have the potential to produce innovative best practices and programs for the individuals we serve. Our goal is to ensure the success of people with I/DD through education, support programs, service models and advocacy, and it is aligned with Sunflower and their vision for services in Kansas.

We are excited to have the opportunity to work with Sunflower and, because of their commitment to collaboration in our community, we support their efforts in responding to the KanCare 2.0 RFP for managed care in Kansas.

Respectfully,

Mike Strouse, Ph.D.
President/CEO

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12/20/2017

To Whom It May Concern:

It is without hesitation that I write this letter of support for the Sunflower State Health Plan and its application to continue as a KanCare Managed Care Organization in KanCare2.0, effective 1/1/2019.

I have appreciated a number of things about Sunflower here in Kansas. Drs. Sandra Berg and Sonsunmolu Shoyinka, and others have done much to support Valeo Behavioral Health Care, Inc. in KanCare1.0, and we are very grateful for that partnership and for the collaboration. These professionals are easy to reach, personable, quick to respond on the issues, and take the time to listen to the needs, concerns, and challenges faced by us and our consumers.

Our talks about the future of managed care have been encouraging as well, as has their recognition of our successes. Sunflower's support of our round-the-clock crisis intervention service array has made a huge difference in the lives of consumers. The outcomes/incentive pilot that we're working on together sets the stage for a day when alternative payment systems come on line. And, Sunflower's credentialing of our Primary Care Clinic at Valeo, something very unique in community mental health, gave us the boost we needed this fall as we've brought that clinic back on line.

We wish Sunflower continued success in its work here in Kansas.

Sincerely,

Bill D. Persinger, Jr. MHA
Chief Executive Officer

5401 SW Seventh * Topeka, Kansas 66606
Phone 785.273.2252 * Fax: 785.273.2736

330 SW Oakley * Topeka, Kansas 66606
Phone 785.233.1730 * Fax: 785.233.0085

24 HOUR CRISIS LINE
234-3300

2401 SW Sixth * Topeka, Kansas 66606
Phone 785.357.0580 * Fax: 785.233.1450

400 SW Oakley * Topeka, Kansas 66606
Phone 785.783.7599 * Fax: 785.354.1068

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MOSAIC

A life of possibilities for people with intellectual disabilities.

January 2, 2018

Stephanie Rasmussen

Senior Director Med Management

Sunflower Health Plan

8325 Lenexa Drive

Suite 200

Lenexa , Kansas 66214

Dear Ms Rasmussen:

Mosaic serves people with intellectual disabilities across the state of Kansas. We are passionate about providing the opportunity for all people to enjoy a full life and to be an active member of their communities.

Our partnerships with community members, civic groups, legislators and funders are critical for us to fulfill both our mission and vision for Mosaic.

Sunflower Health Plan has been responsive to strategies to best meet the need of the people we serve. They have been creative in pursuing options for individuals that are both effective and efficient while eliminating burdensome processes.

They have listened to our feedback and have reached out for creative solutions to meet the needs of those we serve. They are responsive to discussions and follow up related to action items.

We support Sunflower Health Plan's response to the KanCare RFP.

Sincerely,

Marlin Wilkerson

Marlin Wilkerson

Vice President of Operations

575 157th Place | Otley, IA 50124 | P 402.896.3884 x38214 |

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KAMU
THE PRIMARY CARE ASSOCIATION OF KANSAS
strength
unity
advocacy

December 31, 2017

Chris Coffey
President & CEO
Sunflower Health Plan
8325 Lenexa Drive
Lenexa, Kansas 66214

Dear Mr. Coffey:

It is our pleasure to write a letter of support for the Sunflower Health Plan in pursuit of their bid submission for KanCare 2.0. While the Kansas Association for the Medically Underserved (KAMU) does not endorse one MCO over another, we have established a strong partnership with the Sunflower Health Plan. Additionally, KAMU member clinics have reported good working relationships and expressed appreciation for the support Sunflower Health Plan provides for members served by these clinics.

Since the inception of KanCare, the Sunflower Health Plan and KAMU has established and strengthened a partnership. As member clinics have identified challenges and concerns, Sunflower has worked directly with the clinic or with KAMU to resolve the issues as quickly as possible. They have demonstrated a thorough understanding of the vital role that federally qualified health centers (aka community health centers) and other KAMU member clinics play in delivering quality care to KanCare members. In 2016, thirty percent of patients served by these clinics were Medicaid/CHIP beneficiaries.

We are particularly impressed with the Sunflower Health Plan's commitment to social determinants of health and have had several conversations about opportunities to collaborate with community health centers to mitigate these factors. Mostly recently, we have discussed implementation of the PRAPARE tool as a way to track patient-level data and provide/refer to interventions accordingly. In addition to benefits at the individual-level, this tool provides important data for population health management.

We are eager to work with the Sunflower Health Plan on efforts to merge practice transformation with value-based payment. In 2018, we will initiate a joint project to support participating clinics in improving and meeting quality outcome targets required by the State of Kansas.

KAMU fully supports the Sunflower Health Plan's efforts to be selected as a Kansas Medicaid Managed Care Organization.

Sincerely,

Denise R Cyzman

Denise Cyzman, MS, RD
Executive Director
Kansas Association for the Medically Underserved

KANSAS ASSOCIATION FOR THE MEDICALLY UNDERSERVED
700 SW Jackson Street, Suite 600 | Topeka, Kansas 66603
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2.6 Experience

2.6 EXPERIENCE

All bidders are preferred to have a minimum of three (3) years continuous active participation in the applicable industry, providing equipment/services comparable in size and complexity to those specified herein.

SUNFLOWER DEMONSTRATED SUCCESS

Sunflower Health Plan (Sunflower) has served Medicaid members in Kansas as a participant in the KanCare program since 2013. We work closely with KDHE, KDADS, and all agencies engaged in the lives of KanCare recipients. Our success is demonstrated by our:

- Longest running NCQA Commendable status by an MCO in Kansas, highlighting our organizational culture of quality
- Focus on improving the health of our members, and enhancing each member's experience, proven through a 95% satisfaction rate from members receiving LTSS
- Integrated model and local approach supporting person-centered care, and fostering behavioral health, physical health, and LTSS integration to address our members' whole-health needs to support 46% of the I/DD HCBS population and 67% of persons with I/DD in an ICF/ID facility in Kansas
- Community partners and an expansive network of Kansas providers supported by our collaborative approach to engagement models, as evidenced by 48% of Sunflower's membership assigned to Primary Care Providers (PCPs) participating in Value Based Purchasing (VBP) arrangements
- Rating as the preferred Medicaid health plan in Kansas according to 2017 Provider Satisfaction results

SUNFLOWER EXPERIENCE

Sunflower has served Medicaid members in Kansas as a participant in the KanCare program since 2013 and currently serves approximately 130,000 members. Sunflower has held NCQA "Commendable" status longer than any other managed care organization (MCO) in the State and has a solid track record of improving member health outcomes, implementing innovative programs, and ensuring our members have access to highly qualified providers. We have an unwavering mission to provide quality health care and personalized services through member, community, and provider partnerships, while promoting better health outcomes at lower costs. This is the driving force behind the programs we create and the decisions we make.

Sunflower is fully supported and enhanced by the significant experience and resources of our parent company, Centene Corporation, and our affiliates' experience nationwide.

Sunflower's Local Approach

Our local approach is the strength behind Sunflower's success. Operations are executed locally by Sunflower's Kansas-based staff, whose unparalleled insight into KDHE's healthcare landscape

and the needs of Kansas' most vulnerable populations, position us for continued success. With company headquarters in Lenexa, Sunflower also maintains satellite office locations in Topeka and Wichita, which support employees and field-based staff located in every region of the state. We will use our experience serving stakeholders of the KanCare program to ensure a seamless and efficient go-live for our existing and new members, providers, and KDHE. Through innovative solutions and with our local approach, experience, and cultivated relationships with member and provider communities, we will continue to drive successful outcomes and align with KDHE's goals for KanCare 2.0.

Sunflower aligns our operations with our parent company to continually improve access, quality, and efficiency. All services that touch health plan members and providers, such as Integrated Care Team, Member and Provider Call Centers, Marketing, Community Health Worker Program, Service Coordination, Utilization Management, Provider Services and Engagement, Contracting, Grievances and Appeals, and Compliance operate in the communities we serve. Services such as Finance and Human Resources are also located in Kansas and supported by Centene. Certain administrative functions, such as Information Technology and Claims Processing, are provided through Centene's corporate offices and service centers, with local support in Kansas by Sunflower staff. Our Kansas-based Chief Executive Officer (CEO) has authority over all plan operations for the KanCare program and reports to Sunflower's local, provider-led Board of Directors. Our CEO serves a cross-functional strategic and oversight role, monitoring health plan performance, interacting with State staff, leading all functional areas to ensure compliance, and driving the integration of best practices.

Sunflower Employees – Our Most Important Asset

Our employees are an integral part of our mission and contribute greatly to our success. We employ over 400 local staff who are committed to improving the quality of life within their communities. Serving KanCare members since the start of the program, Sunflower staff are integrated within the local culture, geography and health care delivery system, which gives them a unique perspective in understanding the needs of our members. The majority of our leadership staff have been with Sunflower and worked with KanCare since our first year of operations in 2013. Our executive management team, who are looked upon as experts in the field, average over 20 years of health care experience, most of which has been local to Kansas. Sunflower prides itself on being a place where our employees enjoy working and we continually strive to provide an enriching work experience. As a result, our employee engagement scores have increased by 12% over the past two years. With an average annual turnover of less than 11%, which is significantly lower than the national average of 19% for the healthcare industry, our employees take pride in working for Sunflower and helping transform the health of their communities.

Experience with KanCare Medicaid Populations

Serving our covered populations since 2013, we build upon our own experience and leverage the experience of our affiliate health plans that support comparable populations. This affiliate experience allows us to collaborate and share best practices with our affiliate health plans, many of whom serve the same or similar populations.

TANF eligible recipients. Sunflower and our affiliate plans provide services for TANF eligible populations including infants, children, pregnant women and parents in 19 states, totaling more than 4.35 million members.

CHIP. Sunflower and our affiliate plans support more than 205,000 members in CHIP programs in 10 states nationwide, including more than 12,900 CHIP members in Kansas.

Foster Care. Sunflower supports more than 5,500 Foster Care members. Our affiliate plans cover nearly 135,000 members in Foster Care in 11 states, including three sole-source Foster Care contracts with Medicaid state agencies. Our affiliated health plans support roughly a third of the nearly 430,000 children in Foster Care programs nationwide, with a fourth sole-source Foster Care contract in Illinois scheduled to commence in 2018.

ABD (duals and non-duals). Sunflower and our affiliate plans support nearly 275,000 ABD dually eligible members across 12 states, and more than 480,000 ABD Medicaid only (non-dual) members across 17 states, including over 15,000 members in Kansas.

Long Term Services & Supports. Sunflower and our affiliate health plans support 233,000 members receiving long term services and supports (LTSS) across eight states, this includes approximately 178,000 members receiving home and community based services and 55,000 members residing in nursing facilities. Sunflower's parent company and affiliates make up the largest Managed LTSS program in the country. In addition, our Pennsylvania affiliate will begin operating a Managed LTSS program in Southwest Pennsylvania on January 1, 2018, with nearly 7,000 additional members.

Persons with an Intellectual/Developmental Disability. As of October 2017, Sunflower supports 46% of individuals on the Developmental Disability HCBS waiver and 67% of persons with I/DD that are in an ICF/ID facility in Kansas. Sunflower and our affiliates are experienced in providing HCBS as a cost-effective alternative to institutional care, and are dedicated to enabling our members to live in the most integrated, least restrictive community setting appropriate to their individual service requirements and needs.

Sunflower's Strong Performance Results

Sunflower's existing operational processes and provider network are established and prepared to seamlessly support the new KanCare Contract from day one. Our growth through 2017 includes a number of strong performance results, such as:

- ***Operations Results:***
  - Sunflower's LTSS membership has increased by 40% since 2013.
  - Sunflower Claims Processors maintained *excellent* performance achieving 99.98% claims payment within 30 days between July 1, 2016 and June 30, 2017.
  - Sunflower's encounter acceptance rate is the highest of the three current MCOs

- Sunflower has a very low overall annual turnover rate of less than 11%. Highlights include our Medical Management department at 9% annually, 10.75% for our Customer Service, and 0% Executive turnover within the past year.

Clinical and Quality Results:

- Sunflower achieved a 95% satisfaction rate from members receiving LTSS.
- Based on 2017 survey results, 98% of Sunflower members who responded to the survey indicated they were satisfied with the help they are receiving or had received from their Sunflower Service Coordinator.
- Sunflower takes pride in the year-over-year improvements in outcomes among our members in foster care. As demonstrated in the below table, more than 85% of the HEDIS results captured for Sunflower's Foster Care membership in 2015 and 2016 improved during that period.

HEDIS Measure	2015	2016
Well Child Visits for 3, 4, 5, and 6 year olds	71%	73%
Immunizations for Adolescents	63%	69%
Annual Dental Visits	68%	70%
Medication Management for those with Asthma	46%	52%
Use of multiple anti-psychotics*	8%	5%
Metabolic monitoring for those on anti-psychotics	30%	41%
Diabetes screening for those on anti-psychotics	66%	74%

**lower value reflects improved performance*

- Sunflower's Psychotropic Medication Utilization Review (PMUR) Program has resulted in an overall reduction in psychotropic medications used by members in foster care from 33.5% in 2013 to 28.9% in 2016; 60+ day psychotropic medication utilization among Sunflower's foster care membership decreased from 13.4% in 2013 to 11.6% in 2016.
- Year-over-year improvements in NCQA measures including:

NCQA Measure	2014	2015	2016
Medication Management for people with Asthma	27.9%	28.9%	33.9%
Annual Dental Visit/Total Population	60.1%	61.2%	63.5%
Weight Assessment and Counseling for Children/BMI	48.1%	50.7%	58.9%
Weight Assessment and Counseling for Children/Nutritional	49.8%	50.5%	61.8%
Comprehensive Diabetes Care / Hemoglobin A1c Testing	84.5%	85.6%	87.4%
Comprehensive Diabetes Care / Diabetic Eye Exam	61.4%	67.9%	70.7%
Comprehensive Diabetes Care / A1c Control Less than 8	40.1%	45.6%	53.3%

Network Results:

- Sunflower's comprehensive provider network includes over 23,500 participating providers serving members statewide, including:

Sunflower Health Plan Provider Network	
Primary Care Physicians	3,006
OB/GYN Providers	374
DME/Medical Supply Dealers	559
Hospitals in Kansas and adjoining states	160
Skilled Nursing Facilities	527
FQHCs	66
RHCs	208

- As of November 2017, 48% of Sunflower's membership was assigned to a primary care provider (PCP) participating in a Value-Based Purchasing (VBP) arrangement
- Pay-for-performance (P4P) programs reach approximately 51,000 (40%) of Sunflower membership
- Sunflower has two active P4P programs fully-integrated into the Provider Portal with monthly scorecards, member care gaps, and full IT support; one for large health systems and FQHCs, and one for pediatric practices
- Sunflower also has an active Pay-for-Performance Program surrounding Timeliness of Prenatal Care using HEDIS measures as a component to improve Sunflower delivery outcomes
- Sunflower has a provider incentive arrangements in place for Community Mental Health Centers (CMHCs) to address both physical and behavioral health outcomes, using HEDIS measures, post-hospitalization follow-up, and readmission rates as components of value-based purchasing
- Sunflower is proposing innovative payment agreements with LTSS providers for Extraordinary Funding and Transition Coordination Services
- Sunflower implemented a LTSS Advisory Committee in December 2016 to collaborate with LTSS stakeholders on areas such as outcomes measurement, value based purchasing, Sunflower policies and procedures, and proposed legislation.
- Sunflower is one of the first plans in the nation to create an innovative incentive for network pharmacy practices that became accredited by the Center for Pharmacy Practice Accreditation (CPPA)
- In 2016 and 2017, Sunflower offered more than 175 training sessions in addition to the State's all-MCO trainings to support our provider network on topics, such as peer-to-peer review, prior authorization and medical necessity, claims assistance, treatment and documentation guidelines, Medicaid, and more
- 2017 Provider Satisfaction Results rated Sunflower as the highest performing Medicaid health plan in Kansas

Experience Increasing Employment and Independent Living Supports

- Sunflower actively participates in the Governor's Behavioral Health Services Planning Council Vocational Subcommittee, which is committed to coordinating supported employment activities and reviewing statewide infrastructure in promoting and sustaining supported employment for fellow Kansans. The Subcommittee recommended sustaining

supported employment through expanding use of the Individual Placement and Support (IPS) model, an evidence-based approach by community mental health centers (CMHCs) to supported employment for individuals with mental illness. In response to this recommendation, Sunflower promoted IPS model adoption among CMHCs through face-to-face meetings and provider education. In addition, Sunflower supported a payment model to encourage CMHCs to use the IPS model with an enhanced payment rate, for which 11 CMHCs billed. In 2015, 261 unique members received 16,620 units (1 unit = 15 minutes) of supported employment services. ***In 2016, the number of unique members steadily increased to 268, and the number of supported employment service units increased to 17,298.*** Two Sunflower staff members have been trained to audit member records for fidelity to the IPS model in conjunction with KDADS staff. Two sites have been audited by these trained auditors to date, and Sunflower continues to support the IPS model through collaboration with KDADS to ensure continued commitment to supported employment.

- Sunflower actively engages Kansas providers that deliver supported employment services. Through in-person meetings, Sunflower reviews the provider's service delivery methods, rates of employment for members within their catchment area, and data integrity with submission of employment data through the State of Kansas Automated Information System (AIMS). In 2016, Sunflower made on-site visits to Pawnee Mental Health Services, Johnson County Mental Health Center, Four County Mental Health Center, Prairie View Mental Health, and the Mental Health Association of South Central Kansas. During these visits, the partners reviewed employment data, specifically comparing the data collected and reported by the State to what is submitted by the CMHCs. There was increased awareness by the partners that CMHC data related to employment had multiple options to describe employment that ultimately translated to either employed or unemployed status when received by Sunflower. During these discussions, the facilitator and providers were able to understand the intent of employment data submission and better define employment classification. For instance, it was discovered that members who volunteered or worked in a shelter were classified as unemployed. ***Ultimately, remediation for appropriate employment tracking allowed providers to submit more accurate member employment data and preserve data integrity.***
- Early on in Sunflower's history, we recognized the data challenges in identifying members with Serious Persistent Mental Illness (SPMI) and/or Substance Use Disorder (SUD) for employment services. To address these challenges, Sunflower's Service Coordination processes were updated to include asking questions related to the member's employment status. Depending on the member's need, support includes developing care plan goals, advocating and coordinating with appropriate parties on behalf of the member for employment status change, and providing employment resources. To measure the work processes' effectiveness, Sunflower reviewed 2015 and 2016 behavioral health case notes for any notes that referenced employment or job. ***Sunflower's revised Service Coordination work processes resulted in an increase of 24.21% unique members with discussion of employment in 2016 compared to 2015.***

- In 2016, Sunflower conducted a training session with our Behavioral Health Service Coordination staff to reiterate the importance of discussing employment with each member contact. The training also discussed barriers for employment, employment strategies and employment resources available for Kansans. The ultimate intent was to engage all members to ensure the unidentified SPMI and/or SUD members were offered employment resources.
- The State of Kansas provided employment-related data for SPMI members on multiple occasions to Sunflower in 2016. The condensed set of employment data represented information submitted by CMHCs through AIMS, which indicated whether members were employed or unemployed. Sunflower used the data provided by the State to identify members that were SPMI to conduct employment related outreaches. ***In 2016, Sunflower identified 909 unemployed Sunflower members within the State's dataset, and subsequently outreached to these members through informational mailings on employment resources.***

Community Involvement

Sunflower's commitment to the local community is demonstrated through our involvement with local public schools, community advocates, health fairs and baby showers, food drives, board of directors' participation with local non-profits, and other events. Sunflower has directly contributed more than $1 million to Kansas communities as part of our corporate social responsibility program, as well as investing in the State's health care infrastructure for continued support.

- ***Partnerships.***
  - Project SEARCH. Sunflower is the statewide coordinator for Project SEARCH, an international program based in Cincinnati, Ohio, designed to secure competitive employment in fully integrated work settings for people with intellectual and developmental disabilities. Sunflower was honored to help Project SEARCH celebrate its fifth year in Kansas, and to date has supported approximately 100 interns in Kansas Project SEARCH programs. Sunflower and its Centene partner LifeShare provide technical assistance to 13 host business sites across the state. In addition to our role as the statewide coordinator, we are entering our fourth rotation as an internship host site and have directly hired two individuals through a competitive interview process.
  - Project Oasis. Sunflower invested $300,000 in a community collaborative aimed at improving access to services in what had been labeled a health care desert area in south central Kansas. GraceMed health clinic partnered with Via Christi Health and the Greater Wichita YMCA to establish a "hub and spoke" clinic model of care for addressing obesity and diabetes, mental illness, and oral health. Project Oasis called for a centralized 'hub' clinic and four 'spokes' – four new GraceMed satellite school-based clinics. Sunflower's involvement helped the partners bring much-needed services to a community working to eliminate barriers to services while improving the health and well-being of our KanCare members.

- Rural Health Grant in Central Kansas. The Centene Foundation for Quality Health Care provided a Kansas grant in support of the behavioral health needs of four counties in central Kansas. This grant supports health related technology solutions, such as computer kiosks in public locations, as well as mobile behavioral health triage tools for first responders, to improve health in rural counties. Our goal to broaden access to behavioral health services through technological solutions is proving effective; in Q1 2017, 202 screenings were completed via mental health kiosks, compared to the 73 kiosk screenings in Q4 2016.
- Farmers Markets. In 2016, Sunflower began a farmer's market voucher program as a way to educate its health plan members on the importance of selecting, preparing, and eating healthy foods. We partner with nearly a dozen community farmers markets across the state in which Sunflower and the market managers host special events for health plan members to use their vouchers on fresh, locally grown produce. At these events, Sunflower staff present $10 produce vouchers to members and talk with them about healthy eating and other lifestyle choices, such as seeing their primary care physician for regular check-ups. In 2016, Sunflower members redeemed farmers market vouchers worth nearly $12,000, and in 2017, Sunflower members redeemed farmers market vouchers worth $13,000. These dollars go directly back to local farmers across Kansas as a full-circle investment in our community.

Awards.

- 2016 DisAbility Champion Award from the Greater Kansas City Business Leadership Network for our commitment to employing individuals with disabilities as well as noteworthy programs and initiatives supporting employment practices.
- 2017 Health Literacy Kansas Trailblazer Award for dedication to our members' engagement and understanding of their health**.** Sunflower added health literacy as a focus within our medical management department, partnering with the training team to advocate and assist in increasing health literacy in Kansas. We began by increasing the understanding with our more than 170 service coordinators and their use of plain language in discussing health care matters with members and their families.
- Elite Health Champion Designation from the American Diabetes Association. This designation recognizes companies and organizations that inspire and encourage organizational well-being and is part of the association's Wellness Lives Here initiative. Our goal is to encourage the adoption of healthy habits that will benefit our team, our members, their families, and our company's productivity and morale overall.

- 2017 Above and Beyond Award from the Derby Health Collaborative for Sunflower's support of the South Wichita/Derby community baby shower and safe sleep initiatives. Sunflower was a key participant in the success of community outreach to pregnant women and families.
- Circle of Caring Award from the United Way of Greater Kansas City for employee participation in fundraising, awarded in 2016 and 2017

Our Future Success

Sunflower will continue its deep commitment to KanCare members and the State's goals to help Kansans achieve healthier, more independent lives while leveraging the experiences, best practices, and lessons learned from our own knowledge, as well as that of our partners, subcontractors, and stakeholders. These combined capabilities will allow us to create a more individualized, person-centered approach to health care. We will continue to build a robust, quality health care program in all regions throughout Kansas,

Expanded Programs and Technology to Support Providers. We will ***expand our Value-Based Purchasing programs*** by continuing to engage a wide variety of health systems and provider types including Primary Care Providers (PCPs), specialists, pharmacists, LTSS, and behavioral health (BH). We will build on the more than 30 years' experience of our parent company, Centene Corporation (Centene), the industry leader in designing and implementing impactful VBP arrangements, in rewarding providers for improving member health outcomes. These programs have demonstrated a significant impact at the national level, such as ***25% higher Quality Scores; 1-2% lower costs: 10-15% lower IP admissions; ~20% lower ED rates; and up to 30% in additional provider payouts.*** We will continue to build on this local and national momentum to successfully transition additional providers to the innovative VBP arrangements.

Sunflower's ***enhanced use of technology will enable providers access to near real-time data*** closer to the point of care, such as through our Provider Portal's ***clinical applications with health information presented in a meaningful, impactful manner***. These clinical functions include: online care gap notifications (alerting providers to health alerts and care gaps), emergency room high utilizer flag (alerting providers if a member has had three or more emergency room visits in 90 days), and an online Member Health Record (MHR) delivering advanced capabilities for clinical service coordination. In 2018, we are enhancing our Provider Portal to include all physical and behavioral health (BH) functions on ***one*** secure platform – further enabling BH and physical health care coordination, and expanding the health information we exchange with all providers via this online presence.

Expanded Programs and Incentives to Support Members. We will continue to focus on whole-person care by using evidence-based tools, such as PHQ-2 and CAGE, to assess and holistically integrate members' needs related to physical health, behavioral health, and social determinants of health and independence (SDOHI). Sunflower is further addressing SDOHI through programs including, but not limited to:

Our ***CentAccount® Rewards Program***, which we are expanding to better align our member incentives around how members interact with their environment and the health care system on a regular basis. Expanded rewards include ***additional incentives for completion of health and wellness activities***, as well as delivering personalized incentives that encourage healthy behaviors, enable trusted relationships, and enhance our members' lives within their community. Our CentAccount card and member ID card will be combined into one card, making it more convenient for members to access and use their CentAccount rewards. ***In 2017, on average, Sunflower paid out over $70,000 in CentAccount rewards each month.***

Sunflower is ***collaborating with the Primary Care Association to better address SDOHI using the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE).*** PRAPARE is a National Association of Community Health Centers (NAC) and partners effort to help health centers and other providers collect the data needed to better understand and act on their patients' SDOHI. PRAPARE is both a standardized patient social risk assessment tool consisting of a set of national core measures as well as a process for addressing SDOHI at both patient and population levels.

Sunflower will offer our ***LifeAlly program*** in Kansas, the cornerstone of which is our Community Resource Database, a comprehensive online social utility for access to local social services and community resources such as, food, housing, transportation, and ***education services that best fit members' needs and can impact their health and wellbeing***. Accessible to all members of the Integrated Care Team, such as Service Coordinators, Community Service Coordinators, Community Health Workers, members, and providers, our Community Resource Database allows users to complete a life barriers assessment and quickly locate recommended resources near them.

We will train our Service Coordinators and Community Service Coordination providers on the ***LifeCourse framework*** to equip them with tools to help individuals and families think about what a good life looks like for them and how to get there. The LifeCourse framework takes the Person-Centered Thinking model a step further, encouraging focus on the family and supports surrounding the individual and the family. This framework ***emphasizes active engagement by families and self-advocates in the person centered planning process, providing individuals with the tools to enhance and communicate their goals***. We currently have a representative participating in the LifeCourse Community of Practice, helping to develop the LifeCourse training course.

Our ***Sunflower Transition to Employment (STEP)***, a workforce development and employment support resource program to address employment barriers, will be available to support all of our members within the communities we serve. ***Through STEP, we will partner with community organizations to provide opportunities for our members*** to further their education and pursue meaningful employment. The STEP program will include community job fairs, GED vouchers, referrals, and assistance with career counseling services.

Sunflower is 100% invested in Kansas and remains a trusted KDHE partner with an entrepreneurial spirit and the backing of a Fortune 100 corporation. Our goal is to continue to manage and effectively address the clinical, functional, social, and other non-clinical needs of our members, while at the same time addressing challenges head on to continuously improve managed care processes within the KanCare program.

2.7 Timeline

2.7. TIMELINE

A timeline for implementing services must be submitted with the bid.

SUNFLOWER DEMONSTRATED SUCCESS

Sunflower Health Plan (Sunflower) has served Medicaid members in Kansas as a participant in the KanCare program since initial implementation in 2013, and we have successfully implemented program changes and policy updates on behalf of KDHE since that time. Our success is demonstrated by our:

- Ongoing partnership with KDHE and other key agencies to meet operational and quality milestones
- Flexibility to quickly and seamlessly implement State policy changes
- Consistent, trusted leadership and expertise
- Incumbency position allowing for the majority of KanCare 2.0 infrastructure to already be in place to support a new implementation

OVERVIEW

Sunflower implemented the current KanCare program in alignment with a January 1, 2013, operational effective date. We developed and followed a detailed implementation timeline with objectives focused on continuity of care for beneficiaries and supporting the provider network's processes under an improved model of care. Sunflower developed our timeline to implement KanCare 2.0 Contract requirements by applying our local experience, best practices, and lessons learned from regular audits by State officials and other external findings. Our timeline for implementing services follows in ***Figure 2.7 Sunflower Implementation Timeline***.

Timeline Approach

Our approach to developing an implementation timeline takes into account Contract requirements and milestones from RFP submission through contract award through effective date. It details highlights and objectives within each functional area to ensure effective operationalization. Our timeline guides an efficient process, allowing Sunflower to clearly track ongoing progress, identify and mitigate potential risks, and provide transparent communication to KDHE regarding our KanCare 2.0 Contract readiness.

Timeline Details

Sunflower identifies timeline progress by identifying tasks by functional area, such as the new KanCare 2.0 Service Coordination model, and detailing requirements associated with the task. We establish a timeframe for completion of each individual task, developing a start and finish date, and monitor the status of each respective task with a color-coded schedule for ease of reference. Each task and its respective requirements are assigned resources, including the departments and individuals responsible for appropriate execution. Our detailed timeline serves as Sunflower's road map to successful implementation in partnership with the State of Kansas, KanCare providers and community support organizations.

Figure 2.7 Sunflower Implementation Timeline*

*KanCare 2.0 Detailed Program Implementation Plan (*Dates and Tasks will be further defined upon Contract Award)*				
Task Name	**Start**	**Finish**	**Status**	**Resource Names**
Implementation Milestones			**On Schedule**	
RFP Proposal Due	1/5/2018	1/5/2018	Future Task	Business Development
Contract Award	6/1/2018	6/1/2018	Future Task	Business Development
Contract Negotiations and Signature	*		Future Task	Business Development
Hire staff and/or reorganize to support Service Coordination model	6/1/2018	8/1/2018	Future Task	Business Development
Internal Contract and Operating Model Review	3/15/2018	3/15/2018	Future Task	HP/Corp
Provider (Service Coordinator) Contracting Adequacy Completed	9/1/2018	9/1/2018	Future Task	HP/Corp
Internal Operations Readiness Review	9/15/2018	9/15/2018	Future Task	HP/Corp
External Kansas State Readiness Review	10/15/2018	10/15/2018	Future Task	Business Development
Open Enrollment Start	11/1/2018	11/1/2018	Future Task	HP/Corp
Member Auto Assignment	12/1/2018	12/1/2018	Future Task	HP/Corp
Implementation Go-Live / Member Effective Date	1/1/2019	1/1/2019	Future Task	HP/Corp
Project Management			**On Schedule**	
Review Contract Requirements and Build Detailed Implementation Work Plan, Structure, and Resources	2/15/2018	3/15/2018	Future Task	Business Implementation
Weekly Integrated Lead Meetings	3/1/2018	1/1/2019	Future Task	Business Implementation
Cross Functional Workgroups	3/1/2018	1/1/2019	Future Task	Business Implementation
Implement Steering Committee	3/1/2018	2/1/2019	Future Task	Business Implementation
Establish recurring meetings with State and other state agencies	3/1/2018	2/1/2019	Future Task	Business Implementation
State Q & A Grid; Issues / Risks Logs	3/1/2018	2/1/2019	Future Task	Business Implementation
Network Development			**On Schedule**	
Customize Policy & Procedures for new state contract requirements	3/1/2018	10/1/2018	Future Task	Network Contracting
Hire / train contracting staff, as needed	3/1/2018	5/1/2018	Future Task	Network Contracting
Obtain current Service Coordinator list	2/15/2018	5/1/2018	Future Task	Network Contracting
Meetings / Relationships with Key Service Coordination groups	5/1/2018	10/1/2018	Future Task	Network Contracting
Develop contracting strategy	2/15/2018	5/1/2018	Future Task	Network Contracting
Develop network tracking and reporting (CRMP system)	2/15/2018	5/1/2018	Future Task	Network Contracting
Implement Contract Processing System and Resources	5/1/2018	10/1/2018	Future Task	Network Contracting
Set-up systems / Geos to track adequacy	3/1/2018	7/1/2018	Future Task	Network Contracting
Provider Contracting Adequacy Completed	8/1/2018	10/1/2018	Future Task	Network Contracting
Draft Contract Packet Approved by DHS (contract, credentialing, FAQ)	3/1/2018	4/1/2018	Future Task	Network Contracting

Provider Contracts developed / approved with all State requirements	3/1/2018	4/1/2018	Future Task	Network Contracting
Implement Contracting Strategy (mailing, telephonic, face-to-face, key provider)	5/1/2018	10/1/2018	Future Task	Network Contracting
Monitor and track progress / adjust resources and methodology, as needed	5/1/2018	1/1/2019	Future Task	Network Contracting
Develop and submit Plan for Provider Licensure Verification	8/1/2018	10/1/2018	Future Task	Network Contracting
Network Adequacy Provider file to state	8/1/2018	10/1/2018	Future Task	Network Contracting
Obtain provider directory approval	8/1/2018	10/1/2018	Future Task	Network Contracting
Audit Find a Provider (FAP)	8/1/2018	1/1/2019	Future Task	Network Contracting
Credentialing / Provider Data Mgmt (PDM)			**On Schedule**	
Customize Credentialing Policy & Procedures w/ State and Service Coordination requirements	3/1/2018	4/1/2018	Future Task	Provider Data Mgmt. (PDM)
Set up Emptoris (contract management system)	3/1/2018	5/1/2018	Future Task	Provider Data Mgmt. (PDM)
Create credentialing packet (State-specific and non-standard requirements / state validation sources)	1/1/2018	3/1/2018	Future Task	Provider Data Mgmt. (PDM)
Set up Portico for new provider types	3/1/2018	5/1/2018	Future Task	Provider Data Mgmt. (PDM)
Load Provider information into Portico	5/1/2018	1/1/2019	Future Task	Provider Data Mgmt. (PDM)
Audit provider load information	8/1/2016	Ongoing	Future Task	Provider Data Mgmt. (PDM)
Portico to Amisys interface configuration complete	5/1/2018	10/1/2018	Future Task	Provider Data Mgmt. (PDM)
Conduct Credentialing Committee meetings (increased frequency as needed)	5/1/2018	Ongoing	Future Task	Provider Data Mgmt. (PDM)
Provider Relations			**On Schedule**	
Customize Policy & Procedures for new contract requirements	3/1/2018	6/1/2018	Future Task	Provider Relations
Train Provider Relations Staff on new requirements/Service Coordination	5/1/2018	10/1/2018	Future Task	Provider Relations
Define new/changing Provider Engagement / Relations Strategy	3/1/2018	7/1/2018	Future Task	Provider Relations
Identify key providers and associations (collaborate with contracting)	3/1/2018	5/1/2018	Future Task	Provider Relations
Develop Provider Training and Outreach Plan	5/1/2018	7/1/2018	Future Task	Provider Relations
Update Provider Manual, State review / approval, post to website	6/1/2018	8/1/2018	Future Task	Provider Relations
Provider Billing Manual updated	6/1/2018	10/1/2018	Future Task	Claims/Config
Develop additional provider training materials, State review / approval	6/1/2018	10/1/2018	Future Task	Provider Relations
Turn on online provider directory and print directory	10/1/2018	10/1/2018	Future Task	Provider Relations
Develop and Produce Provider Directory (online, print, Find-A-Provider)	5/1/2018	1/1/2019	Future Task	Provider Relations
Conduct Provider "town halls"	8/1/2018	1/1/2019	Future Task	Provider Relations
Conduct provider orientations (welcome packet / orientation materials)	8/1/2018	1/1/2019	Future Task	Provider Relations

Conduct provider " Open Mic " calls and/or other implementation provider outreach, as needed	9/1/2018	2/1/2019	Future Task	Provider Relations
Compliance			**On Schedule**	
Customize Policy & Procedures for new/changing contract requirements	3/1/20918	6/1/2018	Future Task	Compliance
Submit Business Continuity / Disaster Recovery Plan	2/1/2018	3/1/2018	Future Task	
Submit Security Management Plan	2/1/2018	3/1/2018	Future Task	
Hire / Train Compliance / Regulatory Staff on new requirements	8/1/2018	1/1/2019	Future Task	Compliance
Conduct State contract load and initial assessment / compliance dashboard	3/1/2018	1/1/2019	Future Task	Compliance
Identify state document approval requirements and manage submission	3/1/2018	10/1/2018	Future Task	Compliance
Identify and review licensing/certification requirements	1/1/2018	3/1/2018	Future Task	Compliance
Review Program Integrity / Fraud, Waste, and Abuse Programs for updates	5/1/2018	10/1/2018	Future Task	Compliance
Review and update complaint /grievance process, as needed	5/1/2018	10/1/2018	Future Task	Compliance
Identify and capture new / changing data and reporting requirements	5/1/2018	10/1/2018	Future Task	Compliance
Customize/develop reports (Internal and State)	5/1/2018	10/1/2018	Future Task	Compliance
Begin delivery of reports (Ongoing)	Ongoing	Ongoing	Future Task	Compliance
Human Resources			**On Schedule**	
Develop organizational chart / structures (Overall & HP) Drafts	1/1/2018	3/1/2018	Future Task	HR
Finalize Staffing Plan including State-defined positions	1/1/2018	3/1/2018	Future Task	HR
Develop and submit Individuals with Disabilities Hiring Plan	2/1/2018	4/1/2018	Future Task	HR
Post Approved Positions / Recruitment Strategy Implementation	3/1/2018	6/1/2018	Future Task	HR
Conduct interviews	4/1/2018	8/1/2018	Future Task	HR
Begin extending offers and start dates	5/1/2018	1/1/2019	Future Task	HR
Develop training plan and identify resources	3/1/2018	6/1/2018	Future Task	HR and Functional Teams
Train new and existing staff, as needed	6/1/2018	1/1/2019	Future Task	HR and Functional Teams
Facilities and Infrastructure			**On Schedule**	
Identify and schedule training space	4/1/2018	5/1/2018	Future Task	Facilities & Infrastructure
Identify new space requirements	3/1/2018	6/1/2018	Future Task	Facilities & Infrastructure
Identify and build out space, as needed	4/1/2018	9/1/2018	Future Task	Facilities & Infrastructure
Establish and install infrastructure and hardware, as needed	8/1/2018	11/1/2018	Future Task	Facilities & Infrastructure
Member Services			**On Schedule**	
Customize Policy & Procedures for new/changing contract requirements	3/1/2018	6/1/2018	Future Task	Member Services
Evaluate Call Center Standards and Tools	2/1/2018	5/1/2018	Future Task	Member Services
Hire and Train Service Center Staff	5/1/2018	1/1/2019	Future Task	Member Services

Update Member Handbook, obtain DHS approval	5/1/2018	10/1/2018	Future Task	Member Services
Review telephone System, update if needed	5/1/2018	10/1/2018	Future Task	Member Services
Determine need for supplemental Call Center (Overflow / Peak Times) - Regional Call Center	5/1/2018	10/1/2018	Future Task	Member Services
Review Service Center Technology and update if needed (CRM, Quality Monitoring, Secure Portals)	5/1/2018	10/1/2018	Future Task	Member Services
Update existing Quality Monitoring	5/1/2018	10/1/2018	Future Task	Member Services
Update Training /Call Center Materials	5/1/2018	10/1/2018	Future Task	Member Services
Update Benefit Quoting Guides	5/1/2018	10/1/2018	Future Task	Member Services
Review Specialty/Vendor Customer Service Training, update if needed	5/1/2018	10/1/2018	Future Task	Member Services
Member and Provider Website Updates Complete	5/1/2018	10/1/2018	Future Task	Member Services
Establish Health Education Advisory Committee	5/1/2018	10/1/2018	Future Task	Member Services
Member welcomes calls begin	1/1/2019	2/1/2019	Future Task	Member Services
Eligibility and Enrollment			**On Schedule**	
Customize Policy & Procedures for new contract requirements	3/1/2018	6/1/2018	Future Task	Eligibility & Enrollment
Determine new / changing eligibility requirements	6/1/2018	10/1/2018	Future Task	Eligibility & Enrollment
Update Core Eligibility Processing, if needed	7/1/2018	10/1/2018	Future Task	Eligibility & Enrollment
834 test file from state	7/1/2018	8/1/2018	Future Task	Eligibility & Enrollment
Full 834 Eligibility File	10/1/2018	1/1/2019	Future Task	Eligibility & Enrollment
Load Initial Production file / develop membership reconciliation process	7/1/2018	1/1/2019	Future Task	Eligibility & Enrollment
Review Change in Status weekly report mechanism	7/1/2018	1/1/2019	Future Task	Eligibility & Enrollment
Contract and Benefit Configuration / Claims			**On Schedule**	
Customize Policy & Procedures for new contract requirements	3/1/2018	6/1/2018	Future Task	Claims/Config
Hire and train Claims Staff, as needed	5/1/2018	10/1/2018	Future Task	Claims/Config
Contracts loaded in config tracker	3/1/2018	10/1/2018	Future Task	Claims/Config
Members and providers in DEV and TEST	3/1/2018	10/1/2018	Future Task	Claims/Config
Identify and configure new / changing benefits	3/1/2018	10/1/2018	Future Task	Claims/Config
Review and update Claims Supporting Processes (COB/TPL, Fraud & Abuse, EDI Clearinghouse), as needed	3/1/2018	10/1/2018	Future Task	Claims/Config
Setup new provider pay classes - standard, derivatives, special arrangements	3/1/2018	10/1/2018	Future Task	Claims/Config
Review and configure new / changing ARQs - TruCare Medical Management System	3/1/2018	10/1/2018	Future Task	Claims/Config
Configure new pay classes	3/1/2018	10/1/2018	Future Task	Claims/Config
Configure new provider contracts	3/1/2018	10/1/2018	Future Task	Claims/Config

Review TPL process, insure any new state reporting requirements are completed	3/1/2018	10/1/2018	Future Task	Claims/Config
Identify and implement new / changing pre-adjudication rules	3/1/2018	10/1/2018	Future Task	Claims/Config
Claims process-ready and first check run scheduled	12/15/2018	12/30/2018	Future Task	Claims/Config
First claims check run	1/1/2019	1/10/2019	Future Task	Claims/Config
Encounters			**On Schedule**	
Review contract for new/changing encounter requirements	5/1/2018	10/1/2018	Future Task	Encounters
Customize Encounter Scorecard and measure KPI, as needed	5/1/2018	10/1/2018	Future Task	Encounters
Create Encounter File	5/1/2018	10/1/2018	Future Task	Encounters
Setup and Test Vendor Files including subcontractors, if needed	5/1/2018	10/1/2018	Future Task	Encounters
Develop and test Encounter Response File	5/1/2018	10/1/2018	Future Task	Encounters
Update Work Plan for correcting errors and related resubmissions, if needed	5/1/2018	10/1/2018	Future Task	Encounters
Medical Management			**On Schedule**	
Review staffing requirements; hire and train staff	5/1/2018	1/1/2019	Future Task	Medical Management
Customize Policy & Procedures for new contract requirements	3/1/2018	6/1/2018	Future Task	Medical Management
Review and update pre-auth list, as needed; obtain DHS approval	3/1/2018	10/1/2018	Future Task	Medical Management
Identify / implement new / changing clinical programs consistent with Contract requirements / RFP response	3/1/2018	10/1/2018	Future Task	Medical Management
Establish contacts with Coordination of Care entities	3/1/2018	10/1/2018	Future Task	Medical Management
Define Transition of Care and Inpatient Strategy	3/1/2018	10/1/2018	Future Task	Medical Management
Review Service Coordination / Utilization Mgmt. programs, update as needed	3/1/2018	10/1/2018	Future Task	Medical Management
Review and Update Lock-In Process, as needed	3/1/2018	10/1/2018	Future Task	Medical Management
Review and update systems, as needed (TruCare, ECM, CRM, Centelligence)	3/1/2018	10/1/2018	Future Task	Medical Management
Quality			**On Schedule**	
Update Policies & Procedures for new contract requirements	3/1/2018	6/1/2018	Future Task	Quality
Hire and train staff	5/1/2018	1/1/2019	Future Task	Quality
Review and update HEDIS process, if needed	5/1/2018	10/1/2018	Future Task	Quality
Review and update QAPI program, if needed	5/1/2018	10/1/2018	Future Task	Quality
IT			**On Schedule**	
Kickoff IT portion of project with appropriate state staff and set/up project communications	2/15/2018	3/15/2018	Future Task	IT

Update Policies & Procedures and Compliance Management System (GRC system) for new state requirements	3/1/2018	6/1/2018	Future Task	IT
Update Contract Compliance Program	3/1/2018	10/1/2018	Future Task	IT
Review capacity planning for all applications and staffing, including EDI Help Desk	3/1/2018	10/1/2018	Future Task	IT
Document, validate, and vet business and technical requirements using ITIL and Agile approach	3/1/2018	10/1/2018	Future Task	IT
Modify Companion Guides to be in line with new / changing requirements	3/1/2018	10/1/2018	Future Task	IT
Onboard and certify new trading partners	3/1/2018	10/1/2018	Future Task	IT
Configure, deploy, and test security infrastructure changes	3/1/2018	10/1/2018	Future Task	IT
Configure, deploy, and test Member Database for eligibility and enrollment changes	3/1/2018	10/1/2018	Future Task	IT
Configure, deploy, and test Provider Data Management System changes	3/1/2018	10/1/2018	Future Task	IT
Configure, deploy, and test: Medical Management System (Trucare) changes	3/1/2018	10/1/2018	Future Task	IT
Configure, deploy, and test claims processing changes	3/1/2018	10/1/2018	Future Task	IT
Configure, deploy, and test encounter processing changes	3/1/2018	10/1/2018	Future Task	IT
Configure, deploy, and test Call Center telephony and service systems changes	3/1/2018	10/1/2018	Future Task	IT
Configure, deploy, and test Centelligence EDW, and configure MicroStrategy Reports changes	3/1/2018	10/1/2018	Future Task	IT
Configure, deploy, and test websites, member and provider portals, and member mobile applications changes	3/1/2018	10/1/2018	Future Task	IT
Configure, deploy, and test infrastructure (network and field office hardware, software, LAN, and services) changes	3/1/2018	10/1/2018	Future Task	IT
Integration testing for member, provider, authorizations, claims, Claim Payments, encounters, and portals	3/1/2018	10/1/2018	Future Task	IT
Readiness Review	10/1/2018	10/1/2018	Future Task	IT
Finance			**On Schedule**	
Update Policies & Procedures for new contract requirements	3/1/2018	6/1/2018	Future Task	Finance
Marketing / Communications			**On Schedule**	
Update Policies & Procedures for new contract requirements	3/1/2018	6/1/2018	Future Task	Marketing / Communications
Hire and train Marketing / Communications Staff	5/1/2018	10/1/2018	Future Task	Marketing / Communications
Determine local market resources (print vendor, PR firm)	5/1/2018	10/1/2018	Future Task	Marketing / Communications
Review and Update Web Content and Approval	5/1/2018	10/1/2018	Future Task	Marketing / Communications
Develop and submit Marketing & Communication Plan for approval	5/1/2018	10/1/2018	Future Task	Marketing / Communications

Review and Update member materials	5/1/2018	10/1/2018	Future Task	Marketing / Communications
Review and Update provider materials	5/1/2018	10/1/2018	Future Task	Marketing / Communications
Review and update Community Outreach Plan	5/1/2018	10/1/2018	Future Task	Marketing / Communications
Service Coordination			**On Schedule**	
Create Policies & Procedures; submit to State	6/1/2018	9/1/2018	Future Task	Compliance
Submit initial Staffing Plan for Service Coordinators	6/1/2018	9/1/2018	Future Task	Medical Management
Develop training for Service Coordinators	3/1/2018	6/1/2018	Future Task	HR/Medical Management
Conduct initial training for Service Coordinators	9/1/2018	Ongoing	Future Task	HR/Medical Management
Assign members to Service Coordinators	12/1/2018	Ongoing	Future Task	Medical Management
Post Implementation Milestones			**On Schedule**	
Conduct Daily Go-live meetings	12/17/2018	1/15/2019	Future Task	Business Implementation
Capture Daily Operations Metrics	1/1/2019	1/15/2019	Future Task	Business Implementation
Conduct Lessons Learned Meeting	2/1/2019	2/15/2019	Future Task	Business Implementation
Ongoing monitoring and adjustments for staffing and training	Ongoing	Ongoing	Future Task	Human Resources

2.8 Methodology

2.8 METHODOLOGY

SUNFLOWER DEMONSTRATED SUCCESS

Sunflower Health Plan (Sunflower) has served Medicaid members in Kansas as a participant in the KanCare program since 2013. Our implementation success is demonstrated by our:

- Project management approach, structure, and methodology
- Ongoing, transparent communication between Sunflower and KDHE
- Trusted, existing partnership with the State to implement any current KanCare adjustments with flexibility and accuracy, ensuring continued expertise moving forward in KanCare 2.0, such as with the new Service Coordination model
- Incumbency position, enabling a seamless transition for members to KanCare 2.0

OVERVIEW

Sunflower looks forward to continuing to serve our members in Kansas, while welcoming new members and providers to the KanCare 2.0 program. Sunflower recognizes the importance of meeting stakeholder needs statewide to ensure successful implementation of a managed care program. As demonstrated in our Implementation Timeline in section 2.7, Sunflower views planning and implementation as fundamental to our core competencies. We understand the State goals and are confident in our ability to meet and exceed expectations without any disruption in service to members or providers. Our direct experience in Kansas will drive our new KanCare 2.0 implementation efforts, which will be supported by our parent company's success record using the detailed implementation methodology described below. This proven implementation approach includes the right combination of executive oversight, senior leadership engagement, and technical expertise to ensure a compliant and accurate implementation. Our relationship-centered approach and local operating model form the core of our business philosophy, and reinforces our continued collaborative relationship with KDHE. We have demonstrated effective health plan management and local approach through our Kansas performance since 2013. We have also demonstrated our commitment to our members, providers, community advocates, and KDHE. As an existing health plan in the State of Kansas and known partner to KDHE, Sunflower's incumbency will support a seamless transition to the new Contract through established and KDHE-approved provider networks, technology, staff, processes, and resources. Our Kansas-based staff's insight into Kansas' health care landscape and the needs of Kansas' most vulnerable populations positions us for continued implementation performance excellence.

PROJECT MANAGEMENT APPROACH

Enterprise Business Implementation Model (EBI Model)

Sunflower bases our program and project management methodology on the same model we used to implement Sunflower's initial operations in 2013, enhanced by our experience in the market over the past five years. Our EBI tools and templates have been developed to specifically meet the needs of Kansas Medicaid managed care projects and encompass the following key areas: project scope, project communications, resource planning, timeline and schedule, risk management, quality control, and cost management. Sunflower starts with these

proven templates and tailors each template to meet new Contract requirements, enabling a custom, adaptive, and streamlined approach. Sunflower follows this model to implement business deliverables according to KanCare 2.0 Contract requirements while leveraging Centene corporate best practices. Our project management approach consists of five key elements:

1. A consistent project lifecycle methodology with defined stages and activities to ensure progress to implement the KanCare 2.0 Contract requirements
2. The deployment of dedicated, local, and highly specialized professionals with defined levels of authority to implement KanCare 2.0 Contract requirements
3. A customized communications plan that ensures adequate and timely reporting to executive management and department personnel and ensures consistent communication between implementation participants
4. A set of industry standard and proprietary tools to define accountability, track progress, and identify and mitigate risks to implementing the KanCare 2.0 Contract requirements
5. A proactive systematic review of implementation progress, issue identification/assessment, alternatives analysis, and resolution

Implementation Project Structure and Oversight

Sunflower's proven methodology, includes the balanced combination of executive oversight, senior leadership engagement, and technical expertise to ensure a compliant and accurate implementation. Below we briefly describe our Implementation Project Structure, beginning with ***Figure 2.8.A Implementation Oversight Teams***:

Figure 2.8.A Implementation Oversight Teams

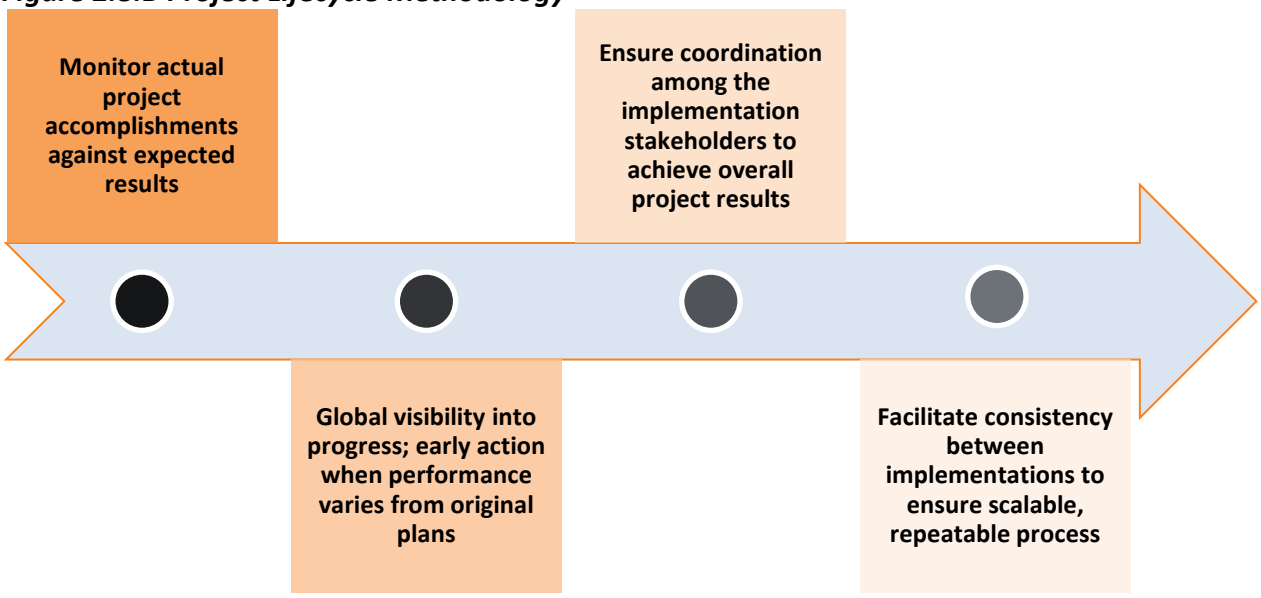
Implementation Oversight Teams	
Executive Steering Committee (ESC)	Centene's Executive Steering Committee functions as the corporate oversight body for Sunflower's KanCare 2.0 Contract implementation. The Executive Steering Committee, a team of Centene and Sunflower senior executives, focuses on ensuring projects stay focused on strategic objectives and meet established requirements. The Executive Steering Committee meets weekly, which demonstrates the level of commitment needed for successful implementations, and ensures appropriate resource allocation and strategic guidance. The Executive Steering Committee: • Guides cross-project implementations from an enterprise point-of-view with regard to strategic direction, Contract compliance, budget, and organization resources • Balances corporate and health plan priorities • Approves project budgets • Removes and resolves cross-project barriers and issues • Monitors project execution through recurring governance meetings and weekly status reports • Serves as the highest escalation point for project issues and barriers Sunflower's Plan President and Chief Executive Officer/Senior Project Director (President and CEO), Chris Coffey, and our Vice President (VP) of Operations/Systems Director, Jonalan Smith (Project Lead), represent Sunflower to the Executive Steering Committee and report on the progress of Implementation Project activities.
Sunflower Steering Committee (SSC)	Sunflower's Steering Committee is comprised of our Senior Leadership Team and is responsible for providing strategic oversight for changes required by the project that

Implementation Oversight Teams	
	impact the overall health plan. The Steering Committee is also the project governance body to which key business decisions and project issues are escalated and resolved, and requires communication on matters that change the scope of the project and its deliverables. The Steering Committee supports the CEO in determining which issues should be escalated to the Centene Executive Steering Committee. Sunflower's Project Lead staffs the Steering Committee and provides all status reports.
Sunflower Project Implementation Team (PI Team)	The PI Team includes Sunflower's Integrated Leads and Subject Matter Experts (SMEs), including subcontractor representatives, responsible for the design and implementation of any new process, program, or technology solution required by KanCare 2.0 Contract requirements, and provides operational and/or technical oversight.
Sunflower Project Leadership and Management	The project leadership and management team below is the group responsible for delivering the implementation within the specified timeline, budget, and scope while ensuring delivery of a quality product. Issues that cannot be resolved at this level are escalated to the Executive Steering Committee.
IT Implementation Team	Centene's IT Implementation Team is comprised of experienced IT Program Managers who will support the Sunflower Project Implementation Team (PI Team) throughout the implementation process. Prior to Contract go-live, a dedicated IT Program Manager will serve as a liaison between our centralized IT resources and local Sunflower staff to help facilitate and coordinate integration and deployment of new systems, applications, and processes across all functional areas (e.g., enrollment, contracting, member and provider services, claims and encounters, and data and analytics).

Project Lifecycle Methodology

Sunflower's project lifecycle methodology provides a solid framework for managing key implementation activities according to a defined set of proprietary standards and the unique needs of KDHE. This methodology provides the same framework as "Project Office" in which resources and tools are deployed in a standardized manner, using the workflow depicted in ***Figure 2.8.B Project Lifecycle Methodology***:

Figure 2.8.B Project Lifecycle Methodology



This approach, combined with oversight by the Sunflower Project Implementation Team (PI Team), enables us to effectively manage the implementation and deploy the following activities:

- Applying standards and metrics to each phase of the implementation life cycle
- Assigning functional owners who can make decisions and ensure project progress / success
- Assigning key milestones and deliverables to each phase with specific ownership
- Reporting weekly status to key stakeholders
- Continually assessing for risk and developing risk mitigation strategies to ensure resolution of every issue
- Establishing initial operations and operating models, as well as system development and support strategies
- Clarifying escalation paths at the beginning of the project to facilitate timely response, priority, and resolution

Project Initiation Phase. During the Project Initiation Phase, Sunflower begins with gathering key information regarding the program including new Contract requirements and our proposal offerings to understand the scope of the implementation. We identify our methodology, approach, resources needed, and engage with all stakeholders to understand any specific nuances and expectations far in advance.

Pre-Implementation Phase. Sunflower initiates the Pre-Implementation Phase at the time of our proposal submission in response to KDHE's Request for Proposal (RFP). We customize our pre-implementation activities based on State requirements. During this Phase, Sunflower reviews, revises and documents scope, communicates State requirements, and develops revised timelines and resource plans. The Pre-Implementation Phase also typically includes the final preparation prior to execution of the Work Plan. During the Pre-Implementation period, the PI Team, comprised of Sunflower and key subcontractor staff, works closely with the State to ensure that essential activities or deliverables for this phase are completed. Key activities for the Pre-Implementation Phase include, but are not limited to:

- ***Scope Creation*****:** Includes research and data collection conducted by the PI Team. We compile information into a "Kick-Off" presentation to ensure all project resources share a similar understanding of the implementation project.
- ***Assessing RFP and Contract:*** Includes the PI Team working to assess new program requirements and initiatives to be addressed in the implementation process.
- ***Finalizing Implementation Methodology:*** Includes the development and approval of the specific methodology to be used to manage the implementation process.
- ***Developing and Confirming Initial Implementation Timeline:*** Includes developing an initial draft of the implementation schedule to establish timing of key project deliverables. The PI

Team reviews the timeline with each integrated lead to ensure the alignment of Work Plan activities and identification of additional resource needs.

- ***Resource Planning:*** Identifies and confirms resources needed to support the implementation schedule, and obtains senior leadership approval to engage these resources.
- ***Finalizing and Engaging Resources:*** Integrates the project resources proposed during Resource Planning culminating in a series of Implementation "kick-off" meetings, delivered as needed, with internal and external resources to ensure consistent understanding of the Implementation Work Plan.
- ***Establishing Project Tools:*** All required implementation project tools are confirmed, labeled and where appropriate, tools and templates are pre-populated.
- ***Finalizing Work Plan:*** All required implementation milestones, supporting activities, delivery dates, and accountabilities are confirmed with each implementation team member to ensure appropriate support.
- ***Refining Operating Model as necessary:*** Using current operating models as the base, PI Team members submit revised functional area operating models to the Sunflower Steering Committee for review and approval.
- ***Assessing Risk:*** The PI Team assesses revised operating models, integrated IT testing schedule, and the KanCare 2.0 Contract to identify immediate program risks.
- ***Miscellaneous:*** The PI Team initiates, as required, other critical activities prior to the Implementation Phase, such as hiring and training planning.

Project Implementation Phase. Notification of the Contract award typically initiates Project Implementation Phase activities. If, however, Sunflower needs to support aggressive KDHE implementation timelines, certain activities may begin prior to Contract award or finalization, such as the new Service Coordination model. Specifically, key implementation activities during this Phase include, but may not be limited to:

- ***Work Plan Execution:*** Activities such as the revision or development of policies and procedures required for Sunflower operations and KanCare 2.0 Contract compliance; revisions or development of member and provider materials; continued network development; and preparation to implement clinical protocols and transition strategies.
- ***Risk Assessment and Mitigation:*** Includes continuous identification, documentation, and assignment of risks for resolution and mitigation planning; and tracking of key decisions on program models.
- ***PI Team and KDHE Meetings:*** Includes conducting standard and recurring internal meetings to monitor project scope, schedule, and key deliverables; review implementation progress; discuss any areas requiring operational clarification; and continue resolving issues and mitigating risks. With KDHE approval, we will continue established meetings between PI Team and KDHE project leadership.
- ***Staff Hiring and Training:*** Includes recruiting and hiring additional staff needed to ensure support for the implementation of all KanCare 2.0 Contract requirements. During this

phase, we develop staff training materials and curricula that will be provided to existing staff and new staff.

- ***Operating Model Revision(s):*** Includes further review, validation, revision, and refinement of functional operating models developed in the Pre-Implementation Phase based on additional information gathered through activities of the Pre-Implementation and Project Implementation phases.
- ***Readiness Review:*** In addition to recurring meetings, we also conduct a series of internal operational readiness reviews prior to Go Live to ensure every functional area is prepared to implement all KanCare 2.0 Contract requirements.
- ***Key Report Development:*** Includes modifying current reports in conjunction with KDHE, or if necessary, developing draft copies of required reports that are used to monitor Sunflower performance after KanCare 2.0 Contract implementation.
- ***Cut-Over Planning:*** Includes developing and communicating clear expectations and timelines for the activities that need to occur during the weeks leading up to, and immediately following KanCare 2.0 Contract Go Live.
- ***System Development:*** Throughout this phase, our corporate IT Lead works with our local PI Team leads to gather new technical and business requirements and prepare key systems for KanCare 2.0 Contract Go Live. We conclude the IT systems development and updating process with end-to-end testing activities, which follow test data through the system. System development, updates, and documentation are managed through an agile process.

Cut-Over Phase. The Cut-Over Phase marks the formal implementation of all new Contract requirements and includes validation that business process metrics meet targeted thresholds. All new KanCare 2.0 Contract requirements cycle through the Cut-Over Phase to meet KDHE requirements under the KanCare 2.0 Contract. We manage a schedule of Cut-Over activities including daily Cut-Over meetings as needed to review issues, escalate to Sunflower Steering Committee and Executive Steering Committee for assistance in removing critical Go Live barriers, and provide ongoing status reporting to all leadership involved in the project. At this point, the Steering Committee verifies that the project meets all KDHE and Sunflower requirements.

During the week of Go Live, we conduct PI Team and all-employee meetings to announce, communicate, and create a shared understanding of the KanCare 2.0 Contract going forward. We also conduct a pre-delegation audit and daily metrics review of subcontractor performance to ensure that contractual requirements are met as well as immediately remediate any issues that are identified. As part of our efforts for continuous improvement, we conduct post Go Live reviews at periodic intervals (e.g., 30, 60 and/or 90 days) from the first day of the new KanCare 2.0 Contract period.

Please refer to ***Section 2.7 Timeline,*** which provides a detailed list of specific tasks and estimated timeframes targeted to occur in each of the four implementation phases.

Lessons Learned. We understand that implementation activities are more than a line item on a work plan, and we apply our experience honed through years of implementations. We apply a

comprehensive approach to evaluating all implementations to identify opportunities to improve our approach and methodology. Sunflower developed our timeline to implement KanCare 2.0 Contract requirements by applying our local experience and lessons learned from regular audits by State officials and other external findings. We also benefit from our parent company's national experience, as well as that of our affiliate plans, to apply best practices when implementing new models, such as the new Service Coordination model for KanCare 2.0.

Consistent Communication between Implementation Participants

By carefully managing communications, Sunflower ensures that all stakeholders understand exactly what needs to be delivered, the scope of work required, who to contact to obtain needed information or to resolve problems, and the current project status at any given point in time. The Project Lead takes a proactive role in ensuring effective communications on this project, and we formalize our implementation communications in our KanCare 2.0 Implementation Communications Plan. The Communications Plan provides the structure for communicating:

- Project scope, schedule, activities, and deliverables
- Project management monitoring and control
- Direction for Integrated Leads to drive the work effort
- Project Progress (schedule, cost, and quality)
- Risk and issue identification, tracking, and mitigation
- Anticipated project trends

Table 2.8.C Communications Matrix below provides a high-level summary of the type and frequency of meetings and other communications we provide during Implementation. Most communications occur in person or and via conference call, with weekly status reports shared via email and hard copy. Deliverables for each meeting include an agenda, meeting minutes, risk/issue log, and project status reports, as applicable.

Table 2.8.C Communications Matrix

Type of Communication and Frequency	Objective	Audience	Owner
Kick-Off Meeting ***Held within one week after Contract Award***	Introduce PI Team members, provide project overview, review objectives, and clarify roles.	Project Sponsor PI Team	Project Lead
Executive Steering Committee (ESC) ***Held Weekly***	Review status of KanCare 2.0 Implementation Take action on key decisions Approve project budget changes above specific threshold Discuss identified risks, issues, and barriers	Centene ESC members Sunflower President and CEO Sunflower Project Lead	Business Sponsor

Type of Communication and Frequency	Objective	Audience	Owner
Sunflower Steering Committee (SSC) ***Held biweekly until three weeks prior to Go Live, then weekly***	Review project status including risks, issues, and barriers Review key decisions by ESC Identify issues for escalation to Centene ESC	Project Sponsor Sunflower Senior Leadership Team	Project Lead
Functional Leads Meeting ***Held weekly***	Review status of project deliverables and progress against Work Plan Discuss actions needed to correct identified risks, issues, and overdue deliverables Communicate decisions/ concerns from SSC/ ESC Identify issues for escalation to SSC	Functional Leads	Project Lead
Project Workgroup Meetings ***Held weekly***	Discuss status of workgroup deliverables and progress against Work Plan Discuss actions needed to correct identified risks, issues, and overdue deliverables Discuss and develop process and technical design solutions for project Identify issues for escalation Report workgroup activities and status at Functional Leads Meeting	Functional Leads Sunflower and Centene Technical SMEs SLT members, as needed	Functional Lead
Project Status Reports ***Held weekly through emails and meeting handouts***	Report the project status, including activities, progress, costs, and issues	Project Sponsor PI Team SSC ESC	Project Lead

Industry Standard and Proprietary Tools

Sunflower uses a set of industry standard and proprietary tools and templates for project management and control to define accountability, track progress, and identify and mitigate risks for implementation. We use recognized, industry-standard tools to document and track project deliverables and timing, task/activity dependencies, and resources.

Microsoft Project. Sunflower uses Microsoft Project to develop our Implementation Timeline and resource (e.g., time and staffing) plans. The Timeline is the basis for assigning responsibilities to individuals and teams, monitoring progress, communicating status, and taking corrective action when necessary. We determine progress by comparing actual work performed against Timeline deliverables. This enables timely corrective action when

performance deviates significantly from the plan. The Timeline includes the time (e.g., duration) required to complete each task and identifies relationships between tasks so we can easily see the impact one task has on another. This enables the PI Team to make changes, as needed, to ensure the overall objectives and timeline remain on course. Sunflower's Project Lead maintains the Timeline and each Functional Lead provides updates for their respective portion of the Timeline.

SharePoint. For many years, Centene has used a corporate-wide intranet site called CNET (Centene IntraNET) as our version-controlled document repository. CNET operates on a top-tier Microsoft SharePoint platform and is fully integrated with Microsoft Office. CNET houses documentation, such as operating models, diagrams, staffing models, business requirements documents, and technical design materials, specific to the business processes being developed for the new Contract. For Sunflower's KanCare 2.0 Contract implementation, we will create a dedicated project implementation SharePoint site on CNET, which includes a standard directory structure. Sunflower will use the site as a single point of reference for all implementation participants. The project site will contain final versions of the RFP and Contract, as well as our KanCare proposal, and also includes access to KDHE announcements, Sunflower specific news articles, and project control documentation along with a calendar of upcoming implementation events.

Compliance Management System (Compliance System): Overall Contract Compliance Management. Upon Contract award, our Vice President (VP) of Compliance, with input from the State as required, reviews the new Contract and documents all contractual and operational requirements in our Compliance System, Sunflower's innovative tool for tracking and monitoring our compliance with all Contract requirements. Recognized internationally as the leading Compliance System software system across all industry segments (including healthcare), our Compliance System allows Sunflower to effectively administer, document, and monitor our internal governance, as well as our contractual and regulatory requirements, all in auditable and transparent fashion. The Compliance System provides for workflow enabled policy and procedure formulation (with complete documentation and sign-off history); document distribution to appropriate internal departments and subcontractors; systematic compliance activity tracking (also with auditable records of management approval and cited contract and regulatory mandates); and ongoing, proactive compliance risk assessment.
With the Compliance System, Sunflower can link the new KanCare 2.0 Contract requirements and related federal and state regulations with internal compliance activities during implementation and beyond, including revisions to or development of policies, procedures, and processes. The Compliance System allows Sunflower to link to policies, procedures, reports, and other evidence documenting our compliance with Contract requirements. The Compliance System also allows the VP of Compliance to perform assessments and monitor compliance by functional area. Any corrective action plans are input into the Compliance System to monitor and track progress. We also use the Compliance System to facilitate communication with KDHE leadership and other state key stakeholders, regarding compliance with all KanCare 2.0 Contract requirements throughout implementation.

2.9 References

2.9 REFERENCES

Provide three (3) references who have purchased similar items or services from the bidder in the last three (3) year(s). References shall show firm name, contact person, address, e-mail address and phone number. Bidder's employees and the buying agency shall not be shown as references.

Sunflower Health Plan's parent organization, Centene Corporation has provided three references from state agencies who have purchased similar items or services in the last three years.

Firm Name:	Illinois Department of Human Services, Division of Medical Programs
Contact Person:	Felicia Norwood, Deputy Administrator for Care Coordination Rate and Finance
Address:	4th Floor, 401 S. Clinton Street, Chicago, IL 60607
Email Address:	Felicia.Norwood@illinois.gov
Phone Number:	(312) 793-5279

Firm Name:	Mississippi, Office of the Governor, Division of Medicaid
Contact Person:	Tara Smith Clark, JD, CHP, Executive Administrator
Address:	550 High Street, Suite 1000 Jackson, MS 39201
Email Address:	tara.clark@medicaid.ms.gov
Phone Number:	(601) 359-9276

Firm Name:	Indiana, Family & Social Services Administration, Office of Medicaid Policy & Planning
Contact Person:	Jennifer Walthall, MD, FSSA Secretary
Address:	402 W. Washington Street - Room W461, Indianapolis, IN 46204
Email Address:	jennifer.walthall@fssa.in.gov
Phone Number:	(317) 233-4690

2.10 Bidder Contracts/ Subcontractor Information

2.10 BIDDER CONTRACTS/SUBCONTRACTOR INFORMATION

Bidders must include with their RFP response, a copy of any contracts, agreements, licenses, warranties, etc. that the bidder would propose to incorporate into the contract generated from this Bid Event. (State of Kansas form DA-146a remains a mandatory requirement in all contracts.)

Sunflower Health Plan is in agreement with the contractual provisions set forth in Event ID#EVT0005464 for KanCare 2.0 Medicaid & CHIP Capitated Managed Care which includes form DA-146a, without exception.

2.11 Technical Literature

2.11 TECHNICAL LITERATURE

All Technical Proposals shall include specifications and technical literature sufficient to allow the State to determine that the equipment/services meet(s) all requirements. If a requirement is not addressed in the technical literature, it must be supported by additional documentation and included with the bid. Proposals without sufficient technical documentation may be rejected.

In addition to the mandatory documentation submitted, Sunflower Health Plan has provided all specifications and technical literature with supporting documentation that meets all equipment and service requirements for the KanCare 2.0 Medicaid & CHIP Capitated Managed Care Contract in the following sections:

- Section 2.0 Proposal Response
- Section 5.0 RFP Background and Scope of Services
- Section 6.0 RFP Purpose, Contractor(s)' Duties, Implementation and General

In a separate binder, we have also included:

- Section 7.0 Cost Proposal

2.12 Procurement Card

2.12 PROCUREMENT CARD (P-CARD)

Many State Agencies use a State of Kansas Procurement Card (currently Visa) in lieu of a state warrant to pay for certain purchases. No additional charges will be allowed for using the P-Card. Bidders shall indicate on the Event Details document if they will accept the Procurement Card for payment.

Sunflower Health Plan has indicated on the Event Details Form that we will not be accepting the P-Card for payment at this time.

5. RFP BACKGROUND AND SCOPE OF SERVICES

5.2 Enrollment, Disenrollment, and Marketing

5.2. ENROLLMENT, DISENROLLMENT, AND MARKETING

SUNFLOWER DEMONSTRATED SUCCESS

Sunflower Health Plan (Sunflower) understands that delivering high quality health care services to our members begins with reliable information systems, understanding who our members are, and effectively engaging new and current members in compliance with the rules and prohibitions governing marketing activities. Our success is demonstrated by our:

- Established, comprehensive processes and policies and procedures to manage enrollment, disenrollment, and marketing practices
- Integrated Management Information System (MIS) successfully handling approximately 2,500 member records per month and hundreds or thousands of enrollment files over our five years in operation as a KanCare MCO.
- Commitment to increasing awareness of the KanCare program. For example, in 2017, Sunflower engaged in a State approved marketing campaign designed to reach existing members and increase knowledge of the KanCare program and Sunflower among the general public.

Compliance with Scope of Work

Sunflower is currently in compliance with all KanCare contracts and all KanCare 2.0 requirements described in Section 5.2 of the Scope of Work (SOW). Sunflower currently serves the eligible populations outlined in this section and has successfully delivered access to covered services as of a member's effective date, including coverage for services during retroactive eligibility periods.

5.2.1. ENROLLMENT

OVERVIEW

Sunflower is proud to be the choice for many KanCare enrollees who recognize that our plan is focused on their needs and able to deliver the services they need. Enrollees choose Sunflower for our robust provider network, comprehensive whole person health management programs, and relationship centered customer service. Throughout our time as a KanCare MCO, Sunflower has built a reputation for excellence serving persons with Intellectual and Developmental Disabilities (I/DD). We have experienced larger numbers of members with I/DD choosing Sunflower as their MCO.

ENROLLMENT AND ELIGIBILITY PROCESS AND SYSTEM

Our member enrollment processes and provision of services to our enrolled members is supported by the member data management (MDM) component of our integrated MIS. In 2018, we are enhancing our MDM component with our **Unified Member View (UMV) system.** UMV features and functionality are currently in place at several of Sunflower's affiliate health plans. UMV provides the single source of truth for all informational aspects of our members'

In 2018, Sunflower is implementing an advanced member data management tool, Unified Member View (UMV) system, which will further facilitate the management of all informational aspects of our members' relationship with Sunflower, across current and historic benefits and product eligibility.

relationship with Sunflower, including member demographics, current and historic benefit plan eligibility, alternate contact information, member communication options, and more. UMV employs a master data management approach to collecting, matching, quality-assuring, storing, and distributing member enrollment data we receive from KDHE to our MIS system components needing that information (e.g., TruCare, AMISYS Advance, and Customer Relationship Management (CRM)). In UMV, member demographic information including member identifiers, address, contact information, confirmed or potential family linkages, special needs, language(s) spoken, current and previous PCP, along with member preferences (e.g., communication options such as e-mail, phone, and/or mail) are stored along with a history of changes to that data. UMV automatically links individual member identifiers to a unique master member index, enhancing our ability to maintain historic member data and resulting in a unified view of a member's enrollment history across all Sunflower programs, eligibility spans, etc.

GENERAL ENROLLMENT PROVISIONS (5.2.1.A)

Sunflower is ready to continue serving KanCare enrollees when enrollment for the new contract period begins prior to November 1, 2018. We have successfully served all of the populations listed in Section 5.2.1.A.1. Our processes and systems will also support the addition of new eligible populations, such as families who would be eligible under the proposed TransMed Program.

Member Enrollment and Assignment (5.2.1.A.1)

According to the Scope of Work, member enrollment/assignment will begin prior to November 2018. As an existing KanCare MCO, Sunflower is ready to receive member enrollments and assignments. Pursuant to the KanCare 2.0 Contract, our systems and processes are configured consistent with the following eligibility and enrollment rules:

- Medicaid members under 21 years of age, and CHIP beneficiaries under 19 years of age, will have a continuous 12-month period of eligibility. Sunflower relies on the 834-enrollment files to be the source of truth regarding member eligibility. If concerns arise with the 12-month eligibility period for these beneficiaries (such as an inappropriate loss of eligibility during the 12-month period), our Enrollment Team escalates to KDHE as appropriate.
- Our systems are configured to establish an eligibility start date consistent with what is included in the 834-enrollment files reflecting the first day of the eligibility month for Medicaid members and the day that eligibility is received by the Medicaid Management Information System (MMIS) for CHIP members.
- We understand that beneficiaries eligible to enroll with Sunflower may be eligible beginning on the first day of the application month, while newborns are eligible as of the date of birth.
- With regards to newborns, Sunflower will provide coverage for eligible mothers enrolled with our plan at the time of their child's birth, and that the child will receive coverage for the birth month and subsequent months that the child remains enrolled with Sunflower. We also understand that capitation payment for the newborn is contingent on submitting

the newborn's information to the State within 60 days of the date of birth. If there is an administrative lag in providing this information to the State which results in Sunflower not receiving a capitation payment for the newborn, the member will be held harmless for any incurred costs.

- Sunflower does not impose any waiting periods or pre-existing condition exclusions for Medicaid or CHIP members. We recognize that the State and its Fiscal Agent are responsible for member enrollment in the Medicaid and CHIP KanCare 2.0 programs.
- Sunflower will make all covered services available to members including physical, behavioral, LTSS, vision and dental services, for those eligible for them, at the time of enrollment.

Eligible Beneficiaries (5.2.1.A.2)

Sunflower understands that beneficiaries eligible to enroll with Sunflower encompass the categories listed in the Kansas 1115 Waiver Special Terms and Conditions. The State has the exclusive right to determine eligibility for Medicaid and CHIP (through its Enrollment Broker), and these determinations are not subject to review or appeal by Sunflower. If Sunflower has reason to believe that a member's eligibility has changed we provide the State with information indicating a possible eligibility change for consideration. This is done through the submission of an electronic 3161 form as well as recording information related to eligibility changes on KDHE's "MCO Change Spreadsheet."

Member Assignment (5.2.1.A.3)

Sunflower recognizes and understands that if awarded a contract, the State's processes for member assignment during the first contract year includes the following:

- Members who were enrolled in Sunflower will be automatically assigned to Sunflower.
- Members who were enrolled with MCOs who previously had a contract with the State but will not continue to contract with the State will be randomly assigned to a new MCO using an auto-assignment algorithm that ensures that family members stay with the same MCO, that existing member-provider relationships are maintained to the extent possible, and that ultimately targets an equitable distribution of members among MCOs based on the number and acuity of members and newly eligible beneficiaries.
- The State, through its fiscal agent, will notify members of the 90-day change period and will provide an enrollment packet with information on all of the available MCOs.

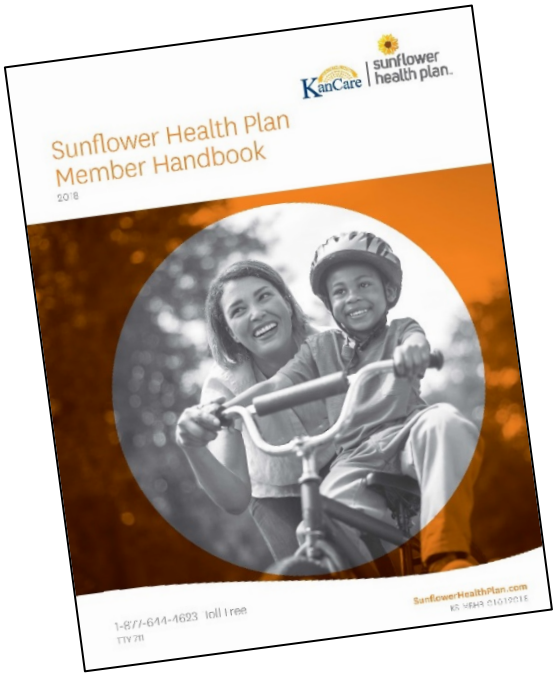
We recognize that the State may alter the algorithm, per federal regulations, by considering additional criteria including the enrollment preferences of family members, previous MCO assignment, quality assurance and performance improvement, procurement evaluation elements, accessibility of provider offices for people with disabilities and other reasonable criteria.

ROLE OF THE FISCAL AGENT (5.2.1.B)

Sunflower recognizes that the Fiscal Agent is responsible for responding to members with questions about enrollment. In the event that a member, regardless of whether they are currently assigned to Sunflower, calls our customer service center with questions related to enrollment, our Customer Service Representatives will transfer the call to the Fiscal Agent. This process is supported by a documented work flow and is incorporated into our training program for Customer Service Staff. We are able to efficiently connect callers to the Fiscal Agent's call center, and will leverage our existing relationships with the Fiscal Agent to make sure that enrollment inquiries are handled appropriately.

MEMBER HANDBOOK AND PCP SELECTION (5.2.1.C)

The Sunflower Member Handbook incorporates the information needed by our members to understand the benefits and resources that are available to them (described below). Additionally, Sunflower will allow members to have 10 business days to select a Primary Care Physician (PCP) or they will be assigned to a PCP. Members may request assignment to a new PCP at any time. The PCP assignment process is described further below. Sunflower's Member Handbook includes, but is not limited to, information on:



- PCP selection
- Member rights and responsibilities
- Covered benefits and services
- Sunflower's health management programs.
- Plan policies, procedures, rules and restrictions
- Reporting fraud and abuse
- Information on initiating a grievance or appeal
- Sunflower's Website
- How to reach Sunflower 24 hours a day
- Structure and operations of Sunflower
- Educational programs and our member incentives, including our CentAccount® rewards program
- Advance directives

Process for Editing the Member Handbook

The New Member Welcome Packet is reviewed and updated annually and when needed due to program changes. Edits to the Member Handbook are submitted by Sunflower business owners beginning in September of each year. The Marketing and Communications Department compiles the edits, completes the handbook design, prepares required translations and submits the updated handbook to KDHE for review and approval by November of each year. Upon

approval, the new handbook is sent to the printer for processing and is published to the Sunflower website.

During the annual review process, Sunflower solicits feedback from members through our Member Advisory Committee and we use this feedback to improve the Welcome Packet. As an example, we are in the process of adding an Office Visit Checklist to the Welcome Packet to assist members in making visits with their PCP more productive. See ***Figure 5.2.1.C_Office Visit Checklist***. The checklist was reviewed by the Member Advisory Committee who felt that the resource would be valuable to new members and their providers.

Figure 5.2.1.C_Office Visit Checklist

KanCare | sunflower health plan.

MAKING MY OFFICE VISIT COUNT

It's all part of my plan.

Your health is important. And Sunflower Health Plan wants to help you get the most out of your visit to your primary care provider (PCP).

The checklists below include suggestions of what you can do before, during and after your PCP visit. Use the worksheet on the back to help you prepare for your appointment and for writing notes during your visit. Take charge of your health by asking questions and sharing information, so your PCP can help you receive the best possible care.

Plan ahead for visits with your doctor!

Use the checklists below before, during and after your PCP visit:

Before Your Visit
- Call to confirm your appointment and to make sure your doctor is part of Sunflower Health Plan.
- Fill out the worksheet on the back and include any questions you want to ask during your visit.
- Write down any health issues you've noticed, like changes in your weight, sleep or mood.

During Your Visit
- Use your worksheet to help you fill out any office paperwork.
- Ask questions about your blood pressure or weight.
- Check about scheduling tests for blood sugar or cholesterol.
- Take notes about any important information you want to remember, like instructions, prescriptions or referrals.

After Your Visit
- Schedule any follow-up appointments and your next wellness visit.
- Check on test results.
- Pick up any prescriptions.

Sunflower Health Plan
1-877-644-4623
SunflowerHealthPlan.com

As KDHE moves towards the implementation of KanCare 2.0, Sunflower offers our support in developing a "joint, model handbook", as required by federal regulation that will serve as a template for all KanCare 2.0 MCOs. We will revise the existing handbook per the process described above to conform to the new template handbook.

MEMBER SERVICE CALL CENTER (5.2.1.D)

Sunflower maintains a local Member Services Center to provide Member Services. Our Member Services Center is staffed Monday through Friday from 8:00 a.m. to 5:00 p.m. Central Time, except for State-approved holidays. After hours, on weekends, and on State-declared holidays, our 24/7 nurse advice line representatives answer our phone line to provide members with administrative assistance as well as nurse advice. For more information on our Member Services call center, please see section 5.10.10.

Sunflower's dedicated Member Services Center provides members and their authorized representatives, culturally competent assistance with their inquiries, issue resolution, health literacy, and service and resource needs. Our toll-free Member Services number is listed prominently on the member ID card, all member materials, and our website, connecting members to personal services from expertly trained Customer Service Representatives (CSRs) who respect our members' time, dignity and privacy. Our Call Center, operating in Lenexa, Kansas, is staffed with qualified CSRs who understand Kansas communities and provide superior service aimed at first-call resolution on even the most complex issues. Through one

toll-free number, Sunflower connects members to knowledgeable CSRs who help members address issues such as PCP selection, changes, and appointment scheduling. CSRs participate in an extensive classroom training program. This comprehensive program trains CSRs on modules including but not limited to Sunflower Plan Benefits and Procedures, Compliance, Member Rights and Responsibilities, the Grievances and Appeals process, Cultural Competency, Customer Service Skills, and Software Applications. CSRs also attend additional trainings which cover claims and billing.

RETROACTIVE COVERAGE (5.2.1.E)

Sunflower is experienced in processing member assignments with retroactive effective dates, including coverage for services rendered during the retroactive eligibility period. Retroactive Medicaid coverage is defined as a period of time generally up to three months prior to the application month. Sunflower has received 834 files with retroactive coverage dates that span several months. Based on the 834 files being received from the State, Sunflower processes an average of approximately 2,500 member records per month that include retroactive eligibility. As these members are loaded across Sunflowers systems using the MDM/UMV, the eligibility effective date is reflected so that services rendered during the retroactive eligibility period can be covered appropriately.

Based on the 834 files being received from the State, Sunflower processes an average of approximately 2,500 member records per month that include retroactive eligibility.

Sunflower's claims system has processes in place to waive timely filing requirements and authorization requirements for claims submitted for services rendered during a retroactive eligibility period. This configuration is outlined in a policy and procedure for retroactive coverage that will be submitted to the State for review and approval prior to the contract start date.

THE ASSIGNMENT ADJUSTMENT PROCESS (5.2.1.F)

Sunflower understands and will cooperate with the Assignment Adjustment Process. We understand that adjustments are triggered by MMIS updates with a recoupment of capitation payments when an assignment is removed, and payment of capitation when assignments are added. We cooperate in this process through our financial reconciliation process and working with the State's fiscal agent and KDHE on any discrepancies between assignment and capitation payment.

SUNFLOWER'S ENROLLMENT RESPONSIBILITIES (5.2.1.G)

Sunflower will accept member assignments without restrictions regardless of a member's race, color, national origin, age, sex, sexual orientation, gender identity, disability, ethnicity, language needs, or health status. Our processes for managing member enrollment are described below.

Established Processes for Processing Enrollment Data

Sunflower has considerable experience processing daily 834-member eligibility and enrollment files. We understand and will comply with the Model Contract and all KDHE requirements regarding processing of member eligibility files. Our goal is continuous improvement in the quality of our member data. We have expert teams that use proven processes to ensure accurate membership eligibility and enrollment information throughout our systems to support our staff, our vendors and subcontractors, our providers, our members, and KDHE.

Processing Member Enrollment Files

The process starts with our Medicaid Eligibility Team' Enrollment Specialist (ES) loading the 834 files into the Sunflower MIS on the same day we receive it through standardized add, term, and modify protocols. The files will be processed through our HIPAA-compliant UMV system which receives, validates, integrates, manages, and distributes all levels of member information to all downstream system components needing that information.

Resolving Discrepancies

Any member records that include discrepancies default into an exception report, which is systematically corrected using standardized data correction routines. Our staff will alert all parties within 24 hours if a file is missing, and then work with our IT team and the State to locate and process the file and ensure we are not delayed in updating member information. If we identify individuals on the 834 who are in eligibility categories not eligible for enrollment in KanCare we will notify KDHE immediately so files can be updated. In addition to these systematic validation and verification processes, on a monthly basis, Sunflower's ES team works with Finance to reconcile our member eligibility and enrollment information against KDHE 's 820 Premium Remittance Advice. Through this process, we also identify any discrepancies between our MIS member information and member demographic information from the 820 file, as well as member demographic information we may have collected via member outreach or from providers. Eligibility staff will be able to add information in real time in UMV that is visible through all of Sunflower's other systems within 24 to 48 hours, so staff, providers and members can see the most current information. If our system is not able to automatically correct discrepancies identified in the Exception Report, staff will make manual corrections. Our Medicaid Eligibility team creates several reports for our vendors, as well as internal teams as follows:

- **Vendor Outbound Reports**
  - LogistiCare
  - NIA
  - Envolve Vision
  - Envolve Dental
  - Envolve Pharmacy Solutions
  - (The Kansas Enrollment inbox receives a Success or Failure email, along with the FTP site where the outbound file is located, when the file is sent out to the vendor each morning)

- **Disenrollment Report** - delivered to all internal departments
- **Pregnancy Report and Foster Care Report** - alerting Medical Management of new members
- **Third Party Liability (TPL) file** – sent to our claims processing system so that appropriate TPL claims edits can be triggered.

COVERED SERVICES POLICIES AND PROCEDURES (5.2.1.H-I)

Sunflower maintains comprehensive policies and procedures related to covered services. These coverage policies are consistent with the terms of the contract and our claims processing system is configured to pay for services according to these established coverage and payment rules.

Coverage for Newborn Children of Members

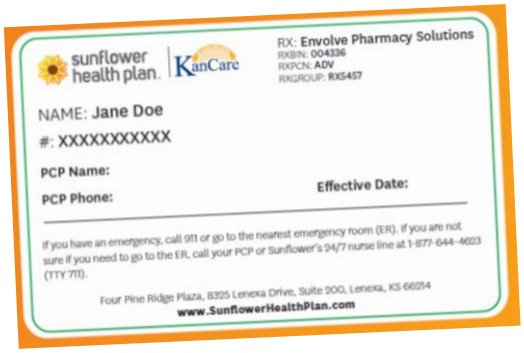
The Sunflower Eligibility policy and procedure provides that newborn children of members have access to all medically necessary services under the appropriate benefit package effective at the time of their birth.

Benefits Available upon the Effective Date of Enrollment

All members will have access to benefits according to their benefit package as of the effective date of their enrollment. This includes retroactive eligibility as described above. Sunflower agrees to make the full scope of benefits to which these members are entitled available as of their effective date of enrollment.

NEW MEMBER ORIENTATION (5.2.1.J)

Sunflower's new member orientation starts with a New Member Welcome Packet being mailed to the new member. The Welcome Packet includes:



- The member's ID card
- A Member Handbook
- Benefits Booklet providing details on contact information, benefit coverage, authorization requirements, and how to obtain an authorization
- Link to online New Member Welcome Page on Sunflower member portal
- Value Added Benefits, Formulary, and Provider Directory, including how to access the searchable online Provider Directory.
- CentAccount information which outlines the Cent Account Program, the member incentive program which is unique to Sunflower
- Member Forms Booklet, which includes a member to do list about how to get started as a Sunflower member, such as how to log on to the Secure Member Portal to access Sunflower's large array of online and self-help tools
- HIPAA privacy notice and member rights and responsibilities
- Sunflower magnet with important phone numbers

The New Member Welcome Packet also includes a Member To-Do List, instructing members to visit the Sunflower Website to create an online account and fill out online versions of the forms described above. The To-Do list also instructs members who don't have access to the internet to either mail their completed forms to Sunflower or to call our Customer Service call center for assistance.

In addition to the outreach described above, Sunflower will incorporate new member orientation activities into our existing community events. For example, when Sunflower will be hosting one of our local farmers market events, as part of our farmers market voucher initiatives, we will notify local members and encourage new members to visit and learn more about their benefits. To the extent possible our staff will have internet connected laptops and/ or tablets that members can use to create a profile on the Sunflower website.

New Member Welcome Calls

Within 30 days of a new member's enrollment, Sunflower conducts telephonic outreach through New Member Welcome Calls. During this call, we use information from the 834 file to identify any new members who have not chosen a PCP so we can work with them to find a good PCP match based on where they live, their health needs, transportation assistance, accommodations for persons with disabilities, culture and language, and other personal preferences. We outreach to members a minimum of three times; to increase the chances of reaching new members, they make multiple attempts via phone on different days at different times of the day, and document in our CRM the details of each attempted contact. When we connect with a new member, we verify the member's PCP choice (if made already) or help them choose one, educate them about how their PCP serves as their medical home, and let members know they can change their PCP at any time.

Additionally, during Welcome Calls, Sunflower staff assist members with completing a Health Risk Screening (HRS). Through the HRS, we identify member-specific health needs including whether the member has any immediate physical health or behavioral health need, or if the member is pregnant.

New Member Orientation at Community Events

In addition to the outreach described above, Sunflower will incorporate New Member Orientation activities into our existing community events. For example, when Sunflower will be hosting one of our local farmers market events, as part of our farmers market voucher initiatives, we will notify local members and encourage new Members to visit and learn more about their benefits. To the extent possible our staff will have internet connected laptops and/ or tablets that members can use to create a profile on the Sunflower website.

MEMBER ASSIGNMENT TO A PCP (5.2.1.K)

Helping Members Choose a PCP

Sunflower understands the criteria that are most important to members when selecting a PCP and we have established processes and systems to elicit information from members that can help us most effectively assist them in selecting a PCP they will stay with as their medical home. Criteria that influence members' PCP preferences include location and ease of access, gender and language, preference for specialty such as pediatrics or internal medicine versus family or general practice, and special expertise or accommodations for members with disabilities. Below we describe the materials and supports we use to help educate members about choosing a PCP.

New Member Welcome Packets (Welcome Packet). Sunflower sends all new members a Welcome Packet within 10 business days of receiving the 834-enrollment file. If the member did not choose a PCP when they enrolled, or has not chosen one before the Welcome Packet is mailed, their Member Identification (ID) Card (included in the Welcome Packet) reflects an automatically assigned PCP. The Welcome Letter and "Guide to this Packet" document both explain how to change PCP assignment or get help choosing a different PCP, and how to get a printed Provider Directory, if desired. The Welcome Packet also includes a PCP Form, which can be mailed back to Sunflower in the postage free envelope (also included in the Welcome Packet), or faxed to the Member Service Center. Members also are advised they can call the Member Service Center and work with a CSR to make a PCP change or complete the action online through the Member Portal.

Auto-Assignments Based On Proven Criteria

For members that have not chosen a PCP, we auto-assign the member to a PCP. As described above, members can change their PCP assignment at any time.

Auto-assigning New Members. Sunflower uses an auto-assignment protocol that includes multiple factors we know are important to members, including any history they or their family might have with a PCP, language needs (if known), age, gender, and area of residence. We assign members only to PCPs with open panels. Additionally, Sunflower is exploring how we can incorporate providers' quality scores into the auto-assignment process, to reward providers who consistently meet high quality standards.

Assigning Members Previously Enrolled With Sunflower. As we have described above our UMV system will support all eligibility and enrollment functions across all Sunflower programs. The UMV system allows us to systematically determine if a member on the 834 was previously enrolled with us, and if so, their most recent PCP relationship.

Assigning Newborns A PCP. We know that establishing newborns with a PCP is a critical part of ensuring they receive all their important visits in their first year. Sunflower's dedicated Pregnancy/Newborn CM staff strive to minimize the lag time between delivery and a newborn appearing on the 834. As soon as we know a member is pregnant, a Service Coordinator (SC)

will outreach to her to let her know about all the programs and services available through Sunflower, such as our Start Smart for Your Baby® Program. Start Smart teams work with expectant mothers to choose a PCP for their baby within 60 calendar days prior to the expected delivery date. If they still have not chosen a PCP for their baby, the Pregnancy/Newborn Service Coordinator will contact new mothers within 30 days of receiving notification of a delivery to assist them with a PCP selection. Once we receive the newborn enrollment on the 834, if the mother has not chosen a PCP, we follow the same process as for other new members to help the mother find a PCP for the baby that best meets her needs.

Helping Members with Special Needs Find the Right PCPs. If our member-facing staff have identified a new member with special needs they explain the options for accessing service coordination services and the important role the PCP plays in supporting ongoing care needs. For example, we help members with developmental disabilities find PCPs with experience or expertise working with them to meet their unique needs. We also allow members with chronic conditions or multiple comorbid conditions, and children with special health care needs, to select a specialist as a PCP.

Sunflower understands first-hand how important it is for children in Foster Care to be connected right away with a PCP that can serve as their medical home. Our dedicated Foster Care Team is prepared to address the immediate needs of any eligible child removed from the home, and has established relationships with providers who can offer immediate assistance to newly enrolled Foster Care children, including the 72-hour screening. To maintain continuity of care and connections for both children and their guardians, we make every effort to keep a child with a PCP with whom they have an existing relationship, even if that provider is not contracted with Sunflower. For children in Foster Care, Sunflower sends an ID card for the child to their Foster Care agency, including KVC and St. Francis, so that they can more readily assist Foster Care families. Additionally, our dedicated Foster Care Team ensures that children with a behavioral health (BH) diagnosis receive immediate referrals to our BH providers, and will assist with scheduling therapeutic psychiatric evaluations and working with BH providers to meet the special needs of every foster child. When appropriate, we also can approve a BH Specialist who is willing and qualified to serve as a PCP for a child with BH needs.

Analytics to Drive Accurate PCP Assignment. Sunflower continuously monitors member utilization to ensure that they are assigned to the PCP from whom they most often seek services. When members are assigned to a PCP but consistently seeks services from a different provider, we update the PCP assignment to increase PCP assignment accuracy. When we identify that a member is seeing a provider other than their PCP of record, we will reach out to the member to change their PCP assignment to that provider. We send the member a PCP assignment letter with a new member ID card reflecting their new PCP. This program helps Sunflower to avoid communicating with providers about patients they are not actively treating, and allows Sunflower to coordinate care with the provider who is actually rendering services to the member.

Supporting Member PCP Choice

Sometimes members have health needs or chronic conditions that require a medical home where they can quickly and easily access specialized support from their PCP. Sunflower recognizes how important it is for these members to build a relationship with a PCP they trust can best meet their needs. We have in place processes that allow members with chronic, complex or special needs – including children - to select a specialist as their PCP. A specialist must contractually agree to meet all the criteria of a PCP, including:

- PCP duties are within the scope their training and clinical expertise
- Actively managing all of the member's care needs
- Providing preventive care, and support access to behavioral health care and community services
- Submitting encounter data
- Admitting privileges at a Sunflower-contracted hospital
- Accessibility to members' 24-hours a day, 7 days a week; we encourage all of our PCPs to have extended weeknight and weekend hours, and offer incentives for them to do so.

RE-ASSIGNING MEMBERS IF THEIR PCP IS TERMINATED (5.2.1.L)

Sunflower maintains a policy and procedure for re-assigning members if their PCP is terminated from the Sunflower provider network. Upon receipt of a provider notice of termination, the Sunflower Eligibility Department runs a PCP Panel listing that contains names, ID numbers and addresses of all members impacted as a result of the provider being the member's assigned PCP. The Sunflower Eligibility Department assigns new PCPs to all members prior to the mailing of the termination notice based on recommendations from Sunflower and/or following auto-assignment methodology. The state-approved "Provider Termination" letters are used to notify all affected members of the provider's termination. If the PCP has provided appropriate and timely notice, the letter advises the member that their PCP will no longer be able to act as their PCP as of "date" and the member may call Sunflower's Member Services Department to choose a different PCP. If the PCP termination occurs without timely notice (such as in the event of the death of the PCP) the letter advises the member that effective immediately their PCP will no longer be able to provide services as a provider in Sunflower's network and the member may call Sunflower's Member Services Department to choose a different PCP. Members receive a replacement Member ID card including their new PCP name and phone number whenever a PCP change is made.

OTHER ENROLLMENT PROVISIONS (5.2.1.M, 5.2.1.N, 5.2.1.O AND 5.2.1.P)

90-Day Change Period

Sunflower understands that members have a 90-day period within which they may change to a different MCO if desired. This 90-day period has no impact on the services we provide to new members or the covered services that are available to new members. Our goal is to orient new members to the benefits available from Sunflower and demonstrate that we are the best MCO to meet their needs. If a member does choose to change plans, Sunflower will transition all information as appropriate to their new plan. New members are made aware of their right to

switch plans in the first 90 days after assignment to Sunflower and that switching plans will not impact their eligibility for benefits. This notification is included in the Member Handbook.

Application for Enrollment

The State's Fiscal Agent is responsible for handling applications for enrollment and assisting members with the process of selecting an MCO. Our Customer Service Representatives are trained to refer calls and inquiries from members who have not been assigned to Sunflower to the Fiscal Agent for assistance. Members who are requesting a change of MCOs are also referred to the Fiscal Agent.

Managed Care Brochure

Sunflower works with the State and its Fiscal Agent to provide information on the Value-Added Benefits we provide for inclusion in the brochure that will be made available to members to facilitate plan selection and is offered in alternative formats including Braille, audio, and American Sign Language and prevalent languages for members with limited English proficiency. Our Value-Added Benefits, explained in further detail in Section 5.10.5, are designed to address member needs while supporting improvements in overall health outcomes.

State Responsibilities

Sunflower recognizes and appreciates the work done by the State in the eligibility determination and enrollment process as outlined in section 5.2.1.P. These responsibilities are also outlined in Sunflower's eligibility and enrollment policy and procedure so that our staff are clear that the State is the sole authority for determining eligibility, and through their Fiscal Agent, assignment to an MCO if the enrollee has not selected one.

5.2.2. DISENROLLMENT

Sunflower is currently complying with all requirements related to disenrollment, including collaboration with the Fiscal Agent around members' plan selection, transferring member information, and tracking reasons for disenrollment. We are proud to say that Sunflower has never requested that a member be disenrolled from our plan for any reason.

GENERAL DISENROLLMENT PROVISIONS (5.2.2.A)

Sunflower's disenrollment policies and procedures are consistent with the requirements outlined in 42 CFR 438.56 including the process and timeframes for health plan disenrollment and valid reasons for disenrollment. Changes on the 834-eligibility file received from the State act as the sole source of truth for processing disenrollments.

MEMBER REQUESTED DISENROLLMENT (5.2.2.B)

Sunflower educates members about their option to disenroll through the Member Handbook and in response to inquiries received by our Customer Service call center or through the member grievance and appeal process. We recognize that members have the option to disenroll:

- During the Member Choice Period (within 90 days of assignment to Sunflower)

- Anytime (for cause) as provided in 42 CFR 438.56
- During the Annual Enrollment Period

Members who express a desire to disenroll will be referred to the State and its Fiscal Agent as described further below. Members will be considered enrolled with Sunflower until we receive an 834-enrollment file from KDHE notifying Sunflower of the member eligibility end date.

SUNFLOWER'S DISENROLLMENT RESPONSIBILITIES (5.2.2.C)

Sunflower members are informed of their disenrollment rights as part of the new member orientation process and in the Member Handbook. A member may request disenrollment by contacting the State or its Fiscal Agent directly. If a member contacts Sunflower and expresses a desire to disenroll we will handle the request as described below.

Disenrollment Requests to the Customer Service Call Center

When a member directly requests to be disenrolled, our CSRs use a Quick Reference Guide approved by KDHE to review the advantages of being enrolled in a health plan like Sunflower, including building a relationship with a PCP that can be their medical home. CSRs explain that any CentAccount® rewards a member may have accrued will not transfer among plans. If there are specific issues or problems a member has experienced that are influencing their decision to disenroll from Sunflower, Customer Service Representatives (CSRs) listen and document those concerns and strive to help the member resolve them, during that contact, or as quickly as possible for matters that require further research. If their provider is not in our network, we will request information for the provider and present it to our Contracting and Network Development Department; if they need a specialist, we will immediately transfer them to the Integrated Care Management team to look for a specialist to assist them. Our experience over the past five years has helped us learn the kinds of concerns that members typically voice as reasons for choosing to disenroll, and develop tools to help them solve problems and answer questions thoroughly and quickly, which often results in their choosing to stay enrolled with Sunflower. We teach them how to use the website and Member Portal, which offer tools and access to information whenever it is convenient for them. If a member still wishes to disenroll, CSRs will document the information in the CRM System. When applicable, the CSR will also educate the member about their appeal and grievance rights, and will assist in filing a grievance as requested. If the member indicates that they want to disenroll despite the actions described above, the CSR will refer them to the Fiscal Agent's Managed Care Enrollment Center to initiate the disenrollment.

Disenrollment Requests to Service Coordination Staff

Sometimes members will express their desire to disenroll to their Service Coordinator or someone on their Integrated Care Team (IC Team). When this occurs, the IC Team will listen to the member's concerns and try to identify specific issues or problems they then can work with the member to resolve. For example, members may not feel their PCP is the right fit, or may express dissatisfaction about difficulties finding a specialist they want or need. As much as possible, the IC Team will assist members with solving their concerns right away. They also may

engage other Sunflower staff, such as our Contracting and Network Development team, to help with more complex issues such as engaging new specialists or additional PCPs in a particular geographic area. First and foremost, they work to ensure the member's needs are met, even if that ultimately means the member still chooses to disenroll.

Tracking Disenrollment Reasons

For members who are referred to the Fiscal Agent for disenrollment by our CSRs notes will be captured recording the reasons expressed for disenrollment. These cases are tracked and reported to the Quality Improvement Committee (QI Committee) so that they can be incorporated into the Quality Assessment and Performance Improvement Process. We also use "good cause" inquiries where members have requested disenrollment for cause, to address issues and concerns that cause members to leave our plan. Sunflower will continue to work with the Fiscal Agent to try to obtain information on disenrollment reasons. When additional information is received from the Fiscal Agent it will be incorporated into the information collected from our system for reporting to the QI Committee.

Transferring Member Information to another MCO

Sunflower maintains a policy and procedure for transferring member information, including medical records, care plans, and other pertinent materials, to another plan after they disenroll. Sunflower takes all reasonable and appropriate actions necessary to ensure the continuity of a member's care upon Disenrollment. Such actions shall include: transferring relevant member medical information, including medical records and other pertinent materials when a member is transferred to or from another Plan.

Coverage for Inpatient Charges for Disenrolled Members

In the event that a member disenrolls from Sunflower while admitted to the hospital, our Concurrent Review staff will notify the hospital of the member's disenrollment prior to the transition. After the disenrollment, Sunflower will retain responsibility for payment of inpatient charges until the member is discharged. The hospital will be instructed to bill Sunflower for these charges. Other non-inpatient (ancillary) charges will be the responsibility of the member's new plan and the hospital and ancillary providers will be instructed to bill the new plan. Our Claims system is configured to handle inpatient claims for members who have disenrolled from Sunflower, but who were admitted to the hospital prior to their disenrollment.

Plan-Requested Disenrollment

Sunflower is able to provide services to all KanCare enrollees and we have never requested disenrollment of one of our members. Should we ever need to request disenrollment of a member it will be in accordance with Section 5.2.2.C.6 and 5.2.2.C.7 as well as 42 CFR 438.56.

5.2.3. MARKETING

DEFINITION OF MARKETING (5.2.3.A)

Sunflower Health Plan (Sunflower) understand that "Marketing" encompasses any communication between Sunflower and a Medicaid/CHIP beneficiary who is not enrolled in our plan that can reasonably be interpreted as intending to influence the beneficiary to enroll with us, not enroll with another KanCare MCO or disenroll from another KanCare MCO. Subject to the requirements and restrictions in the Contract, Sunflower engages in very limited marketing activities, but rather focuses primarily on general consumer education on health topics and KanCare 2.0 benefits with robust oversight by our Marketing and Communications Department with documentation to demonstrate compliance to the State. Additionally, we use an approved general brochure explaining who we are and what benefits are available from Sunflower. This brochure is made available to beneficiaries during open enrollment along with other materials compiled by the State's enrollment broker.

In 2017, Sunflower did engage in a marketing campaign, approved by the State, with messages that were designed to reach our existing members but that also served to increase awareness of the KanCare program and Sunflower among the general public. This campaign included:

- Billboards
- Public Transit Signage
- Ads through digital channels
- Radio advertisements

Sunflower Sponsorships

Sunflower considers sponsorships of events, conferences, and Kansas-based organizations to be an important part of our marketing strategy. Sponsorships not only provide an opportunity to promote the Sunflower brand generally, they reinforce the existing collaborative relationships we have with KanCare stakeholders. Through our sponsorships, we are also able to financially support organizations who are doing work that positively impacts KanCare beneficiaries. Examples of some of Sunflower's recent sponsorships include:

- Interhab's annual Power Up Conference for I/DD providers
- Kansas Association for the Medically Underserved annual conference
- Self-Advocates Coalition of Kansas (SACK) annual conference

- Alzheimer's Association Conference on Dementia
- Safe Sleep Task Force – Distribution of infant cribs in Wyandotte Co.
- Becoming a Mom – Course curriculum printing for sites statewide
- Midwest Ability Summit
- KS Medical Group Management Association Spring Conference
- American Diabetes Association, Tour de Cure
- 2017 Symposium on Teen Suicide Prevention and Depression Awareness

PROHIBITED ENROLLMENT INCENTIVES (5.2.3.B)

Sunflower's marketing policies and procedures outline all prohibited marketing activities. Sunflower does not and will not offer any compensation, reward, or benefit to members to influence enrollment with our plan other than additional health-related services or informational or educational services that have been approved by the State. These Value-Added Benefits are described in more detail in section 5.3.2.

MARKETING RESTRICTIONS (5.2.3.C)

Sunflower actively trains staff and monitors compliance with restrictions on Marketing. Restricted marketing activities include but are not limited to the following marketing methods:

- Door to Door
- Telephonic
- Email
- Texting
- Any other "cold call" marketing

Further, Sunflower does not engage in any communication to a person who is not a Sunflower member that could be interpreted as seeking to influence any enrollment or disenrollment decision that a beneficiary may make.

Training and Monitoring to Prevent Prohibited Activities

We do not engage in Marketing to influence potential members to enroll with Sunflower or to disenroll from another plan. To ensure compliance with Marketing requirements and restrictions, we have developed and implemented policies, procedures and processes that address training staff, providers and subcontractors about allowable and prohibited activities; monitoring compliance, following KDHE 's material development and approval process; and monitoring and addressing complaints promptly. Sunflower's policies, procedures and processes comply with all State and federal law and contractual requirements related to Marketing, including those outlined in the Contract and 42 C.F.R § 438.104. Sunflower employs a comprehensive training and monitoring approach to ensure that our community education and outreach activities align with State and federal Marketing restrictions. Our policies and procedures (P&Ps) clearly stipulate prohibited Marketing activities, and our training will address

all prohibited activity in the Model Contract. We adhere to KDHE requirements for submitting our Marketing P&Ps, work plan, schedules and marketing materials for review and approval.

All Employees. Sunflower provides training to all employees on State and federal Marketing restrictions as part of our new hire orientation process and annual training, and employees will be required to review and initial a copy of our relevant P&Ps. The Manager of Marketing and Communications works with the appropriate department leads to ensure department staff (such as Member Services and Service Coordination) receive additional guidance on how Marketing restrictions impact their interaction with members and the larger community.
To augment our standard training on marketing activities, in 2017 we also distributed information via a "seat drop" leaving a one-page marketing resources guide at the desks of all employees. The guide included reminders related to ensuring that documents and literature being shared with members had been created through the established process and approved by KDHE. It also provided instructions for locating desk guides explaining the processes for requesting new materials, promotional items, and adding outreach events to our unified events calendar. Finally, the resource guide reminded employees to review desk guides that include instructions and key information for employees exhibiting at a conference, health fair, or other public event.

Community-Facing Staff. Sunflower's Manager of Marketing and Communication trains and provides direct oversight to our community-facing staff, including Community Relations Representatives, Community Health Workers and Provider Services Representatives. Initial first-month orientation training includes a detailed review of Marketing P&Ps with a focus on defining prohibited activities using clear examples. In addition, new CSRs shadow experienced outreach staff and/or problem solve using fictitious scenarios that spotlight Marketing infractions. The Manager of Marketing and Communications also conducts random observations of CSRs activities during community events to ensure they are adhering to Marketing restrictions. We require staff to conduct community outreach in a non-discriminatory fashion, regardless of individuals' health status and future need for health care services. We will prohibit the use of language that could be construed to confuse or defraud members or misrepresent any entity.

Providers and other Entities. Sunflower's Network Management and Contracting Director is be responsible for ensuring our network providers and subcontractors understand how Marketing restrictions apply to them. In addition, our P&Ps clearly communicate State and federal prohibitions on promotional items, including the use of items that can influence a member's selection of a particular provider, practitioner, or supplier for which payment may be made, in whole or in part, by Medicaid. We will contractually obligate our providers and subcontractors to comply with the restrictions clearly outlined in all contracts. We provide ongoing education via Provider Newsletters and weekly e-mail blasts. All of these materials will are available on our website.

Monitoring and Resolving Complaints

Sunflower's VP of Compliance oversees development and implementation of procedures to log and resolve Marketing Complaints, including procedures to address the resolution of Complaints against Sunflower, our employees, contracted providers, or subcontractors. We will forward to KDHE for further investigation and resolution marketing complaints that cannot be satisfactorily resolved. Our VP of Compliance is responsible for submitting all required documentation and reports to KDHE within the required timeframes, including the quarterly Complaint Tracking Log. To date, Sunflower's quarterly complaint log has no complaints to report.

MARKETING MATERIALS (5.2.3.D)

Compliance in Developing Materials

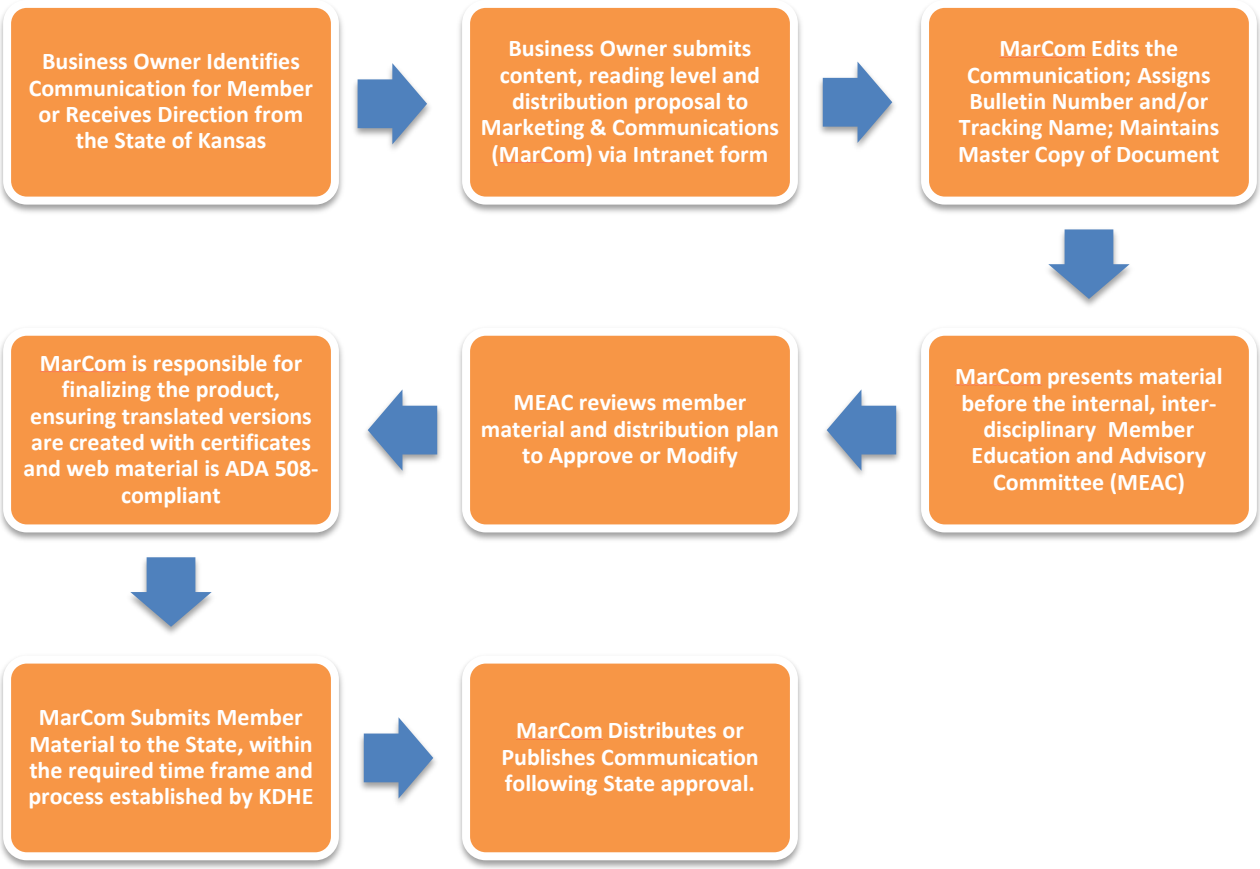
Sunflower submits all educational and marketing materials within required timeframes and ensures they are accurate and KDHE-approved prior to using them. We only distribute pre-approved materials and seek approval even for slight modifications. We will not distribute benefit charts that are intended for KDHE distribution. All of our materials, as well as our website, are certified as readable at, or below, a 6th grade reading level and we provide language translation and interpretation services as requested by our members. We will submit website screenshots to KDHE for review and approval prior to making the website available and whenever we update it. Sunflower's website also meets all ADA Section 508 compliance regulations and includes a translation tool.

Our process for the development of marketing materials also ensures that the following prohibitions are observed:

- Materials do not contain any assertion or statement indicating that a beneficiary must enroll with Sunflower in order to not lose KanCare benefits.
- Materials do not contain any assertion or statement that Sunflower is endorsed by CMS, the federal or State government or any similar entity.

The following flowchart in ***Figure 5.2.3.D_ Member Materials Development Process*** reflects Sunflower's material development process. Our process is designed to ensure that materials are accurate, clear and compliant prior to submission to the state. Material creation and editing starts with the Sunflower business owner (manager of relevant Sunflower Department). The Business owner submits the proposed material to the Marketing and Communications Department who then solicits feedback from the Member Education and Advisory Committee (MEAC) and the Provider Education and Advisory Committee (PEAC). Once proposed changes are incorporated and the materials go through quality checks they are submitted to the state for review and approval. Any edits received from the state review are incorporated and final, approved versions are uploaded to a shared drive for use by Sunflower Staff. Staff may only use materials that have been approved and must use the final approved versions of the materials located on this shared drive. Approved materials are also posted and archived on an internal SharePoint site. Materials are posted in a non-editable format.

Figure 5.2.3.D_ Member Materials Development Process



Desk guides have been created to assist business owners with the development of member materials. These guides include an overview of the material development process and a checklist for creating/revising member materials including tips and instructions on readability, translations, and the review and approval process. Additionally, our marketing materials development and submission process is tracked in our compliance management system to support consistency and tracking of these activities.

DISTRIBUTION OF MARKETING MATERIALS (5.2.3.E AND 5.2.3.F)

As described above, our marketing materials development process is designed to ensure that only those materials that have been reviewed and approved by the State are used. Through the state approval process, we also receive authorization to co-brand marketing materials, materials will be distributed with the required co-branding unless otherwise authorized.

In general, marketing materials are distributed to the entire State unless otherwise authorized by the State. This ensures that our marketing messages are directed towards all potential new members without targeting based on geography.

OTHER MARKETING REQUIREMENTS (5.2.3.G, 5.2.3.H AND 5.2.3.I)

Sunflower understands and currently complies with all of the requirements in sections 5.2.3.G-I. To that end, we:

- Do not and will not offer the sale of any other type of insurance product as an enticement to enroll with Sunflower in the KanCare 2.0 program.
- Ensure that our marketing plans and materials are accurate and do not contain false or misleading information, and that our marketing does not mislead, confuse or defraud KanCare enrollees or the state. This is supported by our internal review process and feedback from our Member Advisory Committee.
- Do not and will not seek to influence enrollment in conjunction with the sale or offering of any private insurance as defined in 45 CFR 155.20.

5.3 Covered Services

5.3. COVERED SERVICES

SUNFLOWER DEMONSTRATED SUCCESS

Sunflower Health Plan (Sunflower) has successfully served the integrated needs of KanCare members since 2013, with our affiliate serving the BH needs for the CHIP population in Kansas since 2005. Our local success is demonstrated through our:

- Quality outcomes in areas such as preventive care and ED diversion, specialty care, behavioral health (BH), long term services and supports (LTSS), and access to services, as highlighted in ***Table 5.3.1.A Sunflower Improved Member Outcomes*** below.
- Presence and participation in the community to help address social determinants of health and independence. For example, in 2016, Sunflower started a farmer's market voucher program to educate on the importance of eating healthy foods and increase access to fresh fruits and vegetables. Since inception, over 2,500 Sunflower members have participated, increasing access to healthier food options and giving over $25,000 back to local farmers across Kansas.
- Robust package of value-added benefits to drive improved health outcomes, enhance member access to care, promote healthy lifestyles, and contribute to program cost-effectiveness. Sunflower is a leader in providing meaningful value-added benefits.
- Use of in lieu of services to keep our members in the community, providing additional community support to assist with over 513 members transitioned from nursing facilities back to home since 2014 and provided other needed equipment and services to keep others safe and healthy in their home community.

Compliance with Scope of Work

Sunflower currently facilitates and administers all Medicaid and CHIP benefits and services deemed "medically reasonable and necessary", in accordance with State and federal law, including the Kansas Administrative Regulations (KARs), 42 CFR § 438.210, and our State Contract, and will ensure continued compliance with the KanCare 2.0 SOW requirements, including Section 5.3 Covered Services and Attachment C of the RFP. Below we describe in detail how we are well positioned to deliver covered services timely and efficiently and introduce value-added and in lieu of services to complement covered Medicaid services. For ease of review we have included SOW references in headers and within the narrative.

5.3.1. COVERED AND NON-COVERED SERVICES

Sunflower is able to provide appropriate covered benefits and services because we maintain a robust provider network that grows and changes to meet members' physical health (PH), behavioral health (BH), long term services and supports (LTSS), social, cultural, and geographic needs; an expert staff; and integrated operations and systems. As a continued partner, we offer the State a winning formula to effectively and efficiently deliver services under KanCare 2.0, including:

- ***Consolidated, integrated systems and programs*** to improve health outcomes and facilitate access to appropriate covered benefits and services, ensuring person-centered and holistic care delivery, personal accountability, and continuity of care.

- ***Active engagement with members and families/caregivers*** to enable access to needed services and to support and promote self-management, health literacy, and independence in the least restrictive setting.
- ***Proven, multi-faceted processes and approaches*** to contract, engage, incentivize, and collaborate with providers in the continual delivery of high-quality, cost-effective care.
- ***Integrated technology and best practices*** that foster accountability, deliver actionable data at the point of care, and remove barriers to care.
- ***An Integrated Service Coordination (ISC) Model and team-based approach*** designed to effectively manage high risk and high cost populations, and address all member needs, including social determinants of health and independence.

DELIVERING COVERED SERVICES UNDER KANCARE 2.0 (5.3.1.A-5.2.1.F)

Sunflower assumes responsibility for the provision of all covered PH, BH, LTSS (including HCBS and NFs), and pharmacy services to all eligible populations as described in the Scope of Work (SOW), including Attachment C, and as defined in the KanCare Section 1115 Waiver. This includes:

- The availability of medically necessary services 24 hours per day, seven days per week, as arranged through our comprehensive provider network. Emergency services are available to all members through any emergency department (ED) with no authorization required. Members are notified of the availability of services, including emergency and urgent care services, through the Member Handbook, Member Newsletters, Member Welcome Call, information provided through their PCP, Service Coordinator, and upon calling Member Services. (5.3.1.B.)
- The continuity, coordination, and integration of PH, BH, and LTSS services, ensuring collaboration among providers, including community providers. We facilitate communication and coordination through our Integrated Service Coordination model as described in Section 5.4. Our Service Coordination program is an important feature of our model of care designed to integrate the full continuum of care and address social determinants of health and independence. We ensure continuity during transitions, allowing for out of network providers to continue to care for members in treatment, in accordance with our Continuity of Care policy. All provider qualifications to support these programs are included within our Provider Manual, as described in Section 5.5.1. (5.3.1.C)
- Services delivered in sufficient amount, duration, and scope to meet each individual member's needs, as administered and monitored through our Utilization Management (UM) program, described in Section 5.8.1, and overseen by our Quality Improvement (QI) program, described in Section 5.9. Sunflower may place appropriate limits on a service in accordance with 42 CFR § 438.210 and in compliance with the Mental Health Parity and Addictions Equity Act (MHPAEA), as documented in our UM plan which is reviewed and approved by our QI Committee annually and individual UM policies reviewed and approved by our UMC which includes network physician representation. (5.3.1.D and 5.3.1.E)
- Medically necessary services provided outside of the State of Kansas, pursuant to 42 CFR § Part 431, subpart B, which are more readily available in other states or needed due to an

emergency medical condition. Sunflower does not routinely cover any services provided outside of the continental United States. (5.3.1.F)

Described below are the primary programs, processes, and approaches that demonstrate our ability to deliver on the State's goals under KanCare 2.0 and effectively deliver and arrange for benefits and services, including coordination of services to address social needs such as transportation, housing, employment, and food and nutrition.

Experience and Innovation

Serving approximately 130,000 members today, Sunflower has a solid track record of improving member health outcomes, implementing innovative programs, and ensuring our members have access to highly qualified providers, as demonstrated throughout this response. Sunflower has the infrastructure, expertise, and experience necessary to provide all covered benefits and services and meet all elements of the SOW. We continue to be a learning, evolving organization, well positioned to meet the Quadruple Aim to reduce costs and improve care, services, outcomes, and the member and provider experience.

Our 350 plus culturally competent staff are located at our headquarters in Lenexa, Kansas and two regional offices in Topeka and Wichita near the greatest concentrations of our membership. With an average of 20 plus years of experience in health care, our plan executives are experts in the delivery of covered benefits and services to Medicaid, CHIP, and low-income populations, including children in foster care, members with Intellectual and Developmental Disabilities (I/DD), members receiving LTSS services, the elderly, and members with special health care needs.

Our history of collaboration with the Kansas Department of Health and Environment (KDHE), the Division of Health Care Finance (DHCF), the Kansas Department for Aging and Disability Services (KDADS), key community stakeholders, members, and providers has given us a comprehensive understanding of the varying and changing needs across the state. With this knowledge and experience, we have been able to tailor our approaches to service delivery to maximize effectiveness, efficiency, and accountability. For example, we use our CentAccount® member incentive program to promote prevention and wellness, paying out, on average, over $70,000 in rewards per month in 2017. Examples of new program innovations to support access to and effectiveness of covered services include:

In 2017, on average, Sunflower paid out over $70,000 in CentAccount® rewards per month.

- Sunflower is collaborating with the Primary Care Association to better address social determinants using the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE). PRAPARE is a National Association of Community Health Centers (NAC) and partners effort to help health centers and other providers collect the data needed to better understand and act on their patients' social determinants. PRAPARE is both a standardized patient social risk assessment tool consisting of a set of national

core measures as well as a process for addressing social determinants at both the patient and population levels.

- Sunflower Transition to Employment (STEP) is a workforce development and employment support resource program to address employment barriers for all of our members within the communities we serve. Through STEP, we will partner with community organizations to provide opportunities for our members to further their education and pursue meaningful employment. The STEP program will include community job fairs, GED vouchers, referrals, and assistance with career counseling services.
- Our Tele-Care Monitoring Program provides real time monitoring of biometric data using web-based technology combined with telephonic disease management coaching for high risk members. The program objectives are to reduce preventable health care utilizations, promote member adherence to treatment guidelines and improve self-management skills. The program objective for pregnant members is to improve glycemic control to promote positive birth outcomes. Conditions covered include COPD, Diabetes, Heart Disease (Heart Failure and Coronary Artery Disease) and Hypertension.
- Building off our farmer's market voucher program, we are supporting Double Up Food Bucks through the Wichita Health and Wellness Coalition. Through a 3 year grant funded by Sunflower, the program matches SNAP dollars dollar for dollar for redemption at the farmer's market.

Our ability to meet and exceed the requirements in providing benefits and services is also founded on the resources, experiences and innovations offered by our parent company, Centene, and Centene-affiliated health plans serving 12.3 million members in health care programs in 29 states, primarily through Medicaid, Medicare, TRICARE and the Health Insurance Marketplace. Centene offers over 33 years of experience in full-risk managed care. As a wholly-owned subsidiary of Centene, Sunflower benefits from the wealth of experience and the support of Centene and its family of affiliated health plans and specialty companies through the implementation of best practices that have been proven to be effective and are described throughout this response.

Demonstrated Success Providing Covered Benefits and Services

Sunflower's ability to administer covered services and benefits is demonstrated by improved member outcomes and experience and appropriate service utilization, as highlighted in the examples in ***Table 5.3.1.A Sunflower Improved Member Outcomes*** below:

Table 5.3.1.A Sunflower Improved Member Outcomes

Preventive Care and ED Diversion	

Well-Child Visits	**Year over year improvements in HEDIS results, for example:**
	• Well Child 15 month – 6 or more visits
	  o *44.33% in Measurement Year (MY) 2014 to 55.22% in MY 2015 to 55.71% in MY 2016*
	• Well Child 3-6 Years & Adolescent Well Child Visits
	  o *62.04% in MY 2014 to 62.99% in MY 2015 to 63.22% in MY 2016*

	• Weight Assessment for Children/Adolescents – BMI, Nutrition & Physical Activity
	  o *BMI: 48.10% MY 2014 to 50.71% in MY 2015 to 58.89% in MY 2016*
	  o *Nutrition: 49.76% MY 2014 to 50.48% in MY 2015 to 61.78% in MY 2016*
	  o *Activity: 47.38% MY 2014 to 56.01% in MY 2016*
	• Adolescent Immunizations – Combo 1 (Tdap & Meningococcal)
	  o *61.58% MY 2014 to 63.59% in MY 2015 to 65.38% in MY 2016*

Prenatal and other Adult Care	• *Since 2014, Sunflower has seen:*
	  o *A decline in reported low birth rates, due to our success in keeping babies in-utero for an increased period of time*
	  o *A decline of babies born at less than 2,500, 1,500 and 1,000 grams*
	  o *A decrease in ALOS for babies in the NICU*
	• *Adult Access to Preventive/Ambulatory Services increased from 81.73% in 2016 to 83.37% in 2017*

ED Diversion	*ED utilization rate reduced from 772 visits per 1000 in 2013 (program inception) to 741 in 2016.*
Dental	**Annual Dental Visits** • *3.7% increase from 2015 to 2016* • *5.5% increase from 2014 to 2016* • *Exceeding 75th percentile rank in Adult Access and Annual Dental HEDIS measures*
Chronic Condition Management	
Diabetes	**Hemoglobin A1c Testing** • *2.13% increase from 2015 to 2016* • *Exceeding 50th percentile ranking* **Hemoglobin A1c Control less than 8** • *16.85% improvement from 2015 to 2016* • *32.7% increase from 2014 to 2016* • *Exceeding 66th percentile ranking* **Retinal Eye Exams** • *4.1% increase from 2015 to 2016* • *15.1% improvement from 2014 to 2016* • *Exceeding 95th percentile ranking*

Other Chronic Conditions Disease Management	**Year over year improvements in HEDIS results, for example:**
	• Asthma Medication Ratio
	  o *58.49% MY 2014 to 59.48% in MY 2015 to 61.70% in MY 2016*
	• Medical Management Asthma
	  o *27.85% MY 2014 to 28.94% in MY 2015 to 33.87% in MY 2016*
	• Pharmacy Management COPD
	  o Dispensed Bronchodilator Within 30 Days of Event
	  ▪ *40.96% MY 2014 to 44.99% in MY 2015 to 46.38% in MY 2016*
	  o Dispensed Systemic Corticosteroids Within 14 Days of Event
	  ▪ *34.16% MY 2014 to 35.26% in MY 2015 to 37.79% in MY 2016*
	• Controlling High Blood Pressure
	  o *50.67% MY 2015 to 55.45% in MY 2016*

Behavioral Health Services	
Behavioral Health Follow Up	7 Day Follow-Up after Discharge • *Increased 2.11% from 2015 to 2016* • *Exceeding the 95th percentile* 30 Day Follow-Up after Discharge • *Increased 3.87% from 2015 to 2016*

	• *Exceeding 90th percentile*
Long Term Services and Supports	
Repatriation	Across all affiliate health plans, including Sunflower, we have transitioned nearly 8,000 members to the community since 2014
Quality of Life	During 2017, over 98% of Sunflower's LTSS members reported that they feel safe in their home as reported on our LTSS Dashboard
HEDIS	In many instances, HEDIS rates for our LTSS population is higher than the traditional Medicaid population, for example: • *Adult Access to Preventive/Ambulatory Services* *October 2016 YTD - All* — *81.73%* *October 2017 YTD - All* — *83.37%* *October 2016 YTD - HCBS* — *90.45%* *October 2017 YTD - HCBS* — *93.14%* • *Annual Monitoring for Patients on Persistent Medications* *October 2016 YTD - All* — *82.09%* *October 2017 YTD - All* — *83.00%* *October 2016 YTD - HCBS* — *85.66%* *October 2017 YTD - HCBS* — *84.70%*
Satisfaction Survey	How satisfied are you with the HCBS services you receive? • *95.92% satisfied or very satisfied* Overall, how satisfied are you with the care you receive from Sunflower Health? • *94.96% satisfied or very satisfied*
Access to Services	
CAHPS	Getting Care Quickly • *Improved from 83% in 2015 to 88% in 2017 (98th percentile compared to Quality Compass)* Getting Needed Care • *Improved from 84% in 2015 to 86% in 2017 (93rd percentile compared to Quality Compass)*
NCQA Accreditation	Access & Services • *4 stars* • *94.3 points*

Overall Approach to Effectively Delivering and Promoting Covered Benefits and Services

Leveraging our current and past successes, knowledge of the population, and proven innovations from our health plan affiliates across the country, Sunflower has a comprehensive approach for arranging care and delivering services to the KanCare population. Included are the following key elements:

- Comprehensive Statewide Provider Network
- Community Collaboration and Engagement
- Proven Integrated Programs and Approaches
- Proactive Member Outreach, Engagement, and Empowerment

Comprehensive, Statewide Provider Network. Our provider network has been designed, developed, and maintained to offer our members choice and timely access to all provider types,

including medical, substance use disorder (SUD), mental health, Home and Community Based Services (HCBS), and institutional transition services. Our network, programs, and systems are designed to be fully integrated, facilitating communication and collaboration across providers and provider types. For example, all authorized providers have access to a member's integrated Care Plan through our secure, web-based Provider Portal and providers are required to share chart notes and pertinent information as described in our Provider Manual.

Sunflower has over 23,000 providers in our network today, including:

- More than 3,400 Primary Care Physicians (PCPs)
- More than 7,300 Specialists
- More than 600 DME/Medical Supply Dealers
- 166 Hospitals in Kansas and adjoining states
- 227 FQHCs/RHCs
- All 26 of Kansas' Community Mental Health Centers (CMHCs)
- All 8 of Kansas' Psychiatric Residential Treatment Facilities (PRTFs)
- More than 3,100 local BH providers
- More than 1,500 LTSS providers
- More than 850 pharmacy providers

Critical to maintaining a robust, quality network is evaluation and monitoring, described in Section 5.5 of this response and our Provider Engagement Model, described in Section 5.6.

Community Collaboration and Engagement. Sunflower understands that by supporting our community partners, we are supporting our members. We regularly seek direct community input from our advisory councils, including our Member Advisory Committee, LTSS Advisory Committee and Physician Advisory Committee. In 2017, Sunflower hosted, planned, and/or participated in 120 member and community outreach events throughout Kansas. We have touched more than 52,280 KanCare members through our involvement in Adopt–a-School, Baby Showers, Back to School, Health Fairs, Community Walks, Volunteer Days and more. By supporting our partners, we help make opportunities for our members available that may not be possible without our collaboration. Current examples of on-going strategic sponsorships and partnerships that promote covered benefits and services include:

- Adopt-a-School Assemblies and Back-to-School Fairs
- Arthritis Foundation
- Chambers of Commerce
- Community baby showers
- American Diabetes Association
- Association of CMHCs
- Chronic Disease Alliance of Kansas
- Community Living Opportunities
- American Heart Association
- American Cancer Society
- Boys & Girls Club
- Clinic Days/Screenings
- Convoy of Hope

- Disability Rights Center
- Farmers Market Voucher Program
- Health centers and social service agencies
- Greater KC Business Leadership Network
- Head Start
- Health Alliance ICT
- Health Literacy Kansas
- Indian Health Services (IHS)
- InterHab
- KanCare Adult Dental Coalition
- Kansas Association for the Medically Underserved
- Kansas Health Care Association
- Kansas Hospital Association
- Kansas Immunization Coalition
- Kansas Medical Society
- Kansas Pharmacists Association
- KS American Academy of Pediatrics
- KidsTLC
- KUMC - Project ECHO
- Latino Health For All Coalition
- LeadingAge Kansas
- March of Dimes
- Member Health Fairs
- Metropolitan Community College
- Mother & Child Health Coalition
- National Association of Mental Illness (NAMI)
- Parent Leadership Conference
- Project SEARCH
- Self Advocate Coalition of KS
- Senior Housing/Senior Centers
- Special Olympics
- Topeka Community Foundation
- United Community Services
- Urban League
- Wichita Healthcare Coalition
- Wichita State University
- Youth Wellness Events

Proven Integrated Programs and Approaches. Our integrated Service Coordination and Utilization Management (UM) programs are based on nationally recognized guidelines and best practices for integrated, coordinated care and services. Our integrated management approach, combined with our technological data integration, reporting and data sharing capabilities, promote primary/preventive care, assure the appropriate use of services, and improve care quality and continuity of care. Our staff use daily, weekly, and monthly reports drawn from integrated data sources that show historical service use, predictive modeling and clinical assessments and other information. Using these reports, staff can quickly identify and reach out to members who have high needs or are at risk of high utilization of services. We also provide reports to our providers and Community Service Coordinators (future capability). Our program goes beyond a purely clinical determination of needs to identify and address social determinants, functional status, and barriers to care, such as lack of caregiver supports, impaired cognitive abilities and food and housing needs. Sunflower takes responsibility for the coordination of all services, not just those for which we are financially responsible or administer directly. Taking a holistic approach to member care and services, we have an obligation to ensure that all member needs are being met, which includes connecting members to community-based agencies and service providers and using various sources of data and information to obtain a holistic view. We also engage our providers to deliver care planning and service coordination services through value-based purchasing, delivering actionable data, and education and training. Our integrated clinical programs are further described under Section 5.4 of this response.

Proactive Member Outreach, Engagement, and Empowerment. Our ability to engage members in taking personal responsibility for their health conditions, using health care services appropriately, and achieving improved health outcomes stems from our understanding of the challenges they face. We reach out to educate multiple times, in multiple formats, and emphasize personalized contact based on the member's needs and preferences. We supplement our general outreach and education with targeted, individualized approaches, such as reminders about appointments, and community-based events that are held in collaboration with trusted organizations, schools and PCP offices. We also incentivize desired health behaviors and members' use of preventive care. We employ a high touch approach and meet members where they are. For example, our outreach team of 19 Sunflower Community Health Workers (CHWs) assist KanCare members one-on-one with understanding their health, health benefits and services and other community resources. CHWs can provide educational services telephonically, at a provider office or community events, or in the home. CHWs assist our members in building a relationship with their provider. CHWs provide assistance such as: finding a physician to meet a member's individual needs, knowing what questions to ask during their appointment, assisting member's with understanding their benefits and access to care standards to ensure timely access to care. They also assist members in accessing transportation, food, shelter, or other health or social programs. We also utilize CHWs to help locate hard to reach members to connect them with health plan clinicians and service providers as well as how to access needed care and services as indicated through predictive modeling and risk stratification. Our member engagement strategies are fully described in Section 5.10 of this response.

5.3.2. VALUE-ADDED BENEFITS

SUNFLOWER HEALTH PLAN'S EXPERIENCE OFFERING VALUE-ADDED BENEFITS

Sunflower has been providing value-added benefits (VABs) for our members since inception in 2013, and is a leader in providing meaningful enhanced benefits to engage members and improve health outcomes and quality of life. For example, Sunflower was the first Kansas MCO to implement adult incontinence supplies as a value add in 2017. This enhancement became a requirement for all MCOs to provide as a state covered benefit mid-2017 following a decision by the Kansas Medicaid program for the care and comfort of KanCare beneficiaries with an incontinence diagnosis. Sunflower also implemented a respite benefit to support caregivers' health while caring for our members on the Intellectual/Developmental Disability (I/DD) waiver waiting list. These caregivers are not currently receiving the State-covered service, and Sunflower aimed to provide interim support. As a result, one member and her parents were able to attend an out-of-town graduation, and a 9-year old child's mother was able to take a break from caregiver responsibilities to recharge.

Making investments in the health, wellness and safety of the community leads to improved health outcomes and reductions in more costly levels of care. Sunflower's proposed VABs for KanCare 2.0 are designed to augment the KDHE benefit package by enhancing access to care, promoting healthy lifestyles, integrating services, and improving outcomes. Our VABs in Kansas

and across all Centene markets have proven to be an effective means to encourage appropriate utilization of preventive services, and providing motivation and education to encourage healthy behaviors. Additionally, our VABs are informed by social support services needed to ease some of the day-to-day pressures, enabling members to focus on their health and quality of life.

EVALUATING POTENTIAL VALUE-ADDED BENEFITS

Sunflower evaluates proposed VABs for inclusion through a process including identification, analysis, and assessment for effectiveness. We gather ideas internally based on experience and through our Member Advisory Committees. For example, in our LTSS Advisory Committee, Sunflower polled members for feedback and requested input from our field-based Service Coordinators. Based on this information, Sunflower determined providing incontinence supplies would meet our criteria to enable members to focus on their quality of life. When considering VABs, we evaluate what best aligns with KDHE programmatic goals, incentivizes members to live healthier lives, enables community living, and reduces overall cost of care.

ADHERENCE TO VALUE-ADDED BENEFITS REQUIREMENTS (5.3.2.A, F, H)

Sunflower understands and will comply with all contract requirements including adherence to federal Medicaid and CHIP regulations and incentives consistent with HHS OIG Special Advisory Bulletin. We will also ensure our VABs are not reported as medical or administrative expenses. Further, we will continue to submit the Value Added Benefits Utilization Report in the format and frequency as required by KDHE.

Value-Added Benefits Offered Today (5.3.2.A-B)

Sunflower takes into account the priorities identified by KDHE for members of the KanCare program, and offers our VABs statewide for all appropriate populations. Our VABs include a range of innovative and evidence-based practices that align with our commitment—and the State's priorities—to measurably improve health care outcomes, promote wellness and healthy lifestyles, and lower the cost of overall care through actual health care services, benefits, or positive incentives to promote healthy lifestyles and improved health outcomes. Sunflower further categorizes our VABs as follows:

- ***Enhanced Benefits:*** enhancement of State Plan-covered services, such as enhanced vision, dental, etc.
- ***Extra Benefits:*** additional benefits not covered by the State Plan, such as care grants, cell phone services, and social determinant of health and independence (SDOHI) benefits including promoting healthy eating, safety in the home, etc.
- ***Programs:*** benefits that incorporate outreach, education, and interventions, such as Start Smart for Your Baby®, disease management programs, etc. (may also include extra benefits as defined above).

Enhancing Value-Added Benefits to Further Align with KanCare Goals (5.3.2.C-E)

The VABs Sunflower offers today align with goals of KanCare and consider adult dental, smoking cessation, services for pregnant women, services for elderly, services that support bridge to

independence, and additional transportation services as part of our criteria when evaluating potential benefits. We understand Sunflower's VABs do not need to be consistent with all KanCare MCOs. While Sunflower's existing VABs are State-approved, Sunflower will seek written approval from the State for all existing and any new VAB offerings listed in ***Table 5.3.2.A*** below, which details how each benefit aligns with KDHE's programmatic goals as part of KanCare 2.0:

Table 5.3.2.A Sunflower's Proposed Value-Added Benefits

Sunflower Health Plan Value-Added Benefits	Coordination and Integration of BH/PH/LTSS	Support Members in the Community	Connect Members to SDOHI	Promote Wellness and Healthy Lifestyles
Enhanced Benefits				
Enhanced Dental Benefit		√		√
Enhanced Respite Benefit		√	√	
Transportation/Meals/Lodging	√	√		
Extra Benefits				
Member Incentives – CentAccount® Rewards Program	√	√	√	√
In-Home Telemonitoring	√	√	√	√
SDOHI - Care Grants		√	√	
Community Memberships	√	√		√
Medication Review	√			√
Behavioral Health Related Extra Benefits	√			√
Care Attendant/Hospital Companionship		√		√
SafeLink® Cell Phone	√	√	√	
Weight Management		√		√
SDOHI – Promoting Healthy Eating		√	√	√
Caregiving Collaborations™		√		
Maternity Related Extra Benefits				√
Programs				
Maternity Care Program	√	√		√
Smoking Cessation Program		√		√
Disease Management Programs	√	√		√
Adopt-A-School Program		√		√
Kids Club Program		√		√
Nursing Home Transition Support Program	√	√	√	
Sunflower Transition to Employment Program (STEP)		√	√	

VALUE ADDED BENEFIT ELIGIBILITY, LIMITATIONS AND RESTRICTIONS, AND IDENTIFICATION (5.3.2.E.1-3)

With KDHE approval, Sunflower will offer the proposed VABs as listed in the above grid. The following section details each benefit's respective eligibility criteria, limitations or restrictions, and how the benefit will be identified in encounter data where applicable.

sunflower health plan

Enhanced Benefits

- ***Enhanced Dental Benefit.*** Eligibility Criteria. Sunflower will offer two dental visits (cleanings, screenings) for adults 21 and older on an annual basis. Children are covered under regular Medicaid benefits on most dental services. We provide practice visits to the dentist's office for members with developmental disabilities and children on the autism waiver to help them become more comfortable with dental preventive care visits. Limitations or Restrictions. Dentures are covered for eligible members receiving Frail & Elderly Waiver benefits. Eligibility is based on medical necessity. Identifying VAB in Encounter Data. Sunflower will continue to submit the required monthly VAB Utilization report where all VABs are identified in detail. We will also submit the required Medicaid Reporting Template (MRT) during rate setting, during which we reconcile VABs back to the monthly VAB Utilization Report to KDHE and remove them from either administrative or medical costs as applicable. For encounterable VABs, such as dental, we will also submit specific codes as part of the MRT process which State actuaries can use to validate the reasonableness of the submissions. Each monthly Financial Status Report (FSR) will also reconcile and remove VABs from appropriate medical and administrative costs.
- ***Enhanced Respite Benefit.*** Eligibility Criteria. Sunflower will offer up to 16 hours of respite care for persons on the I/DD waiting list, persons on the Frail Elderly waiver and children adopted out of the Foster Care system. Limitations or Restrictions. No limitations or restrictions exist for this benefit. Identifying VAB in Encounter Data. For VABs not based on claims and therefore non-encounterable, Sunflower will continue to reconcile the monthly FSR and the annual MRT to the monthly VAB Utilization Reports submitted to KDHE and back out the amounts from the administrative or medical costs as appropriate. Each monthly VAB Utilization Report will include detailed VAB information.
- ***Transportation/Meals/Lodging.*** Eligibility Criteria. Sunflower will offer transportation services above and beyond covered benefits on a case-by-case basis. For example, we may assist in transporting a member from an out-of-state facility to admit at a nursing facility due to a more cost effective in-state benefit. Additionally, in the event an expectant mother needs to be closer to a hospital near delivery, Sunflower may assist with lodging at an extended stay hotel, which is more cost effective than an emergent delivery and subsequent transport to a NICU 200 miles away. Sunflower will also coordinate with nonprofit organizations, such as Angel Flights, to assist with transporting families when transportation would not otherwise be approved by the family. Limitations or Restrictions. Transportation, meals, and lodging are restricted to eligible members and subject to Service Coordinator approval. Identifying VAB in Encounter Data. For VABs not based on claims and therefore non-encounterable, Sunflower will continue to reconcile the monthly FSR and the annual MRT to the monthly VAB Utilization Reports submitted to KDHE and back out the amounts from the administrative or medical costs as appropriate. Each monthly VAB Utilization Report will include detailed VAB information.

sunflower health plan

Extra Benefits

- ***Member Incentives – CentAccount® Rewards Program.*** Eligibility Criteria. In an effort to better align our member incentives around how members interact with their environment and the health care system on a regular basis, Sunflower is expanding our CentAccount® rewards program to offer additional member rewards for completion of health and wellness activities. Our expanded program gives Sunflower the ability to empower our members by delivering personalized incentives that encourage healthy behaviors, enabling trusted relationships, and ultimately enhance our members' lives within their community, one person at a time. Through CentAccount®, Sunflower offers financial rewards to members based on evidence-based, preventive and primary care interventions that address Social Determinants of Health and Independence, have the greatest impact on health outcomes, and are most relevant to our members. When a member completes a reward activity, we load the reward onto a Sunflower-issued CentAccount® card. In 2019, the CentAccount® card and member ID card will be combined into one card – making it more convenient for members to access and use their CentAccount® rewards. The rewards program is tailored based on member preference and can be accessed through a member's smartphone or through our Sunflower member mobile application. Current incentives available through the CentAccount® Rewards Program are included in the following ***Table 5.3.2.B Current CentAccount® Rewards Program Incentives***.

Between January 1 and September 30, 2017, more than 45,000 Sunflower members earned CentAccount® Rewards worth nearly $650,000

Table 5.3.2.B Current CentAccount® Rewards Program Incentives*

Behavior/Activity	Eligible Population	CentAccount Incentive
Completing a Health Risk Screening (one per calendar year)	All members	• $10
Infant Well Care Visits (before 30 days old, and at 2, 4, 6, 9, 12, and 15 months old)	Infants up to 15 months old	• $10 per visit ($60 max)
Immunizations (MMR, VZV)	Infants age 12 to 15 months old	• $10
Child Well Care Visit with a primary care doctor	Children and Young Adults (ages 2-20)	• $10
HbA1c test (two per calendar year)	Members with diabetes (ages 18-75)	• $10 ($20 max)
Comprehensive Diabetes Care • HbA1c test* • Kidney Screening • Retinopathy screening	Members with diabetes	• $50 (must complete all three within one calendar year) *If 2 HbA1c tests are completed in the calendar year, then total maximum reward is $70
HPV Vaccine (2 shots within 12 month period)	Members ages 9-12	• $15

Pregnancy Care**	Pregnant women	• $15 (must submit completed Notification of Pregnancy Form within first trimester) • $15 (for every 3rd prenatal doctor visit**; $45 max) • $10 (postpartum doctor visit** completed 21-56 days after you deliver your baby) ** To be eligible for these rewards, members must notify Sunflower of pregnancy by submitting a Notification of Pregnancy Form

**Incentives and dollar amounts may be adjusted based on membership needs.*

Limitations or Restrictions. Members (or their parents/caregivers) can use the card at merchants they already use every day, such as nationally recognized retail stores to buy a wide variety of health-related items including some over-the-counter medications as well as goods and services not covered by Medicaid such as transportation (e.g. bus passes), utilities, pest control, childcare, and items promoting member wellness and safety (e.g. smoke detectors, fans, light bulbs). Identifying VAB in Encounter Data. For VABs not based on claims and therefore non-encounterable, Sunflower will continue to reconcile the monthly FSR and the annual MRT to the monthly VAB Utilization Reports submitted to KDHE and back out the amounts from the administrative or medical costs as appropriate. Each monthly VAB Utilization Report will include detailed VAB information.

- ***In-Home Telemonitoring.*** Eligibility Criteria. Sunflower will offer a Tele-Care Monitoring Program that provides real-time monitoring of biometric data using web-based technology combined with telephonic disease management coaching for high-risk members. The program objectives are to reduce preventable health care utilizations, promote member adherence to treatment guidelines, and improve self-management skills. For pregnant members, the program objective is to improve glycemic control and promote positive birth outcomes. The Tele-Care Monitoring Program provides daily monitoring* of biometric data using web-based technology to capture and record real-time participant data. This data is reviewed by Health Coaches, who will provide the appropriate interventions including, but not limited to:
  - Alerting physicians (by fax and phone) when values are above acceptable ranges
  - Calling 911 when medically appropriate
  - Following up with members on physician interventions to ensure compliance
  - Communicating subsequent values with physician
  - Providing disease-specific education
  - Promoting self-management techniques according to condition
  - Providing printed education materials to reinforce education

Limitations or Restrictions. Covered conditions include COPD, Diabetes, Heart Disease (Heart Failure and Coronary Artery Disease), and Hypertension. Identifying VAB in Encounter Data. For VABs not based on claims and therefore non-encounterable, Sunflower will continue to reconcile the monthly FSR and the annual MRT to the monthly VAB Utilization Reports submitted to KDHE and back out the amounts from the administrative or medical costs as appropriate. Each monthly VAB Utilization Report will include detailed VAB information.

- ***SDOHI Care Grants.*** Eligibility Criteria. Sunflower will work with local nonprofit agencies to fund, support, and develop innovative programs or services that target subgroups of our membership, such as children in care management or members facing health care disparities. The focus of each grant may include facilitating health care delivery, mentoring health care literacy, creative approaches to community outreach, purchasing safety supports for the home, or normalizing the life of children in care management. These small cash grants provide creativity and flexibility in meeting needs related to mental and physical health. Sunflower has developed a Care Grant fund with a designated annual amount, and requests for the grants may be made by Sunflower staff as well as external individuals who interact with the member, such as caregivers and providers. Care Grants can also fund wraparound and person-specific supports and resources, such as air conditioners and hypoallergenic sheets for those with asthma, or may also be used to provide services such as purchasing books in Braille for a visually-impaired child who demonstrates a passion for reading, purchasing a tablet and communication application for nonverbal children, or computer software or hardware to promote literacy/educational supports. Limitations or Restrictions. Each grant will be determined on a case-by-case basis, subject to Service Coordinator approval. Identifying VAB in Encounter Data. For VABs not based on claims and therefore non-encounterable, Sunflower will continue to reconcile the monthly FSR and the annual MRT to the monthly VAB Utilization Reports submitted to KDHE and back out the amounts from the administrative or medical costs as appropriate. Each monthly VAB Utilization Report will include detailed VAB information.
- ***Community Memberships.*** Eligibility Criteria. Sunflower is committed to providing free services and events to promote healthy lifestyles for kids. To assist Sunflower members in developing social and leadership skills, Sunflower will offer community programs for children, such as membership fees to Boys & Girls Clubs. Limitations or Restrictions. This benefit is available to all Sunflower members ranging in age from 6-18 years old. Identifying VAB in Encounter Data. For VABs not based on claims and therefore non-encounterable, Sunflower will continue to reconcile the monthly FSR and the annual MRT to the monthly VAB Utilization Reports submitted to KDHE and back out the amounts from the administrative or medical costs as appropriate. Each monthly VAB Utilization Report will include detailed VAB information.
- ***Medication Review.*** Eligibility Criteria. Sunflower will provide a Comprehensive Medication Review with a local pharmacist to eligible members. The review includes a 30 minute face-to-face consultation with a local pharmacist. Limitations or Restrictions. Eligible members must have a chronic disease (asthma, bipolar disorder, chronic alcohol/drug abuse, chronic

lung disorder, COPD, diabetes, HIV/AIDS, or schizophrenia) and take 5 chronic medications. Identifying VAB in Encounter Data. For VABs not based on claims and therefore non-encounterable, Sunflower will continue to reconcile the monthly FSR and the annual MRT to the monthly VAB Utilization Reports submitted to KDHE and back out the amounts from the administrative or medical costs as appropriate. Each monthly VAB Utilization Report will include detailed VAB information.

- ***Behavioral Health Related Extra Benefits.*** Eligibility Criteria. Sunflower will provide members access to the myStrength online program, which offers eLearning to help members overcome depression and anxiety. This online program includes simple tools, weekly exercises, mood trackers, and daily inspirational quotes and videos. Limitations or Restrictions. The program can be used on its own or in conjunction with other care, and is available to all members. Identifying VAB in Encounter Data. For VABs not based on claims and therefore non-encounterable, Sunflower will continue to reconcile the monthly FSR and the annual MRT to the monthly VAB Utilization Reports submitted to KDHE and back out the amounts from the administrative or medical costs as appropriate. Each monthly VAB Utilization Report will include detailed VAB information.
- ***Care Attendant/Hospital Companionship.*** Eligibility Criteria. Sunflower will provide members on the I/DD waiting list with a care attendant for medical appointments if needed. In addition, we will provide up to 16 hours of hospital companionship for persons on the I/DD and Frail & Elderly waivers. Limitations or Restrictions. Subject to necessity and Service Coordinator approval. Identifying VAB in Encounter Data. For VABs not based on claims and therefore non-encounterable, Sunflower will continue to reconcile the monthly FSR and the annual MRT to the monthly VAB Utilization Reports submitted to KDHE and back out the amounts from the administrative or medical costs as appropriate. Each monthly VAB Utilization Report will include detailed VAB information.
- ***SafeLink® Cell Phone.*** Eligibility Criteria. Sunflower will offer eligible members a free smartphone through SafeLink®, which provides up to 350 free minutes of service per month. This service includes unlimited texting and 1GB of data per month for the first three months (then 500MB per month). Members will be able to have telephone access to their KanCare providers and unlimited calling to Sunflower. Limitations or Restrictions. One phone per eligible household. Identifying VAB in Encounter Data. For VABs not based on claims and therefore non-encounterable, Sunflower will continue to reconcile the monthly FSR and the annual MRT to the monthly VAB Utilization Reports submitted to KDHE and back out the amounts from the administrative or medical costs as appropriate. Each monthly VAB Utilization Report will include detailed VAB information.
- ***Weight Management.*** Eligibility Criteria. Sunflower will offer adult and pediatric members weight management programs to help overweight and obese members achieve long-term physical health improvement by targeting and working to achieve permanent healthy lifestyle habits. Limitations or Restrictions. Members age 12 and older are eligible for this Value-Added Benefit. Members over age 17 must have a BMI greater or equal to 30. Pediatric members age 17 and younger are considered medically eligible for this program if their BMI is >85th percentile for age. Member must have a referral from their PCP. Identifying VAB in Encounter Data. For VABs not based on claims and therefore non-

encounterable, Sunflower will continue to reconcile the monthly FSR and the annual MRT to the monthly VAB Utilization Reports submitted to KDHE and back out the amounts from the administrative or medical costs as appropriate. Each monthly VAB Utilization Report will include detailed VAB information.

- ***SDOHI – Promoting Healthy Eating.*** Eligibility Criteria. Sunflower members can receive produce vouchers worth $10 at special events with participating Farmers Markets. Sunflower staff will be at the market to welcome members and distribute the vouchers for produce purchases. Sunflower held 10 farmers market events in 2017 and served nearly 1,000 members. This benefit also supports local growers and their communities. Limitations or Restrictions. The vouchers for health plan members must be picked up and redeemed at the market on the same day of the event. Identifying VAB in Encounter Data. For VABs not based on claims and therefore non-encounterable, Sunflower will continue to reconcile the monthly FSR and the annual MRT to the monthly VAB Utilization Reports submitted to KDHE and back out the amounts from the administrative or medical costs as appropriate. Each monthly VAB Utilization Report will include detailed VAB information.
- ***Caregiving Collaborations®.*** Eligibility Criteria. Sunflower seeks to support the caregiver through various channels including our Caregiver Portal, Caregiver Resource Center, and Caregiving Collaborations® application.
  - **Caregiver Portal.** Our Caregiver Portal allows authorized caregivers to view the member's care plan, and other information necessary to support the member.
  - **Caregiver Resource Center.** Our Caregiver Resource Center, accessed via the Sunflower public website, offers information about early symptoms, exacerbation identification, managing illnesses, and balancing needs, as well as tools, tips, and links to community-based resources. For example, it includes information on using and storing medications, nutrition, and preparing healthy meals. The Caregiver Resource Center also provides links to disease-related websites, an informative health library, tips on caregiving, and resources for coping with stress.
  - **Caregiving Collaborations® Application.** Our Caregiving Collaborations application, accessible by smartphone or tablet, enhances the caregiver's ability to connect with the Service Coordinator and other integrated care team members using group chats and bi-directional video and file sharing. The application will allow caregivers to provide notification of condition changes and request information or assistance and will allow Service Coordinators to push out reminders for preventive care as well as confirm back up plans and appointments more easily.
  - **Caregiver Journal.** The Caregiving Collaborations program also includes a caregiver journal (in English and Spanish), which will be distributed to caregivers (pending State approval) for them to write about stressors, strategies they use to manage stress and how effective they are, and other aspects of their caregiving journey.
  - **"Thanks to You" Package.** This provides information and products intended to support caregivers, such as magnets with Sunflower contact information, a waterproof keepsake bag, caregiver education materials, and information regarding support groups and other items. Limitations or Restrictions. This benefit is available to one primary, informal

support caregiver per member. Identifying VAB in Encounter Data. For VABs not based on claims and therefore non-encounterable, Sunflower will continue to reconcile the monthly FSR and the annual MRT to the monthly VAB Utilization Reports submitted to KDHE and back out the amounts from the administrative or medical costs as appropriate. Each monthly VAB Utilization Report will include detailed VAB information.

- ***Maternity Related Extra Benefits.*** Eligibility Criteria. Sunflower will provide gifts such as blankets and thermometers in addition to our CentAccount member incentives program. These benefits are available to all pregnant members who have completed and submitted a Notification of Pregnancy form. Limitations or Restrictions. No limitations or restrictions apply to this benefit. Identifying VAB in Encounter Data. For VABs not based on claims and therefore non-encounterable, Sunflower will continue to reconcile the monthly FSR and the annual MRT to the monthly VAB Utilization Reports submitted to KDHE and back out the amounts from the administrative or medical costs as appropriate. Each monthly VAB Utilization Report will include detailed VAB information.

Programs

- ***Maternity Care Program.*** Eligibility Criteria. Sunflower will offer our Start Smart for Your Baby® program to pregnant members, babies, and families. Start Smart offers nursing support, education, and helpful gifts at no cost to the member.
  - In-home help with health care and social service benefits
  - Special texting program for Start Smart participants
  - Community baby showers for pregnant members, including diapers and other gifts
  - Birthday programs for children
  - Sunflower covers mosquito repellant spray for pregnant members

  Limitations or Restrictions. No limitations or restrictions apply to this benefit. Identifying VAB in Encounter Data. For VABs not based on claims and therefore non-encounterable, Sunflower will continue to reconcile the monthly FSR and the annual MRT to the monthly VAB Utilization Reports submitted to KDHE and back out the amounts from the administrative or medical costs as appropriate. Each monthly VAB Utilization Report will include detailed VAB information.
- ***Smoking Cessation Program.*** Eligibility Criteria. Sunflower members may participate in a smoking cessation program offered through our Healthy Solutions for Life program. (Nicotine replacement therapy is a regular Medicaid benefit when prescribed by the doctor.) Limitations or Restrictions. No limitations or restrictions apply to this benefit. Identifying VAB in Encounter Data. For VABs not based on claims and therefore non-encounterable, Sunflower will continue to reconcile the monthly FSR and the annual MRT to the monthly VAB Utilization Reports submitted to KDHE and back out the amounts from the administrative or medical costs as appropriate. Each monthly VAB Utilization Report will include detailed VAB information.

- ***Disease Management Programs.*** Eligibility Criteria. Sunflower will offer population-based disease management programs. Our current disease management programs are available to members with asthma, COPD, diabetes, heart disease, or high blood pressure. We will modify our current programs to meet member needs based on population health assessments. Limitations or Restrictions. This program is available to eligible members with qualifying disease states. Identifying VAB in Encounter Data. For VABs not based on claims and therefore non-encounterable, Sunflower will continue to reconcile the monthly FSR and the annual MRT to the monthly VAB Utilization Reports submitted to KDHE and back out the amounts from the administrative or medical costs as appropriate. Each monthly VAB Utilization Report will include detailed VAB information.
- ***Adopt-A-School Program.*** Eligibility Criteria. Sunflower has partnered with several Kansas public schools to hold Adopt-A-School events, including elementary and middle schools, Boys & Girls Clubs, and Head Start Classes. For example, at one event, a team made puppets and put on a show about bullying. Another team partnered with a dental group to talk to elementary children about the importance of going to the dentist and eating healthy food. Sunflower also brought Michelle Bain, the Centene author, to Kansas for a school event to the debut of the Kansas Lieutenant Governor's book about cleft palates, Every Face has a Special Smile. We will be involved with the "No One Eats Alone" initiative targeted at middle school children as part of the Centene Charitable Foundation's three-year sponsorship, to help combat social isolation and promote inclusion in middle schools across the nation. Social isolation in adolescents has been recognized as a precursor to teasing, bullying, self-harm, and even community violence, as well as adverse effects on a teen's health. Sunflower will also identify local universities or community organizations with an existing community garden program and an opportunity for collaboration in implementing a garden program at the school. This partnership would include volunteers to start the garden and helping students engage in hands-on exploration of food and nutrition as well as emphasizing healthy lifestyle choices. The selected school will commit to incorporating healthy foods from the garden into the lunch menu and provide volunteers to maintain the garden throughout the year. Limitations or Restrictions. Schools that are selected for funding-associated programs must commit to healthy eating and physical education as a priority at the school. Identifying VAB in Encounter Data. For VABs not based on claims and therefore non-encounterable, Sunflower will continue to reconcile the monthly FSR and the annual MRT to the monthly VAB Utilization Reports submitted to KDHE and back out the amounts from the administrative or medical costs as appropriate. Each monthly VAB Utilization Report will include detailed VAB information.

- ***Kids Club Program.*** Eligibility Criteria. Sunflower will offer children access to the Sunny's Kids Club program, based on our health plan mascot. This program mails a new book to a child's household four times per year. The book series is aimed at promoting physical activity and the importance of being healthy, and focuses on different stages of a child's development. Limitations or Restrictions. Parents must subscribe to the program. Identifying VAB in Encounter

Data. For VABs not based on claims and therefore non-encounterable, Sunflower will continue to reconcile the monthly FSR and the annual MRT to the monthly VAB Utilization Reports submitted to KDHE and back out the amounts from the administrative or medical costs as appropriate. Each monthly VAB Utilization Report will include detailed VAB information.

- ***Nursing Home Transition Support Program.*** Eligibility Criteria. Sunflower will offer nursing home transition support by partnering with providers to complete the following:
  - Pre-placement participation in transition meetings, finding and securing housing, securing household items, confirming informal supports, completing in-home risk assessment, assisting with hiring of caregivers (if member chooses self-direction), and other hands-on placement needs
  - A visit within the first week to ensure services and equipment are in place and meeting the members' needs, that the member has a PCP appointment, to complete a follow-up environmental risk assessment, and to deliver a case of water
  - A visit at 2 weeks from a Home Health provider RN for a wellness check
  - One week of home delivered meals for each member transitioning out of a nursing facility
  - Members may also be eligible for additional financial assistance transitioning to independent living situations

  Limitations or Restrictions. (Transition Coordination providers have the opportunity to request support from Sunflower, such as for utilities, subject to Service Coordinator approval and provided the member has exhausted available community resources through Transition Supports. Identifying VAB in Encounter Data. Sunflower will continue to submit the required monthly VAB Utilization report where all VABs are identified in detail. We will also submit the required Medicaid Reporting Template (MRT) during rate setting, during which we reconcile VABs back to the monthly VAB Utilization Report to KDHE and remove them from either administrative or medical costs as applicable. For encounterable VABs, such as Wellness Monitoring and Home Delivered Meals, we will also submit specific State-approved or existing procedure codes as part of the MRT process which State actuaries can use to validate the reasonableness of the submissions. Each monthly Financial Status Report (FSR) will also reconcile and remove VABs from appropriate medical and administrative costs.

- ***Sunflower Transition to Employment Program (STEP).*** Eligibility Criteria. Sunflower Transition to Employment Program (STEP) is a workforce development and employment support resource program to identify and remove employment barriers for all of our members within the communities we serve. STEP will provide employment resources and opportunities to achieve financial independence for our members and provide a connection for our members to existing community resources. The framework of STEP will be implemented throughout the State; partnering with community organizations to provide opportunities for our members to further their education and pursue meaningful employment. STEP will include community job fairs, GED vouchers, referrals and assistance with career counseling services. As a Referral Resource, we will connect members with a

benefits specialist to learn how their income may impact their benefits, refer members to various organizations such as End Dependence Kansas and Accelerating Opportunities in Kansas as well as assisting with completion of paperwork and follow-up.

- **GED Prep Test Vouchers.** For Sunflower members who are interested in pursuing their GED (cost may be absorbed for the test as part of the AO-K pathways program), Sunflower will provide vouchers to purchase the GED prep test for each testing section (4 sections).
- **Scholarship Program.** Sunflower members wanting to pursue a college degree would complete a STEP scholarship application. The scholarship will be funded by Sunflower employees through fundraising opportunities held throughout the year at the health plan.
- **Job Fairs.** Sunflower will partner with Wal-Marts, FQHCs and other community organizations throughout Kansas to host job fairs and career counseling seminars. The job fairs will include local employers, career counseling and job placement as well as support services.
- **Supported Employment Incentive Program.** Sunflower will provide enhanced reimbursement for providers that provide supported employment where members hold a successful job for six months at minimum wage or above for at least 25 hours a week.
- **Enhanced Transportation.** To support members seeking gainful employment, Sunflower will offer an enhanced transportation benefit to certain employment-related activities, such as job fairs and interviews.

Limitations or Restrictions. STEP components are available to all members eligible for each activity listed above. Identifying VAB in Encounter Data. For VABs not based on claims and therefore non-encounterable, Sunflower will continue to reconcile the monthly FSR and the annual MRT to the monthly VAB Utilization Reports submitted to KDHE and back out the amounts from the administrative or medical costs as appropriate. Each monthly VAB Utilization Report will include detailed VAB information.

VALUE-ADDED BENEFIT NOTIFICATION, ONGOING EDUCATION AND TRAINING (5.3.2.E.4-6)

For all VABs described above, Sunflower provides initial and ongoing notification to our providers and members regarding available VABs. To ensure Sunflower's providers, beneficiaries, and members are notified of our VABs, we will include information on all enhanced benefits, extra benefits, and programs in our member materials including the Member Handbook and the member and provider resources sections on the Sunflower website. Ongoing information will be included in our VAB brochure and periodically in our Member Newsletter, provider trainings, and Provider Newsletter to highlight specific benefits as well as communicate updates to ensure continued education and awareness of Sunflower's VAB offerings on our website, at community meetings, and at health fairs. All Sunflower employees will have access to VAB-specific training. For example, toward the end of 2016, we conducted four Lunch & Learn sessions addressing VABs we planned to offer in 2017, and repeated the process in 2017 for 2018 VABs. We also provide VAB information during provider sessions. We will follow this procedure for all subsequent Contract years, and include our

Community Service Coordination providers in the Lunch & Learn sessions. Our member-facing staff receive more in-depth VAB training related to their role at Sunflower, whether Customer Service Representatives, Community Health Workers, or our Service Coordination Teams. Sunflower also plans to continue special presentations for our HCBS providers to support their understanding of our VAB offerings.

VALUE-ADDED BENEFIT COST, DESCRIPTION, AND REPORTING ADHERENCE (5.3.2.F-H)

At no time will Sunflower VABs be reported as allowable medical or administrative expenses, and we will not pass on the cost of VABs to providers or members. All materials will clearly describe any limitations or conditions specific to VABs, including restrictions, responsible providers, and how to access the VAB. Additional detail will indicate that there are no grievance and appeal rights for VABs, and that these benefits will be provided throughout the Contract term. Sunflower will continue to provide VAB reporting in the format and frequency as requested by the State.

5.3.3. IN LIEU OF SERVICES

OVERVIEW (5.3.3.A-B)

With State approval based on our cost-benefit analyses, Sunflower supports offering "in lieu of services" in a medically appropriate and cost effective manner to address members' social determinants of health and independence (SDOHI). We will not require members to receive in lieu of services in place of covered services, and acknowledge that we will offer any of these approved services at our option. Sunflower acknowledges that if the State approves the in lieu of services, the State will take into account the utilization and actual cost for the services in rate setting, unless otherwise prohibited by Federal law.

PROPOSED IN LIEU OF SERVICES

With KDHE approval, Sunflower proposes the following services for supported member care:

- Intensive Outpatient Therapy to support members' behavioral health
- HCBS over members' benefit limits, such as Personal Care Services or Specialized Medical Care services in the member's home
- HCBS outside members' HCBS eligibility when a member is eligible for one HCBS program and needs a service from another program, for example, Home Delivered Meals
- HCBS for members who are not HCBS-eligible, such as Home Modifications
- Transition Coordination to help a member find a home and household supplies
- Other non-covered services, such as extermination, refrigerators, alternative or temporary housing, and mold remediation services to reduced emergency room visits and inpatient readmissions.

Services are health related and medically appropriate. Additionally, we have used value-added benefits that are not, and generally cannot be, included in the state plan or under the managed care contract but that can improve health outcomes.

Impact of Services that Address Social Determinants

A Sunflower member was hospitalized due to bed bug bites so extreme she was losing skin. Her physician would not release her to return to her home until extermination for the bed bugs had occurred. The physician contacted Sunflower, and we assigned the member to a Service Coordinator. We admitted the member to a long term care facility as the member had no personal resources to complete the necessary extermination. Sunflower consulted with Protective Services, local charities, the treating physician, and our internal clinical staff, and subsequently approved a plan to provide the extermination through “in lieu of” funds. The member’s Service Coordinator located an exterminator willing to provide the services, and Sunflower’s Member Advocate negotiated an acceptable fee. The Service Coordinator also coordinated with the member’s newly established guardian and landlord to ensure the clothes dryer was functioning to help with future preventive measures. After extermination, the member returned to her home and continued to heal in a safe environment. She continues to reside in her home, and is grateful for her health and the ability to remain in her community.

5.4 Service Coordination

5.4. Service Coordination

DEMONSTRATED SUNFLOWER SUCCESS

Sunflower Health Plan's (Sunflower's) person-centered, whole-health approach to Service Coordination is well-tested and tailored to meet the individual needs of KanCare beneficiaries. We integrate physical health (PH), behavioral health (BH), long-term services and supports (LTSS), functional, social, and other services the member receives to create a system of care responsive to each individual. Our model is based on a high-touch experience as demonstrated by our Community Health Worker (CHW) Program and Sunflower's LifeShare program. Through this model we have demonstrated the following success with our KanCare membership:

- We have successfully reduced emergency department (ED) visits from 772 ED visits/1000 in 2013 to 748 ED visits/1000 in 2017 annualized.
- We reduced total expenditures in the first 10 months of 2017 (compared to the first 10 months of 2016) by 30.2% for 450 high cost members with inappropriate utilization or poorly controlled chronic conditions.
- In 2016, our field-based CHWs successfully assisted in the completion of more than 3,478 Assessments, providing 14,461 resources. In addition, 19 of Sunflower's field-based CHWs recently received CHW certification and are trained in engagement skills, trauma-informed care, Person Centered Thinking and cultural, disability and poverty sensitivity.
- We have safely transitioned 513 individuals out of nursing facilities to community settings since 2014.
- We have successfully supported member self-direction as evidenced by the overall percent of our LTSS members that self-direct one or more of their services out of total number of members in the waiver program.
- Exceeded the NCQA Quality Compass 90th percentile in Follow Up After Hospitalization for Mental Illness and 75th percentile in BH services and screening in our pediatric population.
- Sunflower's experience monitoring and impacting quality outcomes in special populations has resulted in improved HEDIS® quality outcomes in our home and community-based services (HCBS) population and exceptional member satisfaction with LTSS Service Coordination: in our 2017 LTSS member satisfaction survey, over 95% of members receiving HCBS reported satisfaction with the help they receive from their Sunflower Service Coordinator (SC) and 99% indicated their SC respects their beliefs and preferences.
- Sunflower has set the national standard for access to BH services and appropriate treatment of BH conditions exceeding the NCQA Quality Compass 90th percentile in follow up after hospitalization for mental illness and 75th percentile in BH services and screening in our pediatric population. These standards can be attributed to our outstanding service coordination program and efforts to close gaps in care.
- Sunflower's integration of LTSS with medical care has been recognized as an exemplary program in a series of case studies recently published by the Long-Term Quality Alliance (LTQA). The case study on Sunflower's LTSS integration notes that, since KanCare's launch in 2013 and the program's subsequent inclusion of services for intellectual and developmental disabilities (ID/D), there have been improvements in quality of care for recipients of LTSS as well as the processes taken on by the network of providers.

Ready to Implement

Since 2013, Sunflower's community-based and culturally anchored model of care has focused on whole-person integrated care. As demonstrated by our successes and outcomes described above and throughout our proposal, we are well positioned to expand our program to accomplish a higher-touch model, in line with the State's expectation of Service Coordination. Our innovative programs, processes, people, and use of data and analytics and technological tools enable us to successfully implement the new SC model to support the objectives and goals of the KanCare 2.0 program. For example, Sunflower will:

- Offer new trainings and tools for Community Service Coordinator (CSCs) supporting near real-time information sharing and data exchange
- Engage all stakeholders through our Member Advisory Committee and LTSS Advisory Committee
- Implement a vetting, monitoring, and training process of CSCs for quality assurance

Compliance with Scope of Work (SOW)

Sunflower is currently in compliance with all KanCare contract requirements and will comply with all KanCare 2.0 model contract requirements described in Section 5.4 of the Statement of Work (SOW)/Request for Proposal (RFP). Below we describe our approach for complying with each element of the SOW, Sections 5.4.1 to 5.4.16. For ease of review we have included SOW references in headers and within the narrative.

5.4.1. SERVICE COORDINATION PROGRAM OVERVIEW

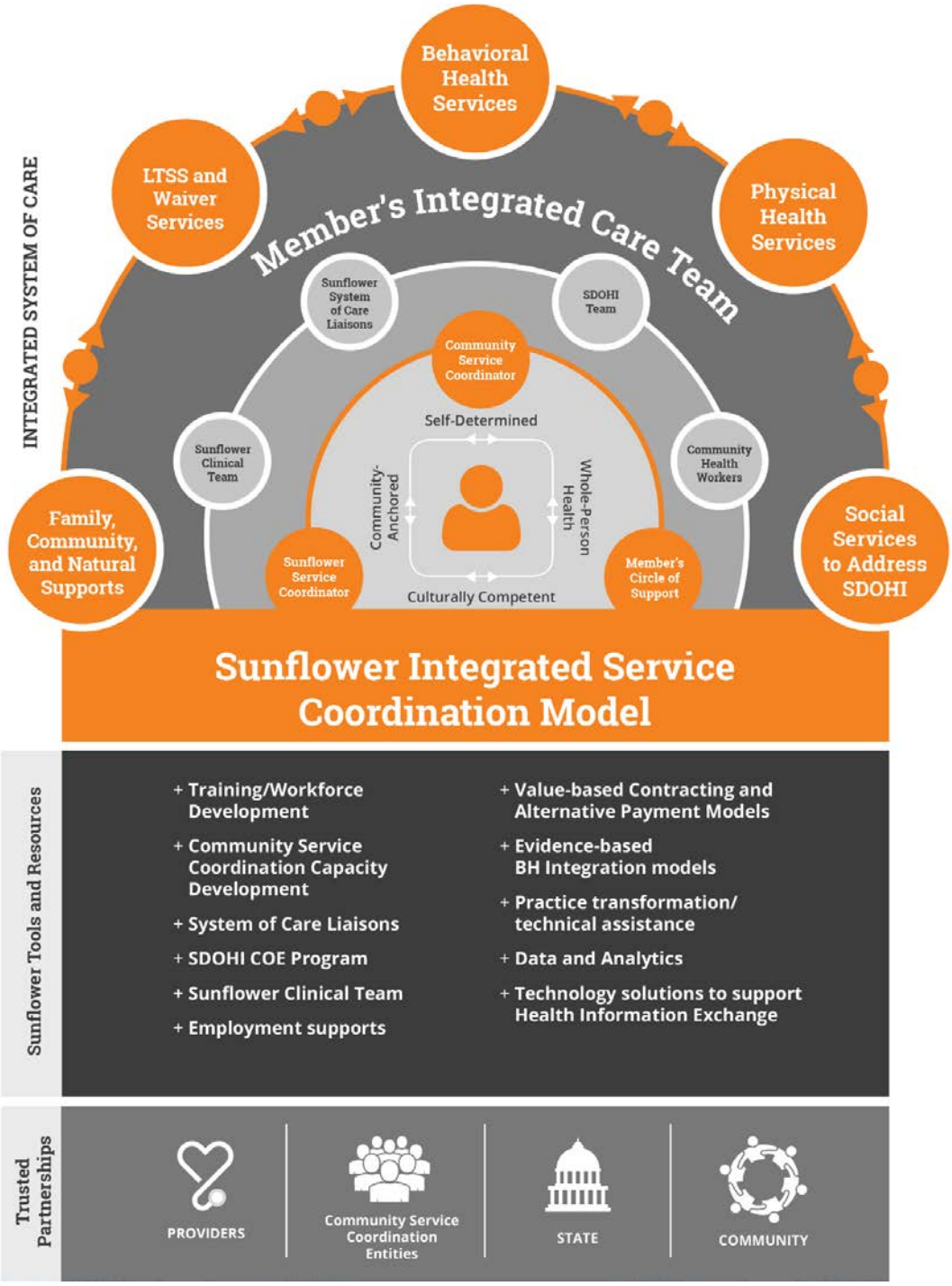
SUNFLOWER'S MEMBER-CENTERED INTEGRATED SERVICE COORDINATION MODEL (5.4.1.A)

Our service coordination program is an important feature of our model of care designed to integrate and coordinate the full continuum of a member's needs and services. Our Integrated Service Coordination (ISC) model incorporates the evidence-based Integrated Care Management approach promoted by the Case Management Society of America. Founded on continuous quality improvement, the program is designed to achieve the Quadruple Aim of improving the experience of care, improving the health of populations, reducing the per capita cost of health care, and improving the work life of our network providers and their staff. We accomplish this by treating the **whole-person and integrating all PH, BH, LTSS, social and other services the member receives** to create a system of care around that individual. Creating this integrated, **community-anchored, culturally competent, relationship-centered system**, that is provided at the point of care whenever possible, allows us to effectively address not only the clinical needs of the member, but also the member's person-centered goals including **social determinants of health and independence (SDOHI)** such as transportation, housing, food, employment, and other non-clinical needs that have an impact on health outcomes and quality of life.

As depicted in ***Figure 5.4.1.A_Sunflower's Integrated Service Coordination Model*** below, we put the member at the center of all service coordination activities. Our role is to facilitate collaboration and coordination as appropriate between the member and his/her SC or CSC; his/her family and chosen circle of support and the member's Integrated Care Team (IC Team).

Through technology solutions, training, and high touch, we ensure that all stakeholders in this system have timely access to the information needed for evaluation and decision making and information-based service coordination.

5.4.1.A Sunflower's Integrated Service Coordination Model



ELEMENTS OF OUR INTEGRATED SERVICE COORDINATION MODEL (5.4.1.B AND 5.4.1.C)

Our Service Coordination model includes **four levels of service coordination** (as described in detail in Section 5.4.5), supported by disease management (DM) programs, discharge planning, and transitions of care activities (described in detail in Section 5.4.12)**,** and collectively referred to as service coordination in our proposal response. Our ISC model is designed to enhance access to services across the full continuum of care and achieve optimal health and quality outcomes through:

- Member-centric and culturally responsive coordinated care that encourages **personal responsibility and member engagement**
- **Population-based predictive modeling** that incorporates claims and administrative system data to identify members at risk for future adverse events that can benefit from service coordination activities
- **Health Screenings, Health Risk Assessments (HRAs) and other assessments** designed to stratify members into levels of service coordination and identify each member's whole person needs
- **Plans of Service/Person-Centered Service Plans (PoS/PCSP) and Person-Centered Planning** that addresses PH, BH, functional needs emergency back-up planning, and SDOHI, and are responsive to each member's preferences and chosen goals
- **SCs, CSCs, and IC Teams** working together with the member and their PCP, chosen circle of support, and providers to support member health and wellness across the continuum of care
- **Sunflower Clinical Service Coordination Team** providing multidisciplinary expertise and consultation to support the member's SC or CSC, and IC Team. This is comprised of Medical Directors including PH, BH and LTSS Medical Directors; Pharmacists; Occupational, Physical, and Speech Therapists; Board Certified Behavior Analysts, Certified Peer Support Providers, certified Behavioral Support Facilitators, licensed social workers, Registered Nurses (RNs), CHWs; and Program Specialists who manage certain initiatives/programs, such as our Start Smart for Your Baby® perinatal management program.
- **Sunflower System of Care (SOC) Liaisons** that are cross-system trained and include our Foster Care Liaison, State Hospital Liaisons, HCBS Program Liaisons, Educational Liaison, Criminal Justice Liaison, and Children and Youth with Special Health Care Needs (CYSHCN) Liaison. These SOC Liaisons enhance member care by supporting providers and working to identify and close system of care gaps and barriers, share information, advocate, and facilitate linkages between the healthcare and community-based service systems. Liaisons also act as a single point of contact to help resolve system issues, facilitating cross-systems protocol improvement and supporting ongoing coordination.

- **Sunflower SDOHI Center of Excellence (COE) Team** that is comprised of the Director of SDOHI, Transition of Care Coordinator, Housing Specialists and Employment Supports Specialists and Member Advocates. These Specialists promote community integration and independence and provide technical assistance and supports to the member, the member's assigned SCs/CSCs and IC Team. This team will work closely with our Director of LTSS.
- **Technology solutions** that support communication and coordination among members of the IC Team, provider network, and contracted Community Service Coordination entities

To support our members, providers, and the KanCare 2.0 program, Sunflower is creating a Director of SDOHI role who has experience working in community-based setting in Kansas.

Sunflower's ISC Model

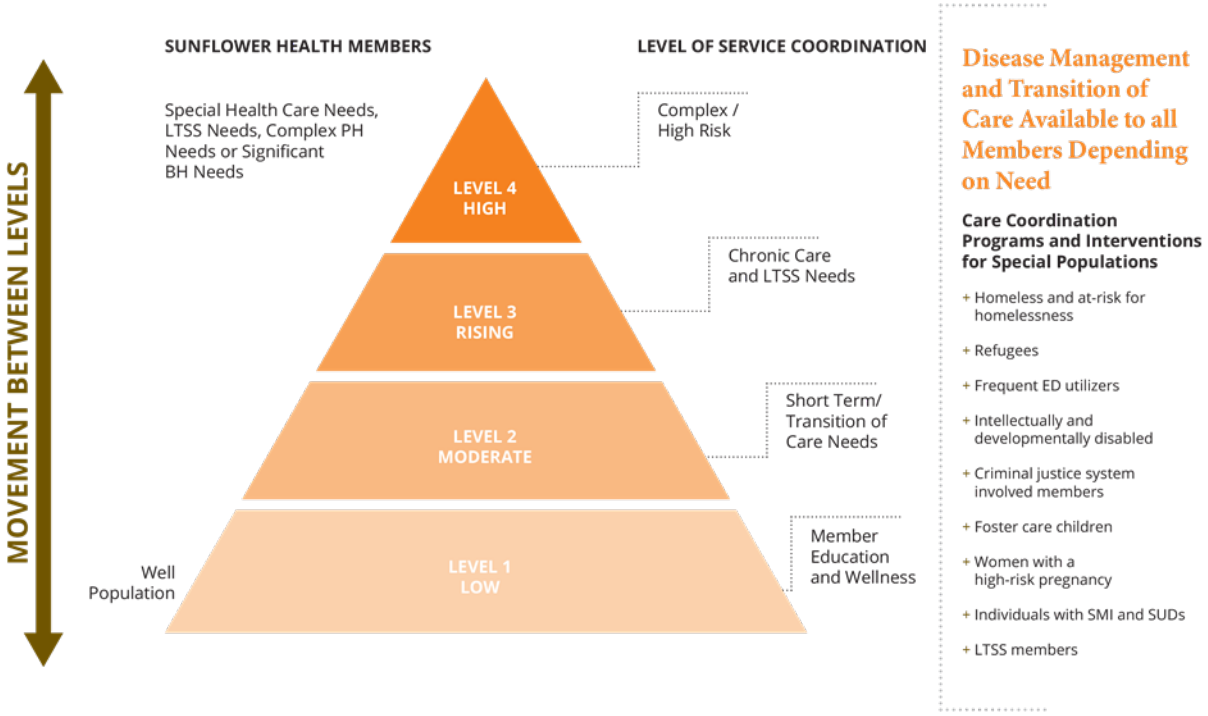
Sunflower's ISC model leverages contracted community-based entities and providers as our trusted partners to promote comprehensive and coordinated care for the member. Sunflower will deploy its ISC model using a community-anchored and delegated approach that provides service coordination at the point of care and utilizes existing service coordination and case management structures at the local level. Service coordination activities will be provided directly by Sunflower and by our trusted partners that include a qualified network of conflict-free community-based agencies and providers, working together as a unified team with Sunflower staff to ensure non-duplication of services and a seamless experience for our members.

Building Community Service Coordination Capacity. Sunflower is committed to building Community Service Coordination capacity in the community and providing service coordination closer to the point of care. We offer and will continue to provide a robust set of tools, resources and solutions to our providers and Community Service Coordination partners that include, but are not limited to: training and workforce development; employment supports; evidence-based BH integration models, tools and best practices; practice transformation resources and technical assistance; data and analytics; access to timely and actionable data; technology solutions; value-based contracting; SOC Liaisons, clinical expertise, and our SDOHI COE program.

Levels of Service Coordination. Our ISC model supports a **member-centric approach** where services and supports are matched to the member based on intensity of needs, setting of care, and Level of Service Coordination, as shown in Figure 5.4.1.B Levels of Service Coordination. The core foundation of our model is to support and maintain members in their community and in the least restrictive, most clinically appropriate level of care, as well as connect members to housing, food, employment, education, and other social supports as needed, further described in Section 5.4.5. As members' care moves up or down the continuum, they have access to ISC services, including care transitions, DM, recovery support, and community linkages to address SDOHI. Service coordination activities and tailored interventions, as described throughout this

response, may be delivered by Sunflower, providers, or the Community Service Coordination entities.

Figure 5.4.1.B Levels of Service Coordination



Disease Management (DM). As part of our ISC model, we offer DM programs for asthma, congestive heart failure (CHF), diabetes, hypertension, heart disease and obesity. Health coaches are integrated with our Service Coordination team, and provide targeted, condition-specific education and coaching. Common elements of these programs include:

- Motivational Interviewing, member-centric assessment and planning, and the use of other strategies – provided by RNs and/or other licensed Health Coaches, and supported by our CHWs – to support member engagement, including in-person interaction for certain high-risk members
- Condition-specific and co-morbidity assessments and targeted interventions, integrated with the member's other health, BH, specialty, and other needs for a whole-person management approach
- Clinical practice guidelines and other tools and support for providers
- Condition-specific education materials geared to specific populations, such as children, non- English speakers, and members with low literacy levels
- High tech solutions such as Tele-Care Monitoring (TCM) and use of email, text messaging, and mobile applications for information, reminders, and support
- Care gap closure programs aligned with HEDIS metrics
- Medication support, which can include outreach by pharmacy staff to members with asthma and diabetes who are not receiving DM coaching

Tele-Care Monitoring (TCM) Program. Sunflower incorporates remote patient monitoring to interact with members through mobile messaging and coaching and to relay important health status indicators in real time to a member's Service Coordination Team. We offer a **Tele-Care Monitoring (TCM) program** that provides real time in-home monitoring of biometric data using web-based technology, combined with telephonic DM coaching, for high risk members. TCM combines leading-edge home monitoring technology with our best-in-class health coaching. TCM allows our team of registered nurses and Health Coaches to monitor high-risk individuals' biometric data in real-time using Bluetooth-enabled, wireless in-home devices that transmit data to a secure web portal. The program objectives are to reduce preventable health care utilizations, promote member adherence to treatment guidelines, and improve medication adherence, health condition stabilization, and increase self-management skills. The program objective for pregnant members is to improve glycemic control. Conditions covered include Diabetes, Heart Disease (Heart Failure and Coronary Artery Disease), and Hypertension. Based upon the data that comes in, we can take immediate action such as:

- Alerting physicians when values are outside of acceptable ranges
- Calling 911 when medically appropriate; following-up with participant to bolster compliance with their physician's treatment plan
- Communicating subsequent biometric values with the participant's physician
- Assisting with appointments with providers and authorizations if urgent needs are identified
- Providing condition-specific education; and promoting self-management techniques in accordance with the evidence-based guidelines for their condition.

Heart Failure Program. An example of a DM program we will continue to offer for our members includes our **innovative Heart Failure (HF) program** that has demonstrated results and positive outcomes. Sunflower's Service Coordination team utilizes analytic data to determine our most at risk and ill members, recently identifying that a member shift created an opportunity to advanced programming and intervention with our most at risk members with HF. We then evaluated our ability to impact these members through service coordination and identified an opportunity to use telemonitoring services, thus developing a collaborative with a local provider, Windsor Place's in-home services, to become our point of service provider in the initiative. Sunflower members with HF can now elect to participate in our telemonitoring program. Upon consultation with the member's primary care physician, Windsor Place installs equipment in the member's home in order to remotely collect vitals such as blood pressure, weight, and oxygen saturation. This information is secure and only provided to the Sunflower's SCs and, most importantly, the providers involved in the care of the member. The goal for this program is to decrease ED utilization, decrease readmissions related to exacerbations of CHF, to provide members with tools and education to better self-manage their disease process, and increase medication adherence. In the five months of the program, early outcomes data show a 10% reduction in overall cost of services for these members, primarily coming from a decrease in acute outpatient visits, presumably historically from exacerbations leading us to believe the members now have better self-management skills. Additionally, we offer telemonitoring services to members with certain diagnoses on the Frail & Elderly (FE) waiver.

Specialized Programs. We also offer a myriad of programs targeted to specific populations. An example of one of these programs is our **Start Smart for Your Baby® perinatal management program** which serves as the umbrella for all of our perinatal management efforts. As part of Start Smart, our High-Risk OB Care Management Program helps high risk members establish and maintain care with the maternity provider and coordinates services to address risk factors that include, but are not limited to prior spontaneous preterm birth, drug/alcohol use, and smoking. SCs provide continuous education throughout the pregnancy and the postpartum period, including information about depression and Substance Use Disorder (SUD) issues, contraception options and reproductive life planning. As a result of our Start for Smart Baby program offered to our pregnant members, we have increased 17P utilization from 29.8% in 2013 to 43% in 2017 and reduced risk-adjusted C-section rates from 16.0% to 11.5 % during the same time period.

Transitions of Care

Our ISC model supports transitions of care with the goal of assuring the member receives needed supports to live in the most integrated community setting possible. Sunflower's transition-oriented service coordination is designed to minimize issues that can occur during transitions, such as declining health, hospital admission or readmission, transcription errors, medication errors and missed follow up appointments. To ensure appropriate care transitions between acute, psychiatric, SNFs, ALFs and home and community residential settings, from fee-for-service to managed care; between KanCare MCOs and waiver programs, and for foster care children and youth during transitions, we employ our evidence-based transition of care protocols that are described in detail in Section 5.4.12.

Key Elements of Sunflower's Integrated Service Coordination Program (5.4.1.C)

Sunflower's ISC model encompasses all the elements outlined in Section 5.4.1.C. 1-12 SOW. In the interest of not providing duplicative information, highlighted below is a ***Table 5.4.1.C_Truncated Scope of Work/RFP Requirement*** that includes the truncated SOW and the Section of the proposal where the requirement is addressed.

Table 5.4.1.C_Truncated Scope of Work/RFP Requirement

Truncated Scope of Work/RFP Requirement	Section Where Addressed
Process for screening members	5.4.2
Process for identifying and enrolling members into Service Coordination	5.4.5
Person-centered service planning process	5.4.4
Monitoring and oversight processes	5.4.15
Transition of care processes	5.4.12
Information and referral	5.4.4
Effectively communicating with member and IC Team	5.4.4 and 5.4.14
Trauma Informed Care and evidence based practices	5.4.1.E and 5.4.11
Member consent and PHI	5.4.4, 5.4.1.E and 5.4.6
Primary point of contact for coordinating health care services	5.4.4 and 5.4.9
Accessing care in emergency situations	5.4.4

Members Eligible for Service Coordination (5.4.1.D)

As described in detail in Section 5.4.5, all members who are eligible for service coordination are stratified into Level I, II, III or IV Service Coordination. Our approach to identifying members eligible for service coordination ensures a comprehensive, 'no wrong door' model and multiple identification methods. We review a wide variety of data about the member, such as PH, BH, LTSS, SDOHI, claims and utilization information; admission, discharge and transfer (ADT) hospital data received electronically; pharmacy data; lab results if available; health screening, HRA and needs assessment data and results; and predictive modeling data that summarize these and demographic data into an algorithm to stratify member health risk and engagement opportunity.

We stratify our entire population to identify both new and existing members who would benefit from service coordination and target our resources effectively to meet their needs. Members may change stratification levels, moving to a higher or lower level of intervention as their acuity and needs change. We use referrals from our providers, nurse advice line, our Utilization Management and Service Coordination staff; CSCs, community agencies; Lead Agencies, state agencies, the judicial system, and members and their family/caregivers. Per the SOW, at minimum the following members will be eligible for and stratified into Service Coordination Level II, III or IV.

- Individuals enrolled on a 1915(c) Waiver or on a Waiver waiting list
- Youth (birth up through age 21) with intensive BH needs
- Youth who are in and out of home placement through the foster care system
- Individuals who are institutionalized in a NF, ICF/I/DD or hospital, PRTF, psychiatric hospital, or other institution
- Adults with BH needs
- Individuals with chronic and/or complex physical and/or mental health conditions.
- Individuals participating in the WORK program or other Employment Programs

DESCRIPTION OF MODEL FOR SERVICE COORDINATION (5.4.1.E)

1. How it will engage Providers in the Service Coordination program and how the CONTRACTOR(S) will build working relationships with needed Providers and community organizations.

ENGAGING PROVIDERS IN SERVICE COORDINATION

Sunflower will engage providers in our Service Coordination program by encouraging their participation in the PoS/PCSP, providing information sharing technology solutions, incentives and partnership opportunities.

Engagement in Plan of Service and Person-Centered Service Plan

Sunflower's SCs and CSCs will employ person-centered planning strategies for the development, implementation and monitoring of the PoS and the PCSP, as fully described below in Section 5.4.4.1. The SC/CSC engages providers in the care planning process through telephone outreach

and participating in IC Team meetings. IC Team meetings can be held virtually or onsite in hospital or clinic settings to best engage participation. After their active involvement with the development of the PoS/PCSP, as orchestrated by the SC/CSC, providers are asked to sign the plan, prior to its implementation. The PoS/PCSP is then made available to providers through our Provider Portal.

Information Sharing Technology

As described in Section 5.4.14, the SC/CSC and other clinical and care planning information, are available to providers through our Provider Portal, which receives real time data and clinical feeds from our Care Management Platform, TruCare.

Partnerships

Sunflower will encourage providers to be active participants in the service coordination by offering a variety of incentive based contracts based on performance in areas such as increased collaboration, clinical quality improvement, cost efficiencies improvement and closing of care gaps. Further described in Section 5.7.1.A, Sunflower is in the process of setting up the following value-based provider programs for participating in service coordination activities for its members:

- **LTSS Transition Coordination program** aims to reward providers for members who have successfully repatriated in the community.
- **Sunflower Select Nursing Facility and Personal Care Service Preferred Referrals Quality Program** aims to facilitate access to quality Nursing Facilities and in-home Personal Care Services that promote holistic and quality health care, identify members for transition out of the Nursing Facility, and keep members out of the hospital and ED.
- **FMS Self-Evaluation, Monitoring, and Quality Program** is designed to improve quality and accountability of our FMS providers through tools and technical assistance while improving information and transparency in provider quality to our members.

BUILDING WORKING RELATIONSHIPS

Sunflower has been building our local provider network and partnerships for over five years. We are committed to working collaboratively and collectively with providers and community organizations. We will do this by developing and supporting capacity for providers and Community Service Coordination entities, facilitating learning collaboratives, and offering ongoing training.

Developing and Supporting Capacity for Community Service Coordination

Sunflower will provide overarching service coordination functions and services, technical assistance and systematic monitoring to see that our providers and Community Service Coordinators are well equipped to understand and address the needs of the member across the entire spectrum of services and settings. This includes access to information, technology platforms, training/ workforce development programs, quality oversight and operational standards and protocols.

Learning Collaboratives

We will convene and participate in State Agency learning collaboratives to share best practices in driving bi-directional practice change. Sunflower is committed to and will participate in the State-chaired KanCare Service Coordination Collaborative designed to ensure consistency and proactively address questions and issues with the implementation of the KanCare 2.0 Service Coordination program. As evidence of our commitment, as a precursor to the KanCare Service Coordination Collaborative Sunflower formed the I/DD Targeted Case Management (TCM) pilot workgroup to enhance the services offered through TCM; reduce duplication of services; streamline the I/DD Person Centered Service Plan with the MCO Service Plan, and to improve member experience through better coordination of visits and information-sharing between the MCO Service Coordinators and I/DD Targeted Case Managers. We continue to host and facilitate this group, involving the other two MCOs, and getting input from other TCM providers statewide. We believe this workgroup is a valuable avenue for piloting processes that will be utilized with future Community Service Coordination providers.

Sunflower staff and leadership have well established working relationships with associations and advocacy organizations, such as the Kansas Healthcare Association, Kansas Medical Society, and Disability Rights Center. For example, we are working closely with the Association of CMHCs toward expanding integrated care models and will invite interested community organizations to participate in discussions. We recognize that there are a range of organizations that are integral to supporting our members' SDOHI; we will work closely with the specialists in our SDOHI COE and SOC Liaison teams to reach out to these organizations and engage them in a dialogue that explores challenges, gaps, and strengths in connecting our members to employment, housing, community re-entry and other SDOHI services. We will build on existing relationships through current partnerships and lead efforts in inviting new providers and community organizations to the table to discuss successes, innovations, and challenges in coordinating care within a range of disciplines.

Training

Sunflower has fully developed training curriculums and clinical trainers with national experience to deliver tailored trainings to providers and community stakeholders. We will offer provider trainings on our Service Coordination framework and a range of topics that support our person-centered approach to care. The trainings that we offer reflect the principles and practices that we strive toward in supporting our providers and communities in delivering person-centered, value based care, such as, Trauma Informed Care, Motivational Interviewing, and Positive Behavioral Support. We embed these trainings into our curriculum so that all new providers and staff have the foundation to weave these practices into their service delivery.

2. How it will engage Members to participate in the Service Coordination program, including any incentives it would propose utilizing, and why it believes those incentives will be effective.

Our member engagement strategies are **individualized and person-centered,** meeting members where they are at every step of the process. Our Service Coordination Team approaches each member as a unique individual focusing on helping members identify goals

they see as important to their quality of life; designating actions steps that members agree to take responsibility for; and asking members to evaluate their own progress towards established goals. We understand that members are not merely passive recipients of healthcare; the member is the best person to determine what it means to be well and what is needed to achieve desired goals.

SUPPORTING MEMBER BEHAVIOR CHANGE

Based on accepted theories of behavior change, we focus on accelerating member's readiness to change and critical beliefs that improve their likelihood of engaging in health promoting behaviors. Specific strategies include: supporting members in achieving their own self-determined goals, teaching self-management skills, engaging peers and other supports, and applying our CentAccount rewards program that provides financial incentives for targeted health behaviors and promotes personal responsibility.

Person-Centered Care Planning

We rely on the members to describe and name the supports that would help them achieve what is important to them, and set collaborative goals. With our trained ability to assess a member's readiness for change, we actively collaborate with them to work toward fulfilling their goals, and adjust goals and action steps according to their motivation. While a member may not be motivated to meet a health plan created goal of taking their rheumatoid arthritis medicine as scheduled, they may be more motivated to subscribe to the activities required to meet a goal of being able to work in the garden without pain. It is critical to compliance that members feel listened to, and that interventions are based on the member's desired goals.

Self-Management Skills

Sunflower offers NCQA and URAC accredited Disease/Care Management programs. These programs use a Health Coaching approach which provides the tools and interventions needed to help individuals diagnosed with a chronic condition adopt healthy behaviors and decrease risk factors to manage chronic conditions. Effective health coaching also motivates and supports members in making small, sustainable behavioral changes that in turn result in measurable, positive health outcomes.

Peer and Other Informal Supports

We recognize that the home environment and family/friends can serve as assets or barriers to the member's behavior change. The SC and the CSC will work with the member, and with consent, engage the circle of support in health coaching to support behavior change. If a member's informal supports are not able to provide the level of coaching and engagement needed, we may, with member agreement, include our Member Advocate to provide peer support or solicit the use of community peer supports to help influence member behavior change by sharing life experience and providing evidence of what is possible.

Addressing Social Determinants of Health and Independence (SDOHI)

As discussed in Section 5.4.10, Sunflower is an active participant and is committed to the Community of Practice that is moving towards integrating Charting the LifeCourse Framework (LifeCourse) into the Kansas system. The LifeCourse framework takes the person-centered thinking model a step further, encouraging focus on the family and supports surrounding the individual and the family. The LifeCourse framework emphasizes active engagement by families and self-advocates in the planning process, providing individuals with the tools to enhance and communicate their goals

MEETING MEMBERS WHERE THEY ARE

Sunflower "meets members where they are" to maximize our ability to identify members that may need Service Coordination and to individualize services according to each member's needs. This means meeting members where they are in the community, as well as targeting information and interventions to the member's willingness to engage, level of health literacy, and other factors that affect their participation in their own care.

Initiatives to Facilitate In-person Engagement

A key lesson learned serving Medicaid and other low-income members is that in-person interaction allows us to establish stronger relationships with members, which in turn increases member trust and willingness to engage with our staff. Sunflower is proactive and resourceful in reducing the rate of members deemed "unable to reach". Strategies based on this approach, which Sunflower has implemented and will expand across the state, include:

- Deploying CHWs in the field to locate moderate and high-risk members who we deem "unable to reach" by traditional means. CHWs are hired from and live in the communities they serve, lending to a deeper understanding of member patterns. Sunflower currently has 19 CHWs who have recently received CHW certification and are trained in engagement skills, trauma-informed care, Person Centered Thinking and cultural, disability and poverty sensitivity. Their new skillset helps enhance collaboration within health plan and across external organizations with the goals of addressing SDOHI, increasing health literacy, giving members more confidence in their healthcare system, and increasing preventive care visits/reduce ER use.
- Assigning staff to each of the four State hospitals (Osawatomie State Hospital, Larned State Hospital, Parsons State Hospital and Training Center and Kansas Neurological Institute)
- Conducting community-based events such as Adopt-a-school events and our Farmers Markets at which our CHWs provide education and activities on health-related topics such as healthy eating and members can receive vouchers for fresh fruits and vegetables.
- Placing CHWs in two Community Mental Health Centers (CMHCs)

Sunflower leverages in-person contact to help members understand their own health conditions and needs and identify the services available to meet those needs. We also provide in-person education and support for accessing recommended care, and identify and address barriers to appropriate access.

SafeLink and Connections Plus®. For high risk members without a cell phone, we can connect with a free smart phone through SafeLink or our own ConnectionsPlus program for members who don't qualify for SafeLink. These phones are pre-programmed with numbers for our Member Call Center, SCs and CSCs, Nurse Advice Line, 911, PCP and other treating providers.

Member Incentives

CentAccount®. New member information included in our Welcome Packet describes the Sunflower CentAccount® program which rewards members for healthy behaviors. Our expanded program gives Sunflower the ability to empower our members by delivering personalized incentives that encourage healthy behaviors, enabling trusted relationships, and ultimately enhance our members' lives within their community, one person at a time. Through CentAccount®, Sunflower offers financial rewards to members based on evidence-based, preventive and primary care interventions that address Social Determinants of Health and Independence, have the greatest impact on health outcomes, and are most relevant to our members. When a member completes a reward activity, we load the reward onto a Sunflower-issued CentAccount® card. In 2019, the CentAccount® card and member ID card will be combined into one card – making it more convenient for members to access and use their CentAccount® rewards. The rewards program is tailored based on member preference and can be accessed through a member's smartphone or through our Sunflower member mobile application. Sunflower aligns our CentAccount program with our VBP program to ensure alignment between provider and member incentives.

Between January 1 and September 30, 2017, more than 45,000 Sunflower members earned CentAccount® Rewards worth nearly $650,000.

3. CONTRACTOR(S)' experience in working with PCPs and Behavioral Health Providers to facilitate a high degree of coordination and communication of care across disciplines for the benefit of its Members.

DIRECT EXPERIENCE INTEGRATING AND COORDINATING CARE

Sunflower is committed to the integration of PH, BH, and the social services delivery systems to support whole person care. Sunflower has been successfully working with our network of PCPs and BH providers to actively promote coordination and communication across these two disciplines since 2013. This integration is operationalized through our integrated care planning process, led by SCs who facilitate sharing of information through appropriate release of information and timely exchange of clinical notes and information as appropriate. We have also designed our technology solutions to share an integrated PoS/PCSP. How we have applied this experience to our fully developed ISC model is further described below in Section 5.4.1.E.11. We also leverage the experience of our national affiliates, currently integrating PH and BH in 19 states, to adopt and adapt best practices that support bi-directional communication and coordination.

Highlighted below are examples of our direct Kansas experience working with PCPs and BH providers to facilitate coordination and communication across disciplines.

Co-location of BH in Primary Care

In November 2017, Sunflower began working with Horizon Mental Health which has a BH professional embedded in the Hutchinson Clinic, primary care practice. The CMHC shares data with our Sunflower SC assigned to high risk cases with both BH and PH comorbidities. To facilitate coordination and communication across disciplines, we track and share information on care gaps, ED utilization and a variety of other outcomes using our Provider Portals and our state-of-the-art Provider Analytics Dashboard and in person phone conversations. We are also tracking and monitoring process indicators for SC interactions with CMHCs to gain a comprehensive understanding of facilitators and barriers to co-located collaboration. Sunflower plans to expand this pilot to additional CMHCs in 2018.

Notification of Pregnancy Form Completion

We encourage BH and SUD screening in OB/GYN practices through incentive payments for Notice of Pregnancy (NOP) completion through our Provider Portal. The screening includes questions related to a history of mental health concerns and substance use. This process helps OB providers identify members at increased risk that require additional treatment or services. In addition, this information is also available for our Sunflower SCs to provide outreach when indicated and make referrals to the appropriate services. Year to date in 2017 Sunflower SCs have completed timely outreach to 92.4% of members identified as high risk on the NOP.

Integrated Primary Care, BH and LTSS Model

We are also partnering with one of our I/DD providers that serves many of our I/DD members. Under this unique partnership, Sunflower and our I/DD provider partner are working closely with a local CMHC and the members' PCPs to successfully support persons with I/DD and/or brain injuries who are at high risk for institutional placement. We have assigned a dedicated Sunflower SC to this I/DD provider and the members they support. Using our whole-person approach, we are working closely with the CMHC, the member's PCP plus other community organizations such as the local police department and community employers to wrap successful supports around each member.

As an example of the high risk and complex populations served by this I/DD partner, the provider has successfully served one member who was residing in an out-of-state TBI rehabilitation facility for a total of five years because he could not find community-based services that would meet his behavioral support needs. They serve another individual who has

Sunflower in Action…

Sunflower works closely with an I/DD provider to support persons with I/DD and/or brain injuries who are at high risk for institutional placement by assigning a dedicated SC to the provider and the members the provider supports. The provider has successfully served one member who was residing in an out-of-state TBI rehabilitation facility for a total of five years because he could not find community-based services that would meet his behavioral support needs. They serve another individual who has I/DD and was in foster care, and for whom the CDDO had requested the State to deny community based services because of the severity of his behavior. He was reported to have had 147 different foster care transitions by the age of 17. He is currently living in the community with one roommate.

I/DD and was in Foster Care, and for whom the CDDO had requested the State to deny community based services because of the severity of his behavior. He was reported to have had 147 different Foster Care transitions by the age of 17. He is currently living in the community with one roommate.

Sunflower believes this integrated model which includes LTSS, BH, PH, judicial and informal/community supports, is a best practice for expansion and replication in other geographic areas of the state to support persons with dual diagnosis (MH/DD). Sunflower's LTSS Director recently attended an invitation-only summit on dual diagnosis hosted by the National Association of Dual Diagnosis (NADD) and shared this model of holistic community supports. NADD invited representatives from associations such as ANCOR, NASDDDS, NASMHPD, and SAMHSA, as well as, other health plans to develop recommendations regarding community-based living arrangements, person centered service planning, and successful training and support programs. The group's summary of recommendations regarding successful community living models included this Sunflower model of care. It is our understanding that NADD is planning to release formalized recommendations in 2018.

Expanding capacity

In 2017 Sunflower integrated one of their BH providers by credentialing them as a Primary Care Provider. Valeo BH, a CMHC in Shawnee County, serves a high ratio of SPMI individuals who struggle getting access to PCPs. Valeo approached Sunflower to request they be able to be credentialed as both a physical and behavioral health provider so they could provider a holistic approach to these members.

Through a Centene Foundation grant, kiosks were placed in health departments and other public areas in Barton, Stafford, Pawnee and Rice Counties and that would allow people to take behavioral health assessments confidentially. The results of these assessments can be emailed to the individual and they are encouraged to take the results if recommended to a PCP or BH provider. In Q1 of 2017, 202 assessments were completed. The pilot has expanded the use of the access to the assessments to a QR scan that can be accessed from a personal cell phone.

Technology solutions to Support Coordination and Communication

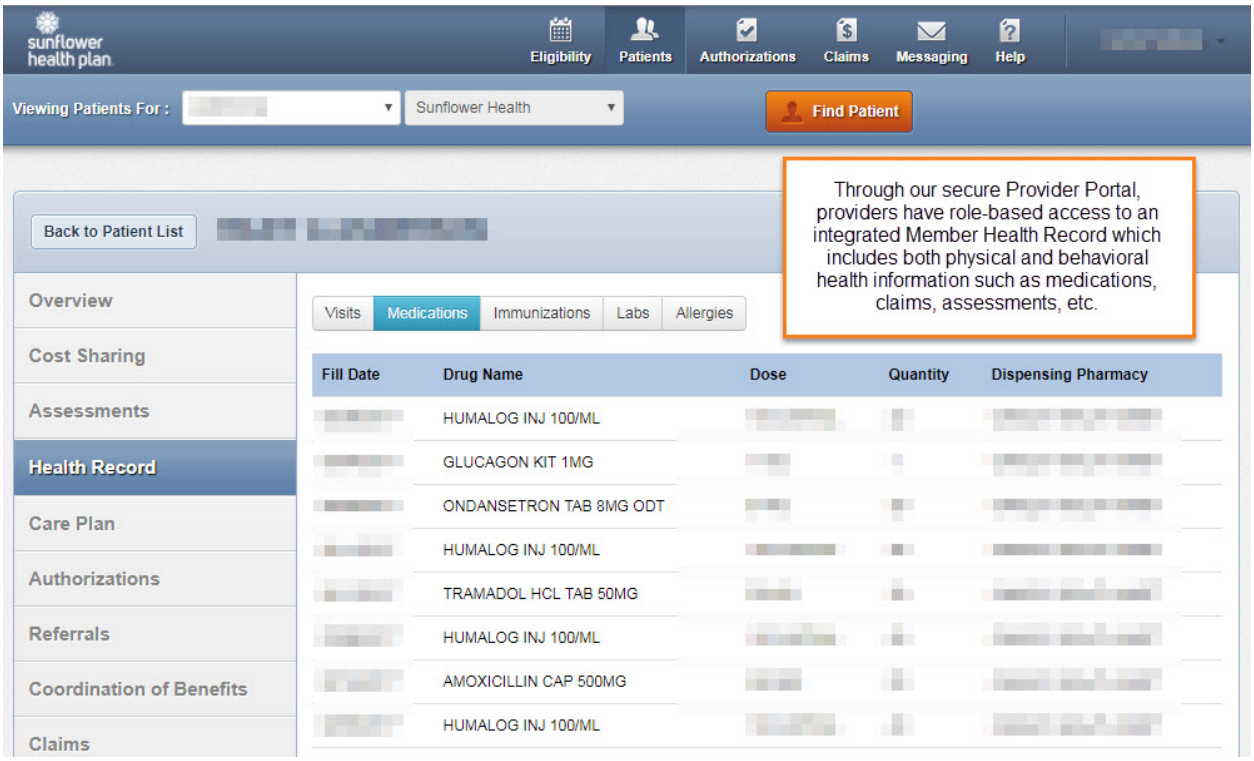
Sunflower also provides technology solutions that support the sharing of information and collaboration across all partners and provider types, including PCPs and BH providers.

Tele-psychiatric pilot – bringing BH to PCPs in nursing facilities. Sunflower recognizes that use of technology to deliver BH services can help address barriers that can prevent our members who reside in nursing facilities from receiving care. In Q1 2018, we are implementing a tele-psychiatric program, supported by the Kansas Health Care Association to expand the availability of psychiatric medication management to members in nursing facilities in rural, frontier, and underserved regions of the State. Recognizing the potential financial burden to nursing facilities due to Medicare reimbursement barriers, Sunflower will directly pay the tele-psychiatry vendor for once a month e-consultations for members on antipsychotics. Through this program,

psychiatrists will ensure appropriate prescribing of psychotropic medications and support PCPs in caring for our members in nursing facilities.

Provider Portal. As described in Section 5.6, our secure **Provider Portal** is a web-based platform that includes a number of clinical applications that supports whole person care. Our secure Provider Portal includes a display of care gap notifications, PoS/PCSPs, and a complete member health record with extensive medical, BH, and medication history. Our secure Provider Portal promotes integrated collaboration across PCP and BH providers, while maintaining the confidentiality of personal and protected health information (PHI). The Provider Portal allows for the sharing of clinical information, including the completion and exchange of member assessments and appropriate PH, BH, pharmacy, and other clinical information, screenings and assessments, care plans, and other documents. This common platform will allow the member's PCP and BH provider, SOC Liaison, SCs and CSCs to closely collaborate and share timely information about members who are accessing primary care and BH services, and the necessary follow-up services. Our web portals use HIPAA compliant role based access controls (RBACs) giving us the capability to safeguard access to specific PHI or other sensitive or confidential information. We have the capability to restrict and share permissible BH information (e.g., SUD treatment), by provider type, for the purpose and enhancement of care integration in compliance with HIPAA and 42 CFR Part 2. Please see ***Figure 5.4.1.E-1 Provider Portal*** below.

Figure 5.4.1.E-1 Provider Portal



Provider Analytics Dashboard. Sunflower's **Provider Analytics dashboard**, powered by Centelligence®, brings together a collection of the most important medical cost and utilization,

pharmacy, emergency department, potentially avoidable events, clinical, population health, and quality data to help Sunflower staff and providers form a cohesive understanding of performance and membership trends and support integration and coordination of PH and BH services. Available to providers through our secure Provider Portal, provider analytics dashboards offer varying levels of information to provider user groups and allow for, among other uses, provider performance analysis, cost and utilization trending, quality measure performance, active and non-active member pattern analysis, disease -state prevalence, readmission analysis, and population health trend analysis. Users are also offered many of these metrics on a risk and severity adjusted basis. Authorized users can interact with the dashboards through extensive custom selection, drill-down, and export capabilities, to identify factors behind clinical and cost performance. The availability of such data facilitates coordination and communication among and between providers and information-based service coordination.

Kiosks to support BH screening and assessments. Through a Centene Foundation grant, we placed kiosks in several local Health Departments and other public areas in Barton, Stafford, Pawnee and Rice Counties to allow individuals to complete behavioral health assessments confidentially. The results of these assessments are emailed to the individual and we also encourage our members to take the results if recommended to their PCP or BH provider for further follow up. In Q1 of 2017 alone, over 200 assessments were completed. We also recently expanded this technology solution to expand access to the assessments using a QR scan that can be accessed from a personal cell phone.

4. How it will engage Members and their physical, HCBS, LTSS, and Behavioral Health Providers under the CONTRACT to ensure optimal coordination and communication, including a description of best practices in this area and how the CONTRACTOR(S) proposes to address any barriers to integration.

INTEGRATED SERVICE COORDINATION

Fully described in 5.4.1 above, our ISC model is designed to surround each member with the services and supports needed to address all PH, BH, LTSS, and social needs. This requires the active participation, engagement, and coordination of the member, family/caregivers, and all providers involved in the member's care. This is achieved through our team-based approach, with each team member aligned through a single, member-driven PoS/PCSP.

Individualized Plan of Service/Person-Centered Service Plan

Our SCs and CSCs appreciate our responsibility to fully understand the member and their family to effectively support development of a PoS/PCSP, including:

- Member and family engagement immediately upon enrollment, initiated by the SC and CSC and supported by our Service Coordination team staff
- Ongoing engagement, facilitated by the SC/CSC, in the implementation, monitoring and updating of that plan through continuing communication and education with the member, family, their chosen circle of support and his/her providers and other IC Team participants

Included in the PoS/PCSP is a communication plan with providers and members, establishing method and frequency of contact. The PoS/PCSP itself also serves as a communication tool to coordinate and integrate service delivery across the continuum of care and provide a mechanism for communicating the member's lifestyle preferences, goals, and action steps made available to all authorized providers and IC Team participants via our secure, role-based Web Portals.

Identifying and Engaging the Circle of Support

In addition to providers, family, friends, and peers, as well as external case managers, such as a Foster Care case worker, juvenile justice case worker, or representative from a child's school individual education plan (IEP) team, can provide critical support in planning and adherence to the PoS/PCSP. As part of the initial outreach, the SC/CSC asks the member who else they would like to participate in the process, and aspects of the process the member desires their participation. As directed by the member, the SC/CSC attempts to contact identified individuals and invite them to participate in the HRA and/or care planning process. The SC/CSC may use teleconference technology or meet in person with the member and representatives at the member's home, provider office, or other agreed upon location that is convenient to the member. The SC/CSC may schedule several meetings to accommodate a member's request to include multiple participants, depending on the participants' availability.

Best Practices

Our best practices to support engagement, integration, and coordination have been developed based on local and national experience, as described throughout our response.

- Our ISC model is anchored by health plan-orchestrated support and infrastructure organized to build system capacity and competency for our providers and CSC partners; coordinate all covered and non-covered services and supports; promote member and provider accountability; encourage prevention and early identification; facilitate care coordination; and ensure **no-wrong door** for access to care. Reinforcing the model are **information linkages** including training, data and analytics, real time rounding and communication, and delivery of actionable data to support information-based service coordination activities. (Further described in Section 5.4.1).
- Our comprehensive provider and community network designed to facilitate **whole-person care, continuity, quality, and member choice**. (Further described in Section 5.5). This involves extending our referral base beyond the traditional set of providers to include a robust network of community-based services and supports, inclusive of services that address SDOHI.
- Our **practice transformation** approach involves fully assessing, leveraging, maximizing, and building capacity and resources across our providers and CSCs, addressing gaps in local systems of care while transformation is underway and while we work with our government and community partners to increase overall capacity (Further described in 5.4.1.E, Question 8 below).

- Our provider **value-based purchasing (VBP) arrangements** meet providers where they are and align incentives, promote integration, and improve member outcomes (Further described in Section 5.7.1).
- Our model is operationalized through our **locally-based teams and field-based staff**, and leveraging statewide knowledge and resources (Further described in Section 5.4.8).
- Our **System of Care Liaisons** are cross-system trained Liaisons that include our Foster Care Liaison, State Hospital Liaisons, HCBS Program Liaisons, Criminal Justice Liaisons, Educational Liaison, and Children and Youth with Special Health Care Needs (CYSHCN) Liaison. These Liaisons enhance member care by supporting providers and working to identify and close gaps, share information, and facilitate linkages between the healthcare and community-based service systems. Liaisons also act as a single point of contact to help resolve system issues, facilitating cross-systems protocol improvement and supporting ongoing coordination (Further described in Section 5.4.1).
- **Sunflower Social Determinants of Health and Independence (SDOHI) Center of Excellence (COE) Team** that is comprised of the Director of SDOHI, Transitions Specialists, Housing Specialists and Employment Supports Specialists and Member Advocates. These Specialists promote community integration and independence and provide technical assistance and supports to the member, the member's assigned SCs/CSCs and IC Team.
- Our **IT solutions**, including our Centelligence™ decision support and predictive modeling platform, allow us to appropriately identify interventions to improve care and outcomes. For example, to better inform service coordination interventions and clinical programs, we recently implemented a **proprietary Substance Use Disorder (SUD) segmentation profile**. Using evidence-based criteria and claims data, this complex data model allows us to stratify individuals into one of **six SUD segments based on utilization, clinical severity, and cost**. The resulting clinical and business intelligence provides both individual and population based analytics to segment members into SUD risk streams for appropriate and timely follow up and service coordination interventions. The overall segmentation program offers a measurement framework to aid identifying high opportunity interventions as well as a mechanism to measure intervention efficacy as well as population health improvement over time. (Further described in Section 5.4.5).

5. How it will focus its integration efforts to get the most value, and what anticipated improved health Outcomes for Members or improved compliance with established medical protocols it would expect based on its efforts to improve the integration of medical and Behavioral Health care.

STRATEGY TO FOCUS INTEGRATION EFFORTS TO GET THE MOST VALUE

Sunflower's strategy toward integrated care follows this goal framework, as fully described in Question 8 below:

- Goal #1: Recognize Barriers to Integration
- Goal #2: Promote and Support use of Existing Resources
- Goal #3: Offer Training and Technical Assistance to Address Knowledge Gaps
- Goal #4: Enhance Existing Resources/ Practices and Pilot New Approaches to Integration

- Goal #5: Create an enabling environment to move BH providers toward outcomes and VBP

ANTICIPATED HEALTH OUTCOMES

Integrated care is a deliberate strategy in Sunflower's goal to meet the Quadruple Aim of improved health outcomes, member and provider experience, and efficiency. Specific to member health outcomes, we look for improvement in:

- HEDIS measures
- Appropriate Utilization (lower ED visits, lower inpatient admissions and readmissions, and higher use of ambulatory PH and BH and preventive care services)
- Maintaining members in the least restrictive setting (Nursing Facility diversion and repatriation)
- Quality of life measures
- SDOHI, such as stable housing and employment

MONITORING QUALITY OF CONTINUITY AND COORDINATION OF CARE

Sunflower is committed to the provision of a well-designed and well-implemented Quality Assessment and Performance Improvement Program (QAPI Program) that will be used to measure and monitor success, as fully described in Section 5.8 and also addressed in Section 5.4.15). For example, we will use a variety of methods to monitor coordination and integration efforts:

- Reviewing claims data to determine utilization patterns for specialty care, BH, and HCBS referrals
- Assessing, through medical record review, the quality of the information exchange between PH and BH providers, including appropriate release of information
- Utilizing pharmaceutical reports to assess the appropriateness of psychopharmacological medications prescribed
- Reviewing PCP guidelines for assessment for BH disorders in at-risk individuals (e.g., eating disorders in adolescent girls or depression in the elderly) and referral to BH providers; and their guidelines for assessment and referral for HCBS eligibility determination
- Monitoring members identified as using the ED inappropriately and their follow-up to referred care or continued ED utilization
- Monitor service utilization for members in nursing facilities including ED and inpatient care, or these metrics in populations undergoing transition from a nursing facility to community placement
- Utilize standardized preventive health metrics to assess effectiveness and the quality and appropriateness of services furnished
- Capturing quality of life assessment indicators, which are self-reported by the members as part of the annual assessment/reassessment process (discussed in Section 5.4.4.2)

PROMOTING INTEGRATION AND IMPROVING HEALTH OUTCOMES THROUGH VALUE-BASED MODELS

To support improved health outcomes for members, we will incorporate the following financial measures and quality outcomes targeted toward integrated clinical care:

- Potentially avoidable ED visits
- Psychiatric hospital readmission rate
- Antidepressant medication management
- 7-day and 30-day follow post psychiatric hospitalization
- Follow up after discharge from ED for mental health, alcohol or other drug dependence
- Mental health treatment penetration and SUD treatment penetration
- Inpatient length of stay
- ED utilization

To support ongoing reporting and improvement in performance measures for providers, we will monitor and propose incentives for the seven new HEDIS measures targeted toward improving care for members with serious mental illness (SMI) and co-morbid conditions:

- Continuity of Antipsychotic Medications for Treatment of Schizophrenia
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications
- Diabetes Monitoring for People with Diabetes and Schizophrenia
- Follow-Up after Hospitalization for Schizophrenia
- Cardiovascular Health Monitoring for People with Cardiovascular Disease and Schizophrenia
- Cervical Cancer Screening for Women with Schizophrenia
- Cardiovascular Health Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications.

6. What other Outcomes, in addition to health Outcomes, it would expect to improve and monitor.

MONITORING STRATEGIES

In addition to the process measures described above, such as the appropriate sharing of information, we measure, monitor, and act to improve member satisfaction and provider satisfaction. For example, we conduct annual CAHPS member satisfaction surveys and post Service Coordination satisfaction surveys. We also recognize that health is not determined by clinical health indicators alone. Health is also determined by access to a variety of resources, such as food, education, employment, housing, and social supports. We value our member's rights to self-determination to carve a healthy path in life that is meaningful to them. We broaden our monitoring strategies beyond health outcomes to also include **SDOHI**.

- **NOMS.** Sunflower uses SAMHSA National Outcomes Measures (NOMs) SDHI data, such as employment and homelessness status, provided by KDHE

- **Permanency of Placement.** We will work collaboratively with KVC and St. Francis to share data, collaborate on cases and continuously review operational processes that affect outcomes for children in Foster Care, including placement
- **Transitional Age Youth.** Our Enhancing Transitional Services Program measures, relevant to Foster Care members preparing to transition out of the system, such as the percentage of members age 17 – 21 years in out of home care that have at least one PCP visit within a 12-month period
- **Progress in Intensive Community-based Programs**. For example, Phoenix Connections is a structured group therapy program designed for adolescents, ages 12 through 17, who exhibit psychiatric symptoms and significant impairment in day-to-day educational, social and interpersonal functioning. We measure each child pre-and post-community treatment admission on performance in home, school and prior community treatment settings, and involvement in legal issues.
- **Other outcomes** that we can track through our SDOHI Center of Excellence include, but not limited to:
  - Housing outcomes
  - Employment outcomes: receipt of Supported Employment services; transition youth who are employed
  - Transitions from institutions to community settings
  - Quality of Life assessment indicators

7. What type of clinical support it will offer to Providers treating Behavioral Health conditions (including but not limited to depression, anxiety and addiction) in the Primary Care setting.

CLINICAL SUPPORT TO PROVIDERS TREATING BEHAVIORAL HEALTH CONDITIONS

Supporting bi-directional integration, and fully equipping our PCPs to care for the whole-person needs of their members, Sunflower offers a range of clinical tools to support PCPs caring for members with BH conditions. Described further in Section 5.7.1.A.5, examples of programs and resources include:

- **Clinical Training.** We offer PCPs access to a comprehensive program and curriculum of clinical trainings that increase their capacity and competency to support members with BH conditions.
  - For example: We offer training on the use of Medication Assisted Treatment (MAT) for opioid dependence and support provider efforts to achieve certification.
- BH Screening Tools such as SBIRT and PHQ2/9, supporting early identification.

Best Practices

- Best practices in screening, treatment, and referral for trauma and BH conditions, including **Mental Health First Aid** (for adults and children/youth) and **Trauma-informed Care**.
- **Psychiatry Consult Line**. Sunflower offers an 800 number that links all of our providers with our BH Medical Director for advice/ consultation on issues related to BH, including SUDs.

- **Project ECHO.** We will develop Project ECHO modules that are responsive to our PCP needs and the care and services they provide to their members, for example, Opioid Abuse.
- **Telehealth.** We will expand the availability of BH telehealth consults in PCP offices.
- **Co-Location.** We will support models such as the evidence-based Collaborative Care Model that include BH clinician(s) available in the PCP office to assess and consult with members during their PCP visit.
- **Actionable Data.** We will equip PCPs with actionable data, made available through the Provider Portal, on their membership that will help close care gaps and ensure provision of or referral to the appropriate level of care.
- **Member Tools.** Providers will be educated and informed on available member tools to support their BH needs, including our Disease Management (DM) programs, Service Coordination, and technology tools such as:
- **The Central Kansas Foundation and Mental Health Association of Central Kansas BH mobile application, Addiction Comprehensive Health Enhancement Support System (A-CHESS).** A-CHESS utilizes an evidence-based approach validated by several clinical studies to positively impact member behavior change.
- **MyStrength**, a customizable self-care website resource offering tools and resources for anxiety, depression, and substance use disorders. This tool allows the member to track their moods and feelings on a daily basis to actively engage in their recovery as well as proactively identify patterns that might indicate a potential relapse trigger. The site also encourages members to take advantage of self-assessments that are available to gain better understanding into managing their own care.

8. How it will promote and support Primary Care based Behavioral Health in pediatric and adult populations; what best practices and recommended protocols it will use to support the integration of medical and Behavioral Health care; and what materials and tools it will utilize in order to engage Members and Providers to improve integration.

APPROACH TO BI-DIRECTIONAL BH AND PH INTEGRATION

Our capabilities to realize the State's vision in the RFP and Contract Requirements come from lessons learned and understanding of the evidence-based practices that support the continuum of integration. This experience informs our strategy to promote and support Primary Care based BH in pediatric and adult populations as framed around the following goals, and realized through our Practice Transformation program.

Goal #1: Recognize Barriers to Integration
Through our range of experience in delivering integrated care, we understand that providers vary in their readiness to practice integrated care. We recognize barriers to BH/PH integration occurs at the system, provider, and member level. For example, we will use the **lessons learned from the State's 2014 implementation of Health Homes** in our future planning for new models/initiatives for integrated care.[1] We will aim to: • Provide enough data for evaluation abilities to determine effectiveness in reducing costs and improving health • Set up pilot periods long enough to gather enough data to use for evaluation • Dedicate time to engaging members and building trust

- Provide clear, understandable notification to members and case managers about health home assignments and avoid duplication of necessary and/or non-consensual CM services[2]
- Enhance the capacity of the provider network to support statewide implementation[3]
- Define risk stratification protocols appropriately to ensure that members received the right services at the right time.

Sunflower plans to **assess our primary care provider network** to identify where they fall on the continuum of incorporating BH practices, namely to what extent they are:

- Utilizing our Tele-Psychiatry Consultation service
- Screening for Depression
- Practicing Screening, Brief Intervention, Referral to Treatment (SBIRT)
- Prescribing psychotropic medications
- Hiring or contracting BH staff for co-location at their clinics
- Trained in integrated care practices, such as billing, managing SUD, depression treatment, trauma informed care etc.
- Actively participating in integrated PoS/PCSPs and/or multidisciplinary team meetings that are driven by SCs specialized in BH.

We will review our Provider Directory to prioritize FQHCs that also provide BH services and include them in our Practice Transformation initiative described below. We will also reach out to our PCMH practices to assess where they need support.

We will work with system stakeholders and providers to identify where community based services or preventative BH care services are not available.

Goal #2: Promote and Support use of Existing Tools and Resources

- We leverage our ISC model and program to support integrated care planning.
- We promote use of our Information Sharing Tools through orientation and ongoing training for all staff. These tools, including our secure, web-based Provide, Member and Service Coordination Portals and Member Health Record, are pivotal for staff to provide fully-informed integrated quality care to our members.
- We will ensure that providers and staff embrace participation Person-Centered Service Planning process by setting expectations for providers with requirements for sharing chart notes, treatment plans, and participating in service planning activities and Care Teams.
- We will ensure that our SOC Liaisons in Foster Care, hospitals, criminal justice, employment, transitions, and housing participate in our multi-disciplinary IC Teams to support the system of care for our members.
- **We will encourage our PCPs to use our Telepsychiatry line in their practices.**
- We will utilize our suite of predictive modeling data analytics to intervene and prevent symptom exacerbation for members at high-risk for acute BH utilization.
- We will work with members and family/caregivers to develop crisis prevention planning and advance directives as part of the PoS to prevent acute BH utilization.
- We will work with BH providers to discuss the importance of primary and preventive care for members with SMI or SED.
- We will make available member health education and self-management tools, like CentAccount and MyStrength.com to increase health literacy and empowerment.
- We will identify available evidence-based treatments and interventions offered in the community, educate the network and members on referring for these services, and provide training and certifications to willing providers in areas where such evidence-based practices are not available.

Goal #3: Offer Training and Technical Assistance to Address Knowledge Gaps in Best Practices and Protocols

We will offer provider and community training on the following topics, using CMEs to encourage provider participation.

- Addressing the Opioid Crisis
- Medication Assisted Treatment (MAT)
- BH and PH Screening Tools
- How to refer for BH and PH services
- Mental Health First Aid
- Trauma-Informed Care
- Removing Stigma
- Training and technical assistance in best practice integration model(s) that best serve each community, such as Collaborative Care

We will also leverage Project ECHO and encourage our providers to complete trainings in topics related to integrated care as part of our Practice Transformation and Training (PTT) initiative described in the Practice Transformation Program section below.

Goal #4: Enhance Existing Resources/ Best Practices and Pilot New Approaches

- Prior to go-live, and through the life of the contract, we will provide **direct assistance for capacity building and practice transformation to provide integrated care**, investing in vital activities critical to rebalancing the BH delivery system while we build provider capacity to maximize value based payments for sustainability.
- Sunflower has multiple tools available today to **support information sharing**. Through continuous enhancements based on provider input and best practices from across the country, we are improving these tools to support more timely and robust communications.
- We will expand our successful IC Team model that provides embedded SC support for clinical practice transformation and facilitate co-location of primary care within BH settings and BH within PH settings. We will support PCPs with VBPs and APMs for bi-directional integration, and PCMH certification for those who are not yet certified.
- We will **improve identification and referral for BH services** across the system of care

  This strategy is focused on ensuring the entire system is educated to promote early identification, referral, and treatment of BH. This includes not only the health care delivery system, but all systems that may interface with our members, such as child welfare, justice, social services, and first responders. Similar to other approaches, the strategy here is multi-faceted, including, but not limited to:

  - Provider, community, and first responder education on Mental Health First Aid, Trauma Informed Care, SBIRT, Depression and SUD Screening Tools, How and Where to Refer Members for BH Services, and Recovery and Resiliency
  - The use of CHWs in hospitals, CMHCs, and social service agencies such as homeless shelters
  - Partnering with CMHCs and RADAC to meet members who present in the ED with signs of BH and screen and refer for appropriate follow up services

Expanding our strategy to go outside of the traditional service delivery system promotes more timely identification and treatment. Members with complex BH conditions often have other SDOHI that may present barriers or otherwise deter them from seeking services in the traditional manner. We don't want to wait for these members to show up in the ED, so we need to identify other system contacts or entry points we can coordinate with to get them in to appropriate care and service. This approach also leverages other resources and trusted relationships that members may already have established.

Goal #5: Create an enabling environment to move BH providers toward outcomes and VBP
• We will develop an internal infrastructure specifically designed to enhance our network provider capacity to move along with VBP continuum through practice transformation, technical assistance, timely and actionable performance data, and training and education. • Through a robust and continuous assessment process, we will work with each provider to review their capabilities, explore their comfort level with risk, and review previous successes to meet them where they are. • We will provide data driven technical assistance and implement VBP to support integration and improved outcomes. • Focus areas for consideration in our VBP and pay for performance with BH organizations could include, incentives for expanding integrated care, access and linkage to SUD treatment, or more typical measures associated with BH practices (increasing follow-up after hospitalization, decreasing readmissions, etc.).

Practice Transformation Program

Our Provider Engagement Team will help to facilitate and oversee expansion of capacity and competency, and support providers to be successful through our Practice Transformation program. Our goal is to support development of a range of coordinated, co-located, and fully integrated care options within each region of the state. Leveraging regionally-based Practice Coaches and SOC Liaisons, we will partner with state and local leaders and serve as an **Integration Accelerator**. Local planning will be guided by population needs based on SAMHSA's 4 Quadrant Conceptual Framework[1] for collaborative planning and its continuum of integration options for primary care and behavioral health (BH)[2]. Please see ***Table 5.4.1.E-2* Provider Options** below for our range of coordinated, co-located and fully integrated care options for providers.

Table 5.4.1.E-2 Provider Options

Coordinated, Co-located and Fully Integrated Provider Care Options	
Level 1:	Minimal Collaboration – Separate facilities and systems, little to no communication
Level 2:	Basic Collaboration at a Distance – Separate facilities and systems, communication based on specific issues or patients
Co-Located	
Level 3:	Basic Collaboration Onsite – Behavioral and physical health providers located at the same site, separate systems, referral process to BH
Level 4:	Close Collaboration with Some System Integration – Providers located at same site, some shared systems and records, some face-to-face communication
Level 5:	Close Collaboration Approaching an Integrated Practice – Providers work as a team, frequent communication, may have separate medical records
Level 6:	Full Collaboration in a Transformed/Merged Practice – Providers work as a team, patients have a single treatment plan, all patients are treated as a whole person

STATE LEVEL SUPPORT

[1] *Mauer, Barbara J. "Behavioral Health/Primary Care Integration and the Person Centered Healthcare Home". April 2009. The National Council for Behavioral Health Care.*
[2] *Options identified by Millbank review and adopted by SAMHSA. Evolving Models of Behavioral Health Integration in Primary Care in 2010 and Evolving Models of Behavioral Health Integration: Evidence Update 2010-2015 in 2016*

We are committed to working with the State to align standards, coordinate incentives, and assume new functions to facilitate transformation toward integrated care, care coordination, and VBP. Specifically related to integrated care, we will collaborate with KDHE to develop a Practice Transformation and Training (PTT) Initiative. A kick-off summit will convene providers across the state to discuss their definition of integration using the SAMHSA models described above as a guide. We will collaborate with the State to inform a strategy planning process, in collaboration with each of the other MCOs. The resulting PTT Toolkit will:

- Clarify terms, levels, types, and models for integration
- Describe the technical support available and planned at the state and local level
- Offer regional information and data to inform each provider's analysis of their own organization/practice

We will continue to collaborate with KDHE and across MCOs to identify and solve any operational issues and ensure system-wide solutions. For example, we will continue to participate in the KDHE-led data transparency workgroup or similar workgroups to analyze data to identify trends and improvement opportunities and facilitate the development of joint initiatives and associated performance metrics to improve coordination of services and ensure capacity, leveraging national best practices.

PROVIDER LEVEL SUPPORT

Providers currently vary considerably in their degree of integration and capacity for further integration. Successfully building and sustaining integrated care at the provider level requires full information about available models and approaches, workforce assessment, HIT needs, practice transformation goals, and business projections to identify and sustain new activities and identify new partners and/or staff to meet evolving needs.

We will assist each provider to undertake a planning process informed by the Practice Transformation and Training Initiative, plus a thorough readiness self-assessment to consider the type and level of integrated care that best meets their population's needs and reflects their organization/practice's capacity for collaborative activities. For example, we can adopt SAMHSA-recognized tools for measuring level of provider integration such as the Integrated Practice Assessment Tool (IPAT) or the Behavioral Health Integration Capacity Assessment (BHICA), which mirrors the six levels of integration described above. Supporting this effort, we will:

- Facilitate provider and community-based trainings
- Meet providers where they are, offering practice transformation and technical assistance based on assessed need
- Build new capacity and support co-located and fully integrated approaches through innovative partnerships and investments
- Based on our local linkages and within our ISC model and system of care framework (as illustrated in Figure 5.4.A above) , we will facilitate connections among partners and establish coordinated care where fully collaborative co-located care is not possible, and/or necessary

- Convene learning collaboratives to share best practices in integration and whole-person care
- Expand workforce through partnerships with regional community colleges for Peer Support Specialists and Recovery Coach Certification
- Deliver actionable information at the point of care

Workforce Training. Project ECHO Leveraging Project ECHO, we will provide community training and technical assistance regarding appropriate use of screenings for BH conditions, appropriate referral for BH care, managing members with co-occurring conditions, crisis planning, person-centered care planning, trauma-informed care, recovery and resiliency, use of peer supports, adherence to CLAS standards to improve care access and reduce health disparities, inclusion of natural supports, and more. The Practice Transformation and Training Initiative program will offer tailored provider trainings, system-wide supports, and engagement strategies to fill identified gaps and move providers further along the integration spectrum relative to their goals and the needs of our members.

Training for CMHCs/BH Providers. In addition to PCP clinical trainings described above, we will orient and train BH providers to screen and manage primary care and chronic disease for those with BH conditions, in collaboration with primary care colleagues. This will include programming to promote health literacy, smoking cessation, address stigma, ensure CLAS adherence, and implement the processes necessary to provide collaborative care (huddles, open access, etc.). A curriculum for licensed professionals, such as LCSWs, LPCs, LACs, etc., will include specialty training on how to communicate effectively with primary care staff, including topics such as how to receive a Warm Handoff, how to write effective and efficient clinical documentation, how to best utilize the PCP's time, approach to the physical exam and health behavior change, and roles for PCPs in the BH environment.

Value Based Purchasing to Support Transformation and Integration. We recognize that providers are at varying levels of readiness to enter into advanced VBP models that support BH integration and system transformation. We understand the unique strengths, challenges and roles of PH and BH providers in the system of care. We have experience addressing performance payment barriers encountered by BH providers, including attribution and lack of statistically significant membership. Throughout the implementation, Sunflower will work closely with our network and the State to maximize VBP, APMs, grants for certification or purchasing needed equipment, and other hands-on support. See Section 5.7.1.A. for a complete description of how Sunflower plans to engage in VBP arrangements with providers.

9. How it will engage Members in order to obtain consent to share PHI across physical health, Behavioral Health, HCBS, and LTSS care Providers, when such consent is required, and its previous experience in obtaining Member consent, particularly as it relates to 42 CFR § Part 2 for SUD care.

MEMBER CONSENT PROCESS

Critical to delivering integrated care is sharing of information across disciplines, which requires member consent. As part of our ISC model, a SC/CSC outreaches to the member to begin

engagement in the ISC process. This initial outreach includes explaining the program and its benefits, as well as obtaining the member's consent to participate in the program and to have their information shared with the member's identified IC Team to promote coordination and integration of services. If not already obtained as part of the initial Health Screening or HRA, the SC/CSC asks the member to complete a consent form to provide permission for Sunflower to access, review, and share all necessary and available medical information, including mental health and substance use information, as appropriate, and other relevant records such as those from State agencies. Upon receipt of the signed consent form, the SC/CSC scans and stores completed consent form(s) in our integrated CM Platform that houses the member's single, centralized record, available for all care team members to access.

Obtaining written consent for release of medical records and relevant health information is critical to ensuring continuity of care and optimal health outcomes. We have developed targeted strategies to raise awareness of the importance of consent, as well as the process for obtaining member consent to release medical and other care and service information, including mental health and substance use information. This includes consent forms provided in our new member Welcome Packets, information in the Member Handbook and newsletters and targeted training and education of the IC Team, inclusive of the member's PCP, LTSS and BH CPs and others involved in the delivery of care. Additionally, when asking members to sign consent forms, part of our process includes explaining why such information sharing is important.

Signed Consent for SUD Treatment

Sunflower complies with all applicable Federal and state privacy and confidentiality laws, including 42 CFR Part 2 and Chapter 42.56 RCW. Sunflower requires the written and signed consent of the member or member's legal representative to release SUD treatment information to another individual/entity. After obtaining written member consent, Sunflower includes a notice prohibiting re-disclosure when sharing information related to SUD treatment. As described in the SC/CSC process above, to facilitate data sharing, Sunflower provides an authorization to disclose health information form to obtain consent and will accept legally compliant forms created by other entities.

TECHNICAL CAPABILITIES TO ENSURE 42 CFR PART 2 CONFIDENTIALITY STANDARDS

Sunflower and our parent company Centene Corporation utilize technical capabilities, business process and policy to ensure adherence to HIPAA mandated rules, and standards per HIPAA Security and Privacy, including those related to "sensitive" information as defined in 42 CFR Part 2, protecting the confidentiality of patient records with substance abuse and addiction information. We implement Role Based Access Control (RBAC) for all core business applications, addressing security risks by defining access rights based on job functions or responsibilities. Our RBAC controls are also compliant with HIPAA Minimum Necessary Rules. Our secure Provider Portal also uses RBAC and administrators have the capability to restrict user access to specific functions such as eligibility checks, authorizations, claims information, member health record, etc. In compliance with state and federal regulations, including appropriate approvals, we have the capability to share permissible BH information with providers for the purpose and

enhancement of care coordination. Our integrated Management Information System configuration has the capability to suppress sensitive health information with specific regard to substance use and other sensitive information. For example, we suppress on our secure Provider Portal information related to HIV/AIDS diagnosis.

Local Experience Ensuring Confidentiality Standards

Sunflower is experienced in ensuring compliance with Kansas privacy rights and has developed protocols and guides to protect member privacy. Our policies and procedures outline the processes we implement to obtain written and signed consent to release information. All of our member-facing staff are trained on member consent requirements and Federal HIPAA Security and Privacy, and Kansas specific privacy laws including the KDHE Security Policies and Standards, the KDHE's Data Security Requirement standards, and Kansas' Office of the Chief Information Officer (OCIO) Security Standards. Sunflower will maintain a statement on file for each individual service provider and Sunflower staff and contracted CSCs who have access to mental health data on our MIS that is signed and attested, acknowledging that providers, Community Service Coordination entities and Sunflower staff follow all regulations on confidentiality.

10. How CONTRACTOR(S) will assist Members with addressing Social Determinants of Health and Independence.

ADDRESSING SOCIAL DETERMINANTS OF HEALTH AND INDEPENDENCE (SDOHI)

Sunflower's System of Care and ISC model are specifically designed to address not only the clinical needs of the member, but also SDOHI, such as transportation, housing, food, employment and other non-clinical needs that have an impact on health outcomes and quality of life. This includes coordination with and referral to community resources. To facilitate this process, we include program SDOHI COE Team of specialists, SOC Liaisons, and CHWs on our internal IC Teams, bringing local knowledge and resources to the teams. Outside of the ISC program, Sunflower has and will continue to implement a continuum of programs and services to assist members with SDOHI.

Farmer's Market

Sunflower's CHWs attend local Farmer's Markets to maximize our ability to identify members in the community that may need Service Coordination and address their social needs. We target members who are receiving benefits from the Supplemental Nutrition Assistance Program (SNAP), as well as any other member looking for health and wellness support. At these events, our CHWs "*meet members where they are"* to distribute vouchers, educational material, perform health screenings, and serve as liaisons to connect members to a range of local resources and community agencies.

Life Ally Program

As part of our approach to addressing SDOHI, Sunflower supports members in overcoming their life barriers and promoting healthy communities by offering our Life Ally program. The cornerstone of Life Ally is Sunflower's Community Resource Database is a comprehensive online social utility for access to local social services and community resources, such as, food, housing,

transportation, and education services that best fit members needs and can impact their health and wellbeing. Accessible to all members of the Integrated Care Team, such as SCs, CSCs, CHWs, members, and providers, our Community Resource Database allows users to complete a life barriers assessment and quickly locate recommended resources near them. The Community Resource Database includes features such as:

- Search capability by both keyword and filters
- Graphical resource mapping display and directions from as a little as a mile up to 50+miles
- Favorites and save functionality

Closing the Loop. Sunflower will provide members, as well as the SCs/CSCs that serve them, closed loop referral tracking and coordination with contracted Community Business Organizations. Through this program, Sunflower will have the capability to track, trend, and report on membership needs (e.g., assistance with utilities) and utilization by geographic area and resolution of life barriers. Through our population health based SDOHI approach, we leverage technology to effectively and efficiently engage and support members. Our Life Ally program, coupled with our integrated model of care, community-based approach, and innovative member programs such as our Double Up Food Bucks (DUFB) program, Life Course training, PRAPARE, and Sunflower Transitions to Employment Program (STEP) provide needed services and supports to positively impact SDOHI.

Sunflower's staff focusing on Social Determinants of Health and Independence, including our coordinators of housing and employment services and supports, would welcome the opportunity to work with the State to consider and develop a list of "approved" Independence Account services and supports that help promote the goals of the TransMed Initiative.

Members Experiencing Housing Instability

Sunflower recognizes that housing is an integral component to the system of care that affects the ability for an individual to live a successfully healthy life. We will have a designated Sunflower Housing Specialist, as part of our SDOHI COE Team, to help identify housing stock and supportive programs. The Housing Specialist will work with our Service Coordination team to connect members to resources and provide additional linkages to the community. Our proposed Housing Specialist has over 20 years of experience with a range of projects and organizations working to enhance the infrastructure in Kansas to provide integrated services to chronically homeless adults. Current activities that support member access to safe and sustainable housing include:

- Active participation in the Kansas Interagency Council on Homelessness
- Participation in the Cooperative Agreement to Benefit Homeless Individuals (CABHI) States Project. The CABHI-Kansas Project is a collaboration with KDADS, KU Center for Public Partnership and Research, KU Center for Mental Health Research and Innovation, three community mental health centers and Heartland RADAC bring together housing services, employment services, peer support, case management, substance use assessment and referral and assistance applying for SSI\SSDI using the SOAR model on one integrated team at each of the three community mental health centers.

- Collaboration with Valeo, Mental Health Association of Central Kansas and the Wyandot Center to obtain supported housing for Sunflower members with SPMI
- Formalizing partnerships with key organizations such as the Housing Resources Corporation and Community Living Pathway to collaborate on housing solutions for the State.
- Sunflower will work in collaboration with our parent company's Housing Specialist to disseminate best practices, programs, and initiatives across our affiliate health plans

Supported Employment

Sunflower's Employment Specialist, part of our SDOHI COE Program Team, helps make employment a reality for members that choose to move back into the workforce. Our Employment Specialist will work proactively with the IC Team to educate about available services and supports throughout the region that can be integrated into the person-centered care planning process. This education includes but is not limited to, engaging members in discussions about pursuing employment, increasing their motivation to work, and offering the full spectrum of employment services (e.g., identifying employment goals, skill development, job placement, and job coaching). Our Employment Specialist will identify and provide technical assistance to specialty Supported Employment providers with proven track records working with individuals with BH conditions (including history of substance misuse), transition age youth and justice system involvement—all circumstances that make finding and maintaining a job more challenging. Sunflower will continue to collaborate with agencies such as Vocational Rehabilitation and our provider partners that offer supported employment to improve job opportunities and sustainable employment that is supportive of individual recovery goals. Additionally, our Employment Specialist will develop a specialty employment network and resource list that will include employment service agencies with expertise in working with individuals with BH conditions. Other resources we will promote with our members include family support services, peer health coaching, peer community re-entry support services, peer system navigator services, peer hospital discharge support services and peer housing support and supported employment services.

We engage in a variety of employment initiatives each year which benefit our members, other Kansans, and Sunflower as an employer of persons with disabilities. Our current initiatives are described further.

Project SEARCH. As of Jan. 2, 2016, Sunflower became the statewide manager for Project SEARCH. Project SEARCH is a nationwide program which supports students with disabilities with obtaining competitive employment when graduating from high school. The project is designed to develop partnerships between school districts and local businesses to offer internship opportunities for students with disabilities who have an employment goal and are transitioning out of high school. Nationwide, Project SEARCH has a 73% success rate for job placement post-graduation. In Kansas, Project SEARCH has experienced a 78% success rate.

Sunflower also became a business internship site in 2015, has hosted two interns and hired one full-time. Sunflower's Director of Human Resources has been invited to be on the steering committee for Project Search. As of mid-May, Kansas Project SEARCH had 35 of 70 interns who secured competitive employment post-graduation. Many were still in the process of applying. 90 interns have been selected to participate during the 2017-2018 school year which is an increase from 72 in 2015 and 83 in 2016-2017. During 2017, one additional school district has signed up to participate in Project SEARCH and will begin their technical assistance phase. Kansas also has a Project SEARCH program for adults in Johnson County and Wichita.

Through Sunflower's leadership, 8 sites were awarded for employment outcomes.

- ***1 Kansas site received a 100% reward***
- ***4 received 80%***
- ***3 received 70% or better***

Project SEARCH has facilitated a total 78% positive employment rate.

Reverse Job Fair. Sunflower recently participated in a Reverse Job Fair organized by Johnson County Mental Health and Johnson County Development Supports. The job fair allowed persons with disabilities a location to display their employment information, and for businesses to come by and visit with them about their skills.

Business Leadership Network – Greater KC. In August 2016, Sunflower is participating in the Greater Kansas City Business Leadership Network, and is being nominated for a Disability Champions award this year. Employment of persons with disabilities is not the sole focus of this network but is one of the main areas of focus.

Disability Mentoring Days. Each year organizations throughout the state offer Disability Mentoring Day activities which can include visiting local businesses, gaining information about job openings, learning how to create a resume, and gaining actual hands-on experience with different employers. Sunflower assists with these activities through financial sponsorships and/or providing volunteers.

Sunflower was named a 2016 DisAbility Champions Award recipient by the Greater Kansas City Business Leadership Network.

Employment Survey. The Kansas Employment Systems Change Coalition disseminated an online survey opportunity in May and June 2016 for persons with disabilities and their providers, families, care managers and advocates to complete. The intent of the survey was to identify barriers to employment. The Disability Rights Center asked Sunflower to assist with getting information out about this survey. As part of our efforts we outreached to and education providers, members, community agencies, and Service Coordinators.

Member Contacts about WORK. KDHE has identified for Sunflower the members we have in HCBS, and members on the I/DD and PD waiting lists who are potentially eligible for the WORK program. Sunflower is contacting each member on this list to help provide education about the WORK program and who to contact for determining eligibility. We provide at least two contacts per year to all of our members who are on a waiting list for HCBS services. We provide

education during these contacts about employment supports and opportunities, and about the WORK program.

Enhancing Care Coordination Initiatives to Increase Employment for People Experiencing SPMI and SUD. To address unemployment and other SDOHI within the context of SPMI and SUD, Sunflower collaborated with KDHE in a pay-for-performance (P4P) program that worked to positively impact:

- Percent of SUD members whose employment status increased
- Percent of Serious and Persistent Mental Illness (SPMI) members whose employment status increased

There were 1,531 unique SPMI members in the 2016 employment initiative. This represents 0.9% of the total 2016 Sunflower population. Likewise, there were 241 unique SUD members in the employment initiative representing 0.1% of the total Sunflower population for 2016. A multifaceted approach was used in developing programs and tailoring interventions aimed at improving employment opportunities. The health plan collaborated with the State Medicaid agencies and community providers, enhanced member and provider engagement, and aligned internal work processes with the goals of the performance measures. Employment measures within the State's pay-for-performance program specifically focused on individuals experiencing SPMI or SUD, and Sunflower developed strategies to improve outcomes with three key initiatives, including payment, member and provider engagement, and data integrity.

Partnership Strategies

As part of Sunflower's strategies for addressing SDOHI in value-based models and the goals of KanCare 2.0, we propose the following delivery system innovations and strategies:

- Partner with KAMU, the Primary Care Association of Kansas, on the use of Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE) at community health centers
- LifeCourse Framework Training for SCs, CSCs, and CHWs
- Sunflower Transition to Employment Program (STEP)

11. Examples of innovative network designs or structures that it has tested or implemented, if any, to facilitate integration of medical and Behavioral Health care services, and any direct improvements that resulted. CONTRACTOR(S) will provide designs or structures to support the development of high-functioning interdisciplinary teams for high-risk members.

LOCAL INTEGRATION EXAMPLES AND OUTCOMES

Integration has been a key strategy for Sunflower since inception. Our current initiatives are primarily focused on training and resources to support integration. As we move into KanCare 2.0, our activities will directly impact network design, practice transformation, and evolution of the delivery system. These include VBP payments and initiatives (see Section 5.7.1.A.1 and 5.7.1.A.5), including bi-directional integration, and our Practice Transformation Program (see this Section 5.4.1.E., Question 8 above). Examples of activities that provide the foundation of our movement toward more innovative network designs and structures include:

P4P for HEDIS measures in CMHCs

All 26 of Kansas' CMHCs participate in this program, impacting more than 20,000 members across the State. This program reimburses CMHCs a bonus payment when they achieve target quality results in the following four HEDIS measures, which are aligned with KDHE's Physician Incentive Plan (PIP): APM – Metabolic Monitoring for Children & Adolescents on Antipsychotics, SAA – Adherence to Antipsychotic Medications for Individuals with Schizophrenia, SSD – Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic medications, and FUH-7 day -7 day follow up visit post discharge for mental health hospitalization visit ages 6 years and above.

For our members served by our CMHCs:

- *Metabolic Monitoring for Children and Adolescents on Antipsychotics 1 to 5 Compliant improved from 33.33% pre VBP (6/2017) to 40% post VBP (12/17)*
- *Diabetes Screening for People with Schizophrenia or Bipolar Disorder improved from 54.05% to 55.04%.*

Co-location

In November 2017, Sunflower began working with Horizons Mental Health CMHC in Hutchinson, which has a BH professional embedded in the local primary care clinic. The CMHC shares data with our Service Coordinator assigned to high risk cases with both BH and PH comorbidities. We are tracking care gaps, ED utilization and a variety of other outcomes. We are also tracking process indicators for Service Coordinator interactions with CMHCs to gain a comprehensive understanding of facilitators and barriers to co-located collaboration. Sunflower plans to expand this pilot to more CMHCs in 2018.

Community Health Workers Coordinating Care. We employ a high touch approach and meet members where they are. For example, our outreach team of 19 Sunflower CHWs assist KanCare members one-on-one with understanding their health, health benefits and services and other community resources. CHWs can provide educational services telephonically, at a provider office or community events, or in the home. CHWs assist our members in building a relationship with their provider. CHWs provide assistance such as: finding a physician to meet a member's individual needs, knowing what questions to ask during their appointment, assisting member's with understanding their benefits and access to care standards to ensure timely access to care. They also assist members in accessing transportation, food, shelter, or other health or social programs. We also utilize CHWs to help locate hard to reach members to connect them with health plan clinicians and service providers as well as how to access needed care and services as indicated through predictive modeling and risk stratification.

Sunflower has also co-located Sunflower CHWs within two CMHCs to enhance and expand their ability to support our members. Our certified CHWs are trained to address SDOHI, increase health literacy, give members more confidence in their healthcare system, and increase preventive care visits/reduce ED use. Using culturally competent and linguistically appropriate care, they connect members to PH and BH care, as well as other support services as appropriate.

CMHC Workgroup to align with Collaborative Care Model. In June 2017, Sunflower initiated a workgroup with the Association of CMHCs to help inform our design of an integrated collaborative care model. Workgroup activities include exploration of lessons learned from the State's previous Health Home initiative, assessing provider status along the integrated care continuum and developing support plans and programs. The goals of this workgroup include:

- Establish and operate a clinically-integrated mental health network that will serve as preferred providers to Sunflower and other third-party payors across the state of Kansas that allows for regional focus
- Share evidence-based, outcome-driven best practices for offering high quality BH services
- Support enhanced efforts for VBP for BH and integrated providers
- Create a patient centric delivery system that promotes access to a BH system of care, integrates PH and BH, provides high quality services, and is cost efficient

Increasing BH Screenings in Home Settings. Through our affiliated subcontractor U.S. Medical Management (USMM) we are incorporating the use of the PHQ-9 during their in-home services to provide increased access to BH screenings and increased access to integrated care through USMM. Additionally, we will work with USMM to ensure members with positive PHQ-9 screenings are referred to local BH resources, such as home-based therapist who consults with a psychiatric nurse and/or psychiatrist to manage identified BH conditions. This will ensure that members have continuity of care, improved quality of life, and the continuous elimination of barriers to receiving integrated BH services in their home.

For 2017, we have performed 1,077 PHQ-9 depression screens through in-home assessments in adults.

Psychiatry Consult Line. Sunflower offers an 800 number that links all of our providers with our BH Medical Director for advice/ consultation on issues related to BH. The Psychiatry Consult Line was born out of consulting with providers and the targeted outreach of the PMUR process. There was positive feedback from providers who expressed appreciation for being able to discuss challenging cases with a specialist. One of the most remarkable cases was contact with a primary care physician out on the frontier. The provider had been providing treatment for a five year old boy with aggressive behavior. This child was on an adult dose of an atypical antipsychotic, with little response. Through consultation, it was realized that no testing had been done for autism, other developmental disabilities or an evaluation for ADHD. The provider was unsure how to help the member and both the provider and the member's family were desperate for help. The provider was receptive to recommendations for testing and medication adjustments. These adjustments resulted in an improvement in member's condition and provider satisfaction.

Developing and Delivering Integrated Training Curriculums Across Providers and Disciplines. Sunflower and all of our affiliate plans have enhanced our provider, clinical and support staff training to include education on the integrated model of care and the importance of early

identification and assessment of potential co-existing PH and BH needs. Other trainings include: Motivational Interviewing:

- Trauma Informed Care
- Recovery and Resiliency
- Harm Reduction
- Mental Health First Aid
- Person-Centered Thinking
- Positive Behavior Support

Foster Care Center of Excellence. Foster Care Youth require focused attention to social and medical integration. Our Foster Care Center of Excellence is built on the premise that a clinical network alone is not sufficient to help a child who has grown up or been thrust into the child welfare system. We focus on the whole child and bring our skills in trauma-informed care, care coordination and integration to address PH, BH and social factors, which leads to improved care and outcomes. More information about our integrated care approach for youth in Foster Care is described in Section 5.4.11.

National Example and Outcomes

Our Florida affiliate implemented a modified IMPACT (Improving Mood Providing Access to Collaborative Treatment) program in 2014-2015 that focuses on those who are newly diagnosed, undiagnosed or have an undertreated BH condition and are at risk of exacerbating a co-morbid medical illness such as a, diabetes or heart disease. IMPACT is listed in SAMHSA's National Registry of Evidenced Based Programs and Practices. Participants are identified by the PCP based on predetermined criteria, such as a PHQ-9 score. Once identified, the member is assigned a BH Wellness Coach, similar to our CCs, who meets with the member at the PCP location (embedded at the PCP location) to complete an initial needs assessment. The embedded BH Wellness Coach administers the PHQ-9, provides education to members about their BH and self-management techniques, coordinates community supports monitors member progress and contributes to consultations with providers. The PHQ-9 score is used to triage the appropriate risk level. Results demonstrate improvement in depression symptoms, increased engagement in BH services as well as overall health care cost reduction.

This program achieved the following results for our Florida affiliate:

- 67% of IMPACT participants were connected to BH services (twice the rate of non-participants)
- 1:3 achieved 50% improvement in PHQ-9 depression score
- Health care costs for participants averaged $2,213 less than non-participants

12. How CONTRACTOR(S) will improve health outcomes, reduce placements and reduce use of psychotropic medication for children in Foster Care.

UNPARALLELED EXCELLENCE SERVING CHILDREN WITH SPECIAL HEALTHCARE NEEDS

Sunflower and our parent company, Centene, offer extensive experience and capabilities in managing and coordinating services for high-needs children.

National Experience and Outcomes

Centene is a national leader in serving high-needs children including children in Foster Care. We manage and coordinate care for almost 697,000 members in 14 states, including 581,300 SSI non-dual eligible/SSI kids and 115,000 children and youth in Foster Care and adoption support in 8 states. Our high-needs children live with chronic conditions; functional or cognitive limitations; physical disabilities, I/DD, and brain injuries; serious emotional disturbance (SED); and potential trauma. There are currently only five sole-source, statewide managed care programs for Foster Care in the nation; Sunflower's affiliate health plans hold the contracts for four of them – Texas, Florida, Washington and Illinois (to go live July 2018). In addition, our affiliate health plan in Mississippi is the state health plan of choice for their fully integrated, statewide Foster Care managed care program. As a result of our specially designed programs and initiatives, our affiliates have achieved the following:

- Through the implementation of a Psychotropic Medication Utilization Review (PMUR) program, our Texas affiliate has reduced overall psychotropic medication use in foster children by almost 37%, class polypharmacy utilization by 48%, and use of 5 or more medications by 51%.
- Texas also developed and implemented an I/DD Service Coordination program to address the large number of children and youth in Foster Care with an I/DD diagnosis. To measure success, the plan asks caregivers to rate severity of behaviors and ability to complete certain activities of daily living. Ratings are taken every 90 days while a youth is enrolled in the I/DDM Program. In 2016, 60% reported problematic behaviors had stabilized, and 15% reported that problematic behaviors had improved.
- As our most tenured Foster Care program, for Texas children in Foster Care less than 12 months with two or fewer placements, placement stability improved from 79% in 2007 to 83.6% in 2012. For children in care 12-24 months, placement stability improved from 53% to 57.8% over the same period.
- Using administrative data, our Texas affiliate now ranks in the NCQA top 90th percentile of Medicaid managed care programs for Children's Access to Primary Care Providers. Childhood Immunizations (Combo 4 rates) increased from 21.7% in 2011 to 43.9% in 2013, reaching the NCQA 75th percentile.
- Between 2014 and 2016, our Florida affiliate doubled the percent of children in Foster Care receiving an annual dental visit from 31.6% to 62.3% and increased the Childhood Immunization Status measure ("Combination 10") from 6.6% to 20.4%.
- Implemented in 2016, our Washington affiliate has received great feedback on improvements in care and service for this vulnerable population. For example, a health plan SC was able to help a member who was wheelchair bound and in the care of elderly

adoptive parents by arranging for a new lift for the family's vehicle and working with a local home builders association, who provided the family with a free access ramp for their home.

Sunflower benefits from these successes by incorporating the lessons learned from these states in our execution of the Service Coordination model to improve health and SDOHI outcomes for Kansas Foster Care children. We have:

- A PMUR program targeted for Foster Care children in Kansas
  - Sunflower's Psychotropic Medication Utilization Review (PMUR) Program has resulted in an overall reduction in psychotropic medications used by members in Foster Care from 33.5% in 2013 to 28.9% in 2016; 60+ day psychotropic medication utilization among Sunflower's Foster Care membership decreased from 13.4% in 2013 to 11.6% in 2016.
- An Integrated Care Team comprised of staff with extensive experience working in Foster Care, I/DD and high-risk children populations and ensuring access to health care and SDOHI services
- A focused approach to preventing Foster Care placement and monitoring permanency

Approach to Improving Outcomes, Reducing Placements, and Reducing Inappropriate Use of Psychotropic Drugs

We recognize that Foster Care youth require focused attention to social and medical integration. Our Foster Care COE is built on the premise that a clinical network alone is not sufficient to help a child who has grown up or been thrust into the child welfare system. We focus on the whole child and bring our skills in trauma-informed care, care coordination and integration to address PH, BH and social factors, which leads to improved care and outcomes. Sunflower incorporates training and principles of trauma-informed care in our work and will provide training to our provider network and community stakeholders. Contributing to all of the question's stated goals is our ISC model and program, which, as described above, is tailored to the unique needs of each individual, including children in Foster Care. For example, the IC Team for a child in Foster Care may include the child's caseworker, adoptive parents, and/or birth parents, as well as a SC experienced in child welfare, and like all of our SCs, trained in trauma informed care. We also have specific programs to support our transition aged youth to successful transition into adulthood, including resources supporting education, employment, and housing.

Measuring and Monitoring Health Outcomes

We align oversight efforts with the HEDIS metrics that are applicable to children. Our quality program tracks both standard metrics such as receipt of preventive care services and immunization rates and metrics specific to this population such as follow up after BH hospitalization, use of psychotropic drugs, and

56 Sunflower Foster Care Members Enrolled in High Risk Cohort in 2016

- ***19% reduction in inpatient admissions***
- ***26% reduction in visits to the ER***
- ***8% reduction in psychotropic prescription fills***
- ***11% reduction in the number of youth taking psychotropic medications***

permanency of placement. Examples of outcomes for our children in Foster Care are included in ***Figure 5.4.1.F_Quality Outcomes*** below.

Figure 5.4.1.F_Quality Outcomes

HEDIS Measure	2015	2016
Well Child Visits for 3, 4, 5, and 6 year olds	71%	73%
Immunizations for Adolescents	63%	69%
Annual Dental Visits	68%	70%
Medication Management for those with Asthma	46%	52%
7 day follow up after ED visit for mental health	N/A	79%
30 day follow up after ED visit for mental health	N/A	88%
Use of multiple anti-psychotics	8%	5%
Metabolic monitoring for those on anti-psychotics	30%	41%
Diabetes screening for those on anti-psychotics	66%	74%

High Risk Foster Care Cohort. Sunflower utilizes predictive modeling software to assess our highest risk members, including those that are likely to disrupt placement. We conduct interdisciplinary team reviews on members that are identified and then submit appropriate referrals based on identified need.

Permanency Goal

The road to wellness and permanency is different for every child in the Foster Care system. Our core training curriculum for staff engaged in Foster Care emphasizes the importance of permanency in placement and well-being, and permanency goals are a key feature of care planning. The DCF permanency goals will be reviewed at every IC Team meeting. Unanticipated changes in permanency goals may prompt additional IC Team meetings. Reassessments may impact permanency goals as well. The PoS will be updated and aligned to the permanency goals as needed. IC Team employs a wrap-around model and works with all providers, community-based supports, and natural supports to ensure that all barriers to permanency are addressed. For example, kinship foster families may need substantial support in caring for children with complex medical needs. The IC Team will work with families to connect to specialized providers. Emotional issues related to expectations of permanency are also an important factor. All providers, caseworkers, family members and others in the circle of support need to provide consistent reinforcement of the permanency plan. We will develop a preferred network of trauma-informed providers so that fundamental issues related to trauma and abuse, which may impair permanency, are identified and treated.

Preventive Approach to Permanency. Through our well-established relationships with St. Francis, KVC and DCF, we work collaboratively with families to prevent Foster Care placement. Our Rapid Crisis Response approach aims to minimize/ prevent escalations and stabilize a current child's environment through the provision of an IC Team consultation conference within 24-hours of being notified of a crisis. Our support team collaborates with the family to identify risk factors, appropriate trauma assessments, specialized, evidence-based, trauma-informed, family oriented treatment services and wraparound supports. Our support team, including our community partners, works intensively to bolster family support through education and coping

skills to maintain intact families. We work closely with providers who are trained in evidence-based models that simultaneously address delinquency, antisocial and aggressive behaviors, MH disorders, school and family problems, and prevention of out-of-home placement, including providers trained in TFCBT and Functional Family Therapy (FFT). Our current Foster Care Liaison is a master trainer in Trauma Systems Therapy, which is an evidence-based, multidisciplinary model that provides a framework for our preventive approach. Knowing the limited prevalence of trained providers in these treatment models in certain areas of the state, we will actively canvas our network and offer training/training support where necessary. We will work with KDADS and the family preservation report to intervene early when a family is identified by DCF as needing added support through family preservation. Through early intervention and targeted family support, we may be able to prevent removal of the child/children from the home. We are also working with KVC and St. Francis to expand the use of Parent Management Training of Oregon for these families who are at risk for out of home placement.

Monitoring Permanency. Our quality program will track both standard metrics such as receipt of preventive care services and immunization rates and metrics specific to this population such as follow up after BH hospitalization, use of psychotropic drugs, and permanency of placement. We will continue to collaborate with the Department for Children and Families (DCF) to have key roles in reviewing outcomes and advising on quality improvement priorities and strategies. We are currently collaborating with DCF and other stakeholders to create innovative approaches to addressing the highest need members in Foster Care.

Psychotropic Medication Utilization Review (PMUR) Program. Built off our successful program in Texas, PMUR was developed out of concern that children identified with high needs, such as children in Foster Care, are medicated in larger percentages than other child and adolescent populations. The goal is to educate and ensure prescribers are acting within an agreed upon standard of care when prescribing to children. The PMUR process includes pharmacy claims review, medical record review, and peer to peer consultation and education. Indicators used to identify a need for further case screening include individuals who have received treatment with psychotropic medication(s) for 60 days or more, as identified through systematic reporting, or that fall into the following categories: all children four and under; anyone whose medication regimen appears to have class polypharmacy; or anyone with four or more psychotropic medications. Reviews can also be triggered by a referral from both internal (CM, UM, Medical Director, pharmacy department, etc.) and external (caregiver, court, caseworker, social worker) referral sources. Licensed clinical PMUR staff do a review or screening of a member's medication regimen and provide answers to general questions, or determine if the medication regimen falls outside the above parameters. A peer to peer discussion/review occurs when the initial medication review finds that the current medication regimen is outside of the established parameters. This requires involvement of the Medical Director and/or a psychiatric consultant.

13. How CONTRACTOR(S) will reduce use of psychotropic medication for nursing home residents.

Sunflower recognizes that use of technology to deliver BH services can help address barriers that can prevent our members from receiving care, including access issues in rural and frontier

areas across Kansas. In Q1 2018, we are implementing a tele-psychiatric program, supported by the Kansas Health Care Association to expand the availability of psychiatric medication management to members in Nursing Facilities in rural, frontier, and underserved regions of the State. Recognizing the potential financial burden to nursing facilities due to Medicare reimbursement barriers, Sunflower will directly pay the tele-psychiatry vendor for once a month e-consultations for members on antipsychotics. Through this program, psychiatrists will ensure appropriate prescribing of psychotropic medications including the decrease or tapering off of Nursing Facility members on antipsychotics.

The goals of our Nursing Facility Tele-psychiatry pilot include:

- Ensuring appropriate prescribing of psychotropic medications for members in nursing facilities
- Increasing member access to behavioral health services in rural and frontier areas
- Increasing member oversight and treatment
- Increasing appropriate metabolic screening for members on antipsychotics and lowering the rate of multiple concurrent antipsychotics use
- Reducing the incidence of polypharmacy, adverse drug effects, and unnecessary pharmacy costs

Additionally, based on a recent KDADS meeting on use of psychotropic medications for NF residents and the policy priority for the state, Sunflower has committed to participating in the **Kansas Partnership for Improving Dementia Care**. The goal of this partnership is to improve the quality of life and care for persons with dementia including reduction of use of psychotropic medications within facilities. We also plan to invite a representative from the partnership to be on our LTSS Advisory Committee in 2018.

Sunflower also offers a **clinical provider training program focused on the nursing home population, and the understanding and management of behaviors**. This training series was initially developed in response to an identified need to assist members who were experiencing high rates of inpatient hospitalization and ER utilization, due to behavior difficulties in nursing facilities. The idea behind this program is to train on the difference between behavioral management/behavioral needs and psychiatric symptomology, while providing skills to utilize for de-escalation. Behavior Management is a short-term intervention to safely address problematic and/or disruptive behaviors, and encourage the occurrence of positive behaviors. The training is currently a three-course series including Behavior Management 101, Behavior Management 102, and Behavior Management Strategies. Our training outcomes demonstrate an average pre-test to post-test knowledge increase of 152%. By increasing provider knowledge and resources for dealing with problematic behaviors, we are able to improve placement stability and both provider and member satisfaction.

We will also leverage and make available **Sunflower's Psychiatry Consult Line,** which is an 800 number that links all of our providers (including our NF providers) with our BH Medical Director

for advice/ consultation on issues related to BH, including appropriate use of psychotropic medication with nursing home residents.

14. How CONTRACTOR(S) will ensure that Medicare-funded healthcare services are coordinated and maximized for populations including HCBS Waiver populations,

COORDINATED CARE FOR DUALLY-ELIGIBLE POPULATIONS

Sunflower is committed to continuing or efforts to work in partnership with the State, providers, and key stakeholders to ensure a more seamless delivery of Medicaid and Medicare benefits and services for dual eligible individuals enrolled in KanCare. We have extensive experience coordinating Medicare and Medicaid benefits for dual eligible individuals in Kansas. We currently serve over 3,600 dual eligible individuals in Sunflower, of which over 3,000 are duals that are eligible for and receiving LTSS. Nationally, Centene currently serves over 160,000 dual eligible members in our LTSS programs and nearly 50,000 dual eligible members in our fully integrated Medicare-Medicaid Plans (MMP). We are committed to developing models of care that enhance and better align the delivery of care and services for duals and will be offering a Dual Eligible Special Needs Plan (D-SNP) in the Kansas market starting in 2019. In addition, Centene holds the nation's second largest membership across MMPs and serves approximately 18,000 dual eligible members in Dual Eligible Special Needs Plans (D-SNPs) in seven states.

Through our combined Medicare and Medicaid experience we are knowledgeable in Medicare and Medicaid services and benefits and have implemented several processes to support this coordination. For example:

- Having a single point of accountability for coordinating both sets of benefits that fully understands each benefit, ensuring Medicaid is always the payer of last resort and that Medicare-funded services are coordinated and maximized for duals, including dual eligible members that are receiving HCBS waiver services
- Establishing coordination protocols between our Service Coordinatorss and unaligned D-SNP and Medicare Advantage (MA) care coordination staff as well as with Medicare providers for dual eligible members that are receiving their Medicare benefits via fee-for-service (FFS) Medicare
- Leveraging our ISC model to connect members with the most appropriate service in the least restrictive setting, regardless of the primary payer for any particular service, and utilizing available Medicaid benefits, unpaid natural supports and community resources to wrap around the member's Medicare covered services and benefits

Service Coordination for Dual Eligible Members

All dual-eligible members eligible for LTSS are enrolled in Service Coordination and assigned a SC or CSC. Our Health Screening, HRA and assessment process identifies the full range of member needs, including those that require Medicare services. The PoS/PCSP incorporates needed covered and non-covered services including Medicare, and addresses how the member's holistic needs will be met, and how Medicare coverage will be coordinated. PCSPs

will further address how LTSS services will be coordinated if the member is eligible for HCBS Waiver services. We will honor member's choice of Medicare PCP and make every effort to involve them in the care planning process, regardless of network status, along with other individuals in the member's chosen circle of support.

Coordinating with Medicare Payers

Whether a member is enrolled in another Medicare Advantage (MA) or D-SNP or FFS Medicare, we ensure seamless, continuous, and appropriate care and services across the care continuum, including transitions between settings and coverages. We proactively coordinate with providers and MA and D-SNP staff for those in another D-SNP, MA plan or Medicare FFS. These providers may access PoS/PCSPs and other information needed to coordinate care via our Provider Portal. Our PoS/PCSP incorporates Medicaid wrap-around services, Medicare, and other services, and addresses how physical health, cognitive, LTSS services and behavioral health needs will be managed, including Medicare benefits. Sunflower educates members and caregivers about the importance of, and our role in, coordinating KanCare and Medicare services, and to inform Sunflower staff if they are enrolled in another MA or D-SNP.

We recognize that the state's dual eligible population currently receives their Medicare benefits primarily through FFS Medicare, MA plans and just one D- SNP (in Sedgwick, Wyandotte and Johnson only). Sunflower works in collaboration with and across Medicare payers and providers to ensure the individual dual eligible member is able to access services included in their PoS and/or PCSP in a timely way and in the most appropriate, cost-effective setting. Our approach accounts for the different ways members receive Medicare services, which impacts provider willingness to coordinate, data available to support coordination, and whether there is another entity's SC to work with. Regardless of Medicare delivery system, each Sunflower dual eligible member will have a single point of accountability for coordinating all needed services.

- For members in MA or D-SNP, our SC/CSCs will coordinate directly with the MA or D-SNP case management staff and participate on their care teams and/or include them in our process, as appropriate. Sunflower SCs and CSCs will collaborate to complete assessments and implement and monitor the PoS/PCSP, initiate requests for Medicare services, provide information to facilitate timely authorization, and notify the other MA or D-SNP's staff of changes to LTSS needs and services and new or changed clinical needs.
- SC/CSCs will identify Medicare FFS providers by asking the member and/or caregiver/family as part of our person-centered care planning process. The SC/CSC will invite those providers to participate in the IC Team and will coordinate as they do with network providers, sharing information and requesting IC Team participation. SCs/CSCs will coordinate initiation of and monitor all PoS/PCSP services (as applicable), including Medicare. We also propose to leverage the Coordination of Benefits Agreement with CMS for access to Medicare eligibility and crossover claims data to better coordinate care for dual eligible beneficiaries.

15. How CONTRACTOR(S) will engage with and CONTRACT with local organizations to provide community services.

ENGAGEMENT AND CONTRACTING APPROACH

As described in Sections 5.4.6 and 5.4.7, we are committed to contracting with a sufficient number of qualified entities to provide Community Service Coordination functions and activities, establishing mutually beneficial relationships where we leverage the resources and expertise held by each party. We intend to utilize the infrastructure and services that are in place today and the expertise and capabilities of community-based agencies and providers that serve complex populations including individuals with BH needs; HCBS waiver populations, persons in institutional settings, and children and youth involved in the Foster Care system.

We will leverage our established relationships and develop new relationships with community-based organizations such as the Centers for Independent Living (CILs) and Area Agencies on Aging (AAAs); Lead Agencies; Community Mental Health Centers (CMHCs); Community Health Centers, Rural Health Centers, SUD providers, I/DD TCM providers; Home Health providers and other social service organizations to create a system of care that addresses the whole person needs of our members enrolled in Sunflower. We will establish new contractual relationships with these, or other qualified, newly developed entities and providers in geographic service areas across the state to align with our local, integrated care model and provide member choice of CSCs. We meet quarterly with our LTSS Advisory committee, to address all matters important to LTSS areas such as outcomes measurement, value based purchasing, state and Sunflower policy and processes, and proposed legislation. Participants include: 1) Disability Rights Center, 2) InterHab, 3) Association for Area Agencies on Aging, 4) Kansas Association for Centers for Independent Living, 5) Minds Matter, 6) Topeka Independent Living and Resource Center, 7) Community Living Opportunities, 8) The Alliance for Kansans with Developmental Disabilities, 9) Craig Home; 10) Maxim, 11) Johnson County Developmental Supports.

To inform our Community Service Coordination contracting and engagement efforts, we have analyzed our existing Sunflower membership in terms of the profile and geographic distribution of members to ensure we have the right mix and adequate number of qualified and **conflict-free** CSCs to meet the needs of our membership and assure member choice of CSCs.

DEVELOPING AND SUPPORTING CAPACITY FOR COMMUNITY SERVICE COORDINATION

Sunflower will provide overarching service coordination functions and services, technical assistance and systematic monitoring to see that our contracted community-based organizations for Community Service Coordination have access to Sunflower's systems, resources, and tools, as well as information and data required for the member's CSC to understand and address the needs of the member across the entire spectrum of services and settings. This includes access to information, technology platforms, training/ workforce development programs, quality oversight and operational standards and protocols.

16. How CONTRACTOR(S) will ensure conflict of interest is mitigated when Subcontracting Community Service Coordination.

As described in our response to Section 5.4.6, 5.4.7 and 5.4.13 of this response, Sunflower is committed to contracting with qualified providers and entities, who meet the **CMS Conflict free**

standards for LTSS, who are not conflicted, to provide Community Service Coordination functions and services, as defined in Attachment L of the model contract, to enhance the integration of LTSS, BH and Foster Care expertise into our person-centered planning process.

Sunflower's assessment, PCSP and PoS policies and procedures supports conflict- free case management services. We will not delegate or subcontract with entities to perform needs assessments; PCSP or PoS development on our behalf for our members if that entity is also a provider of service or conducts components of the HCBS waiver eligibility process. If after numerous documented attempts we are not able to contract with a conflict-free community-based organization or provider in a certain geographic area, we will discuss and seek prior approval from the State before contracting with the entity and we will propose strategies for mitigating the conflict of interest pursuant to CMS requirements and State policy. We are also committed to and will work with identified community-based organizations and the provider network to develop capacity to provide conflict-free case management services and the appropriate safeguards and mechanisms to protect against conflicts of interest.

The Sunflower LTSS Director will have primary accountability for overseeing the performance oversight and monitoring of the Community Service Coordination entities in partnership with the Compliance Department, and the Sunflower Director of Behavioral Health. We will oversee and evaluate the performance of all delegated Community Service Coordination entities by conducting a comprehensive pre-delegation assessment and readiness review prior to delegation of functions focused on key areas including compliance with 42 CFR § 431.301(c)(1)(vi) and 441.730(b) regarding Conflict Free Case Management.

Sunflower's pre-delegation assessment, performance monitoring and quality oversight program is designed to confirm entites are qualified and meet expected standards and outcomes for performing service coordination activities and interventions. Sunflower will delegate service coordination activities to qualified entities that have demonstrated capacity and ability to work collaboratively with Sunflower, providers and systems of care to improve health and quality outcomes. All community-based organizations and providers that we contract with to provide Community Service Coordination services and functions must be able to demonstrate a business and staffing structure that is compliant with the CMS Conflict Free requirements for the HCBS population.

Sunflower will also use our robust credentialing process to mitigate potential conflicts of interest when subcontracting to Community Service Coordination providers. To fully support providers through the process, we approach each provider and/or provider agency as a customer with individualized needs. This approach enables us to customize supportive training, education, and engagement around our credentialing processes to ensure a smooth entrance into our network. Sunflower ensures a quality provider network by verifying provider credentials based on NCQA guidelines, communicating network participant responsibilities, and conducting peer reviews before granting entrance into our network. Our credentialing procedures address program oversight, provider specialty types, provider nondiscrimination, and application processes. Sunflower will work with KDHE and KDADS to further develop the

State conflict of interest policy and related requirements for service coordination provider conflict-free standards.

5.4.2. HEALTH SCREENING, HEALTH RISK ASSESSMENTS, AND NEEDS ASSESSMENTS

IDENTIFICATION OF PHYSICAL HEALTH, BEHAVIORAL HEALTH AND LTSS NEEDS OF MEMBERS (5.4.2.A)

A key component of Sunflower's ISC model is our member screening and assessment process designed to assess and address each individual member's PH, BH, functional and social needs. We have established systems, policies and protocols in place to assess the whole person needs of Sunflower members and provide appropriate follow-up, referrals and interventions as a result of the screening and assessment results. For example, under our current KanCare contract, we successfully complete an average of 694 HRAs and functional assessments each month. Further, we also complete assessments for LTSS members within seven days of enrollment into the health plan. As such, we are well positioned to and will comply with the Service Coordination workflow processes and timelines in Attachment K of the Contract.

Our multi-faceted and community anchored approach to member engagement has resulted in a significant reduction in members that we are unable to reach- from 34% in 2015 to 14% in 2017.

Ensuring Immediate Member Needs Are Met (5.4.2.B and 5.4.2.C)

We make every reasonable effort to outreach to members to complete the Health Screening and Health Risk Assessments (HRA) in an expedited manner to ensure the health and well-being of the member. In an effort to successfully engage and complete the Health Screening and HRAs, our policies, procedures and protocols currently require Sunflower SCs and in the future, will require CSCs to make separate outreach attempts over several days and at varying times of the day. The SC and CSC shall attempt to contact the member by phone at least three times. If after these three attempts the SC or CSC is unable to successfully reach the member, a letter is mailed to the member within 10 business days of the date of enrollment into Sunflower for all new members. Information mailed to the new member includes information on the importance of and how to complete the health screening and HRA process; information on how to contact the SC or CSC to complete the HRA (in-person or telephonically) as well as other options for completion of the HRA, such as electronically via Sunflower's Member web-portal or the self-completion of the form via mail. If we are still not able to successfully reach and engage the member as result of our telephonic outreach and written correspondence, we will continue our efforts to successfully complete screenings every 90 days or sooner based on HCBS Waiver requirements.

High-Touch Member Outreach Supports Completion of HRS and Assessments. We recognize the greatest challenge in completing screenings and assessments is reaching members. This is often due to outdated or incorrect information. For difficult to reach or engage members, such as members without telephones or members with unstable housing, we will leverage our CHWs

to meet members where they are at. Our CHWs function as an integral member of the IC Team and are culturally adept, specially trained, locally hired, locally based, and locally connected. These high touch member outreach staff meet members in their homes, at work, or in the community, as needed and work in collaboration with the member's primary SC or CSC to assist with completion of Health Screenings and HRAs. In addition to the use of CHWs, we also use concurrent inpatient opportunities and claims data to identify and outreach to the member's PCP and pharmacy providers to assist us with locating members. Often PCPs and pharmacy providers have more current and up to date member contact information that we utilize to successfully reach and engage our members. We also partner with several community based organizations, such as Heartland Regional Alcohol and Drug Assessment Center (Heartland RADAC) to reach hard to locate and difficult to engage members. Heartland RADAC utilizes a myriad of strategies and best practice to find and engage members who have chronic or high-risk SUD issues and assist these difficult to engage members with locating affordable housing, employment and recovery services.

Using TruCare to Conduct Health Screening, HRAs and Needs Assessments (5.4.2.D)

As described in Section 5.4.14, Sunflower uses TruCare, our member-centric service coordination platform to support our service coordination work flow processes. TruCare houses assessment information and results for our members, including Health Screenings, HRAs, needs assessments, and other screenings and assessments, such as for specific medical and behavioral conditions. To assist SCs and CSCs in the development of evidence-based PoS and PCSPs, TruCare allows SCs and CSCs to administer straightforward assessments and offers a library of evidence-based service coordination interventions that can be custom tailored to the member's needs. TruCare's system functionality also allows for the collection and reporting of short term and intermediate outcomes, such as member risk level and acuity. TruCare will also interface with the State's Kansas Modular Medicaid System in the format and method specified by the State.

Configuring TruCare to Support KanCare 2.0 Program Requirements. We will adopt and incorporate into our service coordination processes and TruCare platform all KDHE required Health Screening, HRA and needs assessment tools and algorithms like what is included in Attachment F of the Model Contract. The Health Screen, state developed HRA tool and needs assessment as well as any condition-specific assessments will be documented in TruCare. We currently track and will continue to track and monitor the timely completion of Health Screenings, HRAs and assessments in TruCare and will adhere to all KDHE assessment timeframes. For members that are assigned to a CSC, we will provide appropriate monitoring and oversight to ensure Health Screens, HRA and needs assessments are completed, as described in more detail in Section 5.4.6 and Section 5.4.7.

Process for Conducting Health Screenings (5.4.2.E)

We will conduct an initial Health Screen telephonically or in-person for all new members within 90 days of enrollment into Sunflower, or sooner as directed by HCBS Waiver or State policy for LTSS and BH members. We will utilize a State developed Health Screening tool and algorithm.

For existing members, we will complete the Health Screen using available member claims data and our robust data analytic and predictive modeling tools, telephonically or in-person. For members with an identified LTSS or BH need, Health Screens will be conducted in-person by the member's assigned CSC. Additionally, if it is determined that additional assessments are necessary, the HRA and /or other assessments will also be completed at the time of the needs screening to minimize burden to the member. We will update the member's Health Screen at least annually through a phone assessment, PCP or analysis of claims data. We will complete the member Health Screen telephonically or in-person at least every other year.

Appointment Wizard's™ secure cloud based technology, allows us to lower provider administrative burdens while ensuring access to care for our members. For example, Sunflower's affiliate health plan successfully piloted Appointment Wizard™, which resulted in care gap closures, an over 85% member appointment completion rate, and improved operational efficiencies for over 200 FQHCs.

As part of our Health Screening process, our SCs and CSCs will assist members with arranging an initial visit with the member's PCP for a baseline medical assessment and required preventive health services such as a well-child exam based on recommended periodicity schedule; to address any identified diseases or chronic illnesses as identified as part of the Health Screening and to close any care gaps, as necessary.

Sunflower will offer members real-time appointment scheduling through **Appointment Wizard™**, which allows Sunflower SCs and CHWs to schedule appointments with participating providers and issue text or email reminders for members. Staff will have access to an online appointment-scheduling portal, and can set-up appointments while on the phone or while meeting with members, without the need for multiple calls to-and-from provider offices. In addition, Sunflower staff can securely attach documentation to the member appointment for specific care gaps (e.g., EPSDT needs) to ensure a thorough member office visit. By leveraging cloud-based appointment scheduling technology, Sunflower strives to lower administrative burdens for providers while ensuring better outcomes for our members through more closely monitoring care gap closure and improving quality measures.

Process for Conducting HRA and Needs Assessments (5.4.2.F)

Health Risk Assessment. Sunflower will complete HRAs on all members whose Health Screen results indicate the need for an HRA, using the State developed tool. The HRA is an integral component of our ISC model that is used to:

- Identify a member's PH, BH, functional and social needs (including social determinants of health and independence such as housing and food security) and employment status
- Stratify the member into the appropriate Level of Service Coordination
- Understand and document the member's self-identified goals, desired outcomes, interests and preferences

- Identify immediate care needs and accessibility requirements
- Inform the development of the member's individual PoS and PCSP

For members whose Health Screen results indicate the need for a HRA, the member's assigned Sunflower SC or CSC will outreach to the member to conduct the HRA within 30 days of the completion of the Health Screen or sooner as directed by the HCBS Waiver or the State's policy for LTSS and BH. For all members that are identified to have BH and/or LTSS needs we will complete the HRA within 14 days of enrollment into Sunflower. We will also utilize findings from the Health Screen indicating urgent or emerging care needs; available historical claims, authorization and PoS information as well as referrals from providers, the state or community agencies to prioritize members for outreach and completion of the HRA to ensure a member's immediate needs are met, as appropriate.

Process for Completing In-Person Assessments. Using the State's developed tool (that will be incorporated into TruCare), the HRA will be conducted in-person. Our experience has demonstrated that in-person, face-to-face assessments are valuable in determining the holistic needs of high-risk and complex members including individuals with LTSS and BH needs. HRAs, needs assessments and reassessments will be completed in the most appropriate setting, honoring preferences of each individual member. For example, for members that are identified as needing LTSS we generally meet with the member in their home as it is easiest for them and allows our SCs and CSCs to assess the individual's environment and social support system that contribute to their health and functional capacity. However, we will always meet the member where they want to meet which could be another location (e.g., a family member's home, church, senior center, etc.).

Our SC staff are trained and have policies and job aides in place to identify scenarios and situations when a home-based assessment may be necessary for additional populations, such as members that are homebound, transitioning from an inpatient setting back to home, and members with significant social and BH needs.

Needs Assessments and Reassessments. If the results of the HRA indicate the need for additional supplemental assessments, the member's assigned SC or CSC will complete the identified needs assessments within 14 days of the completed HRA or sooner to comply with the State's HCBS Waiver or the State's policy for LTSS and BH. Sunflower will utilize the State prescribed assessment tool for each of the HCBS waiver programs based on the member's functional eligibility determination. Additionally, we will also utilize the State's prescribed tool for the assessment of the member's BH needs. The member's SC or CSC will conduct these assessments in person and preferably in the member's home or primary residence.

Annual Reassessments. We will reassess a member's needs for services at least annually; upon a significant change in the member's condition or status, or as frequently as the member needs (e.g., if the member requests additional services). The member's assigned SC or CSC will note a significant change in condition in the member's record within one business day of notification

and conduct a reassessment of the member's needs within 3 calendar days of discovery of a significant change in condition or need. SCs and CSCs will re-assess the member's needs during each visit and will work with the member and his/her chosen circle of support to revise the PCSP to include any new goals, interventions or authorized services. The CSC will work with the member, the member's circle of support and IC Team to update the PCSP based on the results of the reassessment and will include new goals, interventions and service authorizations and appropriate signatures as described in our response to Section 5.4.4. below.

Referral Process. As described in Section 5.4.5 below, we utilize the results and findings of the Health Screening and HRA to identify members that can benefit from Service Coordination and stratify members into the appropriate Level of Service Coordination. Outreach and assessment findings by our SCs and CSCs, CHWs, and/or other Service Coordination Team staff will be used to refine and even re-stratify the member's level of care to meet newly identified issues or changes in conditions. Members may move through those stratification levels as their conditions change. At every contact, the SC or CSC or CHW reviews Centelligence ® reports and other clinical information and conducts assessments to determine member needs and progress. As needed they re-stratify risk and make adjustments to the PoS and/or PCSP. Sunflower will re-evaluate the appropriateness of each individual member's Service Coordination level, in person, at least annually or more often based on a change in the member's condition or status, or at the request of the member, the member's legal guardian or legal representative.

5.4.3. LONG-TERM SERVICES AND SUPPORTS FUNCTIONAL ELIGIBILITY DETERMINATIONS

SYSTEMS, PROCESESS, AND PROTOCOLS FOR PROACTIVE MEMBER IDENTIFICATION

As a current KanCare MCO, Sunflower has systems, processes and protocols in place today for proactively identifying members who may need and be eligbile for LTSS and referring these members to the appropriate entity for functional eligibility determination. We identify members that may be eligible for LTSS, including home and community-based services, via mutliple mechanisms such as, through our Health Screening and HRA process; use of MDS data and service utilization trends and by referrals from providers and state agencies. Additionally, we will utilize a LTSS algorithm developed by our Texas affiliate health plan that proactively identifies members that may be functionally eligible for LTSS, using data mining, predictive modeling and analytics.

Member Referral Process

All members identified as potentially eligible for enrollment in HCBS Waiver programs and/or admission to Adult Care Homes, NFs and ICF/I/DD are referred to an appropriate conflict-free entity, such as Aging and Disability Resource Centers (ADRCs), Community Developmental Disability Organizations (CDDOs), CMHCs, TA Assessors and the State Program Managers to determine if they meet functional eligibility. The member's assigned SC and/or CSC is responsible for making the appropriate member referral within two business days of determining a posible need for LTSS and following up to ensure the referred entity has scheduled and completed the functional eligiblity assessment in a timely manner. For members

that are determined to be eligible for LTSS, using a case note, the Sunflower SC documents the LTSS functional eligibilty in our case management platform and contacts the member to offer a choice of Community Service Coordination providers. The Sunflower SC will then make a referral for Community Service Coordination for the the initial visit assessments and PCSP to be completed within seven business days of LTSS eligibility. The Sunflower SC will review the assessments and PCSP, determine the type and amount of services to approve, and provide a copy of the approved plan to the member, authorized representative and providers for signature. Once the plan is signed, the Sunflower SC will trigger the authorizations to be built in TruCare and for notices of action to be sent.

System Supporting Integrated SC Workflow. TruCare, our fully integrated service coordination and care management documentation and authorization system, supports our Service Coordination work flow processes. We utilize TruCare's tickler functionality to prompt the Sunflower SC when a task is due. This automated feature allows the SC to monitor and support the CSC with timely follow up, tracking and monitoring of member referrals, including referfals for functional eligbility determination for HCBS Waiver programs and LTSS. Sunflower currently has a monthly report showing timely visit and assessment compliance for both new member and annual assessment and plan development. This report is being transitioned to Centene's LTSS key performance indicator (KPI) dashboard and will be made available to Sunflower managers, SCs, and CSC managers as another tool to track and ensure timely referrals and completion of LTSS functional eligibility determination.

5.4.4. PLANS OF SERVICE AND PERSON-CENTERED SERVICE PLANNING

Sunflower will meet all PoS requirements for KanCare members who receive coordination. Additionally, we will meet all Person Centered Service Planning requirements for KanCare members who are enrolled in HCBS waiver programs, members with BH needs and children and youth in foster care. Our Sunflower SCs and Community Service Coordination providers will employ person-centered planning strategies for the development, implementation and monitoring of the PoS and the PCSP. As part of our process, we also establish and document in the member's record in TruCare necessary permissions from the member to coordinate care among different providers.

PLAN OF SERVICE (5.4.4.1)

Results of the Health Screen, HRA and needs assessment form the basis for the development of the individualized PoS, aligning a member's needs and preferences to services and interventions. The PoS includes services and supports that the member needs to stabilize or improve his or her health, safety and well-being and address SDOHI.

Member Participation in Plan of Service Process (5.4.4.1.A)

Sunflower SCs, or CSCs when applicable, will serve as the single point of contact for the member and will build trust through respectful discussions that encourage member engagement in all phases, from identifying unmet need to evaluating the success of services. The SC/CSC will work in collaboration with the member to assure the member is able to

participate in a PoS process to identify measurable PH, BH, and functional and social support goals and develop interventions to address the identified member goals. As part of the service planning process, SCs/CSCs also take into consideration the availability of unpaid supports provided by the member's family and other natural supports. The SC/CSC also provides information and referrals to community resources, services and supports to address a member's SDOHI.

Sunflower's PoS is developed in conjunction with the member, the member's authorized representative or guardian, authorized family members, support circle, PCP, and other members of the healthcare team.

Members determine, from their perspective, what it means to be well and what is needed to achieve their desired goals. The role of the SC and CSC is to fully understand the member and his/her needs, strengths, goals, and lifestyle preferences through standardized assessments, motivational interviewing, Person Centered Thinking strategies and active listening, so we can provide assistance that is consistent with the member's expressed preferences, values and culture. Our SCs and CSCs will work with member and the member's IC Team and chosen circle of support to examine the member's whole person needs and develop a PoS that address these identified needs. Additionally, the PoS functions as a road map for the member and a mechanism to authorize services based on each individual member's assessed needs.

The PoS is developed in conjunction with the member, the member's authorized representative or guardian, authorized family members, support circle, PCP, and other members of the health care team. Member prioritized goals are established and barriers to meeting goals or complying with the PoS are identified, as well as possible solutions to the barriers. The proposed PoS is based upon chosen member preferences and goals, functional status, environmental and safety status, medical necessity, informal and community resources available, backup planning considerations, and member agreement to engage in the plan. The SC/CSC who develops the plan assists the member with identifying strategies for accomplishing his/her goals and overcoming the identified barriers.

Plan of Service Process and Template (5.4.4.1.B). Sunflower's PoS template includes all the required data elements described in Section 5.4.4.A. 1-22. Upon contract award, we will submit to KDHE for review and approval our PoS procedures and samples of our instruments and tools we use as part of our person-centered PoS process. For an example of our current PoS, please see ***Figure 5.4.4.A_PoS Template Examples*** below.

Figure 5.4.4.A_PoS Template Examples

Editor | Related Information | Care Plan History

Custom Problem | Enter Name...

+ | - | Filter By: All

	Status	Priority
▼ PROBLEM: Abnormal lab results related to diabetes.	Open	
▼ GOAL: Member will adhere to scheduled testing in and Physician follow-up.	Open	High
BARRIER: Knowledge Deficit	Open	
INTERVENTION: Educate member on potential reasons for false positive readings (exercising hard or infection)	Open	
INTERVENTION: Facilitate/coordinate scheduling for test.	Open	
INTERVENTION: Educate member on diabetic nephropathy.	Open	

Editor | Related Information | Care Plan History

Custom Problem | Enter Name...

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	Status	Priority
▼ PROBLEM: Member would like to obtain competitive employment	Open	
▼ GOAL: member is recieving wages and has a working schedule	Open	High
BARRIER: Impact of disability on ADL's and IADL's	Open	
INTERVENTION: Address the members transporation needs	Open	
INTERVENTION: Assist member in contacting Vocational Rehabilitation services for employment options	Open	
INTERVENTION: Evaluate members skills, competence, and areas of interest	Open	

Plan of Service that is User Friendly (5.4.4.1.C, 5.4.1.E, 5.4.4.1.I). The SC /CSC is responsible for ensuring the member's PoS is understandable and user friendly to the member and/or member's representatives and circle of support. The PoS is written in plain language and in a manner that is accessible to members with disabilities or with limited English proficiency. As described above, the PoS will include services and supports to address each member's identified whole person needs, including SDOHI.

Plan of Service-Key Elements (5.4.4.1.D). Sunflower's PoS complies with the State's PoS policy. Key elements of the PoS include, but are not limited to, the following:

- Identification of the member's level of Service Coordination
- SC/CSC name and contact information
- Key dates and timeframes, such as the date of PoS development; date of service authorization, and dates (and due dates) of annual assessment and reassessments and schedule of next SC/CSC contact
- Information on member's eligibility and patient liability, as appropriate
- Member contact information, primary/preferred language, preferred method(s) of contact, communication needs, and cultural considerations

- Specific, mutually agreed upon and measured, prioritized goals, interventions and timeframes that take into consideration the member's stated health, quality of life and care desires and recognized potential barriers
- Member-identified circle of support, support systems and emergency contact(s)
- Current health status and stability
- Member's understanding of health status, health trajectory and self-care capacity
- Current and active providers (including contact information) and gaps (e.g., assessed need for behavioral health) with scheduled follow-up appointments
- Identified PH, BH, functional, environmental and social support needs with an integrated approach to meeting these needs
- Recommended benefits and services to meet the individual needs of the member, including the availability of unpaid natural supports and services; in lieu of services; value added benefits and services
- Authorization of services
- Medication list and pharmacy contact information
- Transportation needs and preferences
- Assessment of member's physical or home environment
- Summary of member's risks, as identified by the SC/CSC, member, providers and/or the member's representative/ circle of support
- Whether the member has elected to self-direct services
- Back-up plan to address any gaps in service delivery for members receiving HCBS or personal care services
- Information on how to access care in emergency situations
- Outcome measures to evaluate the success of meeting stated goals, as well as follow up intervals for reassessment

Supporting Caregivers. Recognizing the value of the member's caregiver and unpaid natural supports, as part of our care planning and PoS development process we will also offer caregiver resources and tools that augment available Kansas caregiver resources to support members in the most integrated community setting. These resources and support include:

- Our comprehensive **Caregiver Resource Center** that provides information about early symptom and exacerbation identification, managing illnesses, and balancing needs, as well as tools, tips and resources, including links to community-based services and resources.
- Our **new Caregiving Collaborations™ Program, which recognizes differences in intensity of caregiver needs** based on whether the person's caregiving responsibilities develop gradually or suddenly or are in a maintenance phase for some time and supports are in place. The Program will include **interactive functionality** through our Caregiver Portal t**o allow caregivers** (as authorized by the member) **to communicate with the SC and CSC**, such as to provide notification of condition changes and obtain information or assistance. Our Caregiver Portal will also allow authorized caregivers to view the member's PoS and

PCSP, PH, BH, and medication history, any gaps in care, and other information necessary to support the member.

- Our **Caregiving Collaborations™ program** also includes a HIPAA-secure care collaboration application that can be accessed via the internet using devices such as smart phones, tablets, and desktop computers. This caregiver application is currently being piloted with caregivers of members who have a diagnosis of Alzheimer's or dementia. The application uses innovative technology to bring clinically relevant health information and resources directly into the hands of members and caregivers, and allows them to connect directly to the member's Service Coordination team, through group chats, at a time that is convenient for them. This application also allows our service coordination team to proactively outreach to the member and caregiver, encourage preventive screenings and vaccinations, confirm appointments, and ensure back-up plans are up to date and accurate. In addition, the tool support bi-directional video and file sharing so a SC can share educational videos and files such as tips for communication, coping with sundowner's syndrome, and appropriate techniques for lifting and transferring a member and a caregiver can share images such as discharge planning instructions or pictures of new medication orders.
- We are also offering a **Caregiver Journal** (in English and Spanish), which is currently with KDHE for approval. We will distribute the journal to caregivers for them to write about stressors, strategies they use to manage stress and how effective they are, and other aspects of their caregiving journey.
- We will also provide training and support options to caregivers and will assess the needs and status of the member's caregiver **and incorporate caregiver supports into the PoS.** Our caregiver assessment tool was developed as a collaborative effort between the National Alliance for Caregiving and Centene.

Supporting Member Self-Direction and Engagement. We also offer several tools and resources to support self-direction and member engagement in their care, such as the use of myStrength. MyStrength is a self-directed, on-demand, and anonymous online peer support tool referred to as a "mental health club for your mind", at no charge to members. Accessible through a computer and also through a member's smart phone, myStrength's customizable tool offers a range of resources to improve mental health and overall well-being. MyStrength offers members the ability to take responsibility for their health care and learn more about their diagnoses, track their symptoms, receive motivational ideas and information, and speak with trained, online behavioral health coaches directly, to work toward solutions. Family caregivers of members with BH issues can also enroll and use myStrength for support and to better understand their family member's BH condition and needs. Members can participate in myStrength to increase awareness of mental health needs and engage in personalized e-Learning programs to help overcome depression and anxiety in a safe, confidential environment.

In 2017, over 330 members used the myStrength online peer support tool for depression, anxiety, drug and alcohol abuse, parenting and relationship challenges.

Sunflower's members will have access to myStrength's message-based coaching service, which will be integrated within the myStrength platform. This coaching service will further support members' and family caregivers' access to a broad range of evidence-based resources. Health coaches, through individual interactions, will employ motivational interviewing interventions to reinforce positive behavior change of members and family caregivers. Additionally, myStrength will be deploying advanced technologies as part of this new coaching service to increase the level of personalized support members and family caregivers experience with myStrength.

Signature and Distribution of Plan of Service (5.4.4.1.F, 5.4.4.1.G and 5.4.4.1.I)

The SC will review the member's PoS with the member and representative/circle of support to ensure it reflects the member's needs as identified during the assessment process; the member's chosen goals and lifestyle preferences; and all state and federal requirements prior to authorizing services. The SC is responsible for ensuring all required data elements are completed and documented prior to the signature process and also assures all parties are in agreement to ensure successful implementation. TruCare is configured to support this work flow process and functions as a check and balance to ensure compliance with this KanCare contract requirement. SCs must complete all required data elements and documentation in the PoS to move forward with the PoS review and signature process. TruCare logic notes any missing information and required data fields and does not allow the SC to submit the PoS for the review and signature process until all required documentation fields are completed.

Once the required data elements and documentation is complete, the member (and representative), to acknowledge his/her participation in, and review and receipt of the PoS, will be asked to sign the document. The SC provides the member with any accommodations required to understand and accept the PoS, such as use of the member's communication board, reading sections of the document, providing detailed examples, or arranging for assistance from a person the member chooses, etc. The Sunflower SC is also responsible for signing the PoS when approved, and ensuring it is signed by the CSC, when applicable, and any providers involved in the development of the plan, prior to the plan being implemented.

Our technology solutions allow for and facilitate electronic signature of the member's PoS by the member, the member's SC and CSC and providers present during the development of the PoS. In situations where we obtain a "wet signature," the SC will scan the signed PoS into TruCare and provide a copy to the member and authorized representative (when applicable), providers and others the member chooses within his/her circle of support.

Making the PoS Accessible. Each PoS will be accessible to the Sunflower SC and CSC and the member's IC Team via TruCare and via our Service Coordinator Portal, to providers via the Provider Portal; and to the member (and family, caregivers or other supports as authorized by the member) via the Member Portal. Members also will be able to review their PoS with their Sunflower SC or CSC through our secure, web-based, TruCare mobile capabilities, which the SC and CSCs can access through their tablet during in-person member meetings. Further, as part of our process, all members will be provided a choice of paper or electronic PoS and the member's preference will be documented in the member's record. Regardless of the member's preference, a completed and signed PoS will be provided to the member prior to the initiation of services.

Plan of Service Review and Updates (5.4.4.1.H). The SC will routinely review the PoS with the member during each member contact, to assess member progress towards meeting goals and objectives and to ensure receipt of recommended services and supports as outlined in the member's individualized PoS. At minimum, the member's PoS is updated and signed at least annually or more often if there are significant changes to the member's PoS.

5.4.4.2. PERSON CENTERED SERVICE PLANNING

PCSP Compliant With State and Federal Rules and Polices (5.4.4.2. A and 5.4.4.2.B)

Sunflower's ISC model incorporates a PCSP that aligns with current Federal and State person-centered planning requirements of MCOs. Please see ***Attachment 5.4_PCSP Template and LifeCourse Tools*** for a copy of our PCSP template, along with optional LifeCourse tools (including the Circle of Support Tool) a member can use to identify their circle of support, life trajectory and most important information (one page profile), a new draft addendum for persons with I/DD that we believe meets the intent of Article 63 requirements for this population. Lastly, we have also included a member "Quick Reference Guide" with information that may need to be updated in a more regular basis. Upon contract award, we will also submit to KDHE for review and approval our PCSP process and samples of our instruments and tools we use as part of our process.

State PCSP Policy. Sunflower also understands that the State is developing a PCSP policy and are committed to complying with the requirements of the policy once it is approved. Sunflower recently initiated a pilot workgroup comprised of TCM providers, and representatives from the other two MCOs, who worked with us to make recommendations about the PCSP policy to KDADS. Our TCM workgroup also proposed to KDADS that a standardized PCSP template be developed for statewide use. Sunflower is committed to being a part of this initiative, if desired by the State. We plan to continue the workgroup's efforts and believe this group would be willing to pilot any standardized forms for future MCO/Community Service Coordination communications and PCSP planning. We also understand the DD Council and other stakeholders are encouraging the State and MCOs to consider utilizing tools offered through the LifeCourse model. We have a representative who has been placed on the National Community of Practice for LifeCourse in support coordination workgroup, and is the lead for

the Kansas Community of Practice support coordination workgroup. She is helping to develop the training program, and bringing the information back to our team. As indicated above, the PCSP template we provided includes our current PCSP content, an addendum to meet the intent of Article 63, and a few of the LifeCourse PCSP planning tools. It will be improved upon as we continue our work with the TCM pilot group, and through recommendations from our LTSS Advisory Committee which includes stakeholders for all HCBS programs. Each version we intend to utilize will be submitted to the State for approval.

Sunflower in Action…

Sunflower recently initiated a pilot workgroup comprised of TCM providers, and representatives from the other two MCOs. Through this workgroup, we made recommendations about the PCSP policy to KDAD including proposing that a standardized PCSP template be developed for statewide use.

Member Participation in the PCSP Process. Sunflower ensures that our person-centered planning processes address the health, BH and LTSS needs of members in a manner that reflects the member's individual preferences and goals. Members are encouraged to direct the PCSP development process to the degree they are comfortable and may include a representative and/or circle of support to the extent the member chooses. In addition to explaining our person-centered planning process, our SCs and CSCs will share a brief brochure that explains the importance of person-centered planning, including key considerations to make the engagement process successful (e.g., the benefit of involving friends and loved ones) and helpful open-ended questions to support the member's identification of personal goals, preferences, and service choices. We will ensure that our person-centered planning process is effective by identifying, as part of the initial assessment and ongoing through routine in-person meetings, the level of support the member needs to be an active participant in the planning and designing of his or her PoS and PCSP. The CSC will assist the member to identify friends, family, and community supports (e.g., friends from church or social groups, CILs, AAAs, Community Developmental Disability Organizations (CDDOs) and/or Self Advocacy Coalition of Kansas (SACK) to support the member to assume an active role in the planning and implementation of his or her PCSP. The member will, through our planning process and the engagement of his/her circle of support, identify his or her goals and preferences, which will become the foundation for the PCSP.

Sunflower will ensure our person-centered planning process is holistic and supports maximum community integration by working with members to identify and address both their medical and non-medical needs (including SDOHI) through not only KanCare covered services, but non-covered services as well. The **Person Centered Thinking training** that we provide to our SCs, and the **Charting the LifeCourse Framework tools** that we will be utilizing, promote use of community supports and employment first as the most independent option for the member.

One way we measure the efficacy of our person-centered planning process is through our **quality of life (QoL) assessment metrics** which are self-reported by the members as part of the

annual assessment/reassessment process. We utilize the findings of this assessment at both an individual member level to inform or make modifications to the member's PCSP as well as at aggregate population level to assess the efficacy of our PCSP process. The QoL metrics are part of our overall LTSS KPI dashboard. ***Figure 5.4.4.2.A_KPI Results*** below highlights some of our results.

Figure 5.4.4.2.A_KPI Results

Over 90% of our members on the physical disability (PD) waiver stated they decide on their daily routine in 2017

Over 98% of Sunflower's members receiving HCBS services have stated they feel safe in their home in 2017

Over 96% of Sunflower's members receiving HCBS services have stated they are satisfied where they live in 2017, including 100% of children (and parents) participating in the TA waiver

Over 90% of our members on the PD waiver stated they get to see family and friends when they want

Additionally, from Q4 2016 to Q3 2017 we saw a 4% increase from 81% to 85% of members on the F/E waiver who decide their daily routine

Supporting Self-direction. Our ISC program and person-centered planning also supports the **member's ability to choose self-direction** and provides the **flexibility members need to manage their lifestyles** and the **opportunity to make informed choices about their care and services**. We provide members with the option to have decision making authority over LTSS and take direct responsibility to manage their services. CSCs will provide members with accessible information on self-direction that includes an introductory summary, either in written or video format, which explains what self-direction is and the member's role and responsibilities. This was built by our parent company, Centene, in partnership with National Resource Center for Participant-Directed Services and Applied Self Direction (ASD).

Sunflower has played an important role and has been successful in expanding members' access to self-direction under the current KanCare program. Our parent organization's long-standing partnership with ASD has informed our development of tools and resources to expand high quality self-direction across our health plans, including the development of member self-screening tools, FAQs, and videos to educate about

We have successfully supported member self-direction - as evidenced by the percent of our LTSS members that self-direct one or more of their services out of total number of members in the waiver program:

- ***FE waiver- 36%***
- ***PD waiver- 73%***
- ***IDD waiver- 28%***
- ***TBI waiver- 51%***
- ***TA waiver- 55%***

self-directed benefits that we will continue to utilize for KanCare 2.0. Centene nationally has almost 65,000 members who self-direct their services (including Sunflower members).

As part of our PCSP process, CSCs will assess member interest and readiness to self-direct and assist the member with determining the potential need for support from a representative. If the CSC and member determine the member requires assistance to direct their HCBS, the CSC will inform the member that they may choose to be responsible for all required functions or may utilize another person to serve as their representative. CSCs will educate members and their chosen circles of support about the self-direction option. In addition, Sunflower has a **Member Advocate, who is part of our SDOHI COE Team, who provides peer-to-peer support to members** who choose or are considering self-direction to assist them with understanding their responsibilities, developing ads for caregivers, assisting with finding sources of potential caregivers, where to obtain information and assistance on tools for supervising their staff, and other assistance with self-direction.

SC And CSC Training on PCSP Principles. As part of our initial and ongoing training program, SCs and CSCs will receive training and education on independent living and PCSP principles. As an example of our PCSP training curriculum, Sunflower's Person-Centered Thinking (PCT) Training uses copyrighted training material developed by the Learning Community for Person Centered Practices started in 1989 by Michael Smull and Susan Burke-Harrison at the University of Maryland. PCT Training is built on the core concept of person-centered practices, providing instruction to providers on how to discover what is important to and important for the member, and how to support the member to find balance. The discovery is used to identify the strengths, capacities, preferences, needs and desired outcomes of the member. It encourages empowerment of the member to make their own informed decisions, develop personally defined outcomes and set their own goals, and identify both community and paid supports to achieve the life/outcomes they choose. The identified personally-defined outcomes, the training supports, and the identified community services, personal care services, therapies, treatments, and or other services including linkages to services aimed at addressing SDOHI (E.g. housing supports, food and nutritional security, employment supports) become part of the member's PCSP.

Sunflower's LTSS Director, Service Coordination Director, Service Coordination Managers, all current SCs and CHWs, and the Education and Training team completed PCT training with Centene's certified corporate PCT trainer in the fall of 2017. This training provided strategies for our team to address member needs and identify member goals in a person-centered, holistic way and to help resolve disputes between the member and his/her support team members when differences arise. We intend to continue to offer this PCT training to the entire Service Coordination team as well as our health plan leadership team.
Additionally, as discussed in Section 5.4.10, Sunflower is an active participant and is committed to the Community of Practice that is moving towards integrating Charting the LifeCourse Framework (LifeCourse), a person-centered framework that highlights Person-Centered Thinking (PCT), into the Kansas system. As a complement to the PCT training, we will train our SCs and Community Service Coordination providers on the LifeCourse framework so they are

equipped with tools to help individuals and families think about what a good life looks like for them and how to get there. The LifeCourse framework takes the PCT model a step further, encouraging focus on the family and supports surrounding the individual and the family. The LifeCourse framework emphasizes active engagement by families and self-advocates in the person centered planning process, providing individuals with the tools to enhance and communicate their goals.

Sunflower's LifeShare Pathway Facilitators

Addressing the Unique Needs of Persons with I/DD and/Or Brain Injury through PCSP.

Sunflower's ISC model is informed by our fully integrated Specialty Company, LifeShare and their innovative "Pathways" approach, which is built on over 20 years of experience in over nine states including Kansas. Sunflower recognizes five "Pathways" (Physical Health; Emotional & Behavioral Health; Supporting Families & Self-Direction; Community Living; and Employment/Day Supports) as the pillars to our successful PCSP approach for persons with I/DD and/or TBI.

Access to Pathway Facilitators. We will partner with our Community Service Coordination providers to identify individualized services and supports and educate stakeholders about the importance of self-determination, choice, and control. In addition, the CSC, the member, circle of support, provider, and IC Team will have access to Sunflower's LifeShare Pathway Facilitators who share relevant resources and training on our "Five Pathways to Independence" as visually presented in ***Figure 5.4.4.2.B_LifeShare's Five Pathways to Independence.*** Our Pathways Facilitators are uniquely qualified to assume a facilitator role given their experience successfully supporting members with I/DD and/or brain injury to live with choice, dignity, and control while also creating reliable mechanisms to monitor member's health and welfare. More specifically, our LifeShare Pathways Facilitators have experience assisting members and their circles of support to implement self-directed services; seek accessible preventative care and manage health conditions; address challenging behaviors that impede the member's quality of life and/or informal support network; identify member strengths and build on these strengths in an educational or competitive employment environment; and identify creative opportunities to support members in the least restrictive setting of their choice and engage in meaningful community participation.

While all our LTSS members will have access to our evidence-based transition and diversion support, a comprehensive LTSS benefit package, and 24/7 mental health crisis response services, we build on our experience to tailor these services and supports to the needs of individuals who have I/DD and/or brain injury to allow for optimal support that meets the needs of these unique populations.

Figure 5.4.4.2.B_LifeShare's Five Pathways to Independence

Signature and Distribution of PCSP (5.4.4.2.C, 5.4.4.2.D)

Our process by which the PCSP is reviewed, approved and signed is similar to the process for the review and approval of the PoS outlined above in Section 5.4.4.1.

The CSC will review the member's PCSP with the member and representative/circle of support to ensure it reflects the member's needs as identified during the assessment process; the member's goals and preferences; and all state and federal requirements prior to sending it to the Sunflower SC for approval and authorization of services. The CSCs will be trained to inform the member that the plan will be sent to the Sunflower SC for review and approval before signatures are obtained. Members are not currently, and will not be asked to sign incomplete plans. The Sunflower SC and CSC ensures all required data elements are completed and documented prior to the signature process. The Sunflower SC will ensure that the document is sent out for signature by the member and providers, and that the signatures are obtained and attempts to contact are documented. The CSC may help with obtaining signatures. The PCSP is fluid however any revisions to the plan will be signed by both the members and providers, in accordance with the State policy for PCSP.

The member (and representative), to acknowledge his/her participation in the process and receipt of the plan, will be asked to sign the document. The CSC provides the member with any accommodations required to understand and accept the PCSP, such as use of the member's communication board, reading sections of the document, providing detailed examples, or arranging for assistance from a person the member chooses, etc. The PCSP will also be signed by the member's Sunflower SC and CSC and any providers involved in the development of the plan prior to being implemented. The PCSP will also be routinely reviewed during each contact

with the member and updated with new signatures at least annually or more often if there are significant changes to the member's PCSP.

PCSP Development and Accountability (5.4.4.2.E, 5.4.4.2.F, 5.4.4.2.G, 5.4.4.2.H)
The CSC will be accountable for the development of the individualized PCSP with the member, the member's IC Team and chosen circle of support that includes recommendations on the amount, scope and duration of services. The CSC is also responsible for the implementation, ongoing monitoring and updates to the member's PCSP.

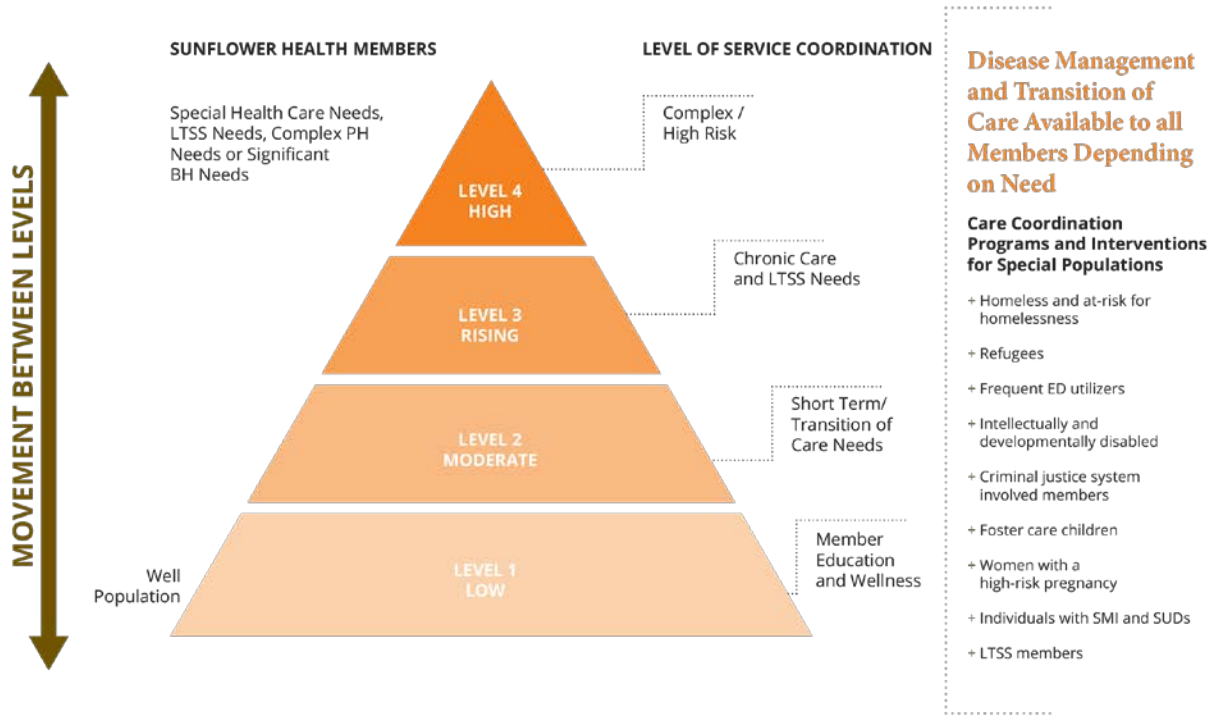
As discussed in Section 5.4.6, Sunflower will have responsibility for reviewing and approving all PCSPs and overseeing the completion of the HRAs and needs assessments for those members assigned/attributed to a Community Service Coordination entity. We recognize that we are ultimately accountable for ensuring all KanCare Service Coordination requirements are met as outlined in the Contract and in Attachment L. We will utilize our qualification and pre-delegation audit process and ongoing quality and performance oversight system to confirm entities meet the expected standards and outcomes for performing service coordination activities and interventions. Our oversight process includes regular audits to ensure the contracted CSC develops a PCSP that includes appropriate recommendations regarding the amount, scope and duration of services and ongoing monitoring to ensure the member receives needed services per the PCSP. Our oversight and audit process also entails ensuring the contracted CSCs obtain all required signatures to comply with state and federal PCSP requirements.

5.4.5. SERVICE COORDINATION STRATIFICATION LEVELS AND CONTACT SCHEDULES

LEVELS OF SERVICE COORDINATION

Our Service Coordination model includes **four levels of service coordination, supported by disease management, discharge planning and transitions of care activities,** collectively referred to as Service Coordination in our proposal response. Please see ***Figure 5.4.5.A_Levels of Service Coordination*** below.

Figure 5.4.5.A_Levels of Service Coordination



Addressing Members Needs Across the Continuum

Our member-centered Service Coordination model recognizes that every member has different needs, commanding a varying level of service and interventions. For example, while not every member will require Level III or Level IV Service Coordination services and interventions, every member, at some time, may need a higher level of service and support, such as short term or intermittent needs for coordination, disease management or transitional service coordination. Our dynamic model is designed to address the individual needs of each member across the entire continuum of care and we recognize that members may move between levels of Service Coordination at any time as their health needs and status change.

Activities Based on the Level of Service Coordination. Our service coordination activities are intentional based on the Level of Service Coordination. For example, service coordination processes in Level I are primarily education and resource coordination activities, such as a PCP provision of education to a Level I member about age-appropriate preventive exams (e.g. EPSDT information) , making a referral to a specialist for the exam if it cannot be performed in primary care, and helping the member with resources to facilitate participation in the exam, such as providing education about the exam to make the member more informed and comfortable or assisting with transportation and other SDOHI. For members stratified into Level II, III or IV, Sunflower SCs and delegated CSCs have established activities, including assessment, interventions and person-centered planning strategies that assure each member is offered care coordination services that fit their individual situation.

All members are stratified into Level I, II, III or IV Service Coordination through a combination of screening and assessments, referrals, and predictive modeling described below.

Service Coordination Identification Process – No Wrong Door Approach

Our approach to member identification ensures a comprehensive, 'no wrong door' model and multiple identification methods. We review a wide variety of data about the member, such as PH, BH, LTSS, and other claims and utilization information; admission, discharge and transfer (ADT) hospital data received electronically; pharmacy data; lab results if available; health screening, HRA and needs assessment data and results; and predictive modeling risk score. We stratify members eligible for service coordination to identify both new and existing members who would benefit from service coordination and target our resources effectively to meet their needs. Members may change stratification levels, moving to a higher or lower level of intervention as their acuity and needs change. We use referrals from our providers, nurse advice line, our UM and Service Coordination staff; CSCs, community agencies, Lead Agencies, state agencies, the judicial system, and members and their family/caregivers.

We have comprehensive operational protocols for timely review and assignment to meet the urgent needs of our members. We supplement our monthly stratification report with more frequent reports and analysis to help us quickly identify members who may need support, such as ED and inpatient reports, pregnant women who may be at high to moderate risk for a poor birth outcome, 834 enrollment files to identify those flagged as having special needs, LTSS members (all of whom receive service coordination under Level III or IV); referrals from providers and other referral sources. We comprehensively assess each member identified with special health care needs (such as those with complex PH/BH conditions, high utilization, intensive service needs, consistent use of services at the highest level of care, or otherwise at risk for poor outcomes) to identify ongoing special conditions that require a course of treatment or regular care monitoring.

Predictive Modeling and Risk Stratification Tools: Centelligence® Health Informatics Platform.

We identify members who need service coordination, case management and disease management support and determine the most appropriate level of intervention through a population-based stratification process that identifies severity as well as acuity of the member's needs. Centelligence® is our comprehensive health informatics platform for population segmentation, risk stratification, and cost analysis. Centelligence® applies a risk stratification algorithm that uses the following data: membership demographics; medical, behavioral health, and pharmacy claims; prior authorization data from TruCare; social determinant data from the HRA and other data sources (e.g., Notification of Pregnancy); and independence risk factors for our LTSS members obtained from face-to-face assessments. The algorithm stratifies our membership to help us determine the appropriate clinical programs and interventions for each member to achieve optimal health. The algorithm then applies a series of business rules to sort members by impactability and the needed intensity of intervention. Because member risk may change over time, we repeat this process to identify changes in severity or acuity. Through these processes members are reassigned to the most appropriate intervention.

SUD Segmentation Model. Our Centelligence platform also allows us to appropriately identify interventions or prevention techniques that are tailored to the member based on the member's risk level. For example, to better inform service coordination interventions and clinical programs, we recently implemented a **proprietary Substance Use Disorder (SUD) segmentation profile**. Using evidence-based criteria and claims data, this complex data model allows us to stratify individuals into one of **six SUD segments based on utilization, clinical severity and cost**. The resulting clinical and business intelligence provides both individual and population based analytics to segment members into SUD risk streams for appropriate and timely follow up and service coordination interventions. The overall segmentation program offers a measurement framework to aid identifying high opportunity interventions as well as a mechanism to measure intervention efficacy as well as population health improvement over time.

Centelligence Opioid Risk Classification Algorithm**.** Additionally, as a tool to identify members for SUD, we also use the **Centelligence Opioid Risk Classification Algorithm predictive modeling** that looks at behaviors associated with opioid abuse to determine who may be abusing opioids or at future risk. Its data sources are member demographics, pharmacy claims, social indicators (such as homelessness or lock in), clinical history, and diagnoses. It reports members into three risk groups: high (likely to be actively abusing drugs); medium (trending towards active opioid abuse); and low (unlikely to be abusing opioids).

Levels of Service Coordination (5.4.5.A, 5.4.5.B, 5.4.5.C, 5.4.5.D, 5.4.5.E, 5.4.5.F)

Collectively, the information, data sources and predictive modeling and analytic tools described above are used to stratify members into **four Service Coordination Levels – Level I (Low-Member Education/Resourcing), Level II (Moderate- Short Term/Transition of Care Needs), Level III (Rising-Chronic Long Term Needs), and Level IV (High Risk/complex case management)** as outlined in Figure 5.4.D above. For example, a member that is being discharged from a hospital after a short term stay that required transition of care support or an individual that is moving from one level of care or service to another will be stratified to Level II. Similarly, a LTSS member that is enrolled in a HCBS waiver or youth in foster care and members discharged from a long term stay in a hospital, State hospital, ICF/I/DD or PRTF will be stratified into either Level III or Level IV, depending on their individual needs, acuity and situations. Members that need more intensive and service coordination activities such as individuals transitioning from a State hospital/ PRTF or NF to the community; individuals that are homeless, and individuals with SMI and SUD will be stratified into Level IV – high risk/complex case management.

Our person-centered approach to risk stratification ultimately relies on the information we directly learn or validate from our members, including their priorities and readiness to change. Outreach and assessment findings by our SCs and CSCs, CHWs, and/or other Service Coordination Team staff will be used to refine and even re-stratify the member's level of care to meet newly identified issues or changes in conditions. Members may move through those stratification levels as their conditions change.

At every contact, the SC or CSC or CHW or CSR monitors Centelligence® reports and other clinical information and conducts assessments to determine member needs and progress. As needed they re-stratify risk and make adjustments to the PoS and/or PCSP in collaboration with the member. Sunflower will re-evaluate the appropriateness of each individual member's service coordination level, in person, at least annually or more often based on a change in the member's condition or status, or at the request of the member, the member's legal guardian or legal representative.

Frequency of Contact by Level of Service Coordination (5.4.5.G)

The level of Service Coordination is used to drive our service coordination activities. SCs, CSCs and CHWs communicate via phone or in person with members (and family/other supports) at a frequency based on risk level and the individual situation of the member to monitor provision of authorized PoS and PCSP, and ensure services are meeting the member's needs. This includes providing education, and facilitating and encouraging adherence to recommended PoS, PCSP and/or treatment plans. Since effective PoS and PCSPs are not static records but living documents that quickly adapt to changes in member health and support status, the Service Coordination Team reviews the PoS and/or PCSP during each member interaction to assess progress on goals, reassess preferences and needs, and work with the member to make any necessary modifications based on changes in health, psychosocial or support status.

Service Coordination contacts differ by Level of Service Coordination as noted in ***Table 5.4.5.B_Frequency of Contact*** below as well as member acuity and preference. Our Service Coordination model hinges on an interdisciplinary team approach, based on the needs and preferences of the member. As such, an individual that is part of the member's individual IC Team may be involved with and make contact with the member, however the member will always have one primary point of contact within the member's IC Team.

Table 5.4.5.B_Frequency of Contact

Level of Service Coordination	Minimum Frequency of Contact
Level I: Low Risk	• Annual contact with any contracted Sunflower provider or member's CHW or CSR
Level II: Rising Risk	• Based on the individual needs of the member, but at least one face-to-face visit after discharge along with necessary telephonic contact to ensure continuity of care
Level III: Moderate Risk	• Based on the individual needs of the member, but at least monthly telephone contact and at least one in-person visit every three months
Level IV: High Risk (Complex Case Management)	• Based on the individual needs of the member, but at least monthly telephone contact and at least one In-person visit every other month

All service coordination activities, including member contacts, touch points and notes about the interaction are documented in the member's electronic record in TruCare. Reminder tasks are

set in TruCare to prompt the SC, CSC and CHW of the upcoming telephonic, in-person member contacts as well as annual Health Screen, HRA, needs assessment due dates to ensure it is completed per Sunflower's protocols and KDHE KanCare 2.0 requirements.

5.4.6. MANAGED CARE ORGANIZATION SERVICE COORDINATION ROLES AND RESPONSIBILITIES

COMMUNITY-ANCHORED, CULTURALLY COMPETENT, RELATIONSHIP-CENTERED SYSTEM

Sunflower will deploy our ISC model using a **community-anchored and shared service coordination approach.** Service coordination activities will be provided directly by Sunflower staff and by a qualified network of community-based agencies and providers. Our person-centered Service Coordination model, supported by evidence-based protocols, policies, procedures, job aids, training, data analytics and decision support tools, will provide consistency in the delivery of service coordination activities across our Sunflower Service Coordination team and delegated partners.

Sunflower Service Coordination Role and Responsibilities (5.4.B)

One of our roles as a health plan is to eliminate waste in the health care system, including duplication of care and services. Another is to ensure that the functions we delegate to community partners and providers meet the requirements of CMS, our state contract, and the agreement Sunflower has with the delegated provider. Under our proposed shared and integrated Service Coordination model we will delegate to a broad range of qualified and conflict-free Community Service Coordination entities, a set of service coordination functions and activities for a defined population. To ensure non-duplication of services, we will clearly delineate responsibilities of each party through a division of responsibility in the Community Service Coordination Delegation Agreement. This includes a description of each activity, who is responsible for delivering it, how it is monitored and how it fits with other non-delegated and delegated functions. The Delegation Agreement will also include process and performance metrics and how each will be reported, monitored and measured.

As part of our quality oversight process, we will ensure all required service coordination activities are delivered as outlined in Attachment L of the Contract, within CMS and State standards, and expected outcomes are met. Our oversight will include assessing for services that might be duplicative, identifying where there may be service gaps, insuring members are getting the full array of PH, BH and LTSS as needed and those services are coordinated with the PCP; monitoring of timely completion of visits and assessments; monitoring quality of assessments and PCSPs; monitoring of member satisfaction and other key performance metrics within our various dashboards, and monitoring of other state-required outcomes. As issues are identified, we will intervene with appropriate training and technical assistance, as appropriate, and implement corrective action plans when necessary.

Sunflower Service Coordination Responsibilities. Sunflower's role as an MCO is to ensure access to care and provide overarching service coordination functions and services, including offering subject matter expertise to our CSCs in the form of team meetings, IC Team rounds,

and individual consults with the CSC and the member's chosen circle of support and IC Team. As an MCO, our key responsibilities also include **accountability for reviewing and approving all PCSPs and PoS, and overseeing the completion of the Health Screenings, HRAs and needs assessments for those members assigned/attributed to a Community Service Coordination entity.** Additionally, we will serve as a resource to the Community Service Coordination entity by providing assistance with the coordination of PH, BH, LTSS, transportation and social determinants of health and independence, as appropriate. For example, the member's assigned CSC will have rapid access to Sunflower's Clinical Team when needed, including our BH specialists, CHWs, Health Coaches, Medical Directors, our Pharmacist; our SDOHI COE Team (Housing, Transition and Employment Specialists); System of Care Liaisons (Foster Care Liaison, State Hospital Liaisons, HCBS Waiver Program Liaisons, CSHCN Liaisons) and our SCs to support them in meeting the whole-person needs of the individual member. The Sunflower SC will serve as the liaison for the CSC to have rapid access to Sunflower service coordination and UM resources.

Assignment of Single Point of Contact. To support an integrated and shared service coordination model, we will align our Sunflower service coordination caseload assignments based upon member attribution to a CSC Provider. This operational and workflow approach will facilitate relationship building, oversight and consistency with our delegate partners and a seamless experience for our members. In this role, the Sunflower SC that is assigned to a CSC entity will:

- Function as a single point of contact and key liaison between the health plan and the CSCs
- Respond to requests from the CSCs for assistance
- Link the CSCs with other members of the Sunflower Service Coordination and UM Team to ensure the whole person needs of the member are addressed
- Review completed Health Screening; HRAs and needs assessments conducted by the CSCs for accuracy and completion according to Sunflower's policies and protocols
- Review and approve PCSPs and PoS, per Sunflower's established guidelines, for members subcontracted to and assigned to the CSC. Our SCs have primary responsibility for completing assessments, developing and approving PCSPs and PoS, with support from our IC Team and Clinical Team today under our current model of care, and as such, are well qualified and trained to review and approve PCSPs and PoS (including the amount, scope, and duration of any service in the plan) under our proposed new integrated and shared Service Coordination model.

Sunflower's Direct Service Coordination Responsibilities. We recognize that Sunflower will have primary responsibility for providing service coordination for a subset of the population not managed by the CSC entities, such as individuals with complex and chronic conditions. As a current KanCare MCO we are providing these services as part of our Integrated Service Coordination model with demonstrated success, including high member satisfaction results and positive outcomes. As such, we are well positioned and qualified to provide these service coordination activities in the future, as specified in Attachment L of the Model Contract.

Under our proposed model, Sunflower SCs will continue to function as the primary point of contact for members with complex needs and chronic conditions. Sunflower SCs responsibilities will include conducting the Health Screen, HRA and needs assessments; developing and implementing the member's PoS, addressing SDOHI, identifying care gaps, tracking care plan progress, and directing all service coordination activities for the member. Consistent with our current multidisciplinary approach, SCs will engage the member's PCP and other IC Team members, as appropriate.

Delegation Oversight and Monitoring

We recognize that we are ultimately accountable for ensuring all KanCare Service Coordination requirements are met as outlined in the KanCare Contract and in Attachment L. Sunflower's pre-delegation assessment, performance monitoring and quality oversight program is designed to confirm entites are qualified and meet expected standards and outcomes for performing service coordination activities and interventions.

Service Coordination Activities. Sunflower will delegate service coordination activities to qualified entities that have demonstrated capacity and ability to work collaboratively with Sunflower, providers and systems of care to improve health and quality outcomes. All community-based organizations and providers that we contract with to provide Community Service Coordination services and functions must:

- Be able to demonstrate a business and staffing structure that is compliant with the CMS Conflict Free requirements for the HCBS population
- Have a comprehensive initial, on-going and annual Service Coordination training plan and curriculum in place that meets the State's requirements and aligns with Sunflower's training curriculum
- Utilize the required Electronic Visit Verification (EVV) system for member visits and caseload assignments
- Have validated policies and procedures in place to provide quality service coordination
- Have executed a detailed contract with Sunflower describing delegation responsibilities and monitoring of contract deliverables and quality measures. Our contracts will have performance metrics, corrective action details, and termination protocols for failure to perform. Our contracts will also include the required HIPPA-approved and 42 CFR Part 2 compliant Business Associates Agreements to address protected health information (PHI).
- Have the systems capability to track all required member information and share needed information with Sunflower in a secure manner
- Maintain the number of qualified staff necessary to meet Sunflower's caseload ratio standards, service coordination process requirements, and outcomes expectations as well as individual whole person member needs
- Have processes for notifying Sunflower when staff openings cause the need to implement an agreed upon backup plan for covering essential service coordination functions

- Allow Sunflower full access to member data and staff to evaluate compliance with contractual deliverables via data reviews, audits, complaint assessments and other methods
- Follow standardized performance improvement protocols
- Apply Sunflower's service coordination protocols in a consistent manner

Performance Oversight and Monitoring. The Sunflower Contract and Network Director will have primary accountability for overseeing the performance oversight and monitoring of the Community Service Coordination entities in partnership with the Compliance Department, LTSS Director, Director of Quality, and the Director of Behavioral Health. We will oversee and evaluate the performance of all delegated Community Service Coordination entities by:

- Conducting a comprehensive pre-delegation assessment and readiness review prior to delegation of functions focused on key areas including, but not limited to:
  - Compliance with 42 CFR § 431.301(c)(1)(vi) and 441.730(b) regarding Conflict Free Case Management
  - Review of Policies and Procedures
  - Review of staffed positions, staff education and qualifications, experience and background checks
  - Review of systems capability for secure, bi-directional transfer of member information and integration with Sunflower's systems
  - Review of training curriculum and plans for new staff and ongoing training
  - Ability to comply with EVV requirements for member visits and caseload assignments
  - Ability to track and report on contractual outcomes measures
  - Systems and staff ability to complete the required Service Coordination functions as outlined in Attachment L of the Model Contract
- Executing a Delegation Agreement outlining expectations and responsibilities of each party, performance guarantees, reporting requirements and Corrective Action Plan (CAP) process
- Performing ongoing monitoring and oversight activities that include, but are not limited to:
  - Reviewing routine reports submitted by delegate
  - Sharing actionable information and data
  - Reviewing claims and encounter data for appropriate utilization of assigned members
  - Tracking and analyzing provider and member complaints, and other performance indices
  - Conducting periodic and annual audits and reviews of systems, staff, and Policies and Procedures
  - Facilitating regular Joint Operating Committee (JOC) meetings between Sunflower and functional leads and delegate counterparts to present actionable data, performance, collaborate and coordinate, and address issues and concerns.

- Holding ad-hoc meetings as necessary between the Sunflower leadership team and delegate counterpart's leadership team to address any issues or concerns, including performance issues.

We recognize that we are one of several KanCare 2.0 MCOs that will seek to contract with qualified community based organizations and providers to provide Community Service Coordination. To minimize administrative burden to these organizations and providers, we propose to partner with the other KanCare 2.0 MCOs to develop a uniform and standardized pre-delegation assessment tool and ongoing audit tool. This proposed process will also meet the goal of the State to ensure consistency in the execution and implementation of the new KanCare 2.0 Service Coordination model.

Developing and Supporting Capacity for Community Service Coordination and Contingency Planning (5.4.4.C and 5.4.6.D)

We recognize that some of our contracted community-based agencies for delegated service coordination may not have the full continuum of capabilities or technology systems and solutions to care for high risk and more complex populations with co-morbidities or chronic illnesses. As part of our contracting and readiness assessment process, we will assess for and determine each provider's level of capability and capacity. Based on this analysis, we will provide necessary service and supports, including additional case management, disease management and service coordination resources and tools to augment and wrap around the services provided by the contracted CSCs, as necessary. We are also committed to expanding Community Service Coordination in the community through our workforce development and training programs described below.

Resources and Tools. We will equip our Community Service Coordination partners with the right tools and supports to successfully meet the unique, individual service coordination needs of Sunflower members and build capacity in the local community for Community Service Coordination. This includes bi-directional information sharing to create and share the key actionable data points that we have found contribute to successful coordination of care and services. Through our sophisticated technology platforms, we will provide our partners with:

- Comprehensive reporting to include members attributed or assigned; care gaps; and under and over-utilization reports and potential health risks
- Shared access to Sunflower's roles-based Service Coordination partner and Provider web portals which provide access to a single, current PoS/PCSP for the member.
- Access to ED and other hospital admissions, discharge and transfer (ADT) information to facilitate transitions of care
- Access to web-based and other mobile tools to promote member engagement, self-determination and recovery and resiliency, such as MyStrength

Training and Workforce Development

Project ECHO. To support the successful implementation and adoption of the State's new KanCare 2.0 Service Coordination Model, Sunflower proposes to host a Service Coordination Project ECHO. The Project ECHO will support workforce development and skill training for community-based organizations and providers across the state and will include sessions to develop individual provider capacity and ongoing video conferences and training modules. Access to Project ECHO will supply providers and CSCs with ongoing education, mentoring opportunities, and support in managing specialty conditions and high-risk populations. It will also serve as a forum to discuss effective service coordination interventions for complex and difficult to engage populations.

Positive Behavioral Supports Training. Through Sunflower's LifeShare program, Sunflower currently has four team members who completed the training in Positive Behavioral Supports (PBS), two of which are instructors and mentors. We have developed a curriculum for teaching our BH SCs PBS techniques such as functional assessment, positive behavioral support planning, and preventative interventions strategies. Our trained SCs are currently able to utilize these techniques in conjunction with Person Centered Service Planning to assist I/DD members who have co-occurring BH needs. Sunflower will further expand the skills and capacity of the overall Service Coordination team by offering this training to Sunflower SC staff and our contracted Community Service Coordination entities.

Quality of Life Assessment Training. We have also received consultation and training through colleagues of Robert Schalock to develop and implement a "deeper dive" Quality of Life assessment for members with I/DD who are in crisis, identified as needing public or private ICF/IID level of care, or otherwise determined as high risk. Two members of the Sunflower LifeShare team are the only individuals in the United States who have received this training and are endorsed to train in the completion of this assessment. During 2016 and 2017, the Sunflower LifeShare team provided 218 of these assessments. The assessment includes a series of observations and discussions with the member and his/her support team. Based on the assessment, SCs provide recommendations for environmental changes, changes in interaction style with the member, changes in schedule or activities and changes in preventative and intervention strategies. Sunflower will provide this training to our Community Service Coordination partners to enhance their capabilities with assessing Quality of Life indicators and supporting high risk members.

Charting the LifeCourse Framework Training. We will also train our SCs and Community Service Coordination providers on the LifeCourse framework so they are equipped with tools to help individuals and families think about what a good life looks like for them and how to get there. We currently have a representative participating in the LifeCourse Community of Practice, helping to develop the LifeCourse training course.

Addressing NCQA Requirements in Service Coordination Oversight

Sunflower is fully accredited with NCQA and our Service Coordination P&Ps, for which delegates are required to adhere to, are based on NCQA guidelines. As such, our P&Ps can serve as a foundation and support for those entities that are interested in seeking NCQA Case Management and/or LTSS Case Management Accreditation. We will also provide data to our delegates that support their service coordination efforts, such as enrollment and eligibility files, timely access to actionable member data and gaps in care. It is our role to not only hold our delegates accountable for NCQA guidelines, but to provide them with the tools and resources to be successful.

Value-Based Reimbursement and Aligned Incentives. Lastly, as discussed in Section 5.7, we will create incentives for collaboration in support of person-centered care. Our relationships with entities to provide Community Service Coordination functions will evolve and scale to robust performance-based partnerships that may include shared risk to drive optimal results on behalf of our members. We will conduct both qualitative and quantitative evaluations to determine a provider's level of readiness, consistently supporting progress along the continuum by developing a customized plan that provides a path to contracting and delegation that meets the needs of the providers, the goals of KDHE and improves the outcomes and experience of members.

Contingency Planning

As part of our oversight process, we will continuously monitor and assess for Community Service Coordination access and capacity through caseload monitoring; monitoring of service levels, and analysis of member complaint and grievance data. Should we affirm there are any short-term gaps in Community Service Coordination capacity in a geographic region or for a given population, Sunflower will be prepared to offer members the choice of another Community Service Coordination provider within the area, or to provide the full scope of service coordination services to meet the member's whole person needs and state requirements on an interim basis if there is not another qualified provider readily available. Under this scenario, Sunflower will notify KDHE of our need to activate the contingency plan and our plans for addressing and mitigating identified gaps. We also maintain documentation of our efforts to contract with community-based organizations for the provision of Community Service Coordination in our Provider Data Management System, and will make this information available to the State upon request.

5.4.7. COMMUNITY SERVICE COORDINATION ROLES AND RESPONSIBILITIES

Sunflower is committed to contracting with qualified providers and entities, who meet the CMS Conflict free standards for LTSS, who are not conflicted, to provide Community Service Coordination functions and services, as defined in Attachment L of the Contract, to enhance the integration of LTSS, BH, and foster care expertise into our person-centered planning process. Sunflower will satisfy all requirements, as described in Section 5.4.6 and 5.4.7 and in Attachment L Service Coordination Matrix of the Model Contract.

ENGAGEMENT AND CONTRACTING APPROACH

We are committed to contracting with a sufficient number of qualified entities to provide Community Service Coordination functions and activities, establishing mutually beneficial relationships where we leverage the resources and expertise held by each party. We intend to utilize the infrastructure and services that are in place today and the expertise and capabilities of community-based agencies and providers that serve complex populations including individuals with BH needs; HCBS waiver populations, persons in institutional settings, and children and youth involved in the foster care system.

Leveraging Established Relationships

We will leverage our established relationships and develop new relationships with community-based organizations such as the CILs and AAAs; Lead Foster Care Agencies; CMHCs; CHCs, RHCs, SUD providers, I/DD TCM providers; Home Health providers and other social service organizations to create a system of care that addresses the whole person needs of our members. We will establish new contractual relationships with these, or other qualified, newly developed entities and providers in geographic service areas across the state to align with our local, integrated care model and provide member choice of CSCs.

To inform our Community Service Coordination contracting and engagement efforts, we have analyzed our existing Sunflower membership in terms of the profile and geographic distribution of members to ensure we have the right mix and adequate number of qualified and conflict-free CSCs to meet the needs of our membership and assure member choice of CSCs.

To inform our approach to partnering with Community Service Coordination entities, we have met with our LTSS Advisory Committee twice to obtain feedback on the structure of Community Service Coordination. From these initial discussions, Sunflower has gathered interest from providers such as the CILs, AAAs, I/DD providers, and Home Health agencies.

To further inform our approach to partnering with Community Service Coordination entities, we have met with our LTSS Advisory Committee twice to obtain feedback on the structure of Community Service Coordination. From these initial discussions, Sunflower has gathered interest from providers such as the CILs, AAAs, I/DD providers, and Home Health agencies. These organizations and key stakeholders believe they have the best knowledge and capability of supporting the identified populations for Community Service Coordination, can also offer peer supports, but need support from our integrated care management team and database; and technical assistance with measurement of outcomes. We plan to continue to meet with this group as well as other individual providers to develop our Community Service Coordination partnerships.

Additionally, as mentioned in other sections of our proposal response, Sunflower also has an I/DD TCM pilot group with which we are working on forms and processes to streamline and reduce duplication between our current Sunflower SCs and TCM agencies. We believe these

processes should transition easily to Community Service Coordination with qualified TCM providers who are interested in contracting with Sunflower.

Additional Partnership Opportunities. Sunflower is also in active discussions with two SUD providers, Heartland RADAC and Central Kansas Foundation that are interested in contracting with Sunflower to provide Community Service coordination functions. Both providers have robust service coordination models which include employment preparation, job coaching, interview techniques, working with homeless populations and those entering the community from incarceration. We have also met with the two Lead Agencies for foster care (KVC and St. Francis) regarding their interest in providing community service coordination for the foster care population. These agencies have extensive experience in helping youth who are either in out of home placement, adoption, or in juvenile corrections. Another provider group that Sunflower has been meeting with regarding our integrated and shared Community Service Coordination model is the CMHCs. Our recent meeting with the Association for Community Mental Health Centers of Kansas Executive Board focused on the approach the CMHCs could take with Community Service Coordination for the behavioral health population. These 26 CMHCs have developed a service coordination model that aligns well with the goals of KanCare 2.0 and Sunflower's approach. We are also in active discussions with KAMU regarding opportunities to contract with their members to provide service coordination services, recognizing the value of providing service coordination at the point of care.

Community Service Coordination Entity Responsibilities (5.4.7.A)

For entities that are determined to be conflict- free, the Community Service Coordination provider will serve as the member's single point of contact for the SED Waiver and Children with Intensive Behavioral Health Needs; HCBS I/DD/TBI/PD/FE/Autism and TA Waiver populations; individuals on the waiting lists for the I/DD and PD waivers, individuals residing in a Nursing Facility/ICF-IID; foster care children and youth; adults with BH conditions and individuals in State hospitals or other institutions.

We will provide members with a choice of at least two Community Service Coordination providers/agencies. The member's chosen CSC, in collaboration with the member's IC Team, will have primary responsibility for key functions that include but are not limited to:

- Completion of the health screen, HRA and needs assessments
- Development, implementation and monitoring of the PCSP and PoS and implementation of the treatment component of the PCSP and PoS, as appropriate
- Choice counseling including assessing member interest and ability to move to a home or community setting for individuals in institutional settings
- Referrals, linkages and information to community resources and non- Medicaid funded services and supports to address SDOHI and social support needs
- Member touch points and contacts including telephonic and in-person visits
- Support for education, employment and housing

- Member education on options for self-direction of HCBS and WORK services and supports for those members that elect to self-direct their services, utilizing Sunflower's self-direction member tools and educational materials
- Health and safety monitoring, including conducting environmental assessments, conducting fall risk assessments, ensuring back-up plans are in place and current, etc.
- Intensive case management and High-Fidelity Wraparound services, monitoring and follow up activities for children enrolled in the Autism waiver or who are diagnosed with a SED
- Transition planning and coordination to support community integration for individuals in NFs, ICF/IID, or children in LTSS transitioning from school to adult life
- Community support coordination for individuals with I/DD, and other members in HCBS to promote independence and community integration and participation
- Transition of care coordination and discharge planning activities in collaboration with Sunflower's Service Coordination and UM staff

Integrated Care Team Supports Community Service Coordinators (5.4.7.B)

As described in Section 5.4.8 below, a key component of our integrated and shared Service Coordination model includes the use of an IC Team. We will utilize an IC Team approach to support our service coordination activities. This team- based approach engages the member, PCP and other treating providers and agencies, and representatives from across the plan and community to represent all member needs and conditions. For our delegated Community Service Coordination entities, we will monitor and oversee the IC Team process, supplementing teams with additional health plan expertise and resources as needed.

Sunflower Service Coordination Team. The member's assigned CSC will have access to Sunflower's Clinical Team for medical and specialty consultation when needed. These resources include our team of Medical Directors including PH, BH and LTSS Medical Directors; Pharmacists; Occupational, Physical, and Speech Therapists; Board Certified Behavior Analysts, Certified Peer Support Providers, certified Behavioral Support Facilitators, licensed social workers, Registered Nurses (RNs), CHWs; and Program Specialists who manage certain initiatives/programs, such as our Start Smart for Your Baby® perinatal management program. In addition, our CSC entities will also have access to Sunflower's SDOHI COE Team (Housing, Transition and Employment Specialists) and System of Care Liaisons (Foster Care Liaison, HCBS Waiver Program Liaisons, State Hospital Liaisons and our Criminal Justice Liaison) to support them in meeting the whole-person needs of the individual member, as necessary. Our team approach also includes non-clinicians (e.g. Program Specialists and CHWs) who are available to support the SCs and CSCs with certain service coordination tasks such as arranging for transportation. Our team approach also enables everyone to function at the top of their credentials and licensure.

We will contract with **certified Peer Support providers to function as members of the Sunflower Clinical Team and IC Team,** as appropriate. Certified Peer Support providers are integral to our person-centered model and provide skills and information, using lived-

experience, to engage members, help remove barriers, identify temporary resources and prevent crises. Certified Peer Support providers will deliver ongoing education on recovery and rehabilitation, including person-centered treatment planning, health and wellness education, self-help coaching, culturally responsive services, system navigation, and reducing social determinants barriers, e.g., unstable housing, under/unemployment, literacy and language and cultural obstacles. We will leverage peer support and recovery services as we link providers to meeting the needs of members in crisis and engaging members before crisis.

We also employ a **certified PBS facilitator to function as a member of our Sunflower Clinical Team and IC Team.** The certified PBS facilitator will continue to be a resource to SCs and CSCs and will be responsible for providing services to our members that includes but is not limited to PBS functional assessment, person-centered planning, and PBS treatment strategies. Additionally, if other PBS providers are interested and qualified, we will also seek to contract with these providers to provide Community Service Coordination services for a subset of our population.

We recognize there is a shortage of certified PBS facilitators in the state. To address this capacity issue, as part of our workforce development efforts, we will help train CSCs on PBS strategies using a curriculum our certified facilitators have developed and used with our Sunflower SCs. This curriculum includes both classroom learning and in the field observation, and competency tests. Sunflower currently has four team members who have completed the PBS training through the University of Kansas, two of which are PBS instructors and mentors. The curriculum they have developed includes topics such as functional assessment, positive behavioral support planning and preventative interventions strategies. Our trained SCs are currently able to utilize these techniques in conjunction with person-centered service planning and have been providing this support for members with I/DD and/or TBI who have co-occurring BH needs. As part of our workforce develop initiative, Sunflower will further expand the capacity of our overall Service Coordination team by offering this training to Sunflower SC staff and our contracted Community Service Coordination entities.

5.4.8. QUALIFICATIONS FOR SERVICE COORDINATORS

Our Service Coordination Model is supported by an interdisciplinary and multi-dimensional team of Sunflower staff and contracted CSCs, strategically located in regions across the State. Sunflower Service Coordination staff and our contracted Community Service Coordination partners will work as a unified team to bring an array of clinical, BH, LTSS, and cultural/linguistic capabilities to the service coordination process that we offer to our members.

SERVICE COORDINATOR/COMMUNITY SERVICE COORDINATOR QUALIFICATIONS (5.4.8 A, B.4.8. B, 5.4.8.C)

Our employed Sunflower SCs and our delegated CSCs will have the experience that is appropriate to the member's primary health care needs and perform service coordination activities within their scope of practice in accordance with all applicable licensing/credentialing rules. Our SCs and contracted CSCs will have a broad representation of experience and areas of

expertise to meet the needs of our members. Our Service Coordinator assignment considers the expertise among our staff and subcontractors that most closely matches the member's needs based on the **member's primary clinical driver and/or LTSS need**, as well as geography, existing relationships, and cultural and linguistic needs. For example:

- For **members with a LTSS need**, the member will be assigned to a Sunflower SC and a CSC that both shall have at least a bachelor's degree in social work, rehabilitation, nursing, psychology, special education, gerontology, or related health and human services area or be a Registered Nurse (RN). The assigned SC and CSC will also have at least one year of experience working with individuals with LTSS needs, and if working with a specific Waiver population (e.g. I/DD, TBI or FE), at least one year of experience working directly with that population. Additionally, the Sunflower SC and CSC responsible for providing services to I/DD members will meet required qualifications outlined in Article 63 and comply with qualifications as described in the State's HCBS Waivers.
- For **members with a Behavioral Health need**, the member will be assigned a Sunflower SC and/or a CSC that shall have at least a bachelor's degree in social work, nursing, rehabilitation, psychology or related health and human services area, or be a RN; have at least one year of experience working with individuals with BH needs and receive training in trauma informed care.
- For **members in custody through the foster care system**, the member will be assigned a Sunflower SC and CSC that shall have at least a bachelor's degree in social work, nursing, psychology or related health and human services area or be a RN; have at least one year of experience working with individuals with multi-system children and receive training in trauma informed care.

Our Service Coordination program description specifies the type of personnel responsible for the functions of Service Coordination. Job descriptions define the qualifications, education, training and professional experience in medical or clinical practice required for the position. In addition, our delegation agreement with community based organizations and providers will include Service Coordination staffing qualifications requirements. In cases where we contract with external entities to provide service coordination functions and activities, we have a qualification process for assuring these entities meet all applicable staffing qualification requirements and standards.

5.4.9. SERVICE COORDINATION RATIOS

INTEGRATED APPROACH CREATING A SYSTEM OF CARE

Our person-centered approach integrates all PH, BH, and LTSS to create a system of care around the member that allows us to effectively address not only clinical needs, but also the functional, social and other non-clinical needs of the member that affect health and quality of life. To ensure effective integration and coordination across providers and the full continuum of care and services, our model uses a primary Service Coordinator who functions as the main point of contact for the member for all their needs to eliminate fragmentation, reduce duplication of services and minimize member confusion.

Methodology for Assigning Consistent and Appropriate Caseloads (5.4.9.A)

For members that are stratified into Level of Service Coordination I, a CHW and/or a Customer Service Representative (CSR) will function as the member's primary point of contact for service coordination, information and referrals and health and wellness activities. Members that are stratified into Level II, III or IV Service Coordination will be given a choice of the Community Service Coordination providers in their area, **based on the member's primary clinical driver and/or LTSS need.** The SC or CSC serves as the central point of contact with the member.

SC and CSC assignment is based on a variety of factors, such as:

- ***Geography:*** Sunflower will assign members to SCs in their geographic areas and regions where they reside. This is particularly important given the rural and frontier nature of the State and the importance of having staff with specific knowledge of the resources available in these regions and communities of the State.
- ***Language and culture:*** To the extent feasible, Sunflower will assign members to SCs that speak their preferred language and share similar cultural backgrounds.
- ***Specialty training and discipline:*** Member assignments will take into account the profile of the member and the qualifications of the SCs and CSCs including any specialized skills or training (i.e., BH, foster care, substance use and disorders, HCBS wavier programs, physical/complex health needs, etc.) and years of experience and responsibilities.
- ***Provision of support staff and location of Service Coordinator:*** Member assignments will take into account the support staff such as Program Coordinators, CHWs, Transition Specialists, Housing Specialists as well as location of the SCs and CSCs, such as SCs embedded in provider's offices, etc.)
- ***Caseloads and acuity:*** Member assignments will take into account current caseloads (including acuity and complexity) of the SCs and CSCs, visit requirements and person-centered planning processes to ensure manageable workload and adherence to Sunflower's SC ratio standards.
- ***WORK program:*** Members that participate in the WORK program will be assigned to one of our designated Sunflower SCs specifically trained and qualified to serve WORK program participants.
- ***Choice:*** Members who are assigned to a CSC will have the choice of at least two qualified CSC providers within Sunflower's network.

We use information obtained from the Health Screening, HRA, needs assessment and available claims and encounter data to validate appropriateness of assignment and adjust as needed. To ensure consistency and standardization, we will require our contracted network of CSC providers to employ Sunflower's methodology and approach for assigning all referred members to the appropriate CSC.

Caseload Ratio Methodology (5.4.9.B and 5.4.9.G)

Sunflower deploys a transparent and data-driven methodology for determining Service

Coordination ratios. Our staffing ratios are driven by multiple factors, including the geographic disbursement of members (since this impacts the time required for SC travel); the extent to which the areas are urban and/or remote or rural (since this often impacts the density of members in one geographic area); the community setting in which members reside (e.g., facility setting, community residential setting, or living alone since this impacts member density as well as potential risk); and the member's level of risk (which influences the frequency of in-person visits and the post visit documentation required). Our staffing model also considers member risk profiles and associated frequency of telephonic and in-person member touch points to determine the level of FTE licensed and non-licensed personnel needed to meet member needs and contract requirements. Additionally, our Service Coordination ratios, take into account our IC Team model and staff that support the work of the SC and CSC. For example, Sunflower SCs whose caseloads include members who participate in the WORK program actively coordinate with and are supported by Sunflower's WORK Program Supervisor, Sunflower's Employment Specialist, and our Independent Living Counselor providers (ILC) to ensure optimum coordination of services.

Sunflower's Ratio Staffing Tool. Through the use of a proprietary tool, we align intensity of member needs with staff caseloads so SCs and CSCs can provide the right level of service. **Sunflower's Ratio Staffing Tool** aligns our Service Coordination ratios with member risk, and allows us to adjust ratios to ensure we have sufficient SCs and CSCs and staff to meet the needs of members. We may implement, when needed, smaller Service Coordinator ratios outside of these ranges for members living in the community with extensive medical, behavioral, cognitive, and functional needs or for members transitioning from a facility to a home or community setting. We will also ensure that if Sunflower's SC or CSC is part of a BH team where staffing ratios are part of a fidelity model that our staffing ratio complies with the fidelity requirements.

Monitoring and Evaluating Caseloads (5.4.9.C)

Staffing ratios and caseload assignments are systematically monitored weekly, monthly and quarterly by the Service Coordination Managers and Supervisors and adjusted as appropriate to coincide with ratio requirements. Our process for managing caseloads is built on monitoring at all levels of Sunflower's employed and contracted Service Coordination workforce. We recognize appropriate caseloads must reflect both the number and complexity of cases while remaining in compliance with KanCare Service Coordination requirements. Provider and Community Service Coordination entities will independently manage caseloads, utilizing Sunflower's requirements and tools, and based on their level of experience with support from Sunflower management team as needed. We will encourage Community Service Coordination entities to work collaboratively with us to design appropriate caseload monitoring and tracking reports, which will include any reports available through the State's required EVV system.

Expanding TruCare Capabilities. TruCare provides service coordination caseload assignment support to facilitate member/service coordinator matches based on a variety of variables described above to optimize member caseload balance. Sunflower is also expanding TruCare's existing caseload monitoring capabilities by adding a comprehensive, interactive dashboard

view of members, and action items for that member, through TruCare's Service Coordinator and Supervisor Dashboard. This page collects key information stored within TruCare, and brings it to one single page where a SC can get a holistic picture of a member's health status and needs. Key information includes member ED utilization alerts and actionable messages, upcoming member contacts and visits, and a caseload planner displaying members coming on and off the caseload as well as a list of members with upcoming Medicaid recertification. Our Service Coordinator and Supervisor Dashboard will provide views of subordinate SC case assignments and caseload tracking, views of member visit schedules with locations, updated in near real-time, member satisfaction data, and other quality metrics.

Adjustments are made to staffing to match the evolving needs including shifting SC responsibilities due to travel requirements, regional imbalances, absences, need for back up, capability, skill level, and managing caseloads for both Sunflower and community-based service coordinators. Sunflower employed SCs and their supervisors meet on a regular basis to review cases, evaluate changes in member needs and adjust care coordination caseloads. Likewise, Sunflower's Manager of Community Service Coordination will meet with CSC providers on a regular basis to monitor these factors.

Member Notification of Their Service Coordinator (5.4.9.D, 5.4.9.E, 5.4.9.F)

As part of our care planning process, members are provided information on how to contact their assigned Sunflower SC and CSC during normal business hours. Each member is provided with written information that includes their assigned SC or CSC's name, direct telephone number and email address, along with an alternate number the member may use in case their SC or CSC is in the field or out of the office. Information is mailed to the member address on file, which is validated during the HRA. For after hours and weekend coverage, members are instructed to use the Nurse Advice line and are provided information on how to access the Nurse Advice line in the Member Handbook and as part of the service coordination planning process, with the expectation that their SC or CSC will follow up with the member within 48 hours. We provide all members, regardless of Level of Service Coordination, with support and education about availability of services and how to access them through our Call Center, 24/7 nurse advice line, Member Portal, and mobile applications, as well as written material. We have managers who provide on-call support to the Nurse Advice line team for after-hours calls regarding non-medical needs such as a member's utilities have been turned off, or a member is without food.

Sunflower's policy is to honor a member's choice of their SC and CSC. As part of our person-centered service planning process, we assign a Sunflower SC but members are able to contact us when they desire to switch to a different Sunflower SC. For members who have a CSC, Sunflower will offer the member choice of their Community Service Coordination agency/provider and we will permit members to change to a different CSC upon request.

We may also need to initiate changes based on caseloads, or staff turnover. In situations where a SC or CSC departs employment, whenever possible we will notify the member by telephone or email at least seven days is advance of the SC/CSC last day of employment. All plan-initiated

SC and CSC changes will be limited and completed in a manner least disruptive to members. For example, for caseload adjustments, we will identify members who have had no or limited contact with their SC or CSC as primary candidates for movement. All changes will be introduced to the member via phone or by mail, with as much notice as possible. As appropriate, our process will include warm hand offs, involving both the incoming and outgoing SC/CSC. Members will also receive follow up written notification with direct contact information for the new SC or CSC within 3 days of the new assignment and instructions for how to change SC and CSCs if they are not satisfied. In the event a Sunflower SC or CSC resigns or has an assignment change, we will utilize the above described assignment and member notification process for reassigning the member to a new Sunflower SC or CSC to ensure continuity of care and a seamless transition for the member.

Staffing Plan for Service Coordination Model (5.4.9.H, 5.4.9.I. 5.4.9. J)

We are particularly proud of the tenure, experience and low turnover rates of our Sunflower Service Coordination staff. For example, our care coordination staff have an average tenure of four years and our turnover rates for Sunflower SC staff is 9.1%, well below industry standards. Our Service Coordinators have an average of 9 years of service coordination experience and the average level of education for our SCs is 9 years of education.

Upon contract award, we will submit a staffing plan for Service Coordination to KDHE which will include our process for monitoring Service Coordination vacancies. We will also provide the State with monthly updates on the status of open positions and positions filled. Included in our response to Section 5.17 is additional information on our Service Coordination staffing model and organizational structure for KanCare 2.0.

5.4.10. SERVICE COORDINATION TRAINING REQUIREMENTS

USE OF DEDICATED TRAINER (5.4.10.A)

In 2017, Sunflower Service Coordination Staff participated in over 3,300 hours of training.

Our Service Coordination training, which we continually refine to reflect our growing experience and industry best practices, ensures SCs are knowledgeable about the KanCare population, benefits, community resources and SC responsibilities. Sunflower Service Coordination staff and our contracted CSCs will participate in a combination of classroom, on-the-job, self-tutorial, and preceptor training. Our training program includes an initial training as well as ongoing training and education for employees and subcontractors to maintain expertise, to increase proficiency and job knowledge, and to disseminate new information. Our **dedicated Service Coordination Trainer** is responsible for the development and maintenance of a comprehensive Service Coordination Training Plan; conducting training; ensuring all training requirements are met, and maintaining records for new hire, initial and annual training completion.

In addition to our dedicated Trainer, we also offer a Preceptor Training. Through our proven mentoring model, experienced staff serve as instructors for new staff members. Preceptors work with assigned new staff for at least six weeks to provide consistent and timely feedback,

provide growth potential and skill development, reduce error rates, and provide a consistent approach to medical necessity decision making. Preceptors encourage dialogue regarding roles and responsibilities, monitor skills development, and conduct role-playing exercises to prepare Service Coordination staff.

As part of our contracting and oversight process, we will hold our delegated Community Service Coordination providers accountable for ensuring their CSCs comply with KDHE Service Coordination and Sunflower's training requirements. To support our delegated community partners, we will offer a Train the Trainer model to interested Community Service Coordination entities. Additionally, we will share our tools and best practices with our Community Service Coordination partners to develop their own training and preceptor programs.

Initial Training (5.4.10.B and 5.4.10.C)

New SCs (all Sunflower Service Coordination and contracted community Service Coordination staff) complete an initial onboarding training within ten days of employment. We provide classroom training within this time period, which begins with an overview of our Service Coordination model and addresses eligibility types, covered services; protocols for coordinating care including community resources; SDOHI, cultural competency; disability awareness; best practice engagement techniques such as Motivational Interviewing and the Recovery Model; member-centered planning, consumer directed care; employment supports; use of the data systems; completion of Health Screenings, HRAs and assessments and guidelines for documenting service coordination activities; and other policies and processes to ensure a good foundation and understanding of the program and staff responsibilities.

Our comprehensive training curriculum also includes in-depth training on **Person Centered Thinking (PCT),** using the copyrighted training material developed by the International Learning Community for Person Centered Practices. Our PCT training module instructs staff on how to discover what is important to and important for the member, and how to support the member to find balance. The discovery is used to identify the strengths, capacities, preferences, needs and desired outcomes of the member. It provides our Service Coordination team with tools to encourage empowerment of the member to make their own informed decisions, develop personally defined outcomes and set their own goals to achieve the life/outcomes they choose.

As a complement to the PCT training, Sunflower participates in the Community of Practice that is moving towards integrating Charting the LifeCourse (LifeCourse), a person-centered framework that highlights Person-Centered Thinking (PCT), into the Kansas system. We will train our SCs and Community Service Coordination providers on the LifeCourse framework so they are equipped with tools to help individuals and families think about what a good life looks like for them and how to get there. The LifeCourse framework takes the person-centered thinking model a step further, encouraging focus on the family and supports surrounding the individual and the family, and encouraging use of community resources and supports as a first option.

Our Initial Training for all Service Coordination and contracted Community Service Coordination staff includes, but is not limited to, the following training curriculum topics and modules noted in ***Table 5.4.10.A_Initial Training Curriculum Topics*** below.

Table 5.4.10.A_Initial Training Curriculum Topics

Initial Training Curriculum Topics	
• Cultural competency	• Conducting health screenings, HRAs and needs assessment and clinical assessment and documentation
• Grievance and appeals	• Person- centered service planning and plan of service
• Social determinants of health and independence	• Self-direction and electronic visit verification (EVV)
• Community resources and partnerships	• Abuse, neglect, exploitation recognition and reporting
• Integrated care management and service coordination strategies and programs for disease specific processes	• Medicaid fraud, waste and abuse
• Motivational interviewing and member engagement strategies	• Trauma informed care and Adverse Childhood Experiences (ACEs)
• Advanced directives	• Member rights and responsibilities
• Eligibility and Special populations	• Physical and behavioral health integration strategies and evidence based models
• Training requirements for the I/DD population	• Medication monitoring
• Documentation, monitoring and follow up	• TruCare case management system, TruCare Anywhere, OMNI
• Transitions of care	• Authorizations- services and processes
• MCO Service Coordination versus Community Service Coordination roles and responsibilities	• KanCare covered benefits and services
• Employment Assistance, Work and Supported Employment	• Community resources
• LifeCourse Model	• Foster care and transition youth out of foster care

Following classroom training, new SCs participate in a minimum of three weeks of shadowing and mentoring with seasoned staff. Our Service Coordination staff average over 9 years of service coordination and case management experience. This ensures new staff train under SCs who have a deep understanding of the KanCare Program and service coordination processes. New staff are closely monitored and coached during this on-the-job training. Shadowing includes both observation of and supervised practice with completion of screenings and assessments as well as documentation. After the shadow period, they spend additional time with SCs on various specialized

Our Service Coordination staff average over 9 years of service coordination and case management experience.

teams. This mentoring process continues for one to two weeks or as needed based on the evaluations of the employee's supervisor and assigned mentors. This cross training broadens their understanding of our model, the unique characteristics and needs of subpopulations such as members with Intellectual and Developmental Disabilities (I/DD), and circumstances in which to pull in expertise of other staff. The new SC engages in essential job functions while being observed and mentored by a tenured SC.

Prior to serving members independently, new staff must demonstrate mastery of information and processes through job readiness auditing. If there are gaps in the knowledge transfer, the Supervisor retrains and coaches the new employee and schedules additional formal training sessions.

Annual and Ongoing Training (5.4.10.D)

Ongoing training ensures that Service Coordination staff and contracted CSCs continue to hone skills and keep abreast of new approaches, best practices, and issues. It also allows us to address any improvement opportunities identified by regular Service Coordinator performance monitoring. We provide weekly webinar trainings facilitated by our dedicated Trainer and our internal subject matter experts, such as our waiver SMEs, our Employment Specialist, our Trauma Informed Care trainers, and our Foster Care manager. We also partner with a broad range of local community-based organizations and providers to enhance our training. Some examples of these partnerships, include:

- Topeka Independent Living and Resource Center to provide training on Self-Direction
- Minds Matter to provide training on HCBS TBI services,
- Community Living Opportunities and Johnson County Developmental Supports to provide training on I/DD services
- Helper's Inc. and Windsor Place to provide training on new member enrollment with FMS providers
- Circles Family USA to provide training on services and resources for assisting members to gain employment and get out of poverty

We also offer e-Learning CME/CEU and Certified Case Management CEU trainings to help staff maintain licensure and reimburse them for expenses incurred in continuing education needed to maintain licensure.

Our annual training curriculum includes, but is not limited to, the following key topics outlined in ***Table 5.4.10.B_Annual Training Curriculum Topics*** below:

Table 5.4.10.B_Annual Training Curriculum Topics

Annual Training Curriculum Topics	
• Cultural competency	• Grievances and appeals
• Social determinants of health and refresher on local and statewide resources and community partnerships	• Abuse, neglect, exploitation recognition and reporting

Annual Training Curriculum Topics	
• Person-centered service planning	• Medicaid fraud, waste and abuse
• HIPAA	• Trauma informed care
• HCBS Eligibility, and Special needs populations to include Children and Youth with Special Healthcare Needs and EPSDT	• Documentation requirements including Service Coordination auditing tools, processes and requirements
• Self-direction and EVV	• Recovery, resiliency and permanency planning
• Employment Assistance, Work and Supported Employment	• MCO Service Coordination versus Community Service Coordination roles and responsibilities

Learning Management System. We also use Cornerstone, a corporate wide learning management system complete with online courses, for ongoing and ad-hoc training. On an ongoing basis, through Cornerstone, our Trainers will develop and deploy continuing education modules addressing topics such as cultural competency, social determinants of health and independence, Sunflower's quality improvement programs and initiatives, new requirements, and a variety of other topics. The management team will require ongoing training sessions regarding department wide emerging issues, trends, and program requirement changes in advance of their implementation. Cornerstone will issue department notifications of upcoming training to all staff, and provide management with electronic notices to confirm which staff required to participate have in fact participated in the training within the timeframe indicated, along with the results of any related content mastery testing.

On-Demand Training. The Cornerstone tutorials provide on-demand, anytime learning, at a pace set by each individual. The Cornerstone technology is flexible and intuitive and allows Sunflower to develop our own course content, incorporate videos from external sources, create flexible scheduling including parameters around frequency, duration, and our own required completion dates. In addition, courses may include a real-time assessment with guided corrections as well as post-tests to evaluate staff understanding of course content. The system provides a variety of management tools and individual employee files containing certificates of completion, all of which aid in maintaining current, individualized educational development plans for staff.

COMMUNITY SERVICE COORDINATORS- WORKFORCE DEVELOPMENT

As described above, Sunflower is committed to equipping providers and CSCs with trainings, tools, and resources through provider to provider consultations and Project ECHO. Through our national contract, Sunflower has access to the database of trainings and programs currently offered through Project ECHOs worldwide. Additionally, our Arizona affiliate will be the first managed care health plan in the country to host their own Project ECHO. We will apply Arizona's experience to develop similar Project ECHO programs, in collaboration with the University of Kansas for Telemedicine & Telehealth. For example, to support CSCs, we will create innovative curriculum and initiate Project ECHO trainings on subjects such as Community Supports, Employment Supports, State Policy requirements, Identification of the top 5 Health Conditions, etc. These trainings will supplement our proprietary Sunflower Service Coordinator

trainings that will be delivered throughout the community in person and through web-based training.

Process to Assess Training Effectiveness and Need for Additional Training (5.4.10.E)

Once training concludes, participants and staff complete a brief survey to rate training for overall satisfaction, efficacy, relevancy, and trainer ability. We also require staff and participants to complete quizzes and applied use tests. Service Coordination staff are also audited by managers to assess any gaps in training. Managers use results to determine effectiveness and identify improvement opportunities. Managers review performance evaluations and member satisfaction and complaint information to identify issues that may indicate strengths and weaknesses in training protocol or curricula. Managers schedule additional training, as needed, and continue monitoring via the methods above to determine effectiveness of new training. We also prepare pre- and post-training surveys to evaluate the effectiveness of training topics. Our Trainer evaluates industry best practices, State program modifications, and State administrative changes to continuously refresh our training curriculum.

Managers also audit a sample of SC and CSC case records monthly and quarterly to evaluate performance and identify trends that indicate the need to modify training. Inter Rater Reliability testing is done at time of training and on an annual basis. Internal service coordination audits are also reviewed with the staff to enhance training support and ensure appropriate adherence to policies and procedures, including coordination of benefits and services for dual eligible members. As part of our continuous quality improvement process, error reports and audit findings ensure any training gaps identified by user are addressed with the individual, and researched as modifications to current Training curriculum.

Monitoring Completion and Comprehension

We will test for competency and monitor for proficiency in professional's skills, effective use of tools, and appropriate customer service delivery before a new employee works independently in any role. For example, SCs "shadow" an experienced staff or supervisor, then take calls for one week under direct supervision and full-time monitoring. Supervisors monitor all new field staff, such as SCs and CHWs, as they conduct one-to-one meetings with participants. New hires must demonstrate mastery of all appropriate skills prior to working alone. If there are gaps in the knowledge transfer, the Supervisor retrains and coaches the new employee and schedules additional formal training sessions. We hold our delegated Community Service Coordination entities to the same requirements and our response to Section 5.4.6 and 5.4.7 describes our process for monitoring CSC staff competency and compliance with our requirements, including staff training.

In 2016, our field-based CHWs successfully assisted in the completion of more than 3,478 Assessments, providing 14,461 resources.

5.4.11 Special Needs Populations

CHILDREN IN FOSTER CARE (5.4.11.A)

Unparalleled Excellence Serving High-Needs Children

Sunflower and our parent company, Centene, offer extensive, unparalleled experience and capabilities in managing and coordinating PH, BH, and social services for high-needs children. Through successful implementation of our ISC model designed to support this population, we have a track-record of demonstrated improvement in outcomes and utilization across our health plan affiliates. As described in 5.4.1.E, Question 12 above, Centene is a national leader in serving high-needs children including children in foster care.

ISC Model for High-Needs Children. Member-centric care planning is a central feature of our Service Coordination model. While our ISC model, described throughout Section 5.4, is the same for all members, we use specialized tools, training, and expertise to ensure that the individual and unique needs of our high-needs children are met. Our team-based model is founded on the integration of medical and social factors, as well as functional and behavioral factors, starting with the assessment and stratification processes. Additionally, as discussed in Section 5.4.10, Sunflower is an active participant and is committed to the Community of Practice that is moving towards implementation of the Charting the LifeCourse Framework (LifeCourse), a person-centered approach that highlights and expands Person-Centered Thinking (PCT), into the Kansas system. For example, while claims data are used for predictive modeling and stratification, we recognize its limitations in "telling the story" of the member. Children without medical complexity are stratified to high-intensity services based on their social needs. The member's designated SC and CSC ensures coordination of appropriate care and services through engagement of an IC Team, identified by the member and/or child's caregiver. This process is also supported by our internal team of experts, including, for example, an employment specialist for a youth member set to age out of foster care and school. Our model also ensures compliance with the SOW that is unique to each special needs population. For example, for our children in foster care, we facilitate team meetings that consists of, at a minimum, our SC/CSC, the foster parent, the children's services case manager, and the BH treatment provider (if one), held via phone or in person within seven days of a new and/or change in placement. Other examples of how our model is adapted for this population include:

Assessment Tools and PCSP. A PCSP will be developed as a result of the HRA and needs assessments and Integrated Assessment (for Foster Care Youth) with direct input from the IC Team. We may augment these assessment tools with additional assessments, such as our specially-developed STARS assessment for Foster Care Youth, the CROPS tool assessing for trauma or the Ohio Scales for youth receiving mental health services. Once assessments are completed, the CSC/SC reviews the results and discusses assessed needs and conditions with the member/family so they are equipped to evaluate service options in a true wrap-around model of care. We help members to identify goals related to PH, BH, functional status, and quality of life, such as school attendance and vocational training. We connect members to appropriate community resources such as utility assistance, food pantries, domestic violence programs, and support groups, and will provide access to our Life Ally program which includes

our online searchable **Community Resource Database.** Through our Community Resource Database, all members of the Integrated Care Team including member's family will be able to search, identify, and access local social services that best fit their need. The PCSP will include all EPSDT services and any specialty PH or BH services or supports required.

Coordinating Care within a Fragmented System. The child-serving environment may include pediatricians and pediatric specialists, but it extends beyond those provider types to include state agencies like Department for Children and Families (DCF), KDADS, Keys for Networking, lead foster care agencies, DME and IE assistive technology providers, school-based care and early intervention, juvenile justice, courts, and informal health systems such as recreational and social supports including scouts and clubs. The difficulties encountered by families are exacerbated by the fact that these systems are siloed and rarely communicate.

Foster Care Center of Excellence (COE)

Our Foster Care COE is built on the premise that a clinical network alone is not sufficient to help a child who has grown up or been thrust into the child welfare system. We focus on the whole child and bring our skills in trauma-informed care, care coordination and integration to address PH, BH and social factors, which leads to improved care and outcomes. Sunflower incorporates training and principles of trauma-informed care in our work and will provide training to our provider network and community stakeholders.

Sunflower in Action…

D is 19-year-old with IDD, who has aged out of foster care and is now living in a supportive group home. His is diagnosed with autism, Disruptive Mood Dysregulation Disorder--recurrent with psychosis and Post Traumatic Stress Disorder. He came into DCF custody in June 2012 due to physical and emotional abuse from his father. He became a Sunflower member in March 2014.

He had 6 acute IP stays in 2014-2015. Following his discharge from the PRTF, D was placed at Youthville in Dodge City. Youthville and the CMHC worked closely together to manage the member's SI and self-harm. Through the collaborative work of CDDO, TCM, St. Francis, Youthville, CMHC and Sunflower FC team and IDD team, the member was approved for the IDD waiver and crisis funding, adult residential and day services, and was appointed a guardian.

Foster Care Roles (5.4.11.A1, 5.4.11.A2)

Recognizing the unique needs of children in Foster Care, Sunflower created a Foster Care COE designated to support this population. Staff on this team have experience working with children and families in Foster Care in addition to their clinical expertise. Individuals in need of Service Coordination are assigned based on the child's primary needs; however, the larger team is available to provide support and expertise which ensures all needs are addressed. Sunflower's **Foster Care team** consists of the following:

- A centralized, dedicated team of BH clinical staff:
  - 2 Service Managers dedicated to providing integrated care management services
  - A Service Coordinator dedicated to identify and locate needed resources for members and discharge planner for new in-patient stays

- A Utilization Manager dedicated to reviewing PRTF requests for admission and ongoing treatment for children in Foster Care
- A Discharge Planner dedicated to coordinating services for children in Foster Care who are discharging from a PRTF

- Twelve regionalized SCs across the state
- Experts in Intellectual and Developmental Disabilities (I/DD) to better serve children with I/DD. Referrals can be made to assist in discharge planning, Quality of Life Assessments, as well as support from a Crisis-Telephonic based program for members that are in need.
- Sunflower has on staff a **Foster Care Liaison**, who has specialty outpatient and youth residential treatment setting experience, expertise, and key relationships with KDADS, KDHE, St. Francis, KVC and a range of community social service providers that serve children, adolescent, and transitioning aged youth. Our Foster Care Liaison ensures that children and youth have access to and are receiving the most appropriate, least restrictive, community-based, and member-centric care.

The Foster Care Team meets monthly to address any ongoing training needs or changes to work processes. Additionally, Sunflower hosts an annual Foster Care Summit in which Foster Care team members from across the state come together for clinical training and to learn about the goals of the Foster Care Program for the upcoming year. The team also takes advantage of monthly web-based clinical training offered through our national Foster Care training team that offers CEU's.

Sunflower will support our CSCs by assisting in locating in network providers, scheduling appointments, obtaining expedited appointments if needed. Essentially, Sunflower staff focuses on overseeing and supporting the member's assigned CSC in getting healthcare needs met for the child while the CSC focuses on safety, placement, permanency, and other social factors, working together to ensure no duplication.

Timeline for Initiation for Foster Care Youth. For Foster Care Youth who have entered custody or who have had a placement change, upon notification, our SC will contact the member/family and assign a CSC. We will conduct a face-to-face visit with member and family within 48 hours to initiate care planning. For any member who is already in foster care at the time of enrollment, we will review the referral documentation and any accompanying information and initiate contact with the member's CSC.

Continuity of Care (5.4.11.A.3, 5.4.11.A.4). Continuity of Care (COC) is the key to a seamless and smooth transition for members entering in or out of care. Our COC program assures a smooth transition and timely access to holistic care services through strategic onboarding processes, augmented by additional staffing as necessary to field temporary spikes in call volume and completion of timely Health Screenings and HRAs. Policies in place prevent disruption in care for members receiving services prior to enrollment with Sunflower. Our

overall strategy for coordinating continuity of care and timely access, regardless of reason, incorporates the following:

- Identification of new members via the 834 file
- Analysis of care management data provided by KDHE, DCF, previous plan, HCBS Waiver provider and any other available data sources to identify ongoing treatment needs
- Timely assessment of all new members' health care needs via a comprehensive Initial Health Screening; members identified, through the screening, as appropriate for service coordination interventions or programs, or who request this support, are immediately referred to the IC Team for additional assessment and support.
- Ensuring existing authorizations with prior plan and/or KDHE are honored during transition, as identified through electronic authorization files, paper authorizations, or verbal request
- Active preservation of provider relationships through contract or Letter of Agreement (LOA)
- Allowing members in an active course of treatment to continue to receive services from a non-participating provider for a minimum of 90 days or until treatment can be safely transitioned or a contract secured
- Approving payment for the dispensing of a refill of an antipsychotic, antidepressant, or antiepileptic medications without regard to length of enrollment or examination by a network provider
- Identification of and notification to KDHE for Children and Youth with Special Health Care Needs (CYSHCN)

Coordination with Early Childhood Intervention programs such as Greenbush, the Interagency Coordinating Council, and other local educational authorities and special education cooperatives.

Facilitating Continuity through Placement Changes. We will establish a process with DCF, KVC and St. Francis to notify Sunflower when a child's placement will change. Our team will also ensure that the child's CSC remains consistent amidst multiple changes. The SC Team will provide information about the member's needs to assist KVC and St. Francis in securing an appropriate placement. For any placement change, the SC will work with the CSC to educate new foster parents and

Sunflower in Action…

SG is a 2-year old little girl with hydrocephalus.

In response to an email request from KDHE, Sunflower's CYSHCN staff collaborated with KDHE to engage the family and coordinate care for her. It took multiple unsuccessful outreach attempts before our SC could reach SG's mother. During SG's assessment, our SC learned that the mother had a hearing impairment and could not hear her phone. Shifting the communication method to secure email, our SC identified the mother's need for adaptive equipment to be able to care for SG, as well as SG's eligibility for TA Waiver benefits. Our PC collaborated with a regional care management nurse to perform a home visit and determine the need for referral. SG was referred for TA services and approved.

Sunflower's partnership with KDHE enabled our team to find the resources that SG's mother needed to be able to communicate successfully to advocate for her daughter. SG is still our member and is thriving.

caregivers on the child's needs and care plan, assist in locating providers, prevent potential duplication of services and disruptions in care. The SC Team will also work with any new providers to share assessment results, care plans, utilization, and other information. Sunflower's Provider Portal also offers a 360-degree view of each member's needs and care; the Provider Portal may be accessed 24/7 to provide information on past care, and help identify potential critical treatment issues that have to be addressed. For youth in foster care who also receive HCBS services, Sunflower takes responsibility for providing oversight in service coordination, in an effort to avoid service duplication.

Identifying authorized representatives for decision-making (5.4.11.A.2). All members of our Foster Care team, and our contracted CSCs in the future, receive regular training that covers appropriate release of informational authorizations and roles of legal guardians and the Lead Agencies specific to foster care. This information is also covered at Sunflower's annual Foster Care Summit, as described above.

Member and Provider Education on Transition Processes. Sunflower notifies members about the transition and continuity of care process through the New Member Welcome Call, Member Handbook, and interactions with our Service Coordination Team. Members prescribed non-formulary medications receive a letter advising them of our 90-day COC program for prescriptions and are provided preferred alternatives, if applicable. For providers, Sunflower offers initial and continuing education about our COC program to promote timely, accurate, and HIPAA-compliant submission or release of member information to Sunflower and other appropriate entities. We educate providers to submit information about services authorized by another plan, so that our UM Department can issue continued authorizations for those services for a period of at least 60 calendar days.

Support for Placement Changes (5.4.11.A5, 5.4.11.A6). Added support for foster care includes navigating community, regional, and state based child protective services, recognizing that child placements may change abruptly. Upon a new and/or change in placement, the SC makes a home visit within forty-eight hours, convenes interdisciplinary support team meetings to be held within seven days, arranges DME and supplies, and quickly connects children to new providers. We create a checklist for Foster Care SCs to ensure that all health needs were addressed during unanticipated placement changes, based on a best practice from our Texas affiliate. To support CSCs, our Service Coordination Portal will include foster care specific information, member/caregiver, Caseworker, and other stakeholder information and consumer friendly PH/BH information, as well as education and interactive assistance customized for each stakeholder (caregiver, Caseworker, etc.). We employ internet and tele-video training through our Foster Care EDU™, a comprehensive educational training initiative endorsed by the National Foster Care Parents Association that regularly provides "Conference to You" training and education. We will provide a dedicated Member Services team for our call center, specially trained to answer questions related to DCF issues and assist with navigation. Finally, SC/CSCs supported by our SDOHI Center of Excellence team and CHWs are a community presence designed to assist families in accessing housing services.

Permanency Goal and Approach. The road to wellness and permanency is different for every child in the foster care system. Our goals and approach for this population are fully described above in our response to 5.4.1.E, Question 12.

BH Training. Sunflower recognizes that every child in foster care has experienced some degree of trauma. Through on-line and in person options, we offer free BH training on a variety of topics to our internal employees and external partners across the state. We require our dedicated Foster Care Team to obtain 6 hours of Trauma training at least annually.

- **Internally:**
  - We provide trauma training on topics such as Trauma-Informed Care, Understanding the Adverse Childhood Experiences Study, Trauma Training for Child Welfare Professionals, Grief and Loss, and Supporting Children with Intellectual and Developmental Disabilities.
  - We also provide training in collaboration with the school system regarding Individual Education Plans (IEPs) and Individualized Family Service Plans (IFSPs).
- **Externally:**
  - We have provided 98 on-line trainings on topics such as; Fetal Alcohol Spectrum Disorder, Hope for Healing Series, Impact of Trauma, LGBYTQ Youth in Care, Working with Birth Parents and Placement Stability. Additionally, we plan to offer 25 more by the end of 2017.
  - Since Go Live we have provided in-person Trauma Focused Cognitive Behavioral Therapy (TF-CBT) training to a total of 248 partners in Wichita, Great Bend, Topeka and Emporia. TF-CBT is the evidence based practice recommended for the treatment of those who have experienced trauma.
  - Sunflower has engaged the two lead agencies (KVC and St. Francis) to offer training specific to the HCBS Programs in KS-with specific emphasis on the I/DD Waiver.

Transitioning Youth Program. Approximately 1000 youth age out in Kansas' foster care system (and about 28,000 in the US) each year. As part of our Transitioning Youth Program, 100% of those youth enrolled with Sunflower who are preparing to age out of Foster Care receive educational materials informing them about their ongoing benefit eligibility and community resources aimed to assist this population. Educational materials are sent to youth 6 months before their 18th birthday. In July 2017, Sunflower kicked off the Foster Care Transitioning Youth Program. The program is designed to identify those youth who are approaching their 18th birthday and need assistance/ support as they age out of Foster Care. Our goal is to improve outcomes for youth as they transition into adulthood by providing education about our health plan and the youth's benefits under Medicaid.

To augment existing efforts to prepare transitioning youth for adult life, we review each 17-year old member's transitional plan and assessment, and work with them to address barriers to successful transition. We will use the LifeCourse Framework to help transitioning youth think about what a good life looks like for them and how to get there. We also connect youth with

transition support services that address SDOHI, including housing, through partnerships and linkages with centers that serve transitioning youth, such as The Wichita Children's Home, Pathways, Circles USA, and Kansas Youth Empowerment Academy. We will provide workshops at these centers on healthcare education including the importance of preventive services, PCP visits, and how to access care. In alignment with the state's goals to provide services and supports to transitioning youth, we will engage with the DCF Independent Living Program to support programs around the state to improve outcomes for these youths.

We also address all PH and BH needs, maintaining or referring to Service Coordination as appropriate. For example, the risk for depression, anxiety, and lack of attention to PH needs put these youth at higher risk for negative outcomes once they leave the foster care system.

As a youth prepares to transition out of foster care, their assigned SC/CSC is responsible for ensuring that they understand any PH and/or BH diagnosis and current treatment protocols.

Proposed Performance Measures. The Enhancing Transitional Services Program proposed will measure relevant transitional metrics for foster care members preparing to transition out of the system.

CHILDREN WITH INTENSIVE BH NEEDS (5.4.11.B)

Like the child welfare population described above, we adopt and adapt our ISC model to children with intensive BH needs. For example:

High Fidelity Wrap-Around Approach

The Wrap-around Model builds on the strength of our system of care (self-determined, community anchored, culturally responsive, whole person), ISC model (person-centered, team-based, and strengths-based) and national expertise in trauma informed care. In "wrap-around," the goal is to serve youth more effectively in their communities and allow them to maintain their relationships with families, schools, and neighbors, which is core to our framework. We currently adhere to the National Wrap-around Implementation Center's (the Center) four key elements: 1) Grounded in Strengths Perspective 2) Driven by Underlying Needs 3) Supported by an Effective Team Process and 4) Determined by Families. All of these are carried out through our ISC model. We contract with the Center to provide train-the-trainer education to our staff so that we can in turn train other staff and CSCs with certified trainers. This is supplemented with our robust training curriculums, such as person-centered care planning. We will utilize the Center's best practice recommendations to monitor this programs effectiveness in conjunction with any performance measures recommended by the state.

Least Restrictive Environment

Sunflower ascribes to the recovery model that aims to treat members with BH conditions in the least restrictive environment to appropriately meet their needs. This philosophy is especially true for children, who risk being over-medicated and over-treated, creating a life-long "sick patient" identity that builds over time. Conversely, we are mindful of potential underutilization

and under-reporting of BH conditions. Our goal is to build standardized operational practices that help to support finding that delicate balance between over/under treating children with BH conditions, and ensure timely access to appropriate care.
We know that youth who live in institutional settings are at greater risk of developing physical, emotional, and behavioral problems that can lead to school failure, homelessness, unemployment, and incarceration. We believe in using the least restrictive environment to support any child's care, so our collaborations with DCF would explore placement alternatives to residential treatment centers that could be heavily reinforced with experienced community-based treatment providers and wraparound supports.

Transition Days

For high-risk children residing in a PRTF who are awaiting discharge but unable to go home, Sunflower allows for transition days, which cover days in the facility while the IC Team locate an appropriate placement with all necessary supports.

To support members' BH needs, Sunflower will offer Intensive Outpatient Therapy as an "in lieu of service".

Intensive Outpatient Program

Phoenix Connections is a structured group therapy program designed for adolescents, ages 12 through 17, who exhibit psychiatric symptoms and significant impairment in day-to-day educational, social, and interpersonal functioning. In Kansas, we saw that there were gaps in the continuum of care that supported children in the community rather than sending them to residential treatment or admitting to inpatient hospitalization. We also saw a need to step children down from those intensive levels of care and have a more supportive transition to the community. The program meets 4 days a week -Monday, Tuesday, Wednesday and Thursday from 4:00 pm - 7:00 pm.
Program Features and Family Services include:

- Multidisciplinary team approach
- Comprehensive assessment
- Medication management available or coordinated with referring Practitioner
- Individualized treatment plans addressing therapeutic needs
- Trauma specific focus
- Psycho-educational groups
- Multi-family group meetings
- Parent coaching support group
- Individual and family therapy (as needed

Outcomes for this program include: Measured performance prior to admission to IOP- Likert scale* 1 poor; 5 very successful:

- Average home performance, 1.3
- Average School performance, 3.3 (however 13 kids were not in IOP during their stay)
- Average prior community treatment performance, 1.6

- Average involvement in legal issues, 4.35

Measured performance 30 days post IOP-Likert scale:

- Average home performance, 3.0
- Average school performance,3.9
- Average Community treatment performance, 4.0
- Average involvement in legal issues, 4.7

Working with Lifeshare

Sunflower's ISC model is informed by our LifeShare program and their innovative "Pathways" approach, which is built on over 20 years of experience in over nine states including Kansas. Sunflower recognizes five "Pathways" (PH; Emotional & BH; Supporting Families & Self-Direction; Community Living; and Employment/Day Supports) as the pillars to our successful PCSP approach for persons with I/DD and/or TBI. Lifeshare has extensive experience in working with children with I/DD. They work closely with families, supported home care providers, and children's residential providers to find appropriate family-based settings for children transitioning out of institutional settings, and children who have repeated admissions to institutional settings.

Trauma Informed System

Our clinical experience in Kansas has provided us a framework to understand how trauma shapes and informs PH, BH, emotional, and social health and well-being for children throughout their lifespan. Children removed from their home and/or those that have been exposed to Adverse Childhood Experiences (ACEs), often experience trauma reactions in their everyday lives, evidencing the need for a trauma informed approach across the entire system.

Sunflower in Action…

DJ is a typical teenager who loves shooting hoops with his neighbors, playing games on a cell phone and has a passion for cars, particularly Ford Mustangs. His struggle with coping with his emotions eventually became unmanageable, resulting in multiple hospitalizations and stays at a Psychiatric Residential Treatment Facility (PRTF).

Our Behavioral Health Intensive Case Manager was assigned to DJ's case and provided ongoing support to DJ's mom including navigation of the IDD waiver eligibility process. During DJ's last hospitalization, our ICM also reached out to the LifeShare team for additional supports. ICM also advocated for the local Community Mental Health Center (CMHC) to reopen their case and reengage with DJ and his family.

Sunflower's circle of support enabled: mom to identify her needs to support DJ, DJ to share his preferred activities and the integrated team to identify appropriate services and supports. The collaborative efforts helped DJ access a variety of helpful resources, including speech therapy and Positive Behavior Supports.

DJ's mom now feels more confident that she can support DJ at home. This story is a work in progress, but with the supports in place, DJ is on his way to having the quality of life every kid deserves.

Symptoms of trauma commonly overlap with symptoms of MH leading to inappropriate diagnoses and treatment. Our approach focuses on the child member, the caregivers, and their entire system of care. We will continue to build on the foundation of Trauma Informed Care (TIC) principles and established research and practice around ACEs in Kansas to create a trauma informed system. All member-facing staff are trained in TIC. Training is also offered to providers, caregivers, and stakeholders across the state, for example, Juvenile Justice.

Screening and Assessment. Upon enrollment, we will screen high-needs children using the STARS, CROPS and/or Ohio Scales screening tools, identifying areas where experienced trauma may have a material impact on the child's current symptoms, functional levels, and resiliency. For BH issues or risks identified during assessment, the assigned SC will follow up, as appropriate, using the Ohio Scales MH assessment instrument and/or the Child Report of Post-traumatic Symptoms (CROPS) tool. Both CROPS and the Ohio Scales are built into TruCare.

Trauma Informed Care Plan. Developing the PCSP for high needs children requires trauma-informed, sensitive, and responsive relationships between all individuals in the member's life. An effective approach to identifying and responding to trauma can promote effective and appropriate interventions, reduce reliance on psychotropic medication, more effectively target treatment and prevent later adult mental health utilization.

TIC Toolkit. A TIC toolkit, leveraged from our affiliate partner, will be adapted for Sunflower and available to all contracted providers through the Provider Portal. The toolkit includes multiple nationally recognized standardized trauma assessment tools. The TIC toolkit includes a description and sample of each tool as well as further resources and information on implementing the assessment tools. It is a resource for providers to encourage the use and knowledge of the most prominent up-to-date recommendations from national entities such as the National Child Traumatic Stress Network. Providers will receive training on determining whether any further trauma assessment is needed during TIC training and have access to training resources through the provider section of our website.

Social Supports

Social factors are different for children than adults. They may include a broad array of natural supports such as extended family, school contacts and peers, sports teams, art clubs, and even pets. Individual social supports may be heavily influenced by family and cultural norms. Our team is trained in culturally responsive ISC. We are always cognizant that children are embedded in families - biological, foster, or adoptive - and we will address the child within their current and envisioned environments and consider the social factors impacting the entire family.

ADULTS WITH BH NEEDS (5.4.11.C)

Applying our ISC model and program to adults with BH needs, below is a description of specific contract requirements and special interventions and initiatives for this population.

Addressing Behavioral Health Crisis and Safety Needs (5.4.11.C1, 5.4.11.C2)

- Sunflower's Service Coordination approach hinges upon **person-centered, recovery and strengths based care planning** that addresses PH, BH, and functional needs, quality of life, crisis planning, and SDOHI.
- We **focus on the member** to identify their circle of support, which includes support systems and emergency contact(s).
- Our **Certified Peer Counselors** provide skills and information, using lived-experience, to engage members, help remove barriers, identify temporary resources, and prevent crises. Certified Peer Counselors deliver ongoing education on recovery and rehabilitation, including person-centered treatment planning, health and wellness education, self-help coaching, culturally responsive services, system navigation, and reducing social determinants barriers, e.g., unstable housing, under/unemployment, literacy and language and cultural obstacles. We will leverage peer support and recovery services as we link providers to meeting the needs of members in crisis and engaging members before crisis.
- We also have **a dedicated discharge planning team** comprised of Discharge Liaisons located at Wesley and Stormont Vail Hospitals; a staff member onsite at two CMHC's (Valeo and Family Guidance Center) as well as post discharge outreach staff (Nurses, Social Workers), and the CCR Nurse. This team plays a key role in addressing SDOHI to support member transitions back to a home or community setting. Our approach allows for the early identification of access barriers, timely condition-specific education, and the elimination of pre-authorization requirements for critical services. The SC/CSC conducts frequent monitoring to gauge the member's risk for re-admission, schedule follow up appointments, and to make any additional changes to the PoS/PCSP and crisis plan to address these risks.
- The PoS/PCSP is routinely reviewed during each contact with the member and updated with new signatures at least annually or more often if there are significant changes.
- **SUD Segmentation Model.** Described in detail in 5.4.5 above, our Centelligence platform allows us to appropriately identify interventions or prevention techniques that are tailored to the member based on the member's risk level, including our SUD segmentation profile. The overall segmentation program offers a measurement framework to aid identifying high opportunity interventions as well as a mechanism to measure intervention efficacy and population health improvement over time.

Referring Members to BH Services. Sunflower SCs are trained to appropriately screen and make referrals for BH. The SC works with the IC Team in a coordinated way to address the member's need, bringing in additional resources as needed, such as a BH clinician or pharmacist. Sunflower also holds regular interdisciplinary team rounds for certain members with high risk needs. Under the new model of Community Service Coordination, the Sunflower SC will support the CSC to access this integrated level support. The need for BH services is documented in the PoS/PCSP, along with related member goals, member preferred providers, and appropriate interventions and follow up, such as referral for assessment or service. SCs/CSCs are knowledgeable on our network of BH providers, and work with the member, PCP,

BH provider(s), and our UM department to ensure timely authorization as required. All services and referrals are determined using a recovery-oriented person-centered approach that follows the LifeCourse framework.

Facilitating Continuity of Care (COC) and Cost-Effective Use of Resources (5.4.11.C.3)

Education on Transition Processes. Sunflower notifies members about the transition and continuity of care process through the New Member Welcome Call, Member Handbook, and interactions with our IC Team. For providers, Sunflower offers initial and continuing education about our COC program to promote timely, accurate, and HIPAA-compliant submission or release of member information to Sunflower and other appropriate entities. This information is provided through initial orientation and in the Provider Manual. We educate providers to submit information about services authorized by another plan, so that our Prior Authorization Unit can issue continued authorizations for those services for a period of at least 30 calendar days. To further support these efforts, Sunflower has internal processes to support continuity, transitions, and cost-effective use of resources. For example, for providers not currently in our network as of a transition, we will invite the provider to contract or enter into a single case agreement for members in active treatment. We will also facilitate the sharing of medical records and release of information and train all SCs/CSCs on our COC processes.

Crisis Diversion. Sunflower recognizes that while a robust system of care is equipped with key recovery support services, early identification and screening along the care continuum with timely interventions and community linkages is key to diverting crises and care escalation. Sunflower will leverage practice transformation efforts to:

- Build capacity in Primary Care settings to perform universal and routine Behavioral Health screening using the PHQ-9, Columbia Suicide Risk Assessment, AUDIT-C, brief crisis intervention, stabilization as appropriate, ongoing monitoring and engage members in recovery based services
- Co-locating and/or financially incentivizing the use of peers in Primary Care settings to support self-management and Whole Person wellness initiatives including peer-led groups and classes
- Using IC Team, ensure members are accessing Whole Person services at the appropriate level given their acuity and needs to avoid service disruption and escalation of distress
- Help Primary Care and Specialty BH providers build registries to track members based on risk, and using the IC Team, provide ongoing outreach, screening and interventions to avoid crisis escalation
- Train Primary Care, Specialty BH and Allied Health (i.e. School -Based and Jail Health) around Zero Suicide, including crisis response planning and lethal means removal training
- Ensure that the IC Team has access to a comprehensive community resource referral source to support providers in connecting to the continuum of recovery-based services available in the region
- Partner with KDHE and other MCOs to develop standardized crisis diversion protocols and continuous improvement projects

- Support law enforcement initiatives in the Crisis Intervention Teams model by providing BH focused training
- Expand training on Mental Health First Aid training to social service providers along the care continuum, such as primary care providers and law enforcement
- Partner with KAMU, the Primary Care Association of Kansas, on the use of Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE) at community-based health centers.

Sharing Information (5.4.11.C.4, 5.4.11.C.5)

We will leverage our Centelligence® health information platform and Community Partner Portal to securely transmit member healthcare information to support care coordination and holistic member care. Our suite of web portals makes role-based, secure information available to our integrated team of providers at the point of care, and to members and authorized caregivers and agencies serving our members. The member's healthcare information is presented in a format consistent with State and Federal confidentiality requirements and as appropriate to each user in the member's integrated care team (the member, PCP, specialists, BH providers, care managers, and other appropriate parties [caregivers, family]).

The eight health systems where we have online access to EHR's provided care for over 45% of Sunflower's KanCare members in 2017.

Delivering Information Closer to the Point of Care. Providers, specialists, hospitals, State agencies and HIEs can interface with Centelligence data exchange capabilities. To further facilitate the sharing of clinical data to improve the quality, timeliness, and cost of care, Sunflower will work with our hospital partners to receive Admission, Discharge, Transfer (ADT) transactions. These transactions allow our IC Team to receive real-time notifications of critical health care events, such as ED visits, affecting our members and allowing our staff, to engage and address our members' priority health needs within one day instead of retrospectively based on claims. From a service coordination perspective, ADT transmissions better enable Sunflower to be automatically notified of a patient visit to the ED or admission to an inpatient facility. This enables SCs and CSCs to contact the member's PCP in a timely manner, enabling coordination between the PCP and hospital to determine and facilitate the appropriate level of care of the member.

Engaging Caregivers and Support Agencies. Engaging family, caregivers, case workers, and other authorized users (such as prisons, acute withdrawal management and sobering centers, homeless service Providers, and the PCP) is critical to a member's whole-person care. The IC Team collaborates with these individuals to enhance and develop a member's natural supports by connecting these formal and informal supports to our, community resources, caregiver education, and PoS/PCSP and crisis response plan development. Through collaboration with the member's support system, the IC Team promotes improved outcomes and decreases health care gaps.

Members Experiencing Housing Instability (5.4.11.C.6)

To have the greatest impact on health, approaches and investments must move outside of the traditional health care systems and target SDOHI—Sunflower recognizes that housing is an integral component to the system of care that affects the ability for an individual to live a successfully healthy life. As part of our SDOHI COE Team, we will designate a Sunflower Housing Specialist, to identify housing stock and supportive programs. The role of the Housing Specialist and an overview of Sunflower's current activities that support member access to safe and sustainable housing is provided under Section 5.4.1.E, Question 10 above.

Individuals in Institutional Settings (5.4.11.D)

Service Coordinator Assignment (5.4.11.D.1). Sunflower will assign a SC/CSC to all individuals residing in institutions, including NF, private or public ICF/IIDs, psychiatric residential treatment facility (PRTFs), and all individuals residing within a State correctional facility once the individual receives a Tier 1 Presumptive Medical Determination from KDHE. To support this scenario, we have a Criminal Justice Liaison to be assigned to judicial districts and work closely with the State to develop protocols for notification of individuals who receive a Tier 1 Presumptive Medical Determination. We also have four State Hospital Liaisons that are members of our SOC Liaison Team, two who are assigned to the State psychiatric hospitals and two assigned to the hospitals that serve individuals with I/DD.

Risk Stratification Levels and Methodology (5.4.11.D.2). Described under Section 5.4.5 above, our ISC model includes four levels of service coordination, supported by DM, discharge planning and transitions of care activities**.** Applying that model, which utilizes the HRA and additional risk stratification and predictive modeling technology, individuals in institutional settings would all fall into high risk, receiving Level 3 or Level 4 intensity of service and contact frequency. To ensure the appropriate level of service, we complete a re-assessment at least annually, or more often based on a change in the member's condition or status, or at the request of the member,

Sunflower in Action…

Sunflower began working with Richard in September 2014 due to multiple IP admissions related to his alcohol and drug use as well as mental health issues.

Richard was homeless at the time, cycling through recovery houses and motels because of continued substance use. Richard worked with our Service Coordination (SC) team, Comcare and MHA to receive BH outpatient and residential substance abuse treatment over the next year and a half.

Our SC Team collaborated with his BH and PCP providers to develop a Plan of Service that addressed his physical and BH needs.

Over the last 3 years, Richard's IP admissions were reduced significantly. In 2014, Richard had 11 admissions; in 2016 and 2017 he had zero admissions. He was approved for a NF in Independence, KS to help address his physical and mental health needs. After 6 months in the NF, he was discharged to his own apartment with OP support from the Four County Mental Health CMHC.

Richard continues to work with Four County Mental Health to address his BH and SUD needs and has maintained safe/stable housing since his discharge from the NF.

provider, or the member's legal guardian or legal representative. In addition, we use our near real-time analytics to monitor changes on a daily basis. Through these processes, members are reassigned to the most appropriate intervention tier, as they move through the continuum of severity (either up or down).

Frequency of Contact by Level of Service Coordination (5.4.11.D.3, 5.4.11.D.4). The level of service coordination is used to drive our service coordination activities. SCs, CSCs, DM Health Coaches, and CHWs communicate via phone or in person with members (and family/other supports) at a frequency based on risk level and the individual situation of the member to monitor provision of the authorized PoS/PCSP, and ensure services are meeting the member's needs. This includes providing education, and facilitating and encouraging adherence to recommended PoS/PCSP and/or treatment plans. Our levels and contact frequency are detailed above, under Section 5.4.5, ***Table 5.4.B_Frequency of Contact.*** At a minimum, our SC/CSC will participate in at least one meeting with the member, family, and facility staff, at the facility, annually.

Care Transitions (5.4.11.D.5, 5.4.11.D.6, 5.4.11.D.7, 5.4.11.D.8, 5.4.11.D.9). Sunflower's approach to transition of care between settings is holistic, culturally responsive, member-centered and involves all needed health and recovery services, including social and community supports. Transition of care planning from an institutional setting begins upon admission. At the time of admission, and prior to discharge, a member's transitional care plan includes the coordination of services with the member's support team which could include a PCP, Health Home, psychiatric and other treating specialists, social supports, the member, family/guardian, community based organizations, care managers, case workers and appropriate State agencies. We also coordinate transportation and community programs that assist with food, clothing, utilities, and housing to facilitate a smooth transition.

Sunflower's Transitions of Care Program (TCP). TCP emphasizing prevention, continuity of care and coordination of services, was developed based on principles established by Eric Coleman, MD, for all members in ICT, including those at-risk for readmission. The TCP identifies those members who are most at-risk for readmission, and deploys specific interventions to address the barriers known to contribute to readmission. The TCP provides dedicated staff and evidence based methods to identify and manage care transitions, including discharge planning and in-person follow-up for members with hospitalizations. To support these efforts, we will maintain written operational agreements with State and community medical and BH hospitals, allied services, residential treatment and long-term care facilities. As part of the program, the assigned SC/CSC meets with their assigned members in the hospital before discharge to establish rapport and visit members in the home or other setting within 48 hours of discharge.

Sunflower's Care Transition process is fully detailed in Section 5.4.12.

Least Restrictive Environment (5.4.11.D.5). As part of our ISC model, we ensure all members receive the right care, at the right time, and in their least restrictive setting of choice. Member choice is always an important factor, keeping in mind the member's safety and reasonable

access to necessary care are not compromised. Therefore, during each contact with the member the SC/CSC will assess if the member's residence is appropriate to meet their needs. If it is assessed that an alternative setting is more appropriate, an evaluation will be made to ascertain if member is able and/or willing to transition from one environment to another. SCs/CSCs will ask the member important open-ended questions to understand their transition interests (i.e., "Where do you want to live?" and "What was life like prior to living in this facility?"). Successful transition is possible only when members can see themselves elsewhere.

Building trust over time, while respecting their choice to call a facility their home, SCs/ CSCs will educate members and their loved ones about the member's right to receive care in the least restrictive setting. SCs/ CSCs will evaluate member's transition interest during face to-face assessments and will request referrals from providers. These evaluations will occur at least annually. Requests for evaluations may also come from the member or their legal guardian, KanCare, or other stakeholders for the member. SCs/ CSCs, if applicable, will also utilize any available transition data, inclusive of Minimum Data Set (MDS) data, to identify members who may be interested in transition. This data also documents member's risk factors to inform transition plans and backup planning. Facility-designated SCs/CSCs will build rapport with facility administrators, and partner with various programs to provide community integration opportunities for members considering transition.

Transition Planning (5.4.11.D.6, 5.4.11.D.7)

During the review process for member transition, the SC/CSC needs to ensure that the setting in which the member resides is "chosen by the individual" member and "is integrated in, and supports full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid." Alternative HCBS settings that were considered by the member are documented in the member's electronic health record by the SC, if applicable. When it has been determined that a member who is in an institutional setting is ready for transition to a new setting, the SC will support the member and member's family by coordinating arrangements to identify discharge and/or transition needs (i.e., safety, home modifications, etc.) request referrals to LTSS providers, and observe new placements.

The SC, member, and member's representative will facilitate person-centered service planning to support the member's transition to a community setting and create a **transition plan** that is inclusive of social, health, environmental, and other appropriate services and supports, both covered and non-covered. Elements of the transition plan include, but are not limited to:

- Community placement choices
- Potential home modifications (if rental, pre-approval of property owner/manager is required prior to home modifications)
- Home and Community-Based Services (HCBS) and providers related to member's Person-Centered Plan of Care
- Transportation needs

- Required budget and related costs for the recommended housing
- Medication management/support
- Obtaining medications
- Treating physician contacts: assist if need to change PCP or specialist and in timely appointment with PCP post transition

The transition plan will be incorporated into the member's PCSP and will include the member's goals and the full range of services and supports to meet the member's needs, including both covered and informal community services, identification of both paid and informal support caregivers, medications, all providers the member will utilize, identification of a backup plan and transition coordination supports provided through community providers such as CILs, AAAs, CDDOs, and other entities. Our community Transition Coordinator, part of our SDOHI COE Team, links the member to housing, household supplies, community resources, and provides in home risk assessment and transitional visits. SCs/CSCs will ensure all **necessary services and natural supports** (including backup plan supports), regardless of payer, are in place prior to transition.

Relocating to another facility (5.4.11.D.8). The SC/ CSC shall assist the member to relocate to another facility if they express a desire to move or the quality of the current facility places a member's health and welfare at risk. As part of the planning process, SCs/CSCs will ensure all the necessary supports are available for a successful transition.

Transitions from PRTFs. The SC/CSC begins discharge planning immediately upon admission of an individual to a psychiatric residential treatment facility (PRTF). The SC/CSC and the BH team monitor member progress throughout their stay until they are ready for discharge to their next setting. For youth who are admitted to PRTFs, our SC team (including our Transition of Care Coordinator) coordinates with the education system and appropriate schools to ensure continuity of developmentally-appropriate education. When appropriate, this may include coordination with Sunflower's LifeShare program. Within a few weeks of discharge, the SC/CSC will work with the school to help them be ready for the child to return. This may include recommendations for an IEP, 504 plan or whatever supports will be needed for the child to be successful in school.

Transitions from the Criminal Justice System (5.4.11.D.4, 5.4.11.D.6). We take a proactive approach to members transitioning to and from the criminal justice system. Community re-entry is a time of opportunity to engage these members. Strategies for supporting effective re-entry include assessment and identification of BH needs with follow up care and transition planning; in-reach programs where SCs provide care planning 30 days in advance of release, which includes at minimum, one Service Coordination meeting with the member and correctional facility staff prior to the member's discharge/release from a State correctional facility; SCs located in the jail setting; and assistance with re-instatement of suspended Medicaid benefits. These programs have been successfully implemented by our Arizona affiliate and in other states and we will leverage our community partnerships and existing programs and

resources to identify and support, where feasible, implementation of these programs in Kansas. For example, leveraging community programs such as Kansas Offender Risk Reduction and RE-entry (KOR3P) and Oxford House.

Post-Transition (5.4.11.D.9)

SCs/CSCs will follow-up with the member immediately after the transition, through a series of planned visits, and then as needed to monitor readmission risks and to identify and address issues. Our LTSS providers will have the ability to alert us of service gaps through an EVV system. Sunflower also will offer services such as tele-monitoring, our HomeLink pilot program, or in-home physician visits to monitor for new or changed needs.

If the member is transitioning to a home and community based setting, the SC/CSC will schedule onsite visits of the identified setting, for member visit, and evaluation of the setting to ensure compliance with the **CMS HCBS Setting Final Rule**. The evaluation should include, but not limited to:

- Access in and out of the residence and any necessary supports in the living quarters (i.e., ramps, stairs, grab bars, etc.)
- Blockages of entrances or accumulation of rubbish and combustibles
- Condition of the home environment, including cleanliness and structural deficits
- Insects, rodents, and other pests
- Loose rugs
- Member's ability to be mobile within the home
- Pets
- Presence of heating and air conditioning
- Plumbing and sanitation
- Safety of the community
- Smoke detectors

If the identified home is a rental that requires home modifications, contact with the homeowner to discuss the proposed modifications, determine if the owner is willing to make the modifications, and will agree to modifications. The SC/CSC contacts the member or responsible party to inform them of the decision of the homeowner and provides assistance to locate another appropriate setting, if needed.

INDIVIDUALS ENROLLED IN HCBS WAIVER AND WORK AND OTHER EMPLOYMENT PROGRAMS (5.4.11.E)

Notice for Adverse Benefit Determination (5.4.11.E.1)

Sunflower provides a notice of action to members in HCBS services and their provider regarding any adverse benefit determination. We report our timeliness of notification during our NCQA reviews and the results for the 2016 period demonstrated an 85% or above for notification to members of any actions taken by the Sunflower Team. The notice of adverse benefit determination letter is approved by KDHE and includes information about the member's ability to appeal Sunflower's determination. Our notice of adverse benefit determination and the timeframe within which we send it, complies with the requirements of our current contract

Attachment D, and will comply with the future contract. Our SCs are trained on these requirements and on the requirement of annually education our members in HCBS about our appeals and grievances process. We document this education with the member. Sunflower will provide training to its CSCs on this process and monitor their compliance as part of our overall quality monitoring process.

Supporting Full Access to the Greater Community (5.4.11.E.2)

Sunflower has provided training to our Service Coordination team on Person Centered Thinking and Motivational Interviewing with the goal of utilizing these strategies to support members in facilitating the development of their plans and driving the action steps. We train our SCs to encourage members to choose the most integrated setting with persons they want to live with, competitive employment as a first option, and full participation in community activities which they enjoy or want to learn. In the future, we will train our CSCs and our SCs on the LifeCourse Framework to compliment the Person-Centered Planning Process, to assist the member with using community-based supports first, and with identifying the most integrated service options.

Voluntary/ Involuntary Closure for HCBS Waiver Services (5.4.11.E.3)

Sunflower follows the State's Policy on Voluntary and Involuntary Termination and our contract. Sunflower SCs currently have access to both claims information and EVV which indicate whether a member is utilizing his/her HCBS services. In addition, Sunflower runs a quarterly report showing which members in HCBS have not used a service for 30 or more days. Using this information, the SC first contacts the member to determine why services are not being utilized. If the member needs services, self-directs, and cannot find caregivers, the SC connects the member with his/her Financial Management Services provider and our Member Advocate to help with a plan to find caregivers, and will offer the option of choosing a community agency to provide the services. If the member is requesting to terminate HCBS services, no longer has a service need, or is otherwise no longer eligible for HCBS, the SC submits a 3161 form recommending closure of HCBS eligibility and sends a Notice of Action to the member and providers. If the member refuses to pay his/her client obligation, the SC works with the agency assigned to the obligation to implement the process that is outlined within the provider agreement with the member, to obtain the obligation. If the member continues to refuse, the SC works with the State Program Manager to determine if eligibility should be terminated. Sunflower utilizes the steps outlined within our contract, Attachment G, to follow the process for members who cannot be located and to communicate this information to the State Program Manager. Sunflower has a policy and work process regarding member signature on the PCSP, PoS, and WORK Individualized Budget and will follow the State's policy (to be developed) on this requirement. Sunflower will provide training to and monitoring of our CSCs regarding these processes and the related requirements. Any time a member's HCBS and/or LTSS services are reduced or terminated, voluntary or involuntary, Sunflower sends the required Notice of Action to the member and providers with information about how to appeal the action.

Termination for the Inability to Contact an LTSS Member (5.4.11.E.4)

We will follow the process listed above in Section 5.4.11.E.3 for LTSS members who are unable to be contacted. Sunflower will ensure that our SCs and CSCs are trained in the above and below to follow these processes accordingly.

- We shall make three attempts to contact the member, including a minimum of one (1) home visit.
- All contacts shall be attempted within fourteen (14) business days from the date of the initial attempt to contact the member. If unsuccessful, we will notify the KanCare Ombudsman and request assistance.
- If all attempts to contact the member by Sunflower or KanCare Ombudsman prove unsuccessful, we will notify the appropriate State agency using the established notification process as described by the State.
- Sunflower is aware that the State agency may intervene to attempt contact with the member, and all Sunflower recommendations must be approved by the State to issue a Notice of Action providing the member 10 days' notice of the impending closure.
- We will mail the Notice of Action to the member's last known address.
- Sunflower will provide the State with the appropriate notice recommendation to close the services and supports for the member.

Liquidated Damages for Failure to Notify the State of HCBS Waiver Services Closure (5.4.11.E.5)

Sunflower understands that our failure to notify the State within State-defined time requirements about the need for closure of HCBS Waiver services, may result in liquidated damages leveraged against our company.

COMPLIANCE WITH SECTION 5.4.11 REQUIREMENTS (5.4.11.F)

Sunflower has monitoring and audit processes for making sure that our current SCs comply with the processes as described in Section 5.4.11, and will employ these monitoring and audit processes with our CSCs. We have a layered system of audits which include audits by Managers, corporate auditors and State HCBS waiver audits. As described in more detail above in Section 5.4.6 and 5.4.7, we have oversight policies and processes in place to monitor and audit our CSCs.

FOLLOW-UP FOR SUSPICION OF MEMBER ABUSE, NEGLECT OR EXPLOITATION (5.4.11.G)

Sunflower provides initial and ongoing training to our SCs on the responsibility of reporting suspected Abuse, Neglect or Exploitation (ANE) and to which entities to report. We also have worked in collaboration with DCF and the KDADS quality staff to remediate situations of potential or confirmed ANE. We educate our members at least annually on the process for reporting ANE and put the contact information on their PoS and/or PCSP. Sunflower will provide this training to our CSCs and provide monitoring of their compliance with reporting requirements. Further detail about our policies and procedures regarding member fraud and abuse is located in Section 5.12.2.

5.4.12. CARE TRANSITIONS AND DIVERSION ACTIVITIES

SUNFLOWER'S EVIDENCE-BASED TRANSITION OF CARE MODEL

Sunflower emphasizes prevention, continuity of care, and coordination of services for all members transitioning from one setting to another. We have adopted evidence-based and emerging best practices for care transitions using Care Transition interventions developed by Dr. Eric Coleman, the Transitional Care Model developed at the University of Pennsylvania, and the vision and recommendations of the National Transitions of Care Coalition. These best practices incorporate onsite clinical resources, member and provider engagement and education, coordination of care and services, and promotion of self-management skills. Our Transition of Care (TOC) model, inclusive of care transition and diversion activities, also considers SDOHI in evaluating risk and identifying services needed to comprehensively address well-being, prevent unplanned or unnecessary readmission, ED visits and adverse health outcomes. Our approach to managing transitions involves a whole person approach designed to meet each individual member's PH, BH and LTSS needs in the least restrictive setting possible.

Management of Transitions of Care Between Settings (5.4.12.A and 5.4.12.B)

Transitions Between Health Care Settings. Our Service Coordination Model supports members transitioning from one care setting to another with a goal of assuring the member receives needed supports to live in the most integrated community setting possible. Sunflower's transition-oriented care coordination is designed to minimize issues that can occur during transitions, such as declining health, hospital admission or readmission, transcription errors, medication errors and missed follow up appointments. To ensure appropriate care transitions between acute, psychiatric, hospital, Nursing Facilities (NFs), Assisted Living Facilities (ALFs) and home and community residential settings; movement from one HCBS waiver program to another HCBS waiver program, and member movement into foster care placement or from one foster care placement to another, we employ our evidence-based transition of care protocols that includes the following key processes and activities:

- Establish a single point of contact for the member's transition activities, which may be the member's assigned Sunflower SC, CSC or Sunflower Transitional Care Coordinator (TCC)
- Notify member's providers, including the member's PCP and IC Team of the transfer and/or transition and involve them in assessment and planning
- Assess current and post-transition needs and goals and update the member's PCSP or PoS in collaboration with the member, the member's PCP and chosen circle of support
- Evaluate the member's need for LTSS taking into consideration the needs and preferences of the member and make appropriate referrals for HCBS Waiver eligibility determination and/or NF placement, as appropriate
- Communicate regularly and coordinate with the member, the member's IC Team, discharge planners and providers, as appropriate
- Assess and evaluate risk of hospital admission to guide the necessary intensity and urgency of follow up care post discharge. Our predictive modeling tools provide a member's risk

score for readmission and also other predictive factors such as behavioral health risk score which may impact a member's readmission.

- Develop a transition plan addressing PH, BH, LTSS, SDOHI, and other needs with the IC Team and the member's SC/CSC, as appropriate. This may include obtaining a copy of an existing discharge/transition plan or developing and/or assisting with the development of a discharge/transition plan and integrating into the member's overall PCSP or PoS.
- Provide discharge planning services that includes making arrangements and authorizing services for a safe discharge placement and ensuing adequate and necessary services and supports are in place such as housing, LTSS, DME, home health services and BH services, as needed
- Authorize Transition Coordination Services, as appropriate, to assist with locating affordable housing, household supplies, finding potential caregivers for persons who want to self-direct, in-home risk assessment, and follow up visits to insure services are provided and are sufficient to meet the individual's needs.
- Authorize and/or arrange for post-transfer services; facilitate authorizations, appointments and transportation and secure necessary equipment or supplies
- Educate the member/caregiver on needed post-transition care and follow up, including education on early symptom recognition to avoid admissions
- Conduct medication reconciliation and address medication needs

Of the of the 206 Sunflower members that have been part of the WORK program since 2013, we have successfully assisted 57 members (28%) transfer to WORK from other HCBS waivers while they were members of Sunflower.

Our approach considers needs related to barriers and the member's social context on par with clinical needs, and we provide intensive support after discharge for those at high risk for readmission. For example, prior to discharge, the SC/CSC will assist with referrals and scheduling post-transition visits or services, such as the 7-day follow-up appointment post discharge from a BH admission. For members identified as moderate or high risk for readmission, the SC/CSC will contact the member within two business days after discharge to confirm appointments and transportation and that in-home services are in place and meeting the needs, as indicated. Unique to our model, our Service Coordination team can directly schedule appointments through Appointment Wizard™, our on-line appointment scheduling system.

Transition of care interventions are designed to support members during especially vulnerable times. Post discharge interventions generally last 30 days, and are followed up by continued SC visits every other month when a person is in Level IV SC, to ensure the member understands signs and symptoms to monitor; keeps a follow up appointment; understands any changes in medications, develops a personal health record to have available to all providers and has a willing and able caregiver if necessary. Transitions that involve foster care children transitioning from youth to adulthood or transitions that involve members transitioning from pediatric providers and agencies include more intensive supports to assure non-disruption of services

and that the medical records are appropriately transferred to the receiving providers or agencies. Described in Section 5.4.11 is additional information on foster care transitions.

Sunflower in Action…

A member was admitted to the hospital due to bed bug bites and the loss of her skin when her clothing was removed. The member's PCP would not discharge her to return home until extermination for the bed bugs occurred. Admission to a NF was imminent as the member had no resources to provide the necessary extermination services. Sunflower, after consulting with Protective Services, local charities, the member's PCP, approved a plan to provide the extermination with "in lieu of" funds. The member's Case Manager also coordinated with a newly established guardian and the member's landlord to ensure the clothes dryer was functioning to help with preventative measures in the future. After the extermination, the member was able to return safely home instead of being discharged to a NF.

Transition from One Waiver To Another. Sunflower has a work process for transitions of a member from one waiver to a different waiver, in compliance with state eligibility processes. Sunflower SCs are trained to identify when a member may be aging out of one HCBS program and be eligible for a different program, or may be eligible for and have needs that are better addressed by a different HCBS program. Sunflower SCs are also trained on which waiver transitions allow members to move seamlessly, and which may require being on a waiting list. The member's SC links the member to the appropriate eligibility entity for eligibility determination and options counseling. If the transition is occurring, the SC completes the health risk and needs assessments to determine the services needed, and creates a Person-Centered transition plan for the member. The SC also notifies the state program manager utilizing the 3161 processes, so that the program manager may confirm eligibility and transition to a new waiver. In the future, our CSCs will be trained on this process and any changes that may be made related to State policy and processes.

Transition and Discharge Planning Activities (5.4.12.C)

Our successes in improving transitions across health care settings is supported by an interdisciplinary Care Team approach and includes early discharge planning and direct member outreach post-discharge to ensure effective coordination of care. Sunflower will ensure a designated point of contact leads the discharge planning process for our members. For members currently in Service Coordination, this will be their assigned SC/CSC. For all other members, this will be a newly assigned SC/CSC or a Sunflower TCC. In all instances, there is one trained and experienced staff person that is accountable for ensuring all needs and contract requirements are met (per Section 5.4.12.C of the SOW), including timely PCP notification, coordination with hospital staff and providers, timely and appropriate outreach and follow up after discharge, and documentation in TruCare.

Since KanCare program inception, Sunflower has successfully reduced ED visits from 772 ED visits/1000 to 748 ED visits/1000 in 2017.

Supporting these dedicated staff are Sunflower Concurrent Review Nurses, Program Coordinators and CHWs. As part of the discharge

planning process, we will work with the SC/CSC, member, representative, and circle of support to understand the root cause for admission and address previous challenges to ensure a successful discharge. To support timely interventions and to prevent unnecessary readmissions, our team utilizes and has access to an Inpatient Daily Census report that identifies members in the hospital as well as the use of a **Potentially Preventable Readmission (PPR) score** for members. The PPR score updates daily as the member's status changes. We also utilize our Potentially Preventable Event (PPE) Analytics tools. Our Centelligence® platform features Clinical Related Group (CRG) software to allow us to analyze claims data, including IP utilization, and identification of Potentially Preventable Events (e.g., ED visits, Admissions). We have the capability to post PPE flags for providers who view a members' health record on the Provider Portal. This capability will inform providers to a member who has undergone treatment that was potentially preventable, including potentially preventable hospital admissions and re-admissions.

We also have a dedicated discharge planning team comprised of CHWs located at Wesley and Stormont Vail Hospitals; a staff member onsite at two CMHC's (Valeo and Family Guidance Center) as well as post discharge outreach staff (Nurses, Social Workers), and the CCR Nurse. This team works together to conduct the initial outreaches, coordinate with any assigned SC/CSC, or make the appropriate referral to a SC/CSC. This team also assists with discharge planning and plays a key role in addressing SDOHI, such as housing, food, utilities and transportation to support member transitions back to a home or community setting, or least restrictive setting possible.

Our established protocols listed below in ***Table 5.4.12.A_Established Discharge Planning Protocols*** will ensure the following are completed as part of the process.

Table 5.4.12.A_Established Discharge Planning Protocols

Established Discharge Planning Protocols
Communication with SC/CSC to ensure s/he is aware of the member's admission and to understand any potential factors that led to admission.
Communication with attending providers, the member's PCP, treating BH providers, and other outpatient providers to understand conditions and communicate learned information to the entire Care Team through TruCare platform documentation.
An assessment, in the hospital, to understand the change in medical and/or functional status that influenced the member's hospital admission (e.g., loss in informal caregiver support).
Communication with members, representatives, and/or circles of support to ensure they understand why the member was admitted and discuss the member's condition and early symptom recognition.
A comprehensive transition/discharge plan which is driven by a multitude of factors linked to members' health, social, and environmental characteristics that drive hospital admissions.
Addressing medication needs, including education on medications, ensuring the member and all relevant stakeholders understand possible interactions and side effects and to allow providers to reconcile medications and make informed decisions about care.
Conducting follow up with the member and the member's provider within 48 hours of discharge to ensure all necessary post discharge services have been provided and follow up appointments have been scheduled.
Coordination with the SC/CSC to appropriately communicate with community agencies, LTSS and BH providers to ensure a seamless transition of care, including ensuring access to needed BH services, personal care services and transportation to medical appointments.

Our approach allows for the early identification of access barriers (e.g., transportation to appointments, need for home modifications, caregiver stress, etc.), timely condition-specific education, and the elimination of pre-authorization requirements for critical services. Members also receive **discharge planning toolkits** (shown in ***Figure 5.4.12.B_Discharge Planning Toolkit***) with information on their transition back to the community and the importance of the outpatient follow up. The SC/CSC/TCC, upon member discharge, will ensure post discharge services have been received and or initiated (e.g., access to required durable medical equipment and specialty equipment). **The SC/CSC/TCC within 48 hours of discharge, will follow up with the member's provider and the member** through a home visit to conduct a reassessment, and telehealth visit or phone conversation, as appropriate to ensure post-discharge activities and services are appropriate and make modifications to the PoS, PCSP and emergency back-up plan, as necessary. The SC/CSC/TCC conducts frequent monitoring to gauge the member's risk for re-admission and to make any additional changes to the PoS and PCSP to address these risks.

Figure 5.4.12.B_Discharge Planning

MEMBER GUIDE

Taking Care of Yourself After Your Hospital Visit

sunflower health plan

Coordination with Inpatient Facility and Initiation of Discharge Planning Protocols (5.4.12.D)
Sunflower has systems and processes in place with all inpatient facilities in the state to ensure prompt notification of inpatient admission and discharge planning occurs for the member. Upon notification, we will employ the above described steps and discharge protocols. In all instances, there is one trained and experienced staff person that is accountable for ensuring all needs and contract requirements are met (per Section 5.4.12.C of the SOW), including timely PCP notification, coordination with hospital staff and providers, timely and appropriate outreach and follow up after discharge, and documentation in TruCare, our integrated care management and service coordination platform.

TRANSITIONS FROM NFS TO THE COMMUNITY- SUNFLOWER'S TRANSITION CENTER OF EXCELLENCE MODEL

Sunflower has successfully transitioned over 513 members from a NF to a home or community setting from 2015 to 2017.

Sunflower and our parent company, Centene, is a leader in institution-to-community transitions. Using our Centers of Excellence (COE) model, KanCare has **successfully transitioned over 513 members since 2014**. Sunflower's affiliates have also successfully transitioned nearly 8,000 members from a NF to the community since 2015 (inclusive of Kansas experience). Based on our success in Kansas, Sunflower will continue to deploy its Transition 'Center of Excellence' (COE) model as part of our broader Social Determinants of Health and Independence

(SDOHI) COE Program for KanCare 2.0 to support the State's goals for community integration and member independence.

Identification

SCs/CSCs will educate members on their right to be served in the least restrictive setting during orientation, when members are considering NF care, when a member enters a NF, and regularly during a NF stay. SCs/CSCs will ask members residing in NFs, during assessment and ongoing during routine in-person meetings, if they choose to transition. With the use of Minimum Data Set (MDS) data, our Centelligence™ Transitions predictive analytics also will identify members in NFs who may be prepared to transition. Centelligence® Transition Analytics is a predictive analytic technology that systematically identifies members in NFs who are likely to be successful in community settings, should they choose to move. Centelligence Transition Analytics identifies members in NFs who are at high risk for admission/re-admission to an acute care hospital or a NF, supporting SCs and in the future CSCs as they work with the member on his/her Person-Centered Service Plan during a transition. Centelligence Transition Analytics uses MDS data, along with other key information, to determine these opportunities and risks. Sunflower will use this technology for our LTSS population, to ensure members receive the right level of support as they transition between settings, and promote longevity in the community. The analytics will be completed in 2018 to leverage KS MDS data and then the output will be built into the TruCare CareLink tool. In addition, we will continue to seek referrals from NF staff and families and train our Sunflower providers and community partners on how to promote use of least restrictive settings.

With the use of Minimum Data Set (MDS) data, our Centelligence™ Transitions predictive analytics also will identify members in NFs who may be prepared to transition.

Pre-Transition. Sunflower uses the HRA, functional needs assessment and supplemental transition tools (including the Centelligence™ Transitions predictive analytics scoring in the CareLink dashboard) to evaluate needs of those interested in transition. We use open-ended questions (i.e., where do you want to live?) to encourage members' thinking about community living. SCs/CSCs will facilitate Person-Centered Service Planning with members and caregivers to identify pre-transition services and post-transition needs. The SC/CSC also will involve providers and the member's chosen support team in transition planning. The PCSP will include the member's goals and the full range of services and supports to meet the member's needs, including both covered and informal community Services, identification of both paid and informal support caregivers, medications, all providers the member will utilize, identification of a backup plan and transition coordination supports provided through community providers such as CILs, AAAs, CDDOs, and other entities. Our community Transition Coordination providers link the member to housing, household supplies, community resources, and provide in home risk assessment and transitional visits. SCs/CSCs will ensure all necessary services and natural supports (including backup plan supports), regardless of payer, are in place prior to transition.

Follow-Up. SCs/CSCs will follow-up with the member immediately after the transition, through a series of planned visits, and then as needed to monitor readmission risks and to identify and address issues. Our LTSS providers will have the ability to alert us of service gaps through an EVV system. Sunflower also will offer services such as tele-monitoring, our HomeLink pilot program, or in-home physician visits to monitor for new or changed needs.

Community Partnerships to Support Transitions

Sunflower is partnering with two providers, Topeka Independent Living and Resource Center and MindsMatter, to provide transition coordination services for persons moving out of nursing facility or other institutional level of care to the community. The services include finding housing and household items, locating providers, assisting with the setup of self-direction (when chosen), in home risk assessment, identification of community and natural supports, and initial visits to confirm services have started, any DME is delivered and working, and initial medical appointments are kept. The two providers are paid a rate upon referral, one upon placement of the member into a community-based setting, and an additional payment if the member remains living successfully in the community for at least 30 consecutive days without readmission to a NF or admission for inpatient treatment. We intend to continue this partnership under KanCare 2.0 as described in more detail in Section 5.7.

Sunflower is partnering with two providers, Topeka Independent Living and Resource Center and MindsMatter, to provide transition coordination services for persons moving out of nursing facility or other institutional level of care to the community.

Member Access to Services and Continuity of Care (5.4.12.E and 5.4.12.F)

We are committed to ensuring non-disruption of services and continuity of care for members that are transitioning from another KanCare MCO or from FFS. We will honor existing services approved prior to the member's effective date with us for up to 90 days, or until we complete a concurrent clinical review for medical or BH services and functional assessment for LTSS. For example, we will authorize visits to a non-participating provider due to an ongoing treatment plan or for care already approved by the member's previous MCO or FFS. We also will ensure continuity of medications, such as for insulin, seizure medications, BH medications, and covered drugs that are not on the Sunflower formulary. For pregnant members past the first trimester, we will authorize services with the current OON OB/GYN through delivery and postpartum care. For persons in LTSS, we will authorize the existing services and units and complete our HRA, needs assessment and PCSP within 30 days to ensure continuity of services.

With appropriate member consent, Service Coordination or Utilization Management staff will contact the relinquishing entity and/or treating provider(s) to obtain current authorizations and related information. We will authorize existing services a new member is receiving, regardless of their provider's network status, as described above. We will then determine necessity of continuing OON services, and either authorize continued OON services or work with the member, family, existing provider, and other treating providers to develop a plan for safe transition to a network Provider as appropriate. Our SC and UM Team and the CSCs will

work with the member to obtain copies of the member's medical records, as appropriate, in a manner that is compliant with Federal and State laws.

Transfers between MCOs and from Sunflower (5.4.12.G)

Sunflower's approach to ensuring continuity during transitions includes the use of data sources to proactively identify members who may need assistance with their transition into Sunflower from another MCO or the FFS system. Our Centelligence® health informatics platform integrates these data sources and applies state of the art analytics to identify members who are or may be receiving services that need to be continued during a transition. It also identifies those with potential risk factors who may require individualized assistance to ensure continuity and coordination of care through a transition. This systematic approach ensures our ability to outreach to providers, authorize services, and provide coordination and other support in a timely manner during transitions.

For both new and departing members, we designate a single point of contact and provide contact information to the member to facilitate a smooth transition and non-disruption of services. We also provide a single point of contact with other MCOs to obtain or provide the necessary information to insure continuity of care.

Components of our approach to continuity and coordination during transitions between Sunflower and other MCOs and among delivery systems include:

- Outreach to the previous MCO to obtain relevant member information including but not limited to information on the member's assessments, PoS, PCSP, authorization of services and list of active providers, as appropriate
- Review the enrollment file indicators, such as those for special needs, to identify incoming members who may potentially be receiving existing services (e.g. Waiver services).
- Utilization of previous MCO's encounter data provided by the State
- Honoring authorizations of existing services that new members are receiving at the time of enrollment, regardless of the network status of their service provider
- Identification of previously utilized non-contracted providers and efforts to execute contracts with these non-participating providers to ensure continuity of care

Transfers from FFS to Sunflower (5.4.12.H)

Sunflower's approach to ensuring continuity of care for members that are transitioning from FFS to Sunflower is similar to our approach outlined in 5.4.12.G above. We will access and utilize all available encounter data provided by the State to determine the member's previously utilized services and providers. Our designated point of contact will also reach out to the member's service coordinators (as appropriate and with member consent) to obtain all PCSPs, PoS data and health records if the member is enrolled in any waivers or high-fidelity models. The member's assigned SC or CSC will also (based on available data, prior service authorizations and our Health Screening, HRA and needs assessment findings) identify any non-participating providers the member is accessing. Based on these findings and analysis, working in

collaboration with the member's assigned SC or CSC, Sunflower's Provider Network team will attempt to execute provider agreements with these providers.

Members Leaving Sunflower Enrollment (5.4.12.I and 5.4.12.J)

We understand member may be disenrolled from Sunflower for the following reasons: loss of eligibility; member is placed in an adult or juvenile correctional facility; member opts to enroll into another MCO during Annual Open Enrollment period; member passes away; member transfers to a Medicaid eligibility category outside of managed care, and to implement a decision of a hearing officer in a formal grievance procedure by the member against Sunflower or by Sunflower against the member. Sunflower's TruCare Platform provides a red-flagged alert when a member is no longer eligible as a Sunflower member. We also provide education to our community providers on the need to notify us when a member is incarcerated. We work as proactively as possible to transfer information to the new MCO, or to obtain consent to be involved with members who are no longer eligible due to incarceration or state ID hospital placement. We provide a single point of contact for other MCOs to request information. For members enrolled in Service Coordination, we will be available as requested by the receiving MCO through our single point of contact to assist with the transition, including participation in transition meetings as approved by the member and receiving MCO. The SC/CSC can provide additional information as requested by the new MCO/FFS such as diagnoses, allergies, current medications, inpatient history, case management summary, Plan of Services, psychosocial information, and current PCP and specialists. The member's designated contact at Sunflower is responsible for obtaining the member's consent to share information, as appropriate and transferring all relevant member information, including medical records to another MCO or another State-administered setting.

Transition of Care Strategy (5.4.12.K)

Upon request, Sunflower will submit our transition of care strategy as prescribed by the State for review and approval.

5.4.13. CONFLICTS OF INTEREST

CONFLICT-FREE SERVICE COORDINATION/CASE MANAGEMENT

Sunflower's assessment, PCSP and PoS policies and procedures supports conflict- free service coordination/case management services. We will not delegate or subcontract with entities to perform needs assessments; PCSP or PoS development on our behalf for our members if that entity is also a provider of service or conducts components of the HCBS waiver eligibility process. If after numerous documented attempts we are not able to contract with a conflict-free community-based organization or provider in a certain geographic area, we will discuss and seek prior approval from the State before contracting with the entity and we will propose strategies for mitigating the conflict of interest pursuant to CMS requirements and State policy. We are also committed to and will work with identified community-based organizations and the provider network to develop capacity to provide conflict-free case management services and the appropriate safeguards and mechanisms to protect against conflicts of interest.

5.4.14. ELECTRONIC CARE MANAGEMENT SYSTEM

MEMBER-CENTRIC ELECTRONIC SERVICE COORDINATION PLATFORM

Sunflower uses TruCare, our member-centric electronic service coordination platform for integrated care management (inclusive of care coordination, case management, disease management, service management and transitions of care) and utilization management. TruCare supports our person-centered, whole-health approach as well as our integrated and shared Service Coordination Model. An integrated component of our Management Information System (MIS), TruCare allows our contracted Community Service Coordination entities, providers and members of the IC Team to conduct and review Health Screens, HRAs and needs assessments, implement interventions, develop, maintain and update the PoS and PCSPs, authorize services, implement interventions and manage member services, including PH, BH, LTSS and SDOHI.

Casenet (TruCare's developer), a wholly owned subsidiary of Centene, was recognized in 2017 by the health care research firm KLAS, as a leading vendor in meeting clients' integrated care management needs and overall performance.

Through our multi-channel communication approach and support of HIPAA compliant communication methods such as secure portals, mobile and direct transactions, we support information sharing with and among our IC Team. Our approach to information sharing transcends silos of care by ensuring that all members of the IC Team can access and retrieve actionable information to impact the health and quality of life outcomes of our members.

Care Management System Functionality (5.4.14.A)

We use TruCare to document, track and monitor service coordination activities. TruCare's functionality is available for use by our providers and our contracted CSCs to support communication and collaboration among members of the IC Team and provider network. TruCare has all the necessary features and functionality to capture, document, track, and monitor the delivery of service coordination activities and supports an integrated profile for each member. Key features include:

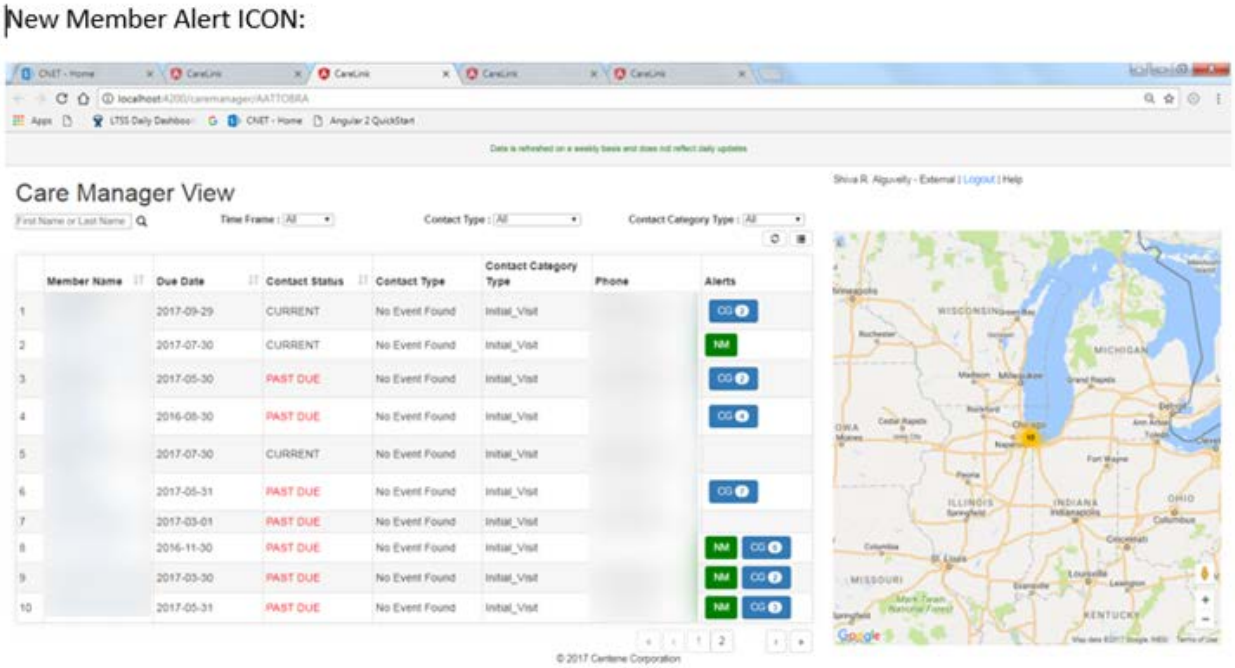
- ***Health Screening, HRA and Needs Assessment*.** TruCare houses assessment information and results for our members, including state approved Health Screenings, HRAs, needs assessments, and other screenings and assessments, such as for specific medical and behavioral conditions and social determinants of health. To assist SCs and CSCs in the development of evidence-based PoS and PCSPs, TruCare allows SCs and CSCs to administer straightforward assessments and offers a library of evidence-based service coordination interventions that can be custom tailored to the member's needs.
- ***Plan of Service (PoS) and Person-Centered Service Plan (PCSP).*** TruCare includes a PoS and PCSP template that captures member identified needs, goals, referrals, interventions, progress, outcomes, completion dates and back up plans. The Platform allows Sunflower Service Coordination staff, contracted CSCs and our provider partners to use the same integrated PoS and PCSP template. This allows the entire Care Team to access a single integrated PoS/PCSP for each member. TruCare supports the input, update, and storage of

the PoS and PCSP as part of the member profile for access by SCs and our authorized users (i.e. delegated community partners and providers) using role based access. All entries in TruCare are electronically date and time stamped indicating user name. Through our integrated approach, all IC Team staff and CSCs can conveniently access the same data during outreach and intervention with members. In addition, providers, members, community agencies/vendors, and caregivers, have role-based access to their assigned members' PoS, PCSP and back-up plans through our suite of secure portals.

- ***Service Coordinator Member Touch Points and Outcomes.*** TruCare is used to document, track and monitor member touch points (e.g. telephonic contacts, in-person visits, etc.) receipt of recommended care and the delivery of service coordination activities. As part of the care planning process, SCs and CSCs schedule routine follow up discussions with members and will review the member's PoS/PCSP at each interaction, confirming items such as progress on goals any revisions needed to goals, changes in need, receipt of approved services and that the services continue to meet the member's needs. The user is able to set reminder tasks in the system to ensure that member follow-up is completed on agreed intervals. Member PoS/PCSPs are documented in TruCare, including recommended care, member supports and member responsibilities, allowing SCs and CSCs to review the information and ask members if they are engaging in the recommended or approved services, such as provider visits or medications, and with agreed upon behavior modifications, such as dietary changes or stopping smoking. The SC and the CSC documents the member's progress and any updates to the PoS/PCSP in the Care Management platform, noting remediation, completion or changes in problems or goals.
- ***Staffing and Visit Scheduling System.*** Our Staffing and Visit Scheduling System allows our SCs to schedule home visits by mapping the most efficient visit sequence based on geographic location. Our system supports use of phone, text, or email to confirm scheduled visits and alert the member of approximate arrival time. It includes service coordination profile information, such as, SC language and assigned location, a caseload calculator, auto-scheduling of member visits aligned with contract requirements, secure transmission to members of specific visit information, automatic rescheduling, and other features to facilitate successful member visits.
- ***CareLink.*** TruCare's caseload monitoring capabilities provide interactive views of the SC's daily action items. This CareLink Dashboard provides member ED utilization alerts and other actionable messages, such as, upcoming member contacts and visits, and members coming on or off the caseload, as well as a list of members with upcoming Medicaid recertification. Our SC Supervisor CareLink dashboard provides a roll-up view of subordinate SC data, providing a powerful resource for monitoring care coordination activities, in near real-time. This dashboard will be made available to the Community Service Coordination provider supervisors. See ***Figure 5.4.14.A_CareLink Dashboard*** below.
- ***Offline and Mobile Capabilities.*** TruCare features **offline and mobile capabilities** that allow SCs and CSCs to complete a face-to-face visit in the member's home, when no internet connectivity is available. When the SC or CSC has internet connectivity again, synchronization technology then updates the member record, giving our SCs and CSCs the

mobile freedom to access needed tools and information, enhancing face-to-face visits with members and caregivers. TruCare offline and mobile capabilities include the ability to: take notes, complete an assessment, view medications a member is currently taking, complete electronic signatures, where needed, scan and capture documents, create authorizations, create and edit PoS and PCSPs, view active cases and view member alerts. SCs and CSCs can use this feature when meeting directly with members to facilitate interaction with the member, family, and caregivers. This functionality enables them to share information such as HRAs, assessments and PoS/PCSPs. It also allows SCs and CSCs to facilitate video education and conduct real-time assessments, thus enabling SCs and CSCs to spend more of their time in the field, face to face with members, caregivers, and providers.

Figure 5.4.14.A_CareLink Dashboard



Comprehensive View of the Member (5.14.B) and Access to Service Management Data (5.14.D)

TruCare's design supports a unique fully integrated profile for each member, including member demographics, Health Screenings, HRA, needs assessments, PoS, PCSPs, referrals, authorizations, member case notes, and member preferences, such as, cultural, linguistic, and special communication needs. Electronic access to timely and actionable member data allows our Service Coordination and UM team, contracted CSC entities, the member's PCP and IC Team to coordinate and communicate care needs across providers and systems of care.

TruCare's integration with our Electronic Data Warehouse and Centelligence® informatics platform provides us and our contracted CSCs and providers with near real-time access to electronic data about a specific member, including:

- Eligibility and benefit information, including past enrollment spans and eligibility for HCBS Waiver programs
- Access to a member's risk score identified through our predictive modeling system and Level of Service Coordination
- Care gaps and care opportunities
- Admission, discharge transfer (ADT feeds)/ED alerts
- Prior authorization data
- Claims information, including PH, BH and LTSS
- PH and BH diagnoses and medications
- PH, BH, and pharmacy claims information
- Disease management (DM) information
- Critical incident data
- Inpatient utilization data
- Authorizations

Streamlining Communication and Care Coordination. We use and will continue to use a multi-channel approach to meet providers and CSCs where they are at with respect to their current technological capabilities. We leverage our integrated MIS and secure web portals to securely transmit member health care information. This promotes information sharing and integrated collaboration across providers, CSCs, and the member's natural supports, while maintaining the security and privacy of the member's personal and protected information. Delegated service coordination partners will have access to TruCare through a secure SC Portal that is web based and is accessible from any mobile or tablet device. Our secure portals allow for the sharing of clinical information including completion and submission of HRAs and assessments, member eligibility checks, submitting documents, viewing the Service Coordination Level and the name of the SC and CSC for a member, viewing risk and care alerts, viewing a member's PoS/PCSP and submitting and viewing associated notes, and access to a member's health record.

Through our Member, Provider, Caregiver, and SC Portals, we will make service management and service coordination information and data (e.g. PoS/PCSP) available to the member, the member's PCP and specialists and others involved in the member's care and service delivery. We will also interface with the State's Kansas Modular Medicaid System or in the format and method specified by the State.

Centelligence® Member Health Record. In addition, Sunflower will enable sharing of electronic member health information with contracted CSCs and providers, through our **Centelligence® Member Health Record,** an innovative approach to bidirectional information usage and exchange. Available through our secure portals, our Centelligence® Health Record allows providers and CSCs to view and update the PoS/PCSP. Members and/or their caregivers will also be able to access member versions of their PoS/PCSP, ensuring that the entire IC Team is literally on the same electronic page. Built on our Centelligence® health analytics platform, our Centelligence® Member Health Record presents an organized view of PoS/PCSPs, along with (for SCs and providers) detailed service utilization for each member, based on LTSS, acute, BH and pharmacy claims information; assessment and screening data; and other information systematically processed in our Centelligence® platform. Providers, via a summary roster and at

the member level, can view care gaps, disease management, and ED high utilizer alerts. Providers can access our Centelligence® Member Health Record directly, or via the multi-payer portal offering a no wrong door approach to information exchange.

New Tools to Support Youth in Foster Care. Designed to support the foster care population and high needs children, our Member Health Record is expanding to include new features. Features include the contact information of persons on the member's IC Team, ability to view completed EPSDT assessments, growth charts, immunizations, etc. Our new features are built to deliver relevant health care information when and where it is needed for youth in foster care within the state of Kansas.

Information Technology Systems that Support Communications (5.14.C)

Our integrated data design and MIS effectively unifies data from a variety of sources to provide a 360 view of the member and facilitate integrated workflow processes across Sunflower departments. To maximize communications and collaboration about a specific member that multiple departments may be involved with, our MIS is able to integrate data from service coordination, UM, Member Services, eligibility and enrollment and claims, to ensure a seamless experience for the member. TruCare sources data from integrated subsystems of our MIS including our eligibility and enrollment system, claims processing system, and EDW for automated exchanges of provider, member, Medical, Behavioral, LTSS, pharmacy claims utilization data and lab test results, eligibility and benefit information, and additional member record information including care gaps and disease management information.

Integrated Workflow Tools. We use integrated workflow tools to easily identify and provide timely follow up on members in need of care, report data to track outcomes, and identify program/quality improvement initiatives. TruCare houses information on outreach efforts, appeals managed by the UM Team, and includes links to care coordination programs designed for special populations. The integrated data design of TruCare enables our SCs and UM clinicians to use TruCare for medical and BH prior authorizations, concurrent reviews, discharge planning, and transition service reviews. Additionally, our Centelligence platform synthesizes and analyzes demographic, claim, and clinical data and systematically identifies and distributes care gaps and health risk information to SCs via TruCare, to Customer Service Representatives via our Customer Relationship Management (CRM) platform, and to providers, members, caregivers, CSCs via our role-based secure web portals, compliant with HIPAA Minimum Necessary Rules.

5.4.15. SERVICE COORDINATION REPORTING AND EVALUATION

SYSTEM FOR MONITORING AND EVALUATING OUR SERVICE COORDINATION MODEL (5.4.15.A)

We use a multi-faceted approach to monitor and evaluate our Service Coordination model that includes looking at outcomes and services at both the individual member and population level.

Individual Member Level Assessment and Monitoring

The member's assigned Sunflower SC and CSC, working together as team when applicable, and their supervisors are responsible for assessing, monitoring and evaluating the effectiveness of an individual's Service Coordination services. This includes monitoring of caseloads, PoS and PCSP goals and progress, individual health outcomes, care gap closures and individual satisfaction and experience. For example, the SC and CSC monitor each individual member's PoS goals and member health outcomes by analyzing utilization data, reviewing progress on steps for goal completion, connecting with the IC Team and meeting with the member. If an individual member is not meeting their PoS goals, the Sunflower SC Supervisor will work with the SC to ensure the goals are achievable and further identify opportunities to mitigate barriers. When a member has a CSC, the Sunflower SC will work with that person to make sure the goals are achievable, and revised when necessary.

We also utilize **CareLink**, a feature of our TruCare integrated platform that provides an interactive dashboard for SCs and their Supervisors. The CareLink daily dashboard aims to drive action by providing actionable analytics presented in a user-friendly format. For Sunflower SCs and CSCs, CareLink enables them to view member ED utilization and inpatient admission alerts, upcoming member contacts and visits, care gaps, and a caseload planner displaying members coming on and off the caseload and members with upcoming Medicaid recertification, all updated in near real-time. For Supervisors, CareLink provides them with views of subordinate SC case assignments and caseload tracking, including views of past-due contacts for SCs under their supervision. Further, the CareLink dashboard is a tool to monitor the efficacy of our program and ensures that Sunflower is compliant with State Service Coordination contact requirements.

Population Assessment and Monitoring. We also assess, monitor and evaluate the effectiveness of Service Coordination by looking at population health and quality of life outcomes, costs and utilization such as our NCQA population health assessment outcomes report; the LTSS quality and quality of life dashboards. Leveraging processes, tools and best practices we identify patterns of under-, over-, and inappropriate utilization by continually monitoring and analyzing claims and encounter data.

Outcomes studies are conducted on an ongoing basis but consolidated once a year in this formal report to determine the relative impact of participation in Service Coordination on generally accepted goals and outcomes. The range of metrics to be looked at include but are not limited to:

- ER utilization
- Provider engagement rates
- Hospitalization rates
- Flu vaccination rates
- Readmission rates
- Medication adherence
- Quality of Life

Service Coordination Measures and Dashboard Reports. In addition to the above, our integrated Service Coordination Program outcomes are monitored and evaluated on a systematic and regular basis. We have Dashboard Reports that look at Service Coordination metrics and outcomes including, but not limited to:

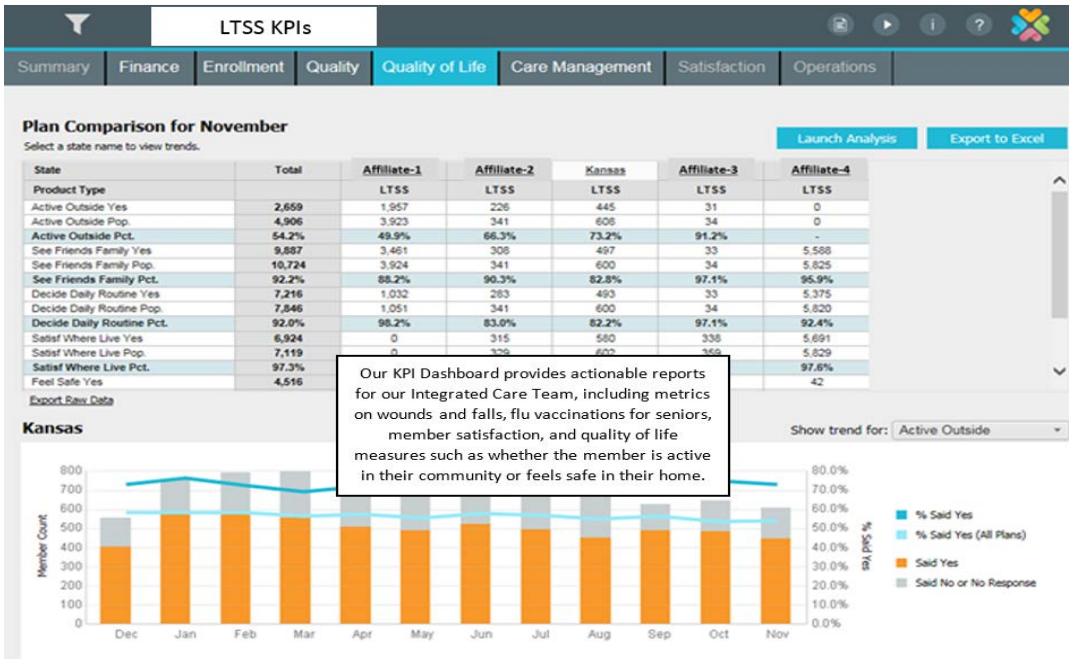
- Member engagement reports
- Safety – (i.e., rate of falls, placement, etc.)
  - Skin integrity/wounds
  - Incontinency
  - Placement transitions (i.e., HCBS to NF, etc.)
- LTSS and HCBS Service Utilization Reports, including a 12-month authorization report for LTSS which shows authorization trends and LTSS dashboard metrics and NF transitions, etc.
- Medical, behavioral health and LTSS costs
- LTSS Quality and Quality of Life metrics (satisfaction with home, employment, community participation, and reports of falls, wounds, UTIs)
- Repatriation from institutional care to a community-based setting
- Improved clinical outcomes
- Improved/stable functional outcomes
- Member/provider satisfaction
- Readmission rate for members in Service Coordination with specific diagnoses such as HF or asthma
- Repeat ED visits for members in Service Coordination
- Rate of member's annual flu vaccine
- Rate of member's pneumonia vaccine
- Rate of diabetic members with HbA1c screening
- Placement rosters
- SC and CSC caseload ratios

Using our integrated service coordination model, we reduced total expenditures in the first 10 months of 2017 (compared to the first 10 months of 2016) by 30.2% for 395 high cost members with inappropriate utilization or poorly controlled chronic conditions.

LTSS Key Performance Indicator (KPI) Dashboard. Sunflower's Centelligence® LTSS Key Performance Indicator (KPI) Dashboard, depicted in ***Figure 5.4.15.A_LTSS KPI Dashboard*** below, provides actionable reports for our teams across Service Coordination, quality, operations, member satisfaction, enrollment and financial metrics. Sunflower leaders can review trends in their own performance, benchmark against other Centene plans, and download data to drill down by SC, CSC or provider. The Dashboard includes metrics on quality of life (e.g., ability to see friends and family, control over daily routine), member satisfaction, and integration risk factors that can lead to institutionalization (e.g., wounds, falls). As a leader

in the LTSS field, Centene is at the forefront of meaningful member measurement, and continues to engage in a variety of activities to inform this effort. For example, we are actively collaborating with the Nation al MLTSS Health Plan Association to develop standard MLTSS quality measures, which will be integrated into our LTSS KPI Dashboard. Our measures are derived, where possible, from recognized and validated national assessment tools such as the Home and Community-Based Services Consumer Assessment of Health Care Providers & Systems (HCBS CAHPS) surveys and National Core Indicators-Aging and Disabilities (NCI-AD).

Figure 5.4.15.A_LTSS KPI Dashboard



Mechanisms for making process improvements. Measurement and analysis of Sunflower's Service Coordination Program is documented as part of the annual Quality Improvement and/or Utilization Management program evaluation. The Service Coordination Program is evaluated at least annually and modifications to the program processes are made, as often as necessary. We evaluate the impact of the Service Coordination Program by using:

- HEDIS data
- Results of the population assessment
- The results of member satisfaction surveys for members in the Service Coordination Program
- Member appeals, grievances, and inquiry data regarding the Service Coordination Program
- Provider appeals, grievances and provider satisfaction surveys regarding the Service Coordination Program
- Member quality of life related to Service Coordination engagement

- Other relevant data, as appropriate

In our 2017 LTSS member satisfaction survey, over 95% of members receiving HCBS reported satisfaction with the help they receive from their Sunflower SC and 99% indicated their SC respects their beliefs and preferences.

The process utilized is the Rapid Cycle Process Improvement process that utilizes the Plan, Do, Study, Act methodology to evaluate data, identify opportunities for improvement, and identify barriers and methods to mitigate those barriers to implement interventions aimed at achieving the desired goal. The annual program evaluation and recommendations are submitted to the Utilization Management Committee and the Performance Improvement Committee for review, action, and follow-up. The final document is then submitted to the Board of Directors/governing body through the Quality Improvement Committee for approval. Additionally, we have a Development Team in place with our SCs, UM staff, CHWs, LifeShare Pathways facilitators and trainers where we develop and test new processes and assessments before rolling them out, and continuously revise existing processes to ensure continuous improvement.

Evaluation of Member Satisfaction with Service Coordination. Sunflower conducts service coordination satisfaction surveys to assess members' experience with the SC program. An analysis of returned satisfaction surveys assists us in identifying aspects of performance that do not meet member expectations and facilitates initiation of actions to improve performance. Sunflower also monitors member complaints about the service coordination program. The survey measures the following areas of member perception including:

- The SC's knowledge level
- Usefulness of educational materials
- Service needs and adherence to recommendations
- Measures of patient experience including quality of life and health status
- Overall satisfaction with service coordination, including member satisfaction with the Sunflower SC

Results of the analysis of member satisfaction surveys and the monitoring of complaints/grievances are used to identify opportunities for improvement, set priorities, and determine which opportunities to pursue regarding changes to the SC Program, as needed.

Below is a description of our LTSS Satisfaction Survey and Care Management Member Satisfaction Phone Survey methodology and 2017 results and findings.

Long Term Services and Supports (LTSS) Member Satisfaction Survey. In 2017, Sunflower launched our first LTSS Member Satisfaction Survey, developed as a pilot project with our parent company, Centene Corporation (Centene). Survey questions were selected based on a review of the NCQA HCBS CAHPS® survey questions, the MLTSS Health Plan Association's performance measures, and LTSS performance measure information from the National Quality Forum. The survey was conducted by mail by SPH Analytics, formerly known as The Meyers

Group, (SPH), an NCQA Certified Survey Vendor, from June to August in 2017. Sunflower also sent letters to LTSS members notifying them that the survey would be coming from SPH and encouraging them to participate. We also had our SCs notify members during regular visits, and encourage their participation.

Sampling Methodology and Response Rate. SPH mailed surveys to all of our LTSS members for whom we provide Service Coordination services and who receive HCBS services through one of the following HCBS waivers:

- Intellectual and Developmental Disability (I/DD) waiver
- Frail Elderly (FE) waiver
- Physical Disability (PD) waiver
- Technology Assisted (TA) waiver
- Traumatic Brain Injury (TBI) waiver

Survey Results. As shown in ***Table 5.4.15.B_LTSS Satisfaction Survey Summary Results by Waiver Type*** below, the survey results demonstrate high HCBS waiver member satisfaction across all waiver types. We have shared this information with our LTSS Advisory Committee and have received recommendations on the lower performing area of PD and FE member satisfaction with frequency of spending time with family, friends and in the community. We intend to use this information to enhance our Service Coordination program referrals of members to supports such as local senior centers, AAAs, CILs, and identification of related community/social goals in the member's PCSP.

Table 5.4.15.B_2017 LTSS Satisfaction Survey Summary Results by Waiver Type

Survey Question	Percentage Satisfied by Waiver Type					Total Percentage Satisfied
	I/DD	FE	PD	TA	TBI	
How satisfied are you with the help you receive from your Sunflower care manager?	94.3%	97.2%	96.4%	95.8%	93.8%	95.5%
When you call your Sunflower care manager, do they respond within 1 business day?	92.9%	95.1%	95.7%	100%	100%	96.7%
Does your Sunflower care manager respect your personal beliefs and preferences during your discussions?	97.9%	98.5%	98.3%	100%	100%	98.9%
Has your Sunflower care manager talked with you about services that might meet your needs and goals?	79.4%	90.3%	93.9%	95.7%	100%	91.9%
Overall, how satisfied are you with the Home & Community Based Services you receive?	96.1%	96.9%	95.3%	91.3%	100%	95.9%

Survey Question	Percentage Satisfied by Waiver Type					Total Percentage Satisfied
	I/DD	FE	PD	TA	TBI	
Do the people who are paid to help you do things in the way you want them done?	96.3%	95.9%	96.1%	95.7%	100%	96.8%
How often do the people who are paid to help you treat you the way you want them to?	98.3%	98.2%	98.2%	100%	100%	98.9%
Overall, how safe do you feel with the people that help you?	98.5%	98.0%	98.5%	100%	100%	99.0%
How often do you do things with your friends, your family or in your community?	93.7%	74.2%	69.2%	87.0%	80.0%	80.8%
If you scheduled transportation through Sunflower, how satisfied are you with the transportation service you received?	93.1%	90.4%	87.2%	50%	90%	82.1%
Overall, how satisfied are you with the care you receive from Sunflower Plan?	97.3%	97.1%	97.9%	95.8%	86.7%	95.0%

Care Management Member Satisfaction Phone Survey. In addition to our LTSS satisfaction survey, Sunflower has adopted our parent company, Centene's, Care Management phone survey (CM Phone Survey) as it allows up to benchmark our performance against our affiliated state health plans. The survey was conducted by Sunflower staff during the second quarter of 2017 to assess members' experience with our Service Coordination program.

Survey Methodology and Response Rate. Survey completions were attempted with all Sunflower members in active physical or behavioral complex case management at the time of survey who had been enrolled for a minimum of forty-five days; no sampling was performed. During the survey period, 640 members were identified as meeting the criteria and outreach was attempted to all 640 members. In total, 192 Sunflower members were successfully contacted and consented to completing the survey, for a completion rate of 30%.

Survey Results. ***Table 5.4.15.C_2017 CM Phone Satisfaction Survey Summary Results*** below summarizes the survey results showing high member satisfaction with our Service Coordination services.

Table 5.4.15.C_2017 CM Phone Satisfaction Survey Summary Results

Survey Question	Percentage Satisfied
How satisfied are you with the help you are receiving or have received from your Care Manager?	97.92%
Were you able to understand the information about your health condition(s) given to you by your Care Manager?	95.08%
Have you been able to follow any of your Care Manager's healthcare suggestions to improve your health?	92.35%

Survey Question	Percentage Satisfied
Was your Care Manager available to speak with you at times that were convenient for you?	97.37%
Did your Care Manager help you get the healthcare services that you needed?	95.74%
If you required additional services, (or services from the community), how satisfied are/were you with those that your Care Manager offered?	96.72%
How satisfied are you with any learning and/or resource health information materials you received from your Care Manager?	96.22%
Did your Care Manager consider and include your personal beliefs and preferences during your discussions?	96.17%
How satisfied are you that the goals worked on by you and your Care Manager have improved your health and understanding of your health?	98.84%
Did we exceed your expectations?	94.41%

State Service Coordination Reports and Data Submissions (5.4.15.B, 5.14.15.C and 5.4.15.D)

Meeting Reporting Requirements. Our Centelligence® platform, provides robust reporting and analytics capabilities that support our Service Coordination Model reporting and data submission efforts. Centelligence® integrates data from internal and external sources, producing actionable information, everything from care gap alerts to online dashboards, population level health risk stratifications, and Sunflower quality management, utilization management and operational reports, as well as Medical Management Department required standard and ad hoc reports. In conjunction with our EDI subsystem, Centelligence® supports the data reporting requirements specified in Section 5.4.15 of the RFP.

We understand KDHE is implementing a new reporting and data collection strategy designed to enhance Service Coordination, mitigate service gaps and promote quality, access and efficiencies. Sunflower is committed to and has the systems, processes and data analytics capabilities in place to provide the state with all required data elements and reports, including data and reports from subcontractors, in a format and frequency determined by the State in accordance with Attachment H of this RFP.

We will report on all Service Coordination measures as outlined in the State's KanCare Quality Strategy. Additionally, we will make Service Coordination data, including SDOHI data**,** available to the State upon request, that we will collect through PRAPARE results as well as use the NOMs data that comes out of the Automated Information Management System (AIMS). As discussed in Section 5.7, we are partnering with Kansas Primary Care Association to help community health centers and other providers collect the data needed to better understand and act on their patients' social determinants of health. We are working collaboratively with KAMU to support CHCs to implement an innovative

PRAPARE aligns with the Sunflower Service Coordination SDOHI data collection through current HRA screening which covers 50% or more of PRAPARE tool core measures including race, ethnicity, employment, insurance status, language, transportation, veteran status and social integration/support.

PRAPARE model designed to assess for and address social determinants. The PRAPARE assessment tool, to be implemented by several CHCs across the state, consists of a set of national core measures as well as a set of optional measures for community priorities. It aligns with national initiatives prioritizing social determinants (e.g., Healthy People 2020), measures proposed under the next stage of Meaningful Use, clinical coding under ICD-10, and health centers' Uniform Data System (UDS). More importantly, PRAPARE emphasizes measures that are actionable. In addition to the PRAPARE tool, Sunflower's HRA tool includes several questions that assess for a member's SDOHI that we capture, act on and can report on in our TruCare platform.

Electronic Visit Verification- Submission of Required Data Elements (5.4.15.E)

Our interoperable Management Information System (MIS) supports the use of the KanCare EVV system that adheres to HIPAA-based standards for transaction formats, and Federal and State standards for security safeguards, data integrity controls, and audit transparency to enable bi-directional sharing of information and data. We will comply with the contract requirements and have systems and processes in place today to provide the required data elements in accordance with a schedule prescribed by the State to the State's EVV vendor, First Data, that includes but is not limited to services approved, number of units approved, scheduled times for service delivery, names of chosen providers, service stop and start dates, names of SCs and their caseloads, names of contracted CSCs and their caseloads. We also understand and acknowledge that the State may make changes in the future to comply with the 21st Century CURES Act and we are prepared to provide any new data elements to comply with these changes.

Sunflower and our affiliate health plans have extensive experience implementing EVV, with systems in place in four states, and two additional states going live in 2018. Affiliates have worked with a variety of EVV vendors and systems. We understand that one of the key objectives of an EVV system is to hold personal care service (PCS) workers accountable for visiting members and providing the right care at the right time. Sunflower will have an identified EVV Coordinator who preventatively monitors reports from First Data, to support internal and external SCs to help members and providers troubleshoot issues, such as missed services, and ensure back-up plans are implemented and service gaps are prevented. We will also use EVV, as described in KanCare 2.0, to monitor the caseloads of our CSCs and their compliance with required visits.

We will utilize our direct knowledge of other EVV vendor solutions combined with our direct experience and knowledge of the First Data Authenticare EVV features and functionality to bring new ideas, solutions, and emerging technology innovations and applications to Kansas to improve quality and member outcomes under KanCare 2.0. For example, working in collaboration with KDHE, First Data and the other MCOs, we will explore the feasibility of providing data elements, such as prior authorizations and PoS, directly to the EVV vendor versus the State's Fiscal Intermediary. We believe this will further expedite authorization turnaround to providers, continue to ensure timely delivery of service to support member

independence and community living, reduce administrative burden to providers and improve member experience.

Data Requests from the State's EQRO (5.15.F)
Sunflower is committed to working collaboratively with the State and the State's External Quality Review Organization (EQRO). As part of our commitment, we will comply with any requests for data from the EQRO.

5.4.16. SERVICE COORDINATION COLLABORATIVE

COMMITMENT TO KANCARE 2.0

Sunflower is committed to and will participate in the State-chaired KanCare Service Coordination Collaborative designed to ensure consistency and proactively address questions and issues with the implementation of the KanCare 2.0 Service Coordination program. As evidence of our commitment, as a precursor to the KanCare Service Coordination Collaborative Sunflower formed the I/DD Targeted Case Management (TCM) pilot workgroup to enhance the services offered through TCM; reduce duplication of services; streamline the I/DD Person Centered Service Plan with the MCO Service Plan, and to improve member experience through better coordination of visits and information-sharing between the MCO SCs and I/DD Targeted Case Managers. We continue to host and facilitate this group, involving the other two MCOs, and getting input from other TCM providers statewide. We believe this workgroup is a valuable avenue for piloting processes that will be utilized with future Community Service Coordination providers.

We are committed to collaborating with the State, the other KanCare 2.0 MCOs, the current I/DD and CMHC TCM and other potential Community Service Coordination providers to share service coordination best practices and resources to improve member experience, facilitate member access to the full continuum of services, improve member outcomes and lower the overall cost of health care in the state.

Project ECHO- Consistency Implementing KanCare 2.0 Service Coordination
As discussed in other sections of the response, to support the successful implementation and adoption of the State's new KanCare 2.0 Service proposes Coordination Model, Sunflower to collaborate with the State and the other MCOs to host a **Service Coordination Project ECHO**. The goal of the proposed Project ECHO is to provide a framework for the State, KanCare MCOs and their contracted Community Service Coordination organizations and providers to deliver consistent and effective person-centered care that meets the needs of Medicaid beneficiaries and aligns with state requirements. The Project ECHO will also support workforce development and skill training for community-based organizations and providers across the state and will include a comprehensive Service Coordination training curriculum program comprised video conferences and video training modules.

5.4 Attachments

Sunflower Health Plan's response to this section is provided in our Proprietary Proposal.

5.5 Provider Network

5.5. PROVIDER NETWORK

SUNFLOWER DEMONSTRATED SUCCESS

Sunflower Health Plan's (Sunflower) approach to network development ensures reliable and attentive access to care with superior results. This approach includes recruitment, credentialing and contracting, partnerships, innovation, and payment. We contract with more than 23,000 providers in the Sunflower network. Sunflower's network currently includes 10,790 individual practitioners and 3,380 unique providers, including 166 hospitals. Time and again providers praise Sunflower's Provider Relations team for our clear communications and responsiveness to provider needs, as demonstrated through our annual provider satisfaction surveys.

Sunflower's provider network successes are a culmination of diverse and focused strategies to enhance access, pursue evidence based practices, innovate, develop and sustain meaningful provider relationships built on a shared goal of quality outcomes, attending to the social determinants of health and independence (SDOHI), rebalancing for long term services and supports (LTSS), and producing satisfaction across the membership and the provider network. Examples of Sunflower's network successes include:

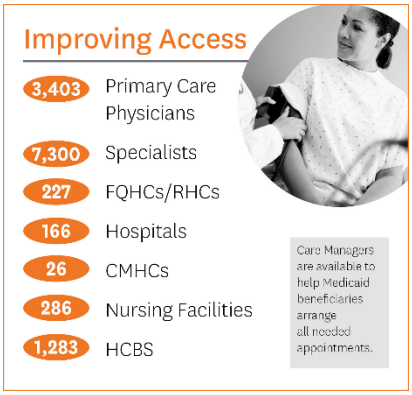
- Enhancing rural access. Sunflower negotiates enhanced reimbursement rates for providers to expand rural access. For example, Sunflower enhanced reimbursement for providers to serve members with autism in rural/frontier areas.
- Advancing evidence based practices. Sunflower partnered with the State to develop and disseminate evidence based policies and procedures for Medication Assisted Treatment (MAT) statewide, training over 100 providers to prescribe these critical treatments.
- Innovating with Telehealth. We have multiple telehealth programs underway, such as our contract with the University of Kansas Medical Center, Center for Child Health and Development to provide eight telemedicine video tutorials with BH providers about disruptive behavior and behavior analytic techniques for children.
- Contracting for Quality. We continue to grow our value-based purchasing (VBP) agreements, many of which are structured around quality HEDIS metrics, encompassing physical health (PH), behavioral health (BH), and LTSS.
- Contracting for SDOHI. As one example, Sunflower has developed a Scope of Work, pending State approval, to support members having successful transition to the community.
- IDD success story. Sunflower initiated an alternative payment strategy with CLO, Easter Seals/Capper Foundation, Mosaic and ResCare to increase specialized services for persons with I/DD who have extraordinary health and/or BH needs. Contract is expected to be effective 2/1/2018.
- Achieving member and provider satisfaction. Our 2016 and 2017 CAHPS surveys indicate an overall satisfaction of Sunflower members for accessing routine and urgent appointments. Further, in 2017, Sunflower received the highest score (61.2%) of all Medicaid managed care organizations (MCOs) in Kansas for overall provider satisfaction.
- Claims Timeliness. In 2017, Sunflower processed 100% (99.98%) of clean claims within 30 days, with an average turnaround time of less than nine days. This includes an average turnaround time for nursing facility claims of less than 10 days.

- Streamlining provider credentialing. Sunflower continues to actively collaborate with the KDHE and other MCOs to standardize the credentialing process for KanCare providers.
- Credentialing timeframes. We demonstrate credentialing turnaround times that exceed KDHE's requirements including 97% within 30 days.

COMPLIANCE WITH SCOPE OF WORK

Sunflower is currently in compliance with all KanCare contracts and all KanCare 2.0 requirements described in Section 5.5 of the Scope of Work (SOW). Below we describe our approach and how we will continue to meet and exceed standards and contract provisions as outlined in Sections 5.5.1 through 5.5.15, as well as all other applicable Contract and regulatory requirements. Please note, references may be out of order from the SOW in our efforts to provide a concise response.

5.5.1. CREDENTIALING AND RE-CREDENTIALING



Credentialing and re-credentialing are key processes in the development and maintenance of a high-quality provider network. They are also key opportunities to streamline administrative processes, improve system efficiency, and improve provider satisfaction. Sunflower (Sunflower) has an established credentialing and re-credentialing program in full compliance with Section 5.5.1 and subject to continuous quality improvement. This includes written policies and procedures and a designated Credentialing Committee to oversee, assess, direct, and improve the process in full compliance with all state, federal, and contract requirements and National Committee for Quality Assurance (NCQA) standards. Under the direction of our Credentialing Committee, as chaired by the Sunflower Chief Medical Director (CMD), the Credentialing Department has accountability for all credentialing activities and policies in collaboration with the Quality Improvement Committee (QIC). Day to day operational accountability is overseen by the Network Management and Contracting Director in conjunction with credentialing staff. On an annual basis, we will complete and provide the results of an annual survey to KDHE describing our assessment of the credentialing and re-credentialing process, provider input received, and modifications undertaken to make improvements.

Sunflower has been working in collaboration with the Lt. Governor's KanCare Improvement Workgroup, KDHE, and other state MCOs to standardize the credentialing process for KanCare providers. To maximize standardization of documentation and minimize provider burden, Sunflower fully supports and will utilize the State provider enrollment system to access all necessary applications and associated documentation. Sunflower has already integrated the standardized credentialing forms into current operations and will continue to streamline processes to be ready for the launch of the new process in January 2018.

PROVISIONAL CREDENTIALING, CREDENTIALING, AND RE-CREDENTIALING PROCESS

Sunflower has written policies and procedures to describe the provisional credentialing, initial credentialing, re-credentialing, and organizational credentialing verification processes and ensure that participating providers meet minimum participation criteria and comply with Kansas and federal requirements and regulations, including but not limited to 42 CFR § 438.12, 42 CFR § 438.214 and 42 CFR § 441.301(c)(4). Our current standards follow NCQA guidelines and include practices for provider/practitioner assessment and reassessment that meet the qualifications of applicable Kansas and federal government regulations.

To further improve the KanCare delivery system, Sunflower will continue our efforts with other MCOs and the State, including DXC technology, to develop a coordinated, consistent process. The process will be incorporated into the State provider enrollment system and designed to reduce provider burden. Sunflower currently accepts and utilizes the State Provider enrollment system and Kansas Standard Credentialing Application/CAQH to process credentialing for all providers and practitioners that require credentialing. After the provider/practitioner enrolls with KMAP, Sunflower reviews and determines next steps to add the provider to our network. As the State refines the process and their automated provider enrollment system, we will modify our policies and processes accordingly (5.5.1.A and 5.5.1.C).

Practitioner Types

Sunflower's written policies and procedures for identification, recruitment, and retention of participating providers, includes a uniform credentialing and re-credentialing policy to address all provider types: acute, primary, BH and LTSS (5.5.1.B). Sunflower verifies the licensure and qualifications for all participating providers, including atypical participating providers and providers not assigned a NPI number (5.5.1.G), on an ongoing basis. This includes provisional credentialing, initial credentialing, re-credentialing, and organizational credential verification of all contracted providers and/or providers who have seen 25 or more Sunflower members (5.5.1.E). Sunflower will submit a plan to the State 90 days before the start of the contract year that includes the process for how licensure will be verified (as further described below) for all provider types on an ongoing basis and the timelines for notification to the State when issues with provider licensure and/or qualifications are identified (5.5.1.H).

Behavioral Health (BH). In alignment with BH integration activities, Sunflower is streamlining the credentialing processes to include BH practitioners as part of our uniform Sunflower credentialing process. By the time of the implementation of the new contract, such processes will be fully operationalized and integrated. Recognizing the traditional credentialing process may be new to some providers, we have designated a Provider Relations Representative to work specifically with our BH and HCBS providers, providing training and assistance with credentialing forms.

HCBS Providers (5.5.1.F). Sunflower ensures that all providers approved as a home and community based services (HCBS) provider are Medicaid enrolled and have completed the HCBS supplemental credentialing form. Sunflower will collaborate with the State and other

MCOs on ensuring HCBS providers complete the State approved curriculum (prior to or within six (6) months of receiving notification of being an approved Medicaid provider or timeframe determined by the State) in compliance with state and Federal settings requirements at 42 CFR 441.301(c)(4).

Sunflower will work with the State, DXC and the other MCOs to develop a plan for the extension of consultation and support to participating HCBS providers to demonstrate compliance with the home- and community-based settings criteria by March 17, 2022. The coordinated, consistent process will assure less provider abrasion. The compliance plan and process may include:

- Obtaining any self-assessment information completed by the provider
- Defining expectations and provide training to HCBS providers on member choice of living arrangement, leases, and integrated living and day/work settings
- Verifying compliance when credentialing and re-credentialing and ensuring 1915(c) qualifications are met initially and on an ongoing basis
- Train Provider Relations Representatives, Service Coordinators and Community Service Coordinators on the identification and reporting of potentially non-compliant settings
- Adding language to the Provider Agreement requiring providers to maintain compliance
- Providing provider education and training to establish and maintain ongoing compliance

Laboratory Services. Sunflower obtains copies of the valid CLIA certificates from the laboratories and/or all entities providing laboratory services funded by Title XIX and Title XXI of the Social Security Act at credentialing and re-credentialing. Sunflower shall provide a listing to the State of all laboratories and/or entities providing laboratory services and shall certify to the State that the laboratories and/or entities providing laboratory services are CLIA certified. Sunflower updates the listing and certification as laboratories and/or entities providing laboratory services are added to or dropped from the list.

Excluded Providers. Completion of the credentialing/re-credentialing process is not required when Sunflower does not select or direct our members to see a specific practitioner or group of practitioners. This includes practitioners who practice exclusively within an inpatient setting or freestanding facilities and who provide care for Sunflower members only as a result of members being directed to the hospital, inpatient setting, or free-standing facility. For example, anesthesiology, neonatology, and pathology. A locum tenens practitioner who does not have an independent relationship with Sunflower and who is covering for a participating provider does not require credentialing.

Credentialing Committee (5.5.1.D)

Our Credentialing Department including the Credentialing Committee chaired by Sunflower's CMD, has complete accountability for all credentialing activities and policies in collaboration with the QIC. Day to day operational accountability is overseen by the Network Management and Contracting Director, in conjunction with credentialing staff. The Credentialing Committee includes network physicians and oversees the credentialing process and evaluates each applicant's credentials and professional conduct and is responsible for acceptance, deferment,

or denial of a provider's application. The Credentialing Committee is also responsible for reviewing monthly reports to measure compliance with credentialing standards.

Certain minimum requirements must be met for a Credentialing Committee/CMD review to occur. If these requirements are not met, termination of the process results and is referred to as “administrative” termination of the application process. Applicants who meet the participation criteria and are determined to have a clean file are approved for Sunflower participation following review by the Sunflower CMD. Credentialing and/or re-credentialing application files that do not meet criteria for clean file review are brought to the Credentialing Committee for review. The Credentialing Committee has been delegated the responsibility from the QIC to review the qualifications of each applicant presented and make approval or rejection determinations.

Credentialing Review Criteria and Primary Source Verification (5.5.1.H)

Once an application is received, Sunflower contracting secures first-signature contracts, provider applications and associated documents from applicant practitioners and forwards to Provider Data Management (PDM). PDM verifies existence of sufficient information needed for enrollment, including the following completed forms and activities:

- Provider Data Form or Provider Roster
- Provider Application signed and dated not more than 150 calendar days prior to enrollment
- Applicable W-9s
- Query of the National Plan & Provider Enumeration System (NPPES) to confirm that the practitioner has a current, valid NPI

PDM provides disclosure forms to the Corporate Compliance department for monitoring of exclusion checking and ongoing monitoring as specified in our written policy. Upon notification from the Corporate Compliance department of a verified exclusion status of an individual or entity with an ownership or controlling interest in the provider or a managing employee of the provider, PDM will initiate the appropriate actions specified in each contract, up to and including termination of the contracting process or participation status.

In conjunction with the enrollment process, if Kansas requirements specify, PDM also performs additional reviews to ensure compliance to requirements in the provider contract. Eligibility to become a Medicaid provider is verified as part of enrollment, as applicable per Sunflower requirements. If any of the required items needed for enrollment are missing or insufficient, PDM notifies the Contracting and Network Development department to secure needed items.

PDM completes enrollment into the PDM system utilizing the provider submitted information. This includes but is not limited to demographic information, NPI, licenses, practice/service location information including accessibility as required by federal, state and local laws, and standards adopted by the Plan, associated groups, education/training, specialty, board certifications, cultural competency training, etc. and forwards documentation to Credentialing. Discrepancies identified during the credentialing process regarding licenses, education/training,

specialty, board certifications or other information verified by Credentialing is updated by Credentialing prior to completion of the credentialing cycle. Credentialing staff updates the Provider record to reflect the Credentialing Committee decision, PDM staff performs a review of the Provider record for practice/service location and associated group information, and identified discrepancies will be updated prior to changing the status from non-participating to participating in the network. When status becomes participating, the record is fed to both the online directory, the call center system, and the eligibility system for member cards and enrollment.

Verification of Items Requiring Primary Source Verification (PSV). Credentialing verifies using primary sources the elements included in this section. Primary sources may include oral, written, and/or internet sources. Any sources used are NCQA accepted. Query images and other documentation reviewed (including those retrieved via oral sources) during PSV are saved, date stamped, initialed, and placed in the applicant's file prior to the credentialing decision. For calculating timeliness requirements on Internet and electronic verifications, the date generated by the source when the information is retrieved is used. If the source does not generate a date, the staff person verifying the credential should note the date of receipt of verification in the credentialing file via date stamp.

The minimum verification elements needed for Provisional Credentialing are noted in the section below.

- Current, unrestricted state license to practice, if license is required to practice (*required for Provisional Credentialing*)
- Education and Training
- Board Certification
- Report(s) of malpractice settlement(s) *(required for Provisional Credentialing)*
- Medicare/Medicaid-specific exclusions *(required for Provisional Credentialing).*
- State Specific Exclusion Lists, as applicable (*required for Provisional Credentialing*)
- Determination if a practitioner has been debarred, suspended, or otherwise excluded from participating in federal procurement activities (*required for Provisional Credentialing*)
- To ensure practitioner has not opted-out of receiving Medicare funds the regional Medicare administrator must be queried for the applicable state in which the practitioner is providing services to Sunflower members, as applicable per Sunflower requirements
- Social Security Administration's Death Master File must be queried for determination if practitioner is deceased, a possible indicator of fraud.

Credentialing Timeframes (5.5.1.I)

For consideration to participate in Sunflower's network, all providers/practitioners who have an independent relationship with Sunflower must complete an application for participation, submit copies of applicable supporting documentation, and meet the participation requirements of Sunflower. Through compliance reporting and internal audits, Sunflower ensures that credentialing of all service providers applying for network provider status is completed within the required timeframes of 90% within 30 days;

Sunflower completes 97% of initial credentialing requests within 30 days.

100% within 45 days. The start time begins when all necessary credentialing materials have been received. Completion time ends when written communication is mailed or faxed to the provider notifying them of the Credentialing Committee's decision.

Provisional Credentialing

Sunflower and the Credentialing Committee may determine the need to occasionally make practitioners available to members prior to the completion of the entire initial credentialing process. The option for provisional credentialing is only available to practitioners who are applying for the first time to the Sunflower practitioner network. A practitioner may only be provisionally credentialed once and for a time-period no longer than 60 calendar days.

Re-credentialing (5.5.1.G)

Sunflower conducts provider re-credentialing at least every 36 months from the date of the initial credentialing decision and subsequent re-credentialing decisions. The purpose of this process is to identify any changes in the practitioner's licensure, sanctions, certification, competence, or health status that may affect the provider's ability to perform services under the contract. This process includes all practitioners, primary care providers, specialists, facilities, and ancillary providers previously credentialed and currently participating in the Sunflower network. Practitioners who are terminated or voluntarily withdraw from the network and subsequently seek to be reinstated must complete the initial credentialing process if the break in service is more than 30 calendar days or if it has been more than 36 months since they were last credentialed. If we are unable to re-credential a practitioner due to military leave, maternity leave or sabbatical; the contract remains in place and the practitioner will be re-credentialed upon his/her return. Credentialing staff will document the reason for this delay in the practitioner's file. At a minimum, the re-credentialing must be completed within 60 calendar days of when the practitioner resumes practice.

For health care practitioners, verification of applicable education and training upon initial credentialing and maintenance of valid professional licensure for practitioner's field of practice upon re-credentialing, which includes requirements for Continuing Medical Education, are accepted as evidence of maintenance of knowledge and ability in practice area(s) for health care practitioner. Sunflower will make the final determination about which practitioners may participate within our network.

Ongoing Monitoring

In between credentialing cycles, Sunflower conducts provider performance monitoring activities on all network providers. This includes an inquiry to the appropriate Kansas licensing agency for a review of newly disciplined providers and providers with a negative change in their current licensure status. This monthly inquiry ensures that providers are maintaining a current, active, unrestricted license to practice in between credentialing cycles. Additionally, Sunflower reviews monthly reports released by the Office of Inspector General to identify any network providers who have been newly sanctioned or excluded from participation in Medicare or Medicaid. A provider's Participating Provider Agreement may be terminated if, at any time, it is determined by the Sunflower Credentialing Committee that credentialing requirements or standards are no

longer being met. For ongoing monitoring, Sunflower will use the Council for Affordable Quality Healthcare (CAQH) Sanctions Track monitoring service. In addition, we conduct a monthly query to the List of Excluded Individuals and Entities (LEIE) database to identify any newly sanctioned providers. Any issues identified via ongoing monitoring will be evaluated and appropriate action will be taken, which would include no action up to terminating the provider from the network and flagged to ensure no further claims are paid for sanctioned providers unless required, such as emergency room care.

Nondiscriminatory Policies and Procedures (5.5.1.J)

Sunflower has policies and procedures developed and implemented that do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. Provider discrimination is avoided by presenting files to the Credentialing Committee with information that might reveal the identity of a specific provider or redacted practitioner; monitoring for potentially discriminatory practices by reporting to the QIC and/or CMD any complaints received that allege discriminatory practices; and on annual basis analyze credentialing denials for potential patterns. If any patterns are identified, a report is presented to the QIC and CMD.

Sunflower's CMD or Credentialing Committee may decide not to extend or continue to extend participation status to a practitioner. The Credentialing Committee Chair or designee notifies the practitioner via certified mail of the Credentialing Committee denial decision within sixty (60) calendar days of the Credentialing Committee's decision. A letter of denial includes information on the practitioner's right to view and/or correct erroneous information. A copy of the letter is retained in the practitioner's closed file and maintained in the Credentialing Department for future reference. If the practitioner's current participation status is being suspended, restricted or terminated based on issue of quality of care or service, Sunflower offers and informs the practitioner of the appeal process in accordance with the associated policies. In order to support compliance with specific Sunflower requirements, Credentialing notifies Compliance of Credentialing Committee denials as soon as reasonably possible after the committee proceedings conclude.

Single Credentialing Verification Organization (5.5.1.K)

Sunflower will comply with State contracting requirements, including contracting with a single credentialing verification organization (CVO) to standardize the credentialing and re-credentialing process across the KanCare program. Sunflower's Affiliates have experience with CVOs in multiple other states, through agreements to assist in handling heavy volumes with state approval. Over the past two years, Sunflower has led and actively participated in the collaborative MCO effort to convene and come to agreement on ways to streamline and standardize the credentialing process, with a single CVO as a potential outcome. Sunflower will continue to engage and coordinate with KDHE and other MCOs to enhance the system to facilitate provider participation and benefit all partners.

Provider Notification and Communication

All practitioners are notified of their right to review information obtained by Sunflower to evaluate their credentialing or re-credentialing application upon receipt of a written and signed request submitted to the Credentialing Department. These rights do not include the right to review references, personal recommendations, or other information that is peer review protected. Practitioners also have the right to receive the status of their credentialing or re-credentialing application at any time by contacting Sunflower. Should the practitioner believe any of the credentialing information to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by the practitioner, he/she has the right to correct any erroneous information submitted by another party. New practitioners who are denied participation for non-administrative reasons have the right to request a reconsideration of the decision within thirty (30) calendar days of the date of receipt of the denial letter. Notification of these rights occur via individual correspondence, in the provider manual and on Sunflower's website.

Opioid Prescribing Providers (5.5.1.L)

Sunflower encourages opioid prescribing providers to register in the Kansas Prescription Drug Monitoring Program, known as K-TRACS. Sunflower's comprehensive approach for combatting the opioid epidemic includes provider education, intervention and monitoring through our pharmacy benefit manager (PBM) and Sunflower Pharmacy Department, including direct consultation with providers by the Sunflower CMD. Provider education and registry promotion occurs through provider newsletters, bulletins, credentialing and re-credentialing trainings, and quarterly reminders. Prescriber education includes information and directives on prescriber participation in the Prescription Drug Monitoring Program (PDMP). Additionally, provider offices integrate registration and tracking of opioid prescriptions into their workflow. Sunflower uses pharmacy data analysis to identify providers who would benefit from peer to peer consultation with our pain management specialist who can assist with implementing system changes to improve prescribing and monitoring of controlled substances.

Our PBM's Retrospective Drug Utilization Review reporting enables Sunflower to identify opioid overuse issues and facilitate a nimble and targeted response. A few of the many reports and tools used include the Top 100 prescribers of controlled substance prescriptions on a bi-annual basis, members with multiple opioid prescribers during a month's time, and individualized Provider Scorecards that can be used to highlight opioid prescribing practices. Based on findings, Sunflower will intervene and educate individual providers, and if necessary, implement CAPs. Our Sunflower Pain Management Specialist Physician, leads the peer-to-peer review process for providers who are outliers to improve utilization rates and developed the provider education toolkit, strategy, and policy around opioid prescribing.

Provider Survey

Sunflower's credentialing/re-credentialing provider survey, initiated in 2016, was distributed to high volume providers for the purpose of obtaining information from contracted providers regarding Sunflower's credentialing and re-credentialing process. High volume providers are

defined by the number of PCPs and specialists employed and the number of members assigned. The 2016 survey was conducted via an online survey tool and was sent to 149 health plan providers consisting of Sunflower's high-volume hospital, FQHC, and RHC providers. A total of 53 of the 149 providers responded to the survey giving a 36% response rate.

Sunflower's outstanding Accounts Receivable greater than 30 days is below the 32.1% FFS benchmark.

Provider feedback regarding credentialing and re-credentialing process demonstrates that providers were satisfied with Sunflower's management of the process. Sunflower received feedback regarding specific steps in the timeframes for the credentialing process. As a result, the Credentialing Committee updated acknowledgement letters to incorporate provider input.

5.5.2. NETWORK DEVELOPMENT

Our success in network development strategy is based on a local approach built on trust and regular provider engagement. Through our five years of experience serving KanCare members, Sunflower has leveraged our local staff in Kansas communities to identify needs and strengthen our network with high-quality providers. Doing so allows us to deliver truly customized, dedicated member and provider service. Sunflower invests considerable time and resources in provider collaborations to inform network activities. In addition to the examples described below, please see Table 5.5.2.C-1 and C-2 for a comprehensive inventory of partnerships underway.

PROVIDER PARTNERSHIPS

Kansas Hospital Association (KHA), the Kansas Medical Society (KMS) and Other Large Provider Organizations

Sunflower actively participates in meetings every other month with KHA and KMS, and attends Technical Assistance Group (TAG) meetings convened by the KHA in which KMS and KDHE participate to discuss approaches for addressing network gaps and developing best practices. Plan leadership and network staff also participate in Joint Operations Committee (JOC) meetings with key hospitals and large provider organizations to discuss administrative issues and policies and address provider concerns. Because executive staff have the authority to implement policy and process changes, we can address many concerns in real time. Offering providers direct communication and collaboration with leadership also helps us to address more complex issues quickly. For example, at a KHA meeting an issue was raised regarding the Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) for which plan descriptions did not match the State descriptions. Sunflower worked with parent company Centene's IT resources to correct this on the Explanation of Payment (EOP) and on the web portal.

Group Practice, Hospital-Based Physician Engagement and LTSS Provider Engagement on the Physician Advisory Committee (PAC) and LTSS Advisory Committee

Sunflower's PAC was formed to solicit face-to-face feedback from network physicians that helps to identify network gaps and inform network development strategies. This group is chaired by our CMD and staffed by our Contracting and Network Development department. The PAC meets quarterly and includes participating physicians in the Sunflower network from medical office or hospital settings, who offer a balanced perspective representing our diverse membership. See our response to Section 5.6, Provider Services which covers complete information about Sunflower's provider engagement activities.

In addition, Sunflower formed a LTSS Advisory Committee in 2016 to collaborate with LTSS stakeholders on areas such as outcomes measurement, value based purchasing, State and Sunflower policy and processes, and proposed legislation. The Committee is representative of all of Sunflower's LTSS population. For more information on this committee, please refer to Section 5.9.1 for our Quality Committee structure.

SUNFLOWER'S NETWORK DEVELOPMENT APPROACH

Sunflower's dedication to high quality care and community health transformation is evidenced by our earning an accreditation status of Commendable from the NCQA in 2016**.** In keeping with this achievement, our approach to developing and managing the provider network begins with a thorough analysis against the state's network adequacy requirements and the network considerations outlined in Section 5.5.2.F. Sunflower develops and maintains a network of qualified providers/practitioners, contracted through written agreement, in sufficient numbers and locations, including all covered services and specialty types, including those described in 5.5.2.G, and in geographic distribution to offer choice and meet the best interest, welfare and healthcare needs of our membership, including adults, children, and special populations such as children in Foster Care, members with IDD (5.5.2.A, C, G). In addition to adequate numbers, through contract provisions, ongoing monitoring, and audits, we will ensure our network is in full compliance with KanCare 2.0's access and availability requirements (5.5.2.D, E).

Sunflower is committed to improving the health of the community, one individual at a time, through a robust and engaged network of highly skilled practitioners and providers, all focused on treating the whole person with the same accessibility in timeliness, amount, duration and scope as afforded non-Medicaid individuals (5.5.2.D). Our approach to network development and provider management integrates and unifies PH, BH, and LTSS and leverages our provider tiering processes to prioritize recruiting higher quality practitioners.

As an incumbent Kansas Medicaid MCO, we are eager to provide a snapshot of our current network as well as highlight our network optimization initiatives that we have begun executing to best meet the needs of our members through KanCare 2.0. Throughout this response, we will describe our compliance with access requirements, continual monitoring, general and targeted network development plan, and capacity management activities.

OUR NETWORK EXPERIENCE AND TRACK RECORD

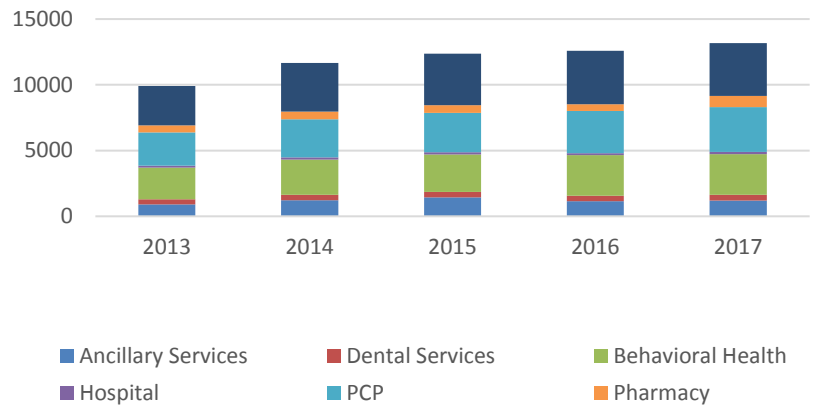
Sunflower has developed a high quality, robust network that comes from a deep understanding of our populations through community engagement, high-level engagement with our provider network, and national experience serving all covered populations; a high touch provider strategy supported by dedicated staff and actionable data; comprehensive training leveraging evidence-based practices and national experts; and quality programs that reward high-performing providers. For example, in Sunflower's current network, 45 provider groups participate in a value-based payment (VBP) arrangement.

We've been ensuring quality health care for Kansas Medicaid members since 2013 and before that since 2005 when Centene held a contract with KDHE for BH coverage of CHIP membership, and we've significantly grown our provider network as indicated by the timeline above. When we commenced operations in 2013, our membership was served by 14,381 providers. In 2017, Sunflower's membership is served by more than 23,000 providers, including 166 hospitals. This includes more than 3,400 PCPs and more than 7,300 specialists, over 3,100 local BH providers and over 1,500 LTSS providers. Further, we have 856 pharmacy providers and contract with any willing pharmacy provider that meets requirements to join the network. We are continually focused on recruiting quality, capable, and committed providers across all specialties to ensure that we meet the unique health challenges while addressing SDOHI of our different member populations, including those who reside in rural, frontier or otherwise underserved regions of the State. We are currently contracted to operate statewide with the State of Kansas to provide PH, BH, and LTSS services for Kansas Medicaid beneficiaries.

Strategic Priorities in Building a Network

We have successfully expanded our network to serve all enrolled populations throughout the state since 2013, and understand what it takes to continually build and maintain a local network to ensure that members have provider choice whenever possible and to meet new challenges and needs. ***See Figure 5.5_Sunflower Network Growth***.

Figure 5.5_Sunflower Network Growth



Sunflower is well-prepared to continue developing our network based upon the following State strategic priorities:

- Accommodate the KDHE and KDADS goal of improving service and community integration and service coordination for LTSS (5.5.2.F.11) and other vulnerable populations
- Ensure that our network is adequate to provide Covered Services to all members, including children with special needs, and that providers ensure physical access, reasonable

accommodations, and accessible equipment for members with physical or mental disabilities (5.5.2.F.1; 3).

- Enhance our network to address key priorities such as: BH adequacy and integration with PH; LTSS; and Foster Care
- Ensure providers offer continuity of care for members in transition including child and adult members as they move from one system of care to another (5.5.2.G.5), including a minimum of six months transition to an in-network PCP for new members (5.5.5.2.E), and provider continuity if desired for pregnant members new to the plan as described further in Section 5.4
- Engage providers to partner with Sunflower to provide access in difficult to serve regions. This is accomplished with, for example, recruitment of providers within 50 miles of the Kansas border in neighboring states, contracting with LTSS providers that travel beyond their county of record, encouraging network providers to expand their county footprint, and telehealth and nurse triage lines to meet the needs of rural, frontier and underserved communities.
- Collaborate with KDHE and KDADS to review HCBS programs with similar services, and that experience service gaps or delays, e.g., Specialized Medical Care Services and Personal Care Services, to determine how other states model these services to address ongoing workforce needs. Collaborating to streamline the provider requirements across HCBS programs would also help simplify how providers enroll to make it possible for them to serve more HCBS programs and members.
- Work directly with member advocacy and other community-based organizations such as those entities mentioned under our discussion of Community Partnerships in Section 5.17.2.G
- Strengthen quality and improve outcomes by ensuring provider network adequacy entails much more than just counting the number of providers signing contracts; provider incentive programs are being developed to strengthen the integrity of the network and quality of service for members (5.5.2.G.10).
- Reduce complexity for members and providers to maximize access to care
- Continue to recruit Ambulatory Surgical Facilities across the State to serve as an alternative to costly outpatient procedures provided in hospital setting
- Continue to identify and contract with Urgent Care Facilities, to provide suitable alternatives to Emergency Room (ER) use, particularly in geographic areas where claims or Medical Management indicators reveal high ER utilization. Sunflower already contracts with 29 providers of urgent care services.
- Develop strategies to address SDOHI through provider partnerships as described in Section 5.8.3
- Explore direct Primary Care local practices for member referral (5.5.2.G.15) to support the State's commitment to helping enrollees who transition from Medicaid to commercial coverage.

In addition to referrals to direct Primary Care local practices, Sunflower will offer other options to facilitate any member transitions off Medicaid to other insurance, including Foster Care children who age-out of the Medicaid system, for example:

- AmBetter, by Sunflower, is our health insurance marketplace option for individuals in Kansas and our provider network overlaps with the Sunflower KanCare network, which minimizes disruption in provider relationships for transitioning members.
- We identify and refer interested, transitioning members to flat fee-based PCPs who offer basic primary care benefits for individuals who prefer this option to commercial coverage.

MAXIMIZING PROVIDER ACCESS IN A PREDOMINANTLY RURAL STATE

Sunflower's five years of experience managing a service area dominated by rural and frontier counties through our existing Contract in Kansas coupled with the national experience of our many affiliates that have participated in statewide contracts involving high percentages of rural counties position us for success. In Kansas, 85% of the state's counties have a rural or frontier designation -- 53 of the state's 105 counties are classified as densely-settled rural or rural and 36 counties are frontier with one-third of Kansas residents.

In support of the collective goals that KDHE and Sunflower share, we advance any initiative on the part of the State that would promote an expedited Medicaid registration process for those providers that are required for adequacy of a Kansas Medicaid network. We are also exploring pay for performance arrangements with rural providers as described further in Section 5.7.

Ongoing Support for Safety Net Providers including FQHCs, RHCs and CAHs (5.5.2.G.4)

Sunflower follows the standard practice of our parent company, Centene, developing a foundational network starting with traditional Medicaid providers who serve our members. These providers play a key role in our networks because:

- They know and are motivated to serve Medicaid beneficiaries, and have the right administrative tools to succeed in a Medicaid managed care environment
- They have long-standing, established relationships with other Medicaid providers
- They have an awareness of resources within the community that serve underserved populations
- They practice cultural competency every day

Sunflower regularly receives positive feedback from our community of safety net providers. For example, during a recent meeting with the CEO and the billing supervisor of Heart of Kansas Family Healthcare (Great Bend), Sunflower was praised for being easy to work with and the FQHC expressed appreciation for Sunflower's provider engagement efforts.

Sunflower's existing provider network includes all Kansas Federally Qualified Health Centers (FQHCs), all Community Mental Health Clinics (CMHCs), Rural Health Clinics (RHCs) across 202 sites and all State Critical Access Hospitals (CAHs). Further, we seek to subcontract and/or collaborate with any local health care provider receiving funds from Titles V and X of the Social Security Act. The following examples demonstrate Sunflower's commitment to these critical safety-net providers:

- To provide high-level support, Sunflower's Provider Relations team includes provider network specialists dedicated to serving as a single point of contact for providers
- The incentive-based Pay for Performance (P4P) program Sunflower holds with large health systems, FQHCs, CMHCs and RHCs, such as GraceMed Health Clinic (an FQHC) and Hutchinson Clinic (a RHC) rewards them for achieving success in five quality measures: 1) childhood immunization combo 10, 2) immunization for adolescent's combo 2, 3) well child visits for members age 3-6, 4) one measure for diabetes A1c testing (adults), and 5) one measure for cervical cancer screening (adults).
- Sunflower has a P4P program with 26 CMHCs to improve four HEDIS measures and one readmission measure. These are: 1) metabolic monitoring for children and adults on antipsychotics, 2) adherence to antipsychotic medications with individuals with schizophrenia, 3) diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotics, 4) 7-day follow-up visit post discharge for mental health hospitalization visit ages 6+, and 5) reduction of readmission rates within 30 days of a discharge for a psychiatric condition.

ADDRESSING CULTURAL AWARENESS THROUGH THE NETWORK (5.5.2.B AND 5.5.2.F.2)

As fully described in 5.5.4 below, we currently and will continue to train providers and their office staff under KanCare 2.0 on cultural competency, services available such as our language line to support members, availability of in person interpreter services including sign language, and on the culture of disability to effectively engage with members. The training is supplemented by our Practice Improvement Resource Center (PIRC), a well-organized, searchable collection of information on evidence-based toolkits and best practices with information pertaining to cultural awareness. We also design our network to be representative of our member population, recruiting providers that speak the languages and share the cultural traditions of our members. We capture the languages spoken by practitioners to assist with assignment to providers for non-English speaking members through the CAQH Data Form and Roster Form. In addition, provider agreements require compliance with federal and State nondiscrimination and cultural competency requirements standards and our provider manual further outlines guidelines and expectations regarding cultural competency. Our provider orientations go over these expectations and we hold annual cultural competency training including information about the SDOHI for providers.

IMPROVING THE COMPETENCY AND CAPACITY OF OUR NETWORK BY SUPPORTING ACTIVITIES TO ADDRESS SOCIAL DETERMINANTS OF HEALTH AND INDEPENDENCE (SDOHI)

As further described in 5.5.4, 5.7.1, and 5.8.3 Sunflower will continue to partner with our network providers and develop interventions to address SDOHI which are often the root causes that contribute to poor health and higher program costs. Social, economic and environmental conditions all play a key role in health outcomes and disproportionately affect low-income populations. Research has shown that when providers conduct consistent collection of individual-level SDOHI information, it can inform and have a positive impact on member interventions. For example, to support this effort and our providers in better serving their patients, we will be partnering with the National Association of Community Health Centers

(NAC) and others to implement PRAPARE. PRAPARE is both a standardized patient social risk assessment tool consisting of a set of national core measures as well as a process for addressing the SDOHI at both the patient and population levels. In addition, our person-centered planning approach uses member-centric information collected during the assessment process, including information on SDOHI, to help our providers engage most effectively with each member. Through this process we consider needed PH, BH and LTSS services as appropriate, but also resources and interventions that mitigate the effects of SDOHI (e.g., poverty, violence, trauma, homelessness/housing insecurity, etc.). Our provider orientations and workshops will review the SDOHI that affect member health and Sunflower's expectations. In addition, provider newsletters will provide actionable information for screening SDOHI in the clinical setting to address gaps and support coordination of social services where needed.

"Having the equipment and being able to take measurements gives me a sense of relief and reduces my anxiety about my diagnosis. I don't have to worry as much about how I am doing because I have the daily measurements to compare."
Sunflower member

TECHNOLOGY INVESTMENTS IN TELEHEALTH, OTHER TECHNOLOGICAL SOLUTIONS (5.5.2.F.5)

Sunflower is committed to expanding the use and effectiveness of telehealth strategies and driving innovation in the delivery of care while improving access through telehealth initiatives. Telehealth includes telemedicine, telemonitoring, and telementoring. Sunflower's telehealth initiatives address disease management, virtual visits, independent living, BH, and chronic pain management. Successful telehealth projects require meaningful collaboration with provider and community partnerships and national and local telehealth experts to effectively address access issues, improve health outcomes, and decrease health care and other costs. We will collaborate with and build upon Kansas' existing telehealth initiatives supported by the Heartland Telehealth Resource Center.

Sunflower members on the Frail and Elderly HCBS program experienced immediate outcomes from telemonitoring between 2016 and 2017. The number of inpatient and ER claims and related costs dropped by 1,078 claims and by $42,462.

Working within the state's telemedicine framework, Sunflower allows all contracted providers to offer telemedicine services within their scope of practice and provides a service covered by the current telehealth codes and has the correct telehealth equipment per State policy. While we support telehealth programs members always have the choice to receive their covered services face to face. Telehealth is advancing to enhance traditional service delivery, for example:

Telehealth and Disease Management (DM)

Sunflower uses telemonitoring services to provide DM for members with asthma, congestive heart failure (CHF), COPD, and diabetes. Through all DM programs at Sunflower, we offer specialized telephonic coaching to help members self-manage their disease. Preliminary results

for CHF telemonitoring in the last five months show an over 10% savings for the 35-member cohort and a decrease in overall per member per month spend, driven by a reduction in primary and specialty care visits as well as hospital outpatient care (see Section 5.7 for further information).

Tele-Care Monitoring

Sunflower continues to explore innovative ways to utilize technology to support our members. Our Tele-Care Monitoring Program will provide real time monitoring of biometric data using web-based technology combined with telephonic disease management coaching for high risk members. Through this program, Sunflower aims to reduce preventable health care utilizations, promote member adherence to treatment guidelines and improve self-management skills. The program objective for pregnant members is to improve glycemic control to promote positive birth outcomes. Conditions covered include COPD, Diabetes, Heart Disease (Heart Failure and Coronary Artery Disease) and Hypertension.

Telehealth and Virtual Visits

Currently, our members and their legal guardians have access to services through our 24/7 Nurse Advice Line. When a member calls our Nurse Advice Line, they are triaged and screened to ensure appropriate contact and coordination with their PCP was first attempted by the member. Where appropriate, this intervention guides the member back to their PCP for timely medical care. We will deploy virtual video visits for members to be connected to a board-certified physician. For example, if the member's PCP cannot be reached, our nurse response representative will stay on the line with the member while connecting them to a telemedicine vendor. This interactive provider to member virtual visit will include medical history and telephonic consultation for stress/anxiety, depression, addiction, domestic abuse and grief counseling as well as dermatology, sexual health and general health symptoms and complaints is conducted by a board-certified physician and can include prescription of medication, if necessary. Offering members near immediate access to a PCP or specialist aims to help reduce potentially preventable events such as ED admissions and supports member's access to care.

Sunflower in Action…

Austin, a Sunflower member with I/DD, previously lived at home with his parents and siblings. He says it was "always my dream to live in a college town… Rock Chalk!" He now lives in his own apartment in Lawrence within CLO's Neighborhood Network. Austin utilizes HomeLink technology which allows him to push a button to access caregiver support, and allows his staff to also detect when he may need them. Austin has a job at a local convenient store. He says his favorite part about his living arrangement is, "Having a lot of independence. Doing anything I want without being told."

Telehealth and Independent Living (Active Sensor Monitoring)

In collaboration with Community Living Opportunities (CLO), Neighborhood Network and HomeLink Support Technologies, Sunflower will partner with CLO to help fund a pilot which will include a model of housing, telehealth and supervision support, and networked onsite living supports for members in LTSS. The Neighborhood Network creates a support system for neighborhoods by using smart home

technology, remote coaches and clinicians, and professional neighbors or roommates to deliver individualized care on demand or as scheduled. CLO provides access to The Neighborhood Network to members in HCBS. The housing is in an integrated setting, but includes neighbors who also receive HCBS services and CLO-employed caregivers. CLO utilizes a combination of onsite and remote caregivers, and HomeLink Support Technologies to provide needed services to members in the most independent living arrangement possible. CLO offers HomeLink Support Technologies to both members in the Neighborhood Network and members who live within their own homes. HomeLink includes a team of 24/7 caregivers, remotely located, who are trained on and monitor individual member needs through a system of individualized sensors and individually tailored responses. HomeLink "connected" homes allow remote caregivers or clinicians to:

- Monitor and respond to a member's PH, BH and safety needs
- Provide individual coaching and support to members regarding ADL and IADL needs
- Control home automations to provide help and ensure safety
- Deploy professional help on demand, for as long as necessary
- Supervise and deploy in-home caregivers to ensure the best and safest care is provided when needed
- Connect a member to CLO's Wellness Clinic for preventative care and/or assessment

Telehealth and Behavioral Health

Sunflower uses telehealth for Crisis Assessments, Psychiatrist Visits, and Therapy. Additionally, through our disease management programs, we offer specialized telephonic coaching to help members self-manage their disease. See Section 5.5.7 for complete information about Sunflower's telehealth and BH initiatives.

Telehealth and Chronic Pain Management

Sunflower is planning to create and support a Project ECHO for chronic pain management which will support providers to improve chronic pain management services and better understand the root cause of medication seeking behavior, symptoms, and treatment options. Project ECHO is a hub-and-spoke knowledge sharing network led by expert teams who use multi-point videoconferencing to conduct virtual clinics with community providers. To create this Project ECHO, we will work with an anesthesiologist and pain management consultant for the Missouri Primary Care Association and lead facilitator for Missouri's Chronic Pain ECHO Project.

KEY POPULATIONS AND INITIATIVES THAT SHAPE THE NETWORK (5.5.2.F)

Based upon the State's goals, our experience under the current Contract, and our national experience and best practices, we give particular attention to network development for specialty services, such as children, adolescents, and adults with IDD or cognitive disabilities, sexual offenders and sexual abuse victims, individuals with mental health and/or substance use conditions, foster children in transition to adulthood, and infants and toddlers under age five. We describe a few of the key focus areas to serve individuals with specialty needs here:

BH Adequacy and Integration with PH

Sunflower is fully committed to providing our members with person centered, holistic care, the cornerstone of which is a comprehensive and robust provider network. We have contracted with 100% of the State's CMHCs, as well as a diverse range of other BH practitioners to meet our members' needs, as outlined in more detail below in Section 5.5.7. We are also pursuing incentive programs to strengthen provider recruitment and retention such as enhanced rates for family therapy as described in Section 5.7 (5.5.2.G.10). We have supported the expansion and enhancement of the KanCare system's BH capacity since our inception in 2013, and will continue to partner with the State to improve integrated services for Kansas Medicaid members living with BH conditions. For example, Sunflower worked with the State to develop and disseminate evidence based policies and procedures for Medication Assisted Treatment (MAT) across the state, and in 2017 we provided training and education to 100 providers within our network to support their ability to prescribe these critical treatments. Through our parent company, Centene, we have also provided grants to rural providers to obtain and implement electronic BH kiosks in community locations (e.g., County Public Health Offices, schools, community hospitals) to expand member access to mental health assessments and connection to treatment as needed. We further facilitate partnerships between our network providers across disciplines, including participation on multidisciplinary care teams, training on evidence based models of integration like the Collaborative Care model, and the implementation of various technologies, including the Provider Portal that supports the creation and implementation one integrated Member Record.

> ***"Laura, you are the best. I have so many moving parts that need to be addressed…help from people like you lighten the load. ☺"***
>
> ***Wilson Medical Center to their Provider Network Specialist***

Members Needing Long-term Services and Supports (LTSS) (5.5.2.G.8; 5.5.6)

Sunflower contracts with LTSS providers enrolled with KDHE as a Medicaid provider including HCBS, residential and institutional providers. This includes 272 skilled nursing facilities, six ICF/ID providers and close to 1,300 Medicaid HCBS providers. We also contract with community developmental disability organizations (CDDO), and their affiliate Community Service Providers, in compliance with K.A.R. 30-64-27 whenever possible to serve members in the developmental disability system.

The Sunflower Contracting team reviews the State's Medicaid provider enrollment report to identify and fill any provider gap, including LTSS providers, where necessary at least quarterly. Maintaining a broad array of LTSS providers requires a more targeted approach than with other provider types, particularly in Kansas with significant rural and frontier service areas. We find that LTSS providers without managed care experience require a higher touch approach and recruitment strategies. Our high touch approach and recruitment strategies for LTSS providers include:

- Identifying traditional LTSS providers, including HCBS providers, residential providers and nursing facilities enrolled with KDHE as Medicaid providers for contracting to ensure that members receive continuity of care and that we minimize disruption of access to services

for members when they transition into managed care, move between MCOs, or transition from one setting to another

- Leveraging our close partners to help secure new LTSS provider contracts
- Working with the LTSS Advisory Committee to help recruit LTSS providers
- Recruiting HCBS provider types in counties in which there are not currently two or more providers in the network, such as Adult Day Care, Speech Therapy – TBI and Autism HCBS programs. Sunflower continues to reach out to providers not yet contracted and/or discuss with contracted HCBS providers to expand services in underserved areas of the State.
- Onboarding of new LTSS providers with special assistance from a Provider Relations specialist that comes from the LTSS industry
- Conducting provider outreach and education to ensure providers understand Kansas Managed LTSS Program requirements, including the use of Person-Centered Service Plans (PCSP), as well as our operations and processes
- Ensuring provider network development staff are equipped to communicate with providers during the recruitment, contracting, credentialing, and post-implementation training phases
- Utilizing provider contracts which include specific requirements regarding respecting the preferences and will of the member
- Customizing provider education for certain LTSS providers that have unique training needs, such as billing assistance
- Use of the LTSS Claims Wizard on the provider portal to improve claims payment turnaround for LTSS providers -- this is designed specifically for LTSS providers with limited coding experience and recurring claims billing needs and coding rules unique to our LTSS program
- Designation of an IDD Provider Relations specialist available to IDD providers who need assistance in coordinating member care and administrative matters.

Accommodating Members with Disabilities (5.5.2.F.3)

Sunflower has processes in place to conduct provider office trainings and offer tools to ensure our provider network pursues positive approaches to increasing physical access, reasonable accommodations, and accessible equipment for members with physical or mental disabilities, as well as access to the tools and supports needed so our members can receive the best care possible. When a complaint from a member or other source is received, our provider relations specialists conduct an office site visit to assess for physical accessibility to the site including the waiting room and exam room environments to ensure accessibility for members with disabilities. The assessment is provided to the Quality Improvement (QI) Department with recommendations for resolution. The QI department initiates a corrective action plan with written follow-up to a provider to resolve the issue if one is identified.

Provider Accessibility Initiative (PAI)/National Barrier Removal Fund (BRF). Sunflower is committed to providing equal access to quality health care and services that are physically and programmatically accessible for our members with disabilities. According to a 2017 CMS analysis, Medicaid and Medicare beneficiaries with disabilities receive less preventive care than those with no disability because health care providers lack accessible exam rooms and/or

diagnostic equipment. Nationally, nearly half of all providers on average lack accessibility. Rural areas in some states see rates of inaccessibility up to 85%. There are three primary causes of provider inaccessibility: lack of awareness of disability access requirements; lack of financial resources to remove access barriers; and lack of enforcement. To begin addressing these root causes, in May of 2017, our parent company, Centene launched a Provider Accessibility Initiative (PAI) to increase the percentage of Centene's providers that meet minimum federal and state disability access standards. A central hallmark of the PAI is a national Barrier Removal Fund (BRF). Centene providers that apply for, and receive awards from the BRF receive individualized technical and financial support such as:

- An on-site Accessibility Site Review (ASR) and Compliance Action Plan (CAP) conducted by a local Center for Independent Living (CIL) that includes recommendations for removal of accessibility barriers in priority order;
- Funding to remediate priority barriers; and
- Staff training to increase awareness.

We will implement the PAI and BRF in Kansas. We will provide grant funding to qualified providers for accessibility modifications and/or equipment, for our members to better access healthcare. Our fund manager for this program is the National Council on Independent Living and we will partner with selected Kansas CILs and other community providers to perform the ASRs and CAPs.

Members in Foster Care (5.5.2.G.2; 11)

Sunflower collaborates with Foster Care stakeholders and works closely with KDHE's Foster Care Workgroup to link with Foster Care agencies and providers that provide services to 5,500 children, youth and families including transitioned aged youth ages 18-21, and infants and toddlers under age five (5.5.2.G.11). Collaborations cover areas such as child welfare, child mental health, and residential youth care. We also developed a plan specifically designed to identify PCPs and BH specialists for Foster Care children and youth, and we contract with all of the State's eight Psychiatric Residential Treatment Facilities (PRTFs). In addition, through our Training and Education programs, we attract and support Foster Care agencies and providers by offering them a team of experts that provide education on health plan benefits, clinical topics and issues affecting children in care, including trauma informed care. We are proud to note that 248 providers in our network have been trained on Foster Care topics including: advocacy, child development, Trauma Focused Cognitive Behavioral Therapy (TF-CBT), introduction to human trafficking, loss and behavior, preventing sexual misconduct, trauma informed care, suicide prevention and more. Nationally Sunflower's parent company Centene has arranged for trauma-focused cognitive behavior therapy for 2,700 providers to date (5.5.2.G.11).

Close to 250 Sunflower providers have received training on topics about Foster Care.

Other specific strategies include:

- ***Engaging with providers for children in Foster Care*** including Stormont-Vail, Children's Alliance, The Shelter, The Villages, O'Connell Youth Ranch and Youthville/Non-profit Solutions
- **Collaborating with Foster Care agencies** including KVC Health Systems and St. Francis Community Services
- ***Working with CMHCs.*** CMHCs participate in Sunflower's care management teams on clinical case staff meetings to review complex cases, plan for discharge from psychiatric residential treatment facilities and inpatient stays, and ensure continuity of care as children move from one part of the state to another.
- ***Soliciting input from foster parents and advocates.*** Foster parents and other advocates serving children in Foster Care are considered part of the Sunflower treatment team. Our care managers consistently work with foster parents to discuss the unique needs of children residing in their homes, incorporate their feedback in care planning, and work with them to eliminate any barriers to care for each child. Additionally, Sunflower participates in the KVC Kansas Community Advisory Board which includes birth parents and foster parents. Feedback from this group is used to better inform our processes and educate our staff about how to better meet the needs of children and families in the Foster Care system.
- ***Contracting with multi-specialty practices*** to support Foster Care children with special health care needs

Children with Special Health Care Needs Many of our strategies to support children and youth in Foster Care can be used to enhance our specialized network for children with special health care needs. This includes working with the State, parents, providers, and advocates to identify providers and current practice patterns, including the Kansas Special Health Care Needs (SHCN) Program, the Special Health Services Family Advisory Council, and Specialty Clinics.

American Indian Members (5.5.2.G.13)

Sunflower upholds the protections afforded American Indian members for seeking health care from any Indian Health Service, tribal and urban Indian organization (I/T/U) program without barriers or limitations. Members enrolled in a federally recognized Indian Nation may access I/T/U and Tribal 638 providers at will and without a referral. Tribal members may receive care from in-network and out-of-network I/T/U providers. Sunflower has a sufficient level of Indian Healthcare Providers (IHCPs) in our network and we honor the State's rates for out of network IHCPs. Sunflower has been proactive in recruiting and retaining IHCPs including all I/T/U providers to ensure timely access to care. The plan accepts a current license to practice in the United States or its territories from any individual provider employed by the I/T/U or the tribal 638 facility. Receipt of this license to meet requirements for network participation.

KEY PROVIDER TYPES FOR COMPREHENSIVE MEMBER CARE (5.5.2.G)

Sunflower recruits and retains a robust provider network appropriate for ensuring good access to care, in keeping with the program goal that in-State members receive services from in-state providers when available at competitive rates and levels of quality (5.5.2.G.7).

Primary Care Network

Sunflower has worked diligently since 2013 to build a comprehensive network of PCPs that ensures PCP choice (5.5.2.C, 5.5.5.2.D) and the right to change providers at any time. Today, Sunflower partners with a broad and diverse network of nearly 3,400 PCPs including, but not limited to, pediatricians, family and general practitioners, internists, physician assistants (under the supervision of a PCP), and advanced registered nurse practitioners (ARNP). PCPs practice in over a thousand locations across the State of Kansas. The PCP network size has been developed and is monitored by the Contracting and Network Development department to satisfy current and anticipated member enrollment and utilization experience (5.5.2.F.1). These providers deliver exceptional and coordinated primary care services in practices ranging from the largest academic medical centers in Kansas to small independent health clinics in the State's most rural areas - and every size practice in between. We recognize that, of the 86 rural and frontier counties combined in Kansas, 18 of them are counties Federally-designated as Primary Medical Health Professional Shortage Areas (HPSAs). Sunflower invests significant resources to continually broaden our network of PCPs in these areas where access to primary care is more limited. We further monitor the primary care network to track panel size, panel enrollment/capacity, and panels that have closed to new patients (5.5.2.F.4). This is critical to ensure that members have good access to primary care, and proximity to their home within the geographic access standards as defined by the managed care Contract. Sunflower offers a network of PCPs to ensure every member has access within KanCare-required travel distance standards.

Sunflower believes close partnerships with PCPs and the sharing of actionable clinical information between Sunflower and our primary care network is critical to ensuring our members receive the best possible care. We also encourage PCPs in our provider orientations to have the ability to electronically send prescriptions (e-prescribing) directly to a member's pharmacy which is another way we seek to ensure the transfer of clinical information to improve efficiencies and quality of care (5.5.2.G.12). By ensuring clinical decision making is based on complete information such as care gaps, recently developed complications, and emergency room utilization Sunflower allows PCPs to see and act upon a complete picture of a member's health, including conditions and treatments that occurred outside of the PCP's office or network. We also track member loyalty to their assigned PCP, which is an indicator of continuity that contributes to improved health. In a November 2017 analysis, 42% of members were exclusively seeing their assigned PCP. We are working with network providers to increase PCP loyalty across the membership by, for example, including a measure which evaluates provider loyalty scores in one of Sunflower's VBP alternative payment models.

Sunflower's primary care and specialty care networks include more than 23,000 providers and practitioners located throughout Kansas' urban, rural and frontier communities.

Specialty Care Network

Sunflower's specialty care network is extensive and provides world class specialty services throughout Kansas and beyond. Like the PCP network, the specialty care network is designed to

extend provider choice (5.5.2.C) with the right to change providers at any time. Over 7,300 specialty providers deliver services in such areas as gastroenterology, cardiology, neurology and numerous other critical fields. Most of our specialists are board certified by their respective professional organizations. Of considerable importance to Sunflower's large child enrollment (84,645 which represents 67% of all members), pediatric sub-specialties and all of Kansas' highly acclaimed children's hospitals are available to members in all regions.

As with PCPs, the specialty care network size has been developed and is monitored to satisfy current and anticipated member enrollment and utilization experience (5.5.2.F.1). We routinely track referral volume and specialty practices that have closed to new patients (5.5.2.F.4). This is critical to ensure that members have good access to specialty care, with proximity to their home within the geographic access standards as defined by the managed care Contract. PCPs are not required to issue paper referrals when a member needs care beyond the scope of primary care, although prior authorization may be required to access certain specialty providers. Referrals are not required for in-network care. If a specialist stops accepting new referrals Sunflower's provider engagement specialists conduct telephonic outreach to confirm, and understand the reason(s) for this, and if necessary, onsite outreach to reinstate member referrals. We also encourage specialists in our provider orientations to have the ability to electronically send prescriptions (e-prescribing) directly to a member's pharmacy which is another way we seek to ensure the transfer of clinical information to improve efficiencies and quality of care (5.5.2.G.12).

Sunflower has considerably expanded our specialty network since inception in 2013; the network has grown to include specialists across the State, and includes many specialists practicing in states located within 50 miles of the Kansas border, including in Missouri, Colorado, Nebraska and Oklahoma. Sunflower will have specialists available in the following categories for adult and/or pediatric members on at least a referral basis, as listed in Table 5.5.2.B.

Table 5.5.2.B Specialist Provider Categories in the Sunflower Provider Network

Allergy	Hematology/Oncology	Plastic and Reconstructive Surgery
Behavioral Health	Neonatology	Podiatry
Cardiology	OB-GYN	Psychiatry
Dermatology	Ophthalmology	Pulmonary Disease
Internal Medicine	Orthopedics	Urology
Gastroenterology	Otolaryngology	Physical Therapy
General Surgery	Physical Medicine/Rehab	Occupational Therapy
Neonatology		

Coordinating care between PCPs and Specialists. Coordination between PCPs and specialists serves as an additional critical link between members, Sunflower, and our members' caregivers. Sunflower has written protocols in place for coordinating care among PCPs and specialists, including information sharing and timelines for response. Specifically, specialists are contractually required to complete a written report and send it to the PCP within one week (five business days) of the visit. Information exchange between PCPs and specialists is essential

when prescribing medication, ordering diagnostic testing, and performing other services that require a high level of coordination. Information on service coordination and requirements around sharing of information are also included in the Provider Manual and via Fax Blast. The name of the member's PCP is always listed on the front-side of their member ID card.

Women's Health and Family Planning Providers (5.5.2.G.4; 5.5.9.J.1)
Sunflower contracts with 14 family planning clinics and close to 1,000 OB/GYNs to provide access to care for women's health. Sunflower has also contracted with one freestanding birth center, the Birth and Women's Health Center to provide an alternative for childbearing families who are screened for a low-risk pregnancy and birth. Female members of Sunflower have direct access to women's health services whether they seek care from an OB/GYN within our network for routine services or seek such care from their PCP for routine gynecological exams. In addition, Sunflower covers family planning services and treatment for sexually transmitted diseases provided by any qualified Medicaid provider. We maximize freedom of choice for these services; network participation, referrals and prior authorizations are not required.

Behavioral Health Network (5.5.2.G.8). Unlike most managed care plans that must rely on outside, non-integrated and non-local business partners to provide behavioral health (BH) services, Sunflower offers BH services from more than 5,450 providers that are truly integrated into the care delivery model. We integrate PH and BH expertise in both clinical and non-clinical areas within the Sunflower service coordination process. Our network development process will ensure that an appropriate number of BH providers exist to meet member needs. Sunflower's network includes BH and substance use professionals including licensed psychiatrists, psychologists, psychiatric nurses, professional therapists, substance use providers, clinical nurse specialists and autism specialists. Services occur in community mental health centers, FQHCs, provider office settings and in hospital settings.

Sunflower provides a geographically strong and integrated network of providers with the capacity to meet the unique needs of our members across the state.

At the community-level, we actively engage BH providers through face-to-face meetings, onsite provider training and educational opportunities, and Provider Relations staff tours of BH facilities to ensure quality of care. Full integration allows the physical and BH needs of Sunflower's members to be seamlessly addressed, thereby eliminating the fragmented silos that weaken person-centered care models. Our active engagement with the communities we serve allows Sunflower to respond to and adjust our BH network whenever necessary to meet the changing needs of Kansas communities in a nimble and efficient manner. See Section 5.5.7 for more information about Sunflower's BH network activities.

LTSS Network (5.5.2.G.8)
Sunflower has the greatest KanCare LTSS market share at 38% which has resulted in preferred MCO contracting status by LTSS providers. We also serve 46% of the I/DD HCBS population and 65% of persons with I/DD who reside in an ICF/ID facility.

Our market share leadership in LTSS has made it possible for us to negotiate service area expansions with, for example, providers of Traumatic Brain Injury (TBI) and autism services to improve access to care for members in need of these services. Sunflower contracts with all the State's Medicaid enrolled skilled nursing facilities (286) and close to 1,300 Medicaid HCBS providers across the almost 30 types of these providers. This ensures that an appropriate number of LTSS providers are in our network to meet member needs.

Sunflower has been working with providers of Shared Living services to develop a statewide manual for best practices for offering this service.

One way we invest in LTSS network development and retention is by developing statewide best practices and representation. Sunflower has been working with providers of Shared Living services to develop a statewide manual for best practices for offering this service. We have also had discussions with the National Association of State Directors of IDD about the value of expanding the services in Kansas. Sunflower is committed to continue our work with KDADS to support this expansion.

Sunflower is committed to network inclusion of any qualified and willing provider whenever possible to maximize each member's choice of LTSS providers, and to ensure undisrupted transitions for members who transfer in and out of plan enrollment. Our inclusive LTSS provider contracting strategy has led to Sunflower contracts with most LTSS providers enrolled with KDHE as a Medicaid provider to serve members who qualify for one of the seven HCBS programs. See section 5.5.6 for further details about Sunflower's LTSS network.

Hospital Network

Sunflower offers a comprehensive hospital network to serve our members and maximize choice by contracting with all 166 Medicaid hospital providers located in Kansas. The hospital network includes medical centers, and tertiary care facilities, including level I and level II trauma centers, specialty hospital services including a major burn care center, organ transplantation, specialty pediatric care with level III (high-risk) nurseries, and rehabilitation facilities, Osawatomie and Larned State Hospitals (5.5.2.G.1) through our BH network, and medical subspecialties available 24 hours per day. Our hospital providers also operate specialty outpatient centers for HIV/AIDS, sickle cell disease, hemophilia, and cranio-facial and congenital anomalies, home health agencies hospice programs, and licensed long-term care facilities with Medicare-certified skilled nursing beds. Hospital services and hospital-based providers must be qualified to provide services under the Medicaid program. In addition to Kansas-based hospitals, Sunflower contracts with hospitals (acute care, rehabilitation, and psychiatric) in 35 locations up to 50 miles across the State border to provide the best possible access to covered services for members living close to state lines.

sunflower health plan

Dental Care Network

We currently maintain a geographically robust and balanced network of more than 400 primary care dentists in 337 locations across all regions of Kansas. Additionally, our dental network includes services provided within safety net providers such as FQHCs and local public health departments (LPHDs). Since many of these providers integrate dental care into their overall delivery processes, our members receive the added benefit of having dental (and in many cases BH) services integrated both at the point of care delivery and at Sunflower. This serves to further enhance the member experience and provide even greater ability to care for the whole person.

Sunflower exceeds the NCQA Quality Compass 75th Percentile on the Annual Dental Visit Metric.

Sunflower provided a higher reimbursement rate for a provider that served a member with special needs in Leoti, KS

Sunflower has been providing comprehensive quality dental care services to our members since program inception in January 2013. We partner with Dental Health & Wellness (DHW) to deliver dental care services. DHW recently changed its name to Envolve Dental, Inc. Envolve Dental is an integrated division within our parent company, Centene, and facilitates a level of integration within the Sunflower care delivery model that is not possible in a traditional external subcontractor relationship. As an integrated partner, Envolve Dental provides the most robust dental network of the three Medicaid MCOs in Kansas. Through Envolve Dental, we strive to be innovative in maintaining the dental network and improving access to care and services for our members.

Sunflower recognizes that easy access to preventive dental services can motivate members. Beyond our efforts to provide a robust dental network, we will take an active role in expanding capacity with contracted dental providers through:

- ***Assistance with scheduling and follow-up reminders*** to minimize "no show" appointments, including assisting with transportation, special reminder arrangements, and outbound telephone calls to members prior to appointments.
- ***Identify high performing, high quality non-FQHC dental homes and provide incentives*** to take additional KanCare 2.0 members. We also will review quality performance mechanisms and member patterns of health care access, and offer select network providers incentives for establishing non-traditional hours and expanding dental service offerings.
- ***Practice visits for members with IDD.*** Recognizing that routinely, members with IDD receive routine dental care in an outpatient hospital setting under general anesthesia, we aim to avoid the additional risks associated with general anesthesia by encouraging members to receive services in the dental office. Through an innovative method of reimbursing dentists for "practice visits" for members with IDD, we help make these visits less stressful. This approach provides an opportunity for members to become familiar with the provider's office, equipment, and processes prior to the actual date of service. This 'role-play' exercise also provides a setting for the member or parent/caregiver to ask questions and express concerns, encouraging the entire family to feel more comfortable with the process. Practice

visits also enable the provider to identify barriers to ensure clear communication before the appointment takes place.

BROADER EFFORTS IN IDENTIFYING AND RECRUITING NETWORK PROVIDERS

Sunflower's overall Network Development Plan employs innovative approaches to identifying new providers, contracting, payment, and incentives. We have leveraged our national ability to quickly build large, state-wide provider networks and combined it with our unique local experience. Our multifaceted approach to ongoing recruitment includes:

- Building a network that meets KDHE quality and cost goals and the adequacy standards to be defined by KDHE including, but not limited to, time and distance; appointment times; HEDIS compliance, ADA requirements; cultural competence; (5.5.2.E)
- Leveraging local resources to identify network expansion targets, by working with Kansas State File data, cross-referenced against National Plan and Provider Enumeration System (NPPES); running quarterly provider access analysis reports to identify gaps based on the network adequacy reporting Geo-Access standards described in Section 5.5.3, and reaching out to providers and correcting provider data
- Conducting monthly reviews of single case agreements
- Identifying graduates of Residency (GME) programs to participate in our provider network upon graduation and State licensing (5.2.2.G.3);
- Partnering with all stakeholders including State agencies and provider associations as described in the Strategic Provider Association and Provider Partnerships tables further in this section to obtain stakeholder input and address issues, concerns and requests (5.5.2.F.9)
- Leveraging existing providers to act as champions and answer questions about interacting with Sunflower
- Expanding provider capacity, competency, efficiency and success through practice transformation using Sunflower provider coaches to deliver training and technical assistance
- Understanding that compliance boosts access for our members. This includes compliance with data points such as cultural and linguistic competence as described in Section 5.5.4 of this response, provider assessment of members' SDOHI, hours of operations, board certifications, and public transportation routes (5.5.2.B).
- Monitoring member satisfaction with provider access and availability (5.5.2.F.7)

PROVIDER OUTREACH IMPLEMENTATION PLAN TO SUPPORT NETWORK RETENTION

We currently fulfill the KanCare network adequacy requirements across the state through signed provider contracts, and will continue to do so under KanCare 2.0 (5.5.2.A; 5.5.6). We divide the network by region and Provider Relations specialists each focus on one of seven territories. We will continue to monitor network coverage by focusing on regions underrepresented by certain provider types to ensure superior access to care and network retention (5.5.2.G). The Provider Relations team will continue to conduct the maximum level of outreach as necessary to ensure the most robust network possible. As of this proposal submission, more than 23,000 providers are under contract. Sunflower partners with local

public health agencies, leverages existing provider relationships, and works with provider associations to add further depth to our local networks. We continue to invest in relationships with safety net providers, including CMHCs, FQHCs, and RHCs.

We focus on quality, not just numbers

Once the viability and efficacy of network access is proven through volume, the focus shifts to improving the quality of our providers through HEDIS and CAHPS measures and other data points (5.5.2.F.7). Through our external benchmarking tool, quality improvement, credentialing, and data analytic activities, we use HEDIS measures, utilization trends, member and provider feedback, and input from our service coordinators to continually improve the quality of our provider network. In addition, we monitor, and address issues, concerns and requests raised by member, provider and other system stakeholders to State agencies, which are communicated to Sunflower for follow-up (5.5.2.F.9).

To further support our focus on quality providers, we are exploring the use of a quality benchmarking tool currently used by Centene's Medicare affiliates to support the build of high-performing networks. The Tool would identify high performing providers and communicate provider performance and improving behavior to support performance improvement goals. As we identify low performing providers, we work with them to improve outcomes through technical assistance and training.

Provider engagement field support

Optimal network development and maintenance requires accurate and efficient tracking of provider related activities including provider visits, topics discussed, and follow-up items and responsibilities. To achieve this level of monitoring, we use our Customer Relationship Management (CRM) platform. Today CRM enables Contracting and Network Development to access information related to provider interactions, issues/concerns, provider data updates, and other information beneficial to managing engagement with the provider. Through the system, Sunflower staff members:

- Access a history of provider office interactions including emails, telephone calls, and faxes
- Maintain data integrity with duplicate record checking and mandatory fields
- Search on any field, and create one-click access to frequently accessed providers

Through program enhancements planned for CRM this year, our tracking will include documenting reasons for provider visits, materials given at the visit, topics discussed, additional medical services available onsite, provider connectivity and meaningful use status, and more.

ATTRACTING, EVALUATING, AND CONTRACTING WITH PROVIDERS

Attracting Providers

Sunflower successfully attracts providers by:

- The Contracting and Network Development staff along with other Sunflower departments have traveled great distances across Kansas, investing time and effort to engage and

outreach to targeted providers, especially those in rural areas. We show providers that they are important to us and will be treated well in serving Sunflower members.

- Offering a VBP system that provides a continuum of payment options that allows us to attract and integrate providers into our network at a level that is comfortable for them and allows them to be successful in Medicaid managed care (5.5.15.A.1).
- Identifying providers that have a genuine interest in serving Medicaid beneficiaries, and explaining the depth and breadth of our commitment and expertise as reflected through Sunflower's continued expansion since 2013. This includes supporting our providers through practice transformation, technical assistance and training to be successful under VBP and improve overall practice efficiency.
- Providing concrete examples as to how we execute processes and solutions to reduce the administrative burden to providers and address concerns that they have in a timely manner. For example, to accommodate our providers' office operations, Sunflower is the only Kansas Medicaid plan that offers three ways to submit prior authorization requests (online, phone or fax).

Evaluating Providers

We effectively evaluate providers by:

- Using a provider profiling evaluation tool discussed in greater detail later in this section. This tool allows us to identify high performing providers; build and maintain high performing networks; communicate performance; and improve a provider's opportunity for success.
- Rigorously reviewing and verifying provider credentials initially and ongoing. The plan has succeeded in conducting 100% of provider orientations within 30 days of the contract effective date. Timely re-credentialing also is on target for the year at 100%. Sunflower currently outsources to two separate Credentialing Verification Organizations (CVOs) – a large, national CVO, Appeture, and a smaller, local one – which provides us with flexibility in fulfilling our responsibilities related to Primary Source Verification. Their review includes active status verification of provider licenses, registration, certification and accreditation (5.5.8.B.3).
- Developing initiatives, in collaboration with Medical Management, to support network growth and evaluation of providers and individual practitioners based on performance, quality/HEDIS goals and cost on an ongoing basis

Contracting with and Retaining Providers

We are successful in establishing contracts with providers and expanding those contracts to comply with KanCare 2.0 by:

- Being transparent during our initial outreach, and providing a comprehensive package of orientation, ongoing education and training, and ongoing information to welcome and empower our providers
- Reducing contracting barriers through other creative incentive strategies based on quality and efficiency, as well as continued efforts to develop non-financial incentives (5.5.8.E) as described in Section 5.5.8 and 5.7

- Consistently treating contracted providers and prospective contracted providers with respect and appreciation, soliciting their input and always closing the feedback loop
- Supporting providers with actionable information that aligns with their performance goals
- Facilitating top-of-licensure service delivery by supplying providers with the tools and support needed to expand their capacity, skills, services and scope
- Attracting and recruiting talented and experienced staff in the Contracting and Network Development, Quality Management and Claims Departments to deliver the highest service levels to our providers. Many of our staff members had experience working in the provider community before coming to Sunflower.

Urban Areas. Sunflower's network under our current contract predominantly serves urban areas in the Kansas City, Topeka, and Wichita regions. As illustrated by the near-100% access compliance in Table 5.5.3.A in the next section of this proposal response, our network for those regions and across the state complies with the time and distance standards.

Rural Areas. Sunflower is contracted with many high-quality rural providers located throughout Kansas, including many FQHC, Critical Access Hospitals, CMHCs, and Rural Health Clinics (5.5.2.G.4). Our provider access analyses reveal that the primary access challenges exist in the State's rural and frontier areas. Sunflower's five years of experience serving myriad rural counties through our existing State Contract positions us for success.

Sunflower understands that the State may impose sanctions for material deficiencies in our network and will commit to preventing that situation by ensuring the continuation of a robust network strategy and provider relationships throughout the State (5.5.2.J).

OUTREACH AND COLLABORATION WITH STRATEGIC PROVIDER PARTNERSHIPS

Sunflower actively builds and will continue to build upon existing essential provider partnerships with providers and their associations and develop new relationships as needed to serve members in KanCare 2.0. Meaningful provider partnerships are developed to address program goals and provider needs, e.g., improving access to care in underserved regions, provider education, advocating for health improvements and prevention, closing care gaps through member outreach, addressing social determinants of health, and easing administrative burden. See Tables 5.5.C-1, Strategic Provider Association Partnerships and 5.5.C-2, Strategic Provider Partnerships for a list of leading associations and providers with which Sunflower has ongoing relationships (5.5.2.F.9).

Table 5.5.2.C-1 Strategic Provider Association Partnerships

Provider Associations	Partnering with the Association
Kansas Association for the Medically Underserved (KAMU)	1. Our continuing partnership with KAMU supports our goal of developing and maintaining contractual relationships with FQHCs and RHCs across Kansas. This relationship also supports Sunflower's rural health initiatives since the CHCs are typically located in areas that have a shortage of providers able and willing to serve those individuals who often are high-risk Medicaid members. We also are a sponsor of their annual primary care association conference. 2. In the fall of 2017 we participated with the other MCOs to deliver a lunch and learn for KAMU members. This lunch and learn, tailored for FQHCs and RHCs, provided specific information on encounter rates, secondary claims, credentialing/recredentialing, and top 10 claims denials for each MCO. Our collaboration with KAMU allows us to ease the administrative tasks for encounters, claims and credentialing. We also provide toothbrush kits for KAMU clinics to support their dental screening capacity.
KanCare Adult Dental Coalition	Sunflower has partnered with this new coalition to support their advocacy for comprehensive adult dental benefits for low-income adults on Medicaid.
Governor's Behavioral Health Services Planning Council Vocational Subcommittee	We participate on this subcommittee to help coordinate supported employment activities and promote the Individual Placement and Support (IPS) model to support employment for individuals with mental illness.
HCBS Provider Associations	Sunflower formed an LTSS Advisory Committee that includes representation from 11 HCBS providers and provider associations. This group meets quarterly to address all matters important to LTSS areas such as outcomes measurement, value based purchasing, state and Sunflower policy and processes, and proposed legislation. Participants include: 1) Disability Rights Center, 2) InterHab, 3) Association for Area Agencies on Aging, 4) Kansas Association for Centers for Independent Living, 5) Minds Matter, 6) Topeka Independent Living and Resource Center, 7) Community Living Opportunities, 8) The Alliance for Kansans with Developmental Disabilities, 9) Craig Home; 10) Maxim, 11) Johnson County Developmental Supports
Kansas Health Care Association (KHCA) and LeadingAge Kansas	Sunflower contracts with all nursing facilities providing skilled nursing and custodial care across the state. We engage with KHCA and LeadingAge Kansas regularly in meetings and targeted communications and issues resolution important to these LTSS providers, take part in related educational sessions, and sponsor their annual convention.
Kansas Hospital Association (KHA), Kansas Medical Society	We have an excellent working relationship with KHA to collaborate in regular meetings to seek input on policies and program enhancements. Sunflower also participates in KHA's Technical Advisory Group.
InterHab	We have a close working relationship with InterHab and our I/DD provider network. This relationship allows us to understand the ongoing needs and challenges with the I/DD population and how we can support those needs. We are a key sponsor of their annual conference and have provided multiple breakout session trainings at their conferences.

Table 5.5.2.C-2 Strategic Provider Partnerships

Providers	Partnering with the Provider
The Association of Kansas Community Mental Health Centers	Sunflower has an arrangement with the association to provide supplementary payments to CMHCs for quality metrics attained throughout the year. The five metrics used in this VBP agreement will improve the coordination of services for Sunflower members and allow the CMHCs to draw bonus payments from Sunflower. Additionally, Sunflower committed one FTE for onsite support at two CMHCs to assist staff and clients/families, which is also an asset to helping these CMHCs exceed the metrics that are part of the new bonus arrangement.
Center for Counseling and Consultation and the Pawnee County Public Health Department	We arranged for a 3-year grant from the Centene Foundation for Quality Healthcare to employ technology solutions to raise awareness, utilization and health literacy for Behavioral Health services across four counties.
GraceMed Health and Dental Clinic	Sunflower supported GraceMed and other providers in the Wichita area to build the capacity to serve patients with disabilities who needed sedation during their dental visits. Additionally, Sunflower invested $300,000 in a community collaborative aimed at improving access to services in what had been labeled a health care desert area in south central Kansas. GraceMed health clinic partnered with Via Christi Health and the Greater Wichita YMCA to establish a "hub and spoke" clinic model of care for addressing obesity and diabetes, mental illness and oral health. Project Oasis called for a centralized 'hub' clinic and four 'spokes' – four new GraceMed satellite school-based clinics. Sunflower's involvement helped the partners bring much-needed services to a community working to eliminate barriers to services while improving the health and wellbeing of our KanCare members.
HealthCore Clinic	Collaboration with HealthCore Clinic to conduct member outreach on increasing immunization rates, conducting health screenings at community events and office sites to provide members with answers to their questions about benefits or access to social support services.
Topeka Independent Living Resource Center (TILRC) and Minds Matter	Partnership to sustain transitional housing supports after Money Follows the Person ended in June 2017. The organizations qualify for incentive payments for facilitating successful home placements after a member's stay in a nursing facility.*
Indian Health Services	Participation in health fairs held by Indian Health Services as well as health strategy meetings to explore other strategic opportunities.
Sedgwick and Johnson County Health Departments	Agreement with these county health departments to close care gaps. These health departments outreach to their patients (Sunflower's members) who need preventive services to assist with scheduling to receive the service(s) through their local health department.
ExamOne World Wide, Inc.	Arrangement with Exam*One*, for Quest to conduct outreach to targeted members to schedule and conduct home visits to complete the necessary lab work.
I/DD Targeted Case Management (TCM) Providers	Collaboration with six TCM providers and the other Medicaid MCOs to develop a proposal to the State for reducing/eliminating the duplication between the I/DD TCM and Care Coordinator Roles.

Providers	Partnering with the Provider
County Health Departments and Maternal & Child Health Initiatives	Sunflower provided funding to enhance and support the continued implementation of a maternal and child health educational program called Becoming a Mom (BaM)/Comenzando bien, with curriculum in English and Spanish from the March of Dimes. BaM in Kansas is coordinated through KDHE's Bureau of Family Health and administered at the local level through approximately a dozen sites statewide, including County Health Departments. Sunflower aims to engage pregnant women early for preventive services with their obstetrician and promote collaboration among community providers.

**Agreement pending State approval.*

We embrace an approach to high-impact collaboration with providers and provider associations, especially as it relates to challenges facing the provider community regarding ADA compliance. Sunflower looks forward to building off our existing relationships to develop enhanced tools and incentives that drive providers to achieving the highest level of access for our members.

5.5.3. PROVIDER NETWORK ADEQUACY STANDARDS

CURRENT COMPLIANCE LEVELS WITH MODEL CONTRACT NETWORK ADEQUACY STANDARDS

Sunflower has demonstrated sustained success in achieving network adequacy throughout the State and will continue to meet and exceed network adequacy standards as developed by the State for KanCare 2.0. As an example of our ability to meet the State's network adequacy standards, Table 5.5.3.A, taken from our October 2017 results, demonstrates our compliance with time and distance standards for frequently used contracted providers to which these standards apply.

Table 5.5.3.A Network Access Percentages by Provider Category and Service Area Density

PROVIDER CATEGORY	SERVICE AREA DENSITY	
	Urban and Semi-Urban % Covered	Rural/Frontier % Covered
PCPs	99.9%	99.9%
Internal Medicine	99.9%	100%
General Surgery	99.8%	100%
Gastroenterology	97%	77.5%
Neurology	99.5%	98.6%
OB/GYN	97.4%	95.2%
Orthopedics	99.8%	98.9%
Ophthalmology	99.9%	99.9%
Behavioral Health	100%	100%
Urology	99.6%	97.9%
Dental Primary Care	99.8%	98.2%
Hospitals	100%	98.9%
Pharmacies	98.3%	99.9%
Physical Therapy	100%	99.9%
Radiology	100%	94.8%

Sunflower applies the State's current Contract standards for time and distance to monitor access by provider type (5.5.3.A.8). For example, adults and children must have access to a PCP within 20 miles or 30 minutes (urban/semi-urban counties) and 30 miles or 30 minutes (rural/frontier counties), and access to a specialist within 25 miles (urban/semi-urban) and 100 miles (rural/frontier).

We will continue to monitor network capacity and sufficiency against newly developed State standards under KanCare 2.0 as they apply to adults and children in primary and specialty care including OB/GYNs, BH (including mental health and substance use disorder providers), applicable LTSS, pediatric dental, hospital and pharmacy services (5.5.3.A.1-7). See our response to Section 5.5.6, Long-Term Services and Supports Provider Network Standards for in-depth information about LTSS network adequacy standards. Sunflower will follow the State's exceptions process in the event the network does not satisfy the KDHE network adequacy standards. We have not had to use the exceptions process since we began operations under KanCare in 2013 (5.5.3.A.9).

Current Network Gaps

Based upon our latest geo-mapping analyses, we have identified the following gaps and opportunities for resolution or mitigation as of the date of submission of our proposal response. It should be noted that for all gaps identified below, we will continue to aggressively outreach to all Kansas Medicaid managed care providers, all Medicaid FFS providers, and all non-KDHE providers through and beyond the Contract effective date. The individual resolutions or mitigations presented below are provider type and region specific.

Table 5.5.3.B Network Gaps and Proposed Resolution or Mitigation

Network Gap by Provider Type and Region	Proposed Resolution or Mitigation
Hematology/Oncology, Rural/Frontier counties: Finney, Seward, Grant, Sherman, Stevens, Kearny, Thomas, Rawlins, Hamilton, Haskell, Gray, and Meade.	Identify counties with gaps and identify candidates to invite into network; Forward candidate data to contract negotiators for outreach and contracting; If candidate is not interested in contracting with Sunflower, engage in single case agreement process; Recruitment within plan's threshold - 50 miles of the Kansas border in neighboring states; Encourage network providers to expand their county footprint
Neonatology, Urban/Semi-Urban counties	Ongoing outreach to neonatologists to negotiate network participation
Plastic and Reconstructive Surgery, Urban/Semi-Urban counties and in Rural/Frontier counties	Ongoing outreach to these specialists to negotiate network participation

5.5.4. CULTURAL COMPETENCY AND HEALTH LITERACY IN THE DELIVERY OF CARE

SUNFLOWER'S APPROACH TO CULTURAL COMPETENCY AND HEALTH LITERACY (5.5.4.A.1, 5.5.4.A.3)

Sunflower views cultural competency as the active implementation of a system wide philosophy that values differences among individuals and is responsive to diversity at all levels. We recognize that by promoting cultural competency and health literacy across our KanCare network, we are better able to engage and retain members in care and provide services that meet their needs to effectively support their improved health and wellbeing. Our approach to cultural competency and health literacy incorporates sensitivity to the needs of members who are associated with diverse racial, religious, age, gender/gender identity, and/or ethnic groups, including those with Limited English Proficiency (LEP) and/or disabilities, accommodating each member's culturally-based attitudes, beliefs, and needs to promote access to health care services. Through our efforts, Sunflower ensures the development and continued promotion of skills and practices among providers and staff to ensure that services are delivered in a culturally competent manner that accounts for and promotes member health literacy.

In a manner that recognizes, values, affirms, and respects the worth of each individual that we serve, Sunflower works to create an environment of cultural and diversity awareness by implementing programs and policies that are fully responsive to the Department of Health and Human Services' (HHS) Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards), as well as the Americans with Disabilities Act (ADA) standards. Our commitment to cultural competency, diversity, and health literacy is built on our philosophy that health care is best delivered locally, enabling Sunflower to provide accessible, high quality and culturally sensitive services that meet each member where s/he is and support his/her health literacy and understanding of available services. Based on our efforts, Sunflower was nominated and awarded the 2017 Health Literacy Kansas Trail-blazer Award, presented at the Kansas Public Health Association Conference. In addition, the Greater Kansas City Business Leadership Network (GKCBLN) named Sunflower as the 2016 DisAbility Champion Award recipient at their annual awards event at Kauffman Foundation Conference Center for our demonstrated commitment to creating and fostering a culture that includes employment of people of all abilities.

CULTURAL COMPETENCY PLAN (5.5.4.A.4, 5.5.4.B)

Sunflower is committed to establishing multicultural and diverse principles and practices that respond to member health literacy and accessibility needs throughout our systems, services, and programs. Within 90 days of this contract award, Sunflower will develop and submit to the State for approval our Cultural Competency Plan, which will incorporate and build upon our established procedures for promoting care and services that honor members' beliefs, promotes sensitivity to cultural diversity, and fosters staff and provider attitudes and interpersonal communication styles that respect members' cultural backgrounds and differing levels of ability.

Specifically, Sunflower's Cultural Competency Plan will address the 15 CLAS Standards, and in particular, include the following elements:

- A description of how care and services will be delivered in a culturally competent, and accessible manner, regarding, at a minimum, ethnicity, gender, cultural background, poverty or low-income status, homelessness, religion, sexual orientation, member beliefs, interpersonal communication styles, and physical and behavioral health disabilities, and how culturally competent care will be delivered in rural areas of the State via telehealth strategies.
- The role of Social Determinants of Health and Independence (SDOHI) in improving and sustaining positive health outcomes. Sunflower will incorporate SDOHI into our internal and external stakeholder communications on an ongoing basis. For example, our Member Newsletters will address topics on access to housing, food and employment, while our Provider Newsletters will provide actionable information for screening and addressing SDOHI in the clinical setting. Sunflower also trains all staff on SDOHI through our employee training and educational series. Further, we will continue to include and build on this information in trainings with our providers.
- Strategies to assess and respond to the health literacy needs of members, including both in-person and telephonic communication standards, as well as comprehensive staff training, described in more detail below.
- Documentation of the Sunflower Trainers' responsibilities related to the development and maintenance of the Cultural Competency Plan. These responsibilities will include reviewing and updating the Cultural Competency Plan on an annual basis, as well as presenting issues related to implementation of the Plan to our Quality Assurance Performance Improvement (QAPI) Committee to ensure involvement and input from all Sunflower departments.
- Goals and objectives for the coming year related to cultural competency and health literacy, which will be aligned with CLAS standards and the unique needs of our members. Examples of goals that Sunflower will work towards as part of the Cultural Competency Plan include:
  - Further increasing awareness of health literacy and cultural competency and accessibility strategies among health plan staff and Community Service Coordinators through the enhancement of our training plan
  - Increasing cultural competency and health literacy skills and understanding among network providers using pre- and post-test survey instruments during provider training
  - Improving member satisfaction scores for those questions related to cultural sensitivity and diversity of health providers
- Training and education methods that Sunflower will use to educate staff, participating providers, and members about cultural competency and diversity, including a description of our training programs, described in more detail below.
- A description of how Sunflower conducts regular assessments of the provider network to ensure services are provided in a culturally competent manner to diverse populations, described in more detail.

Overall, Sunflower's Cultural Competency Plan will incorporate our current values of (i) honoring member's beliefs, (ii) remaining sensitive to cultural diversity, and (iii) fostering in staff and providers attitudes and interpersonal communication styles that respect members' cultural backgrounds, diverse abilities, and health literacy. These values will be communicated to all staff, providers and subcontractors to ensure we are creating an environment of cultural competency for the member, including—in addition to the Cultural Competency Plan—sharing them as part of our Policies and Provider Manuals. In addition, all of Sunflower's provider agreements require compliance with state and federal nondiscrimination and cultural competency requirements, such as timely use of professional interpreter services and meeting access requirements under the Americans with Disabilities Act (ADA) to accommodate members with disabilities.

In 2017, 94% of Sunflower's members reported that they felt that their doctors communicated with them well. -2017 CAHPS 5.0H Adult Survey

To ensure we incorporate meaningful information for providers that accurately represents local populations, we will solicit input on the cultural beliefs and sensitivities we include in our Plan, and how we describe them, from local organizations with expertise in the diverse populations and cultures represented within our membership. This will include, but is not limited to, our LTSS Advisory Committee which includes representation from the major aging and disability advocacy groups. With State approval, we will publish our Cultural Competency Plan on our website to not only provide transparency around our goals and policies, but also to create an opportunity for continuous feedback from our providers, members, and community partners.

CULTURALLY COMPETENT PROVIDER NETWORK (5.5.4.A.6)

As an existing KanCare Medicaid MCO, Sunflower maintains a comprehensive network of diverse providers able to provide members with access to culturally and linguistically appropriate community health and social service resources. We currently have processes in place to identify and assure our provider network can meet the needs of our members with culturally appropriate, accessible delivery of care and services. We continually monitor our network using information about demographics, types of providers needed, historic and projected enrollment, member and provider feedback, travel distances, regional infrastructure, and special needs of the populations we serve. These analyses allow us to pinpoint where there may be gaps in linguistic, cultural, or disability-related expertise to meet member needs and target network recruitment accordingly. We also monitor services at the individual member level to ensure we are able to address each member's cultural and ability needs on an ongoing basis. For example, if a Service Coordinator identifies that a member's assigned PCP, who speaks the member's preferred language, is retiring from a group practice, the Service Coordinator will proactively work with the member to identify an alternate provider who speaks that language and/or arrange interpreter services as needed to support the member's choice to continue receiving services through the same practice.

On an annual basis, Sunflower's QI Department analyzes data about member cultural needs and preferences to determine whether the current practitioner network is meeting these

needs. Membership demographics are continually assessed through CAHPS survey results on respondent race and ethnicity. Today, the majority of Sunflower's adult membership is white (77.2%) followed by Black/African Americans (15%) and then by Hispanic/Latino (12.8%), while the majority of child and youth membership are white (81.5%), followed by Hispanic/Latino (31.7%) and then Black/African American (10.1%) (numbers greater than 100% due to race and ethnicity being captured by separate questions on the survey). We also utilize CAHPS survey results to monitor for disparities across our membership in terms of race/ethnicity, addressing any identified issues using our rapid cycle improvement process led by our QAPI Committee. As illustrated by the sample metrics included in the table below, Sunflower maintains consistently high levels of member satisfaction, with no significant variation between racial/ethnic groups.

Table 5.5.4.1_2017 CAHPS Survey Results (Adult)

Rating (% satisfied)	White	African American	Hispanic
How well doctors communicate	94%	95%	95%
Overall rating of personal doctor	85%	86%	80%
Overall rating of Plan Customer Service	88%	94%	88%

In our member materials, we communicate that members may submit grievances to the contractor related to inability to obtain culturally appropriate or accessible care, and on an ongoing basis, Sunflower assesses complaints from members relating to cultural, linguistic, or accessibility concerns. Review and analysis of the total grievances over the last several years indicate that Sunflower did not receive any grievances related to cultural or linguistic needs or accessibility of provider facilities. As described, identified issues related to cultural competency and health literacy are reviewed with the QAPI Committee, and, moving into KanCare 2.0, Sunflower will review any disability access issues with the LTSS Quality Review Committee.

Through our credentialing and re-credentialing process, Sunflower identifies languages used by network providers, including American Sign Language, supporting our ability to assign non-English speaking members to providers who speak their preferred language when appropriate. Within our current network, we have just under 3,000 practitioners that offer services in a language other than English, 34% of whom provide services in Spanish, 5% who offer services in Hindi, 5% in French, 4% in Arabic, and 2% in German. Our linguistically diverse provider network, along with our language line interpretation services and bilingual staff members, described below, allows us to fully meet the diverse linguistic needs of our membership.

In addition to language, to ensure our ability to competently meet the needs of members with disabilities, we request information about each provider's expertise, capabilities and special accommodations through our credentialing process. We provide this information to our Service Coordination and Member Relations staff to assist members in locating providers who can meet their unique needs. For example, Sunflower connects members with specialized needs (e.g., developmental disabilities) to dental providers with the capability to meet these needs, such as those who offer dental sedation or a "practice visit" to get members comfortable with being in the dental exam chair and the equipment used in the dental office.

As described under 5.5.2 above, Centene operates a Provider Accessibility Initiative (PAI) and Barrier Removal Fund (BRF), on which Sunflower will partner to provide grants to Kansas providers to enhance physical accessible for our members with disabilities, beginning in 2019. Specifically, BRF dollars can be used by providers for activities like:

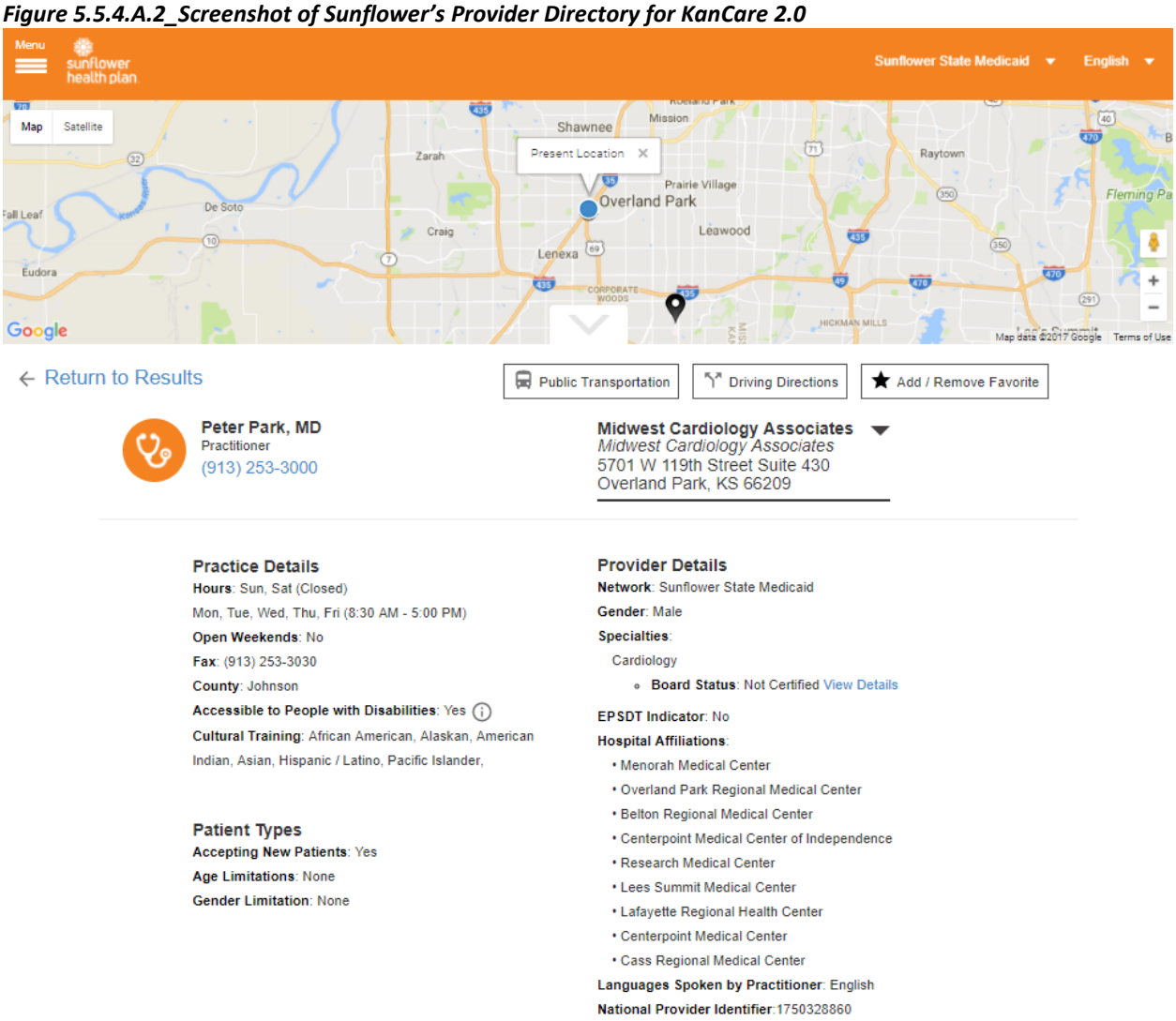
- An on-site Accessibility Site Review and corresponding Compliance Action Plan, including recommendations for removal of accessibility barriers in priority order, conducted by a local Center for Independent Living (CIL)
- Funding to remediate priority barriers (e.g., physical site modifications, accessible scales and exam tables)
- Staff training to increase disability competency and awareness

In addition to the BRF, the PAI also includes shared learning opportunities and dissemination of model policies and procedures related to disability access across all of Centene's affiliate health plans, allowing us, once this partnership begins, to bring best and evidence based practices from across the nation to Kansas to support our KanCare 2.0 members.

Provider Directory (5.5.4.A.2)

Today, Sunflower's online Provider Directory includes each provider's linguistic capabilities, as well as whether they are accessible to individuals with disabilities. Members can search for providers on the Provider Directory and refine the search by languages spoken and whether the provider is accessible to persons with disabilities. For KanCare 2.0, Sunflower will collect information about each of our network provider's specialized accommodations for individuals with physical disabilities and whether the provider has completed cultural competency training, which will also be included in the Provider Directory. A visual representation of our enhanced Provider Directory for KanCare 2.0 is included below as ***Figure 5.5.4.A.2_Screenshot of Sunflower's Provider Directory for KanCare 2.0.***

Figure 5.5.4.A.2_Screenshot of Sunflower's Provider Directory for KanCare 2.0



All the information contained in our Provider Directory is compiled and stored on the Provider Data Management (PDM) component of Sunflower's Management Information System (MIS). Our PDM Department enters and updates provider data within the system, coordinating with Sunflower personnel from other departments (e.g., Network) to ensure that the information is correct and up to date.

CULTURAL COMPETENCY TRAINING (5.5.4.A.5)

Provider Training

During Sunflower's initial provider orientation and ongoing trainings, we provide cultural competency information related to topics like cultural sensitivity, special needs of target populations, linguistic competence, and processes for arranging interpreters for appointments through Sunflower. Our trainings emphasize provider practice requirements and expectations, such as compliance with CLAS, the ADA, and Civil Rights Act. Moving forward, we will educate all providers on the special needs and characteristics of the diverse KanCare members we serve.

As noted above, our Cultural Competency Plan will incorporate information on the cultural beliefs, attitudes, and nuances of different subpopulations/communities to enhance our network's ability to provide culturally competent care. Our trainings, tools, and best practices related to cultural competency and health literacy are further supported by our Provider Manual and website, as well as Sunflower's quarterly provider newsletters.

To support the promotion of cultural competency and health literacy in rural areas, we will specifically outreach to and engage providers that are implementing services in rural communities in our web-based trainings on cultural competency and health literacy. We will also ensure that all agreements for coverage or support of telehealth services contains contractual language to place emphasis on cultural competence.

In addition, to enhance our ability to support providers to provide services that are culturally competent and promote member health literacy, we leverage the resources of our parent company, Centene, which has a national reputation for cultural and disability competence. For example, Centene offers an interactive Poverty Competency training that we can leverage for our providers to help them more effectively reach and engage members who may fall into the demographic of generational, working class, situational or immigrant poverty. The goals of this training are to help providers better understand members struggling with poverty and lack of resources and to provide tools that help remove barriers to success for this population. The program draws on Dr. Donna Beegle, Ph.D.'s Poverty Institute training (San Antonio, Texas). The four core training goals for the program are:

- Help recognize and reflect on current beliefs about poverty
- Help gain a true perspective on realities of those living at or under the poverty line
- Experience poverty through activity
- Learn applications that empower and support members

Finally, specifically related to disability competence, both Centene and Sunflower have disability advisory committees, with some shared membership, who advise on topics such as the formats of information we provide, accessibility of our provider network, and how to best engage our members with disabilities. Sunflower's LifeShare program also offers trainings on topics related to meeting the needs of individuals with disabilities through both virtual and in person modalities. This includes the "Visions for an Integrated Life" training, which supports Sunflower employees and our providers to think about how they can best encourage and support individuals with I/DD in today's context to realize their full potential and achieve their own preferred quality of life. Overall, these trainings reached over 400 external stakeholders in 2016, and over 500 external stakeholders in 2017.

Our Disability Competency trainings reached over 400 external stakeholders in 2016, and over 500 external stakeholders in 2017.

Provider Monitoring (5.5.4.A.7)

On a monthly basis, Sunflower's QI Department monitors member complaints related to cultural competency, such as complaints regarding language barriers, difficulty communicating with providers, difficulty accessing interpreter services, and disability access. This information is

provided to the Contracting and Network teams to support the identification of trends that may help define and enhance the overall provider education program or help target specific providers that may need additional training and education. When we receive a complaint about a provider, Sunflower's Provider Relations staff will address it immediately with that provider, which may involve helping the provider record an after-hours message in Spanish or a Corrective Action Plan if the issue involves discrimination or lack of accommodations for individuals with disabilities. If complaints show a pattern indicating a need for focused provider training, our Quality, Contracting, and Network teams coordinate to ensure that the provider in question receives appropriate training and support and that they are monitored for improvement. In such cases, we may also solicit assistance from our Consumer Advisory Committee to help identify and/or address issues.

Sunflower Staff Training

Sunflower will require all staff, regardless of role or responsibility, to complete training on cultural competency and health literacy upon hire, and at least annually thereafter. Our training program, based on CLAS Standards and Sunflower's own Cultural Competency Plan, will review the challenges facing many of our members, such as limited mobility, behavioral health, and other disabilities; linguistic barriers and resources for members with LEP or low literacy; and the impact of poverty on health (such as lack of stable housing/shelter, food, and social supports). Training will also focus on the impact of culture on health care decisions, and the employee's own culture and potential biases, including ethnicity and gender. We will also continue to provide disability sensitivity training, such as the LifeShare "Visions of an Integrated Life," and including topics on People First Language, the ADA, and misconceptions about persons with physical and behavioral disabilities.

In addition to this annual training, Sunflower will continue our practice of requiring staff with member contact to participate in more frequent trainings on cultural competency and health literacy. For example, in 2017, Sunflower's Medical Management team received targeted, interactive Health Literacy education designed to increase their understanding about how to use "plain language" when discussing health care matters with our members and their families. Sunflower held two formal training sessions on this topic and provided additional information through emails, handouts, newsletters, interactive games, and meetings. After these targeted efforts, post-training survey results indicated significant improvement in the Team's understanding and ability to address and promote member health literacy through the use of plain language.

Moving forward, Sunflower will leverage our strong community connections to enhance our cultural competency training for our staff, as further described in Section 5.17.2. Our team at all levels, including our Service Coordinators, Housing and Employment Specialists, and Quality Team, will be trained to consistently assess changes in the unique needs of our membership as part of their everyday work. When a need related to health literacy and/or cultural competency for a particular group or sub-group is identified, Sunflower will partner with our Advisory Committees (member, physician, LTSS) and leverage our strong connections to Kansas' communities to identify a provider/entity with specialized capacity and knowledge related to

the identified need. For example, to enhance the knowledge and skillsets of our staff members working with members who are in and aging out of Foster Care, Sunflower recently engaged Saint Francis Community Services to provide our Service Coordination Team an interactive training about the unique needs of children, youth, and families impacted by the Foster Care system.

Staff and Subcontractor Monitoring (5.5.4.A.7)

Sunflower continuously monitors staff and subcontractor performance to ensure culturally competent services and processes as described in detail in Sections 5.5 and 5.9. For example, Sunflower's Quality Specialists monitor the performance of Member Service Representatives through our Call Witness application to ensure that each CSR has the appropriate skills to support members, including those with diverse and/or special needs. Other Sunflower departments use a similar staff monitoring approach.

For subcontractors, Sunflower implements a multi-layer risk management approach to monitoring and evaluating performance. Cross-functional teams at both Sunflower and our parent company, Centene, monitor subcontractor adherence to performance standards, including those related to cultural competency and health literacy. Our process includes pre-delegation assessments, annual sub-contractor audits, ongoing monitoring of compliance with contractual requirements using our comprehensive compliance management technology system, as well as continuous monitoring of all member and provider complaints and grievances related to subcontractor performance. If an issue is identified involving discrimination or accommodations for individuals with disabilities by one of Sunflower's subcontractors, we immediately intervene, requiring the subcontractor to develop and implement a Corrective Action Plan, at a minimum, to address the issue.

OTHER STRATEGIES AND APPROACHES FOR ENSURING MEMBERS RECEIVE COVERED SERVICES IN A CULTURALLY COMPETENT MANNER THAT IS RESPONSIVE TO MEMBER'S HEALTH LITERACY NEEDS

Identifying and Addressing Member Language and Communication Needs

Sunflower tracks member ethnicity and language information and preferences, provided on the State's enrollment file, through our Member Demographic System (MDS), a component of our Customer Relationship Management (CRM) System. Today, just over 3% of our members speak Spanish primarily (our largest non-English language preference), which we support through a network of bilingual providers (described above), as well as bilingual staff members, including both our Customer Service Supervisor and Call Quality Analyst. Tracking which languages are preferred by members helps ensure that we have sufficient resources to respond in that language.

For phone and language interpretation services, Sunflower subcontracts with Voiance. Through this contract, interpretation/translation services are available for members during both telephonic and on-site interactions, and these services can be arranged by Sunflower for member interactions with both Sunflower staff and network providers. In 2016, Sunflower saw a 14% increase in telephonic translation services compared to 2015. While Spanish continues to

be the top language requiring translation for Sunflower members, translation for several languages increased in 2016, including Burmese (2.38% in 2015 to 3.06% in 2016), Arabic (0.82% in 2015 to 2.6% in 2016), Russian (1.01% in 2015 to 1.3% in 2016), and Nepali (0.94% in 2015 to 1.94% in 2016), indicating a more linguistically diverse Sunflower population. We continue to monitor these trends on an ongoing basis to ensure we are able to meet the diverse linguistic needs of our membership.

Table 5.5.4.3_Sunflower Telephonic Language Assistance Services in 2016: Top 10 Languages Requested

Language	Number of Calls	% of Total
Spanish	5239	83.71%
Burmese	192	3.06%
Arabic	159	2.54%
Nepali	121	1.93%
Russian	102	1.62%
Somali	60	0.95%
Vietnamese	57	0.91%
Karen	45	0.71%
Swahili	43	0.68%
Mandarin	36	0.57%

In addition to interpretation services, Sunflower provides instructions to members in multiple ways regarding how to obtain materials in languages other than English or in other formats. This information is shared through our New Member Welcome Packet, New Member Handbook, Member Newsletters, Provider Manual, during case management visits, and on our website.

Incorporating Stakeholder Feedback to Enhance Accessibility of Materials

Sunflower obtains feedback on how well we ensure culturally competent service delivery that promotes health literacy in a number of ways. Our Member Advisory Committee (MAC) and LTSS Advisory Committee both meet on a quarterly basis. The LTSS Advisory Committee includes advocacy groups, associations, and providers, while the MAC consists of KanCare members and their families. Both committees are designed to allow these stakeholders to provide input and feedback on Sunflower's operations, including helping to ensure we meet diverse member needs across all our services, member materials, website/online features, and operational changes. These groups help us to ensure that our materials are responsive to our member's needs related to cultural competency and health literacy. For example, prior to launching our HPV vaccination PIP targeted to older adults, Sunflower presented our member education and outreach materials to the LTSS Advisory Committee, who provided feedback that we incorporated into the materials prior to distributing them to ensure that they were easily understandable and accessible to members within the targeted group.

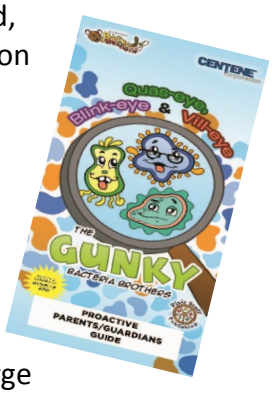
Member Resources to Promote Health Literacy

Sunflower's New Member Handbook, which is available to all members online and in hard copy upon request, is a detailed guide to each member's healthcare benefits that supports member health literacy and education. It explains each member's rights and responsibilities as a

member of our Health Plan, as well as how to access healthcare services. In addition, on an ongoing basis, Sunflower distributes innovative member-focused educational resources that promote health literacy and healthy behaviors, such as our Book Series about the Adventures of Boingg & Sprockette. The books that we produce range in topic (e.g., related to specific healthy behaviors or health condition) and are written for children, teens, and adults to promote health education and consumer empowerment. Each of the books are available in multiple languages and formats. A selection of topics from our Boingg & Sprockette Book Series includes the following:

- The Adventures of Boingg & Sprockette: Adventures through Fitropolis, about the importance of nutrition, healthy eating, and exercise. The book includes tips on sensible snacking, avoiding fast food, staying hydrated, keeping your body active, and making good choices when dining. In addition to the story, Adventures through Fitropolis features coloring pages, a quiz, connect-the-dots, stickers, a maze, a word search, and other activities. There is also an associated Parents/Guardians Guide that parents can use to supplement the story/activities to help their children make smart nutrition choices.
- The Adventures of Boingg & Sprockette: Super Centeam 5 Cookbook (winner of the 2011 National Health Information Bronze Award), a fun cookbook that features healthy recipes for kids, by kids. The book also contains stickers, a coloring page, recipe cards, a bookmark, and cooking & nutrition tips.

- The Adventures of Boingg & Sprockette: Adventures with Smokey Yuckpak (winner of the 2012 National Health Information Bronze Award), a story about how a visitor, Smokey Yuckpak, offers the members of the Boingg Bouncers basketball team cigarettes, in response to which Darby, Dr. Von Wheezles, Kit Sprockette, and the gang spell out the dangers of harmful chemicals, breathing problems, yellow teeth, bad breath, diseases and more. These facts help Smokey see the light and change his ways. There is also an associated Proactive Parents/Guardians Guide, which has supplementary insights on how to talk to children about smoking and the dangers of tobacco use.
- The Adventures of Boingg & Sprockette: Quas-Eye, Blink-Eye, & Vill-Eye, the Gunky Bacteria Brothers (winner of the 2014 National Health Information Merit Award, the 2015 Hermes Gold Award, and the 2015 National Health Information Bronze Award), a story that teaches children and youth about hygiene involving the Gunky Bacteria Brothers. This book teaches kids the importance of hand washing, bathing, brushing teeth, and staying clean to stay healthy. The associated Proactive Parents/Guardians Guide helps parents and guardians teach their kids about staying clean and keeping bacteria and germs away.



We also encourage members to increase their health literacy and take charge of their own wellness by accessing our extensive online resources and online Health Library

powered by Krames. The Krames Library features a searchable health sheet database with more than 4,000 topics. Available in both English and Spanish, many of the health sheets provide information to support our member education activities. For example, our Service Coordinators can direct members to information in the library or we can print and provide information. In addition, online searches yield medication information so that members can learn about their health issue and the medications used to treat it, all with one search.

5.5.5. PROVIDER NETWORK ACCESS STANDARDS

Sunflower's network throughout the state is developed to maximize not just geographic sufficiency for our members but also to ensure Sunflower's provider network has the true capacity to serve members effectively. Consumers value timely access to medical care. To ensure members receive the best access to appointments possible, Sunflower monitors PCP and specialist adherence to appointment accessibility and after-hours access annually (***see Attachment 5.5 Provider Network Appointment Accessibility and Wait Times***) against standards to ensure members have access to medical care 24 hours a day, seven days a week and initiates actions as needed to improve network performance (5.5.2.E, 5.5.5.1.A). All participating providers are expected to provide care for their Sunflower members within these access guidelines. Providers must offer access comparable to that offered to non-Medicaid members or if the participating provider serves only Medicaid members, comparable to Medicaid FFS (5.5.2.D).

Our After-Hours Access Surveys conducted with PCPs noted that 82% of PCPs had acceptable after-hours coverage in 2013 and 75% of PCPs had after hours coverage in 2014 (a 2017 survey was completed but the results were not available in time for this proposal submission). Our Quality Improvement Committee (QIC) reviewed the results and proposed actions to improve after-hours access to care. We resurveyed PCPs in 2016 to assess after-hours access by examining more closely the methods of access by primary care office. For example, urgent requests were assessed for after-hours access by one of three options:

1. Offering to page the doctor on call to call the member back (an acceptable response)
2. Offering to transfer the member's call directly to the doctor on call (an acceptable response)
3. Offering to take a message so the doctor can call the member back the next business day (an unacceptable response)

We performed similar after-hours surveys to track emergency access, and to track providers with answering machines. All the PCP offices who were successfully contacted had an acceptable method of providing after-hours access for members.

Described below are the access standards against which Sunflower's departments of Contracting and Network Development, Member Services and QI collaborate to monitor provider availability. We described the processes and activities that demonstrate how we

monitor compliance to ensure access across our network in Section 5.5.8, Network Management.

GENERAL, PRIMARY CARE PROVIDER AND SPECIALTY CARE ACCESS STANDARDS (5.5.5.1, 5.5.5.2 AND 5.5.5.3)

Sunflower applies the State's standards of having a sufficient supply of providers to give members choices in every county, and ensuring good provider access to care (5.5.2.F.6; 5.5.5.2.D). Access to care standards for routine PCP appointment accessibility will not exceed three weeks from the date of member requests, urgent care appointments must be within 48 hours from the time of the request (or referral for mental health services). Access to routine specialty care must occur within 30 days of request, and within 24 hours of an assessment for pregnant women. Sunflower also monitors office wait times with a KDHE-compliant wait time as within 45 minutes from time member enters a practitioner office, for PCPs, specialists and BH providers. If a provider is delayed the member must be notified immediately, and offered a new appointment if the anticipated wait will exceed 90 minutes. In addition we will encourage providers to extend office hours to cover evening and weekend appointments under KanCare 2.0 (5.5.5.1.A). While some providers currently offer extended hours, Sunflower recognizes that a more focused strategy for making appointments available in the evenings and on weekends will further expand network access and responsiveness to member needs.
Sunflower requests that providers inform our Customer Service department whenever a Sunflower member misses an appointment, so we may monitor that in our system and provide outreach to the member on the importance of keeping appointments. We have found that this assists our members to reduce missed appointments and the inappropriate use of emergency room services.

PCP ACCESS (5.5.5.2)

Practitioner availability monitoring to ensure access to care and member choice (5.5.2.C; 5.5.5.2.C; D) is performed throughout the year for PCPs and in an annual Practitioner Availability Analysis. Sunflower defines PCPs as physicians with a primary specialty designation of family medicine, general internal medicine, pediatric medicine, or a subspecialty related to those specialties. Advanced practice clinicians under the personal supervision of an eligible physician may also be eligible. Sunflower also may allow a specialist provider to serve as a PCP for members with special healthcare needs, multiple disabilities, or with acute or chronic conditions as long as the specialist is willing to perform the responsibilities of a PCP (5.5.5.2.D). Further, Indian Health Care Provider (IHCP) PCPs with capacity may provide primary care to American Indian members (5.5.5.2.G). Sunflower works with families to select PCPs for children and will promote the assignment of pediatricians and family practitioners to serve as PCPs for eligible children. Between 2016 and 2017 Sunflower's ratio of pediatricians to members under age 19 was reduced from 1:324 to 1:265. As of November 2017, there were 35.8% of child members assigned to a pediatrician up from 32.9% in December 2016. (5.5.5.2.B).

All PCPs contacted in 2016 had a method of providing after-hours access to care.

SPECIALTY CARE ACCESS (5.5.5.3)

The annual Practitioner Availability Analysis is also completed for high volume specialty care practitioners. Sunflower identifies high volume practitioner specialties through the analysis of the number of episodes of care, as reported through Impact Intelligence. Impact Intelligence is our parent company, Centene's healthcare decision-support solution from Ingenix, and uses claims and encounter data. In 2015 and 2016 Sunflower identified high volume specialties as: OB/GYN, cardiology, orthopedics and hematology/oncology. When a network specialist is not available near the member's home, Sunflower considers alternatives such as identifying network specialists who travel to multiple hospitals as in western Kansas, as well as along the state border with Oklahoma.

EMERGENCY ACCESS TO CARE STANDARDS (5.5.5.4)

In 2016, 46,460 Sunflower members had 92,125 emergency room (ER) visits and 99.25% of those visits occurred at an in-network facility. Sunflower members have access to in-network and out-of-network emergency medical care, if necessary on a 24-hour-a-day, 7-day-a-week basis at the nearest facility available regardless of whether the emergency provider is a participating provider. Emergency room utilization increased from 591 to 655 members per 1,000 between 2014 to 2015; we worked with the provider network to successfully reduce ER dependence for low-acuity, non-emergent care and lowered the rate to 635 members per 1,000 in 2016. To ensure that members do not hesitate to obtain true emergency care, and that providers do not defer or delay emergency care services, we apply the prudent layperson definition of emergency services and do not require prior authorization for these services. This information is included in the provider manual and member handbook, and reviewed during new and quarterly provider orientations. The provider manual outlines guidelines and expectations regarding appointment access and wait times. In addition, provider agreement language requires participating providers to meet State standards regarding appointment access.

We also promote the use of our 24-hour nurse advice line to give member's immediate access to a clinician which can help to reduce inappropriate use of emergency services.

Sunflower pays out-of-network emergency providers 90% of the State Medicaid rate according to State reimbursement requirements as required for all contracted plans.

NON-EMERGENCY MEDICAL TRANSPORTATION SERVICE STANDARDS (5.5.5.5.)

Sunflower contracts with LogistiCare to provide statewide and pre-approved out-of-state transportation for all members to covered services including physical, BH and LTSS services. More than 470 contracted providers serve every county in the state to drive members to and from medical appointments. In the first nine months of 2017 member trip volume averaged 5,366 per month. According to LogistiCare's latest report of on-time performance, 91% of trips to medical appointments were on-time. Members can schedule a trip reservation up to 30 days in advance via our Member Portal or by phone. We track LogistiCare's performance in a monthly and quarterly dashboard report. They have demonstrated reliability and responsiveness to member needs with an ability to meet, and in many cases, exceed the goals set forth in the contract.

Sunflower holds LogistiCare to a higher standard than the KanCare 2.0 requirement that members shall arrive at the provider location no sooner than one hour before their appointment; we require that at least 95% of all trips arrive no sooner than 30 minutes to improve service to members. This year's performance measures demonstrate outstanding access to transportation services. We have listed a sample of the transportation performance outcomes based on the monthly LogistiCare Performance Scorecard from 2017. This monthly audit tool is used to track performance against the contract (5.5.5.5.E).

Trip Reservations and "Where's My Ride" Calls

LogistiCare met and exceeded all the Reservation and the "Where's My Ride" performance measures for almost all the first nine months in 2017. They received on average 1,356 calls per month from member calls with questions about their scheduled trip. Six percent of all member trips per month result in a telephone inquiry. We have listed examples of these performance results.

- All transportation reservation and "where's my ride" calls were answered by an individual or electronic devise without a busy signal
- At least 80% of transportation reservation and "where's my ride" calls were answered within 30 seconds the majority of the time
- They experienced an excellent call abandonment rate of fewer than 1% of callers as compared to the goal of less than 5%

In 2017 LogistiCare demonstrated strong trip reservation and customer service performance against predetermined performance measures.

These results and member feedback demonstrate that Sunflower has greatly improved transportation service performance through LogistiCare in the last few years. In a 2015 Accessibility of Services analysis of member grievances the most common grievance within the Access to Care and Services category was related to transportation, comprising 50% of the grievances in this category, and representing 22% of grievances overall. Sunflower worked closely with LogistiCare to decrease grievances related to transportation to identify trends with specific transportation providers.

On time performance (5.5.5.5.A-D)

In addition to the measures described, we will require and monitor LogistiCare to ensure that members arrive at least 15 minutes prior to their appointment time and not wait more than one hour after the appoint for a return trip. LogistiCare monitors rides with field monitoring and reporting, and with real-time trip problem resolution to prevent delays. If the driver does not show up within 15 minutes of the scheduled pick up time, members are advised to call the "Ride Assist" line. LogistiCare tracks driver performance using a scorecard to continuously improve upon service to members. Their operations center coordinates communications with drivers and in turn, with members about the driver's estimated arrival time or possible changes to arrival time. They also communicate with healthcare providers to facilitate member transportation services. Drivers use the most efficient routes of transport today with assistance from GPS technology, and as a policy do not make unscheduled stops during a scheduled ride. These standards will continue under KanCare 2.0.

Accommodating members with urgent or same-day requests (5.5.5.5.F)
When members need to schedule a trip on short notice for a same day appointment LogistiCare transfers the call to Sunflower's Care Management department. LogistiCare will confirm with the member's provider that an appointment has been scheduled, and then contact Sunflower's care management team for prior authorization.

Mileage, lodging and meals reimbursement (5.5.5.5.G)
During a member call to schedule a trip, the LogistiCare customer service representative will ask if the member has access to other means of transportation. If other means are available, the customer service representative will offer to input the reservation as mileage reimbursement. Today mileage reimbursement requests may be called in 30 minutes prior to the medical appointment to receive a trip number. Mileage reimbursement trips do not require a prior authorization unless the trip is over 250 miles one way. Mileage reimbursement does require a prior authorization when the trip requires meals and lodging and/or travel to unapproved border cities.

"I appreciate the team you have at Sunflower. I wish all the people we support were with Sunflower!"
Options Services, Inc.
Residential and Day Support

Prior authorization policies under KanCare 2.0 for mileage, lodging and meal reimbursement will be submitted for State approval.

5.5.6. LONG-TERM SERVICES AND SUPPORTS PROVIDER NETWORK STANDARDS

Sunflower is the largest KanCare Medicaid managed care contractor by enrollment at 35% of the state's Medicaid population, and consequently serves the greatest member cohort for LTSS at 38% in Kansas. Sunflower serves over 12,000 LTSS members with 73% in home and community based services (HCBS) and 27% in an institutional setting. This balance in service utilization emphasizes HCBS over institutional care, and reflects our success in achieving the state's goal for enabling members to live in the least restrictive setting of their choice and to enable community independence (5.5.6.C).

As we briefly described in Section 5.5.2, Network Development, Sunflower contracts with LTSS providers enrolled with KDHE as a Medicaid provider to serve members who qualify for one of seven HCBS programs. Sunflower's LTSS provider network is divided into two categories: 1) home and community based service (HCBS) providers including alternative residential providers, and 2) institutional providers (including nursing facilities). Today Sunflower has contracts with all the State's Medicaid enrolled skilled nursing facilities (272), all six ICF/ID facilities and close to 1,300 Medicaid HCBS providers. Sunflower is committed to network inclusion of any qualified and willing provider whenever possible to maximize each member's choice of LTSS providers, and to ensure undisrupted transitions for members who transfer in and out of plan enrollment (5.5.6.G).

LTSS NETWORK STANDARDS - COMPLIANCE WITH FEDERAL REQUIREMENTS (5.5.6.A, 5.5.6.B)

States with managed LTSS programs are required by the Centers for Medicare and Medicaid Services (CMS) to use HCBS network adequacy standards and monitor networks in managed long-term services and supports (MLTSS) MCO networks to meet the needs of individuals using HCBS providers and institutional services. States and MCOs must contract with an adequate number of providers with sufficient service capacity, as well as offer the right types of providers with experience serving unique LTSS subpopulations. CMS published the updated Medicaid managed care rules (42 CFR 438) in May 2016 that for the first time, added standards for LTSS provider access including HCBS. The new rules go into effect on July 1, 2018. The Rule modernizes and adds certain standards and rules that are universal for all Medicaid managed care and specifies certain requirements that are specific to MLTSS. CMS stated that states are in the best position at this time to set HCBS standards given the lack of consensus in this area. Although not an existing KanCare LTSS geo-access standard, Sunflower is able to monitor the time and distance standards for site-based LTSS provider types to which a member must travel to receive services for KanCare 2.0. If geo-access standards are applied to site-based LTSS providers, we would begin this analysis for LTSS providers as identified by KDHE.
Sunflower follows KanCare's existing network access standards for LTSS and will support the development of improvement to these standards under KanCare 2.0.

MEETING OTHER LTSS NETWORK STANDARDS (5.5.6.B AND 5.5.6.D)

Sunflower will work with KDHE, KDADS, and MCOs to develop and implement additional network adequacy standards and metrics specific to the LTSS population. We will invest in ways to track and address that, for example:

- Providers of home-based services have enough direct care workers on staff using State provider licensure updates
- Enough direct care workers are available to travel to the homes of members in both urban, rural and frontier settings
- Direct service providers do not miss scheduled visits and visits are not late
- HCBS providers are trained on and practice person-centered care delivery and support the service plan across all HCBS service settings
- Members' LTSS services begin timely with no gaps in service delivery from the time of service authorization to service provision
- HCBS, NF and ICF/ID providers are trained on and practice person-centered service delivery and support the member's individualized Person Centered Service Plan across all service settings

MEETING THE HCBS SETTINGS RULE (5.5.6.E)

Sunflower will work with KDHE, KDADS, and MCOs to develop standardized processes and forms for measuring compliance with the 2014 federal final rule for HCBS settings. Through this joint effort, Sunflower will incorporate the HCBS setting requirements including development of provider training/education, monitoring, and technical assistance to help HCBS providers comply with the State's HCBS Transition Plan.
In accordance with federal requirements, Sunflower will ensure HCBS settings:

- Are integrated in and support access to the greater community
- Are selected by the member
- Ensure individual rights and freedom from coercion and restraint, and
- Optimize autonomy and independence in life choices, and facilitates choice of services and providers

HCBS settings will also meet the needs of members who have cognitive impairments, BH needs and other special medical needs.
In response to this RFP we provide Sunflower's current performance to existing LTSS network standards, will comply with standards developed for KanCare 2.0, and offer approaches to monitoring LTSS access for future consideration.

Compliance with member choice of HCBS providers by county

Sunflower maintains a robust network of at least two HCBS providers including IDD HCBS providers in most counties across
the state. The defined KDHE access standard is the availability of two providers per county (although not required to have a physical address in the county) for all covered HCBS services.

In counties with one or zero HCBS providers, or where we learn that existing providers are not accepting new members, Sunflower's Contracting and Network Development team will continue to reach out to providers not yet under contract and to other existing providers about expanding their service capacity in underserved regions. We continue to encourage expansion of existing providers for all HCBS specialties, with special attention to the following:

- ***Adult Day Care*** – Sunflower offers at least two providers in 49 of 105 counties. An additional 31 counties have one adult day care provider. Twenty-five counties have no providers.
- ***Health Maintenance Monitoring*** – Sunflower offers two or more of these providers in all but 10 of 105 counties and one provider in the 10 counties.
- ***Intermittent Intensive Medical Care*** – Sunflower has two or more of these providers in all but 11 of 105 counties and one provider in each of the remaining 11 counties.
- ***Speech Therapy – TBI Program*** – Sunflower has two or more of these providers in 50 of 105 counties and the remaining 55 counties have one provider.
- ***Speech Therapy – Autism Program*** – Sunflower has two or more of these providers in 12 of 105 counties. Sixteen counties have one provider. There are 77 counties with no providers.
- ***Wellness Monitoring*** – Sunflower has two or more of these providers in all but two of 105 counties. The remaining two counties have one provider.
- ***Supported Employment Services –I/DD*** -- Sunflower has two or more of these providers in 98 of 105 counties. The remaining seven counties have one provider. None of the counties have zero providers. The count represents those State-listed HCBS IDD providers offering this service.
- ***Specialized Medical Care – RN/LPN*** -- Sunflower has two or more of these providers in all but one of the counties in Kansas and the remaining county has one provider. None of the counties have zero providers. The count represents those State-listed IDD providers offering this service.

While Sunflower has a network of Personal Care and Specialized Medical Care service providers that meets current contract requirements, we understand that these are two services for which members in certain HCBS programs, and in certain geographic areas still experience access challenges, due to workforce issues. We will continue to work with our existing providers and the State to develop options for expanding the capacity of these services.

In addition to tracking the LTSS standard of least two HCBS providers per county we will work with KDHE, KDADS, and MCOs to implement a consistent, standard process to monitor travel distance to HCBS services to which members must (5.5.6.A).
Last, Sunflower contracts with all Medicaid enrolled, Kansas-based FMS providers across the state to support a member's decision to self-direct HCBS services. We will continue to work with FMS providers to facilitate the self-direction model under LTSS and will assist in processing claims and payments to their direct support workers. Sunflower reimburses FMS providers separately for administrative functions and direct service worker payments (5.5.6.F). Sunflower is developing a program to support quality improvements with FMS providers (See Section 5.7 - FMS Self Evaluation Monitoring and Quality Program).

Compliance with Member Choice of LTSS Institutional Providers
While the State does not require geo-access maps for contracted skilled nursing facilities, we report the total number of contracted providers of this specialty type to monitor access to LTSS services in this setting. Sunflower is pleased to report that we currently contract with all enrolled Medicaid nursing facilities (272) and six ICF/ID facilities (5.5.6.G). When a member requires a nursing facility placement we strive to have them admitted to a facility that is near their home. We find that this makes it easier for family caregivers to visit them and places the member in proximity to their community which can ease in future discharge planning and transition back into the community. In addition to contracting with all Medicaid enrolled nursing facilities, we also closely monitor the nursing facility licensing status in notifications we receive from KDADS to ensure that members are selecting nursing facilities in good standing and with adequate staffing levels. We suspend placements to nursing facilities that have been sanctioned; if a nursing facility provider is terminated for cause, we discontinue placements and relocate members in that facility to another in-network nursing facility.

Sunflower is developing our Sunflower Select nursing facility program based on quality outcomes that will ensure members' choices for LTSS institutional providers that deliver the best care possible (5.5.6.G). Details of this program are included in Section 5.7.1.

5.5.7. BEHAVIORAL HEALTH PROVIDER NETWORK STANDARDS

Leveraging our BH experience and expertise from our existing KanCare operations, Sunflower has successfully developed a comprehensive, fully credentialed mental health and substance use disorder (SUD) provider network in Kansas. As an incumbent plan, our BH provider network is comprised of the entire array of BH providers and specialists across Kansas' urban, rural, and

frontier communities as described in the KanCare 2.0 SOW. All mental health providers in our network are Qualified Behavioral Health Providers (QBHP), sent through credentialing, and held to NCQA credentialing standards. All of our network SUD providers are licensed by KDADS/BHS to provide SUD treatment services, and all providers determining medical necessity of SUD services (using the ASAM criteria) are a Behavioral Sciences Regulatory Board (BSRB) licensed practitioner practicing within their scope as defined by the BSRB. Additionally, we remain actively engaged and have established strong relationships within our state's BH community, including with the Association of Community Mental Health Centers of Kansas, which further enhances our provider network recruitment and retention efforts across the state.

EXISTING BEHAVIORAL HEALTH NETWORK (5.5.7.A)

To ensure a robust BH provider network across urban, rural, and frontier counties, Sunflower actively engages BH providers at the community level through face-to-face meetings, on-site provider training and educational opportunities, and tours of BH facilities to ensure quality of care. Sunflower has also co-located Sunflower Community Health Workers within two CMHCs to enhance and expand their ability to support our members. Further, our active engagement with the Kansas communities we serve allows Sunflower to respond to and adjust our BH network whenever necessary to meet the changing needs of Kansas' communities in a nimble and efficient manner. For example, in recent years, in collaboration with our BH provider partners, Sunflower recognized a need for an intermediary level of service for children who were leaving a BH hospitalization and returning to the community. Therefore, we developed and authorized an 'in lieu of' service that provides intensive outpatient treatment services to support this population specifically. Sunflower also develops and regularly runs reports on out-of-network authorizations, which we use to identify trends that can inform our network development efforts.

Today, Sunflower partners with more than 4,500 qualified and dedicated BH providers throughout Kansas. Our statewide BH network reflects a broad range of credentials and specialties including board certified psychiatrists, psychologists, masters level counselors, as well as inpatient and outpatient mental health and substance abuse providers. Sunflower currently contracts with 100% of the Community Mental Health Centers (CMHCs) in Kansas.

Table 5.5.7_1_Selected Behavioral Health Provider Network Numbers

Behavioral Health Provider Type	Number of in Network Providers
Community Mental Health Centers	26
Psychiatrists	354
Public Health or Welfare Agency and Clinics	81
Alcohol and Drug Rehabilitation Providers	42
Independent Living Counseling Providers	30
Behavior Management Providers	15
Autism Specialists	54
Respite Care Providers (Autism)	20
Parent Support Providers (Autism)	21
State Mental Hospitals	2

In addition to maintaining a comprehensive BH services network, we maintain 100% geographic coverage across our BH network in urban, rural, and frontier counties across the state, as illustrated by the following table, which illustrates the average member distance to their three closest BH providers.

Table 5.5.7_2_Behavioral Health Network Coverage

	Urban/Semi-Urban (90,175 members)	Densely Settled/Rural (23,283 members)	Rural/Frontier (14,888 members)
Distance to 1st Closest Provider	1.5 miles	3.9 miles	12.8 miles
Distance to 2nd Closest Provider	1.9 miles	5.0 miles	17.1 miles
Distance to 3rd Closest Provider	2.1 miles	5.7 miles	20.8 miles

Further, Sunflower works to ensure our network maintains the capacity to serve individuals with specialized BH needs, such as children in Foster Care. In support of these efforts, Sunflower has created a Foster Care Center of Excellence, which brings together BH practitioners with others involved in supporting a child in Foster Care (e.g., family care practitioners, Foster Care case workers, etc.), so that they can collaboratively address each child and family's holistic needs through the use of one Plan of Service. In addition, within this Center of Excellence, Sunflower's team supports these practitioners through training and education on best practices related to serving children in Foster Care.

METHODS TO MONITOR BEHAVIORAL HEALTH PROVIDER COMPLIANCE WITH KANCARE 2.0 ACCESS STANDARDS (5.5.7.C, 5.5.7.D & 5.5.7.E)

As part of this contract, Sunflower will adhere to all of the new KanCare 2.0 Scope of Work requirements related to access to BH providers. We will continue to monitor appointment availability and access compliance within our BH network using methods similar to those we use to monitor and evaluate access to services at other provider types (e.g., primary care, LTSS), described throughout this section. Specifically, Sunflower will survey providers to assess the performance of the BH network. We will also monitor access-related member complaints, further assessing access to BH services by evaluating responses to the standardized Experience of Care and Health Outcomes (ECHO) member satisfaction survey, including member responses to the Getting Treatment Quickly composite. As described in Section 5.4, our Community and Plan Service Coordinators will be trained in all KanCare 2.0 network access standards, including those related to BH, so that they can serve as an additional set of eyes and ears to support our monitoring of compliance with all access standards. When issues with access to BH services are identified by a Service Coordinator, they will notify Sunflower of the concern and address all identified access issues in coordination with Sunflower's Quality and/or Contracting and Network Development departments. Finally, moving forward, Sunflower welcomes the opportunity to collaboratively work with the State and other selected MCOs to develop processes to evaluate compliance with the State's new appointment access standards for BH providers, included in the table below, such as through our annual Access to Care Survey or regular appointment availability telephone audits.

Table 5.5.7_3_KanCare 2.0 Behavioral Health Network Access Standards

Appointment Type	Standard and Performance Goal
SUD urgent, non-emergency appointment requirements	Members with urgent, non-emergency needs shall be assessed within 24 hours of a request for services. Services shall be delivered within 24 hours of the date and time of the assessment
SUD non-urgent appointment requirements	Members with non-urgent needs shall be assessed within 14 calendar days of the date the services are requested
SUD appointment requirements for pregnant women	Pregnant women who are intravenous drug users and all other pregnant substance users, regardless of Title XIX status, must receive treatment within 24 hours of assessment. When it is not possible to admit the member within this timeframe, interim services shall be made available within 48 hours of initial contact to include prenatal care
SUD appointment requirements for injection drug users	Individuals who inject drugs must receive an assessment and shall be admitted to treatment no later than 14 calendar days after making the request for assessment. If no program has the capacity to admit the member within the required timeframe, interim services shall be made available to the member no later than 48 hours after such request. Admission to treatment must not exceed 120 calendar days of the request for assessment
Mental Health emergency appointment requirements	For emergency mental health needs members shall be referred to services immediately
Mental Health urgent, non-emergency appointment requirements	Members with urgent, non-emergency needs shall be assessed within 72 hours of a request for services
Mental Health non-urgent appointment requirements	Members with non-urgent needs shall be assessed within 14 business days of the date the services are requested

As part of this contract, Sunflower will document, and make available to the State upon request, waiting lists preventing admission to treatment in the prescribed timeframes.

BEHAVIORAL HEALTH CRISIS RESPONSE (5.5.7.E.4)

While Sunflower's goal is always to prevent crisis through appropriate services and service coordination, we are fully prepared to respond to BH crises experienced by our members. Today, Sunflower has contracts in place with all 26 CMHCs, which are designated as crisis assessment and intervention providers for members. Through our contracts with them, CMHCs are accountable for providing after-hours access in the event of a member crisis, through an on call system that they operate 24 hours a day, seven days a week. In addition, Sunflower's Call Center and Nurse Advice Line, fully described in Section 5.10, is equipped to respond to BH crises as needed. Specifically, we have trained all of Sunflower's Customer Service Representatives (CSRs) on Mental Health First Aid (MHFA) and having processes in place to warmly transfer a crisis call to an available BH clinician if assessment and/or additional expertise is needed. Through this combination of Plan and community resources, Sunflower is able to offer emergency treatment and first response for BH crisis 24 hours a day, seven days a week, 365 days a year, in full alignment with all of the requirements within the Scope of Work section 5.5.7.

When a member's crisis cannot be de-escalated verbally by phone and/or addressed through either an urgent or routine appointment, our staff work directly with Kansas' first responders or

the appropriate CMHCs to arrange an in-person crisis assessment and/or de-escalation services. Using the information gathered during the member's call, Sunflower's BH clinicians work with the first responders/CMHC to determine and implement an appropriate course of action to stabilize and support the member.

Following a BH crisis, the Service Coordination team will follow up with any member provided with an emergency service who was not admitted for inpatient care and treatment to determine the need for any further services within 72 hours of the resolution of the crisis. If the member is admitted to an inpatient facility, the Service Coordinator will follow up one to two days post discharge to ensure the member has a follow up appointment scheduled with a mental health practitioner, assisting with appointment and/or transportation arrangements, as well as the resolution of other potential barriers to keeping an appointment, as needed.

BEHAVIORAL HEALTH NETWORK DEVELOPMENT AND ENHANCEMENT STRATEGIES (5.5.7.B)

As described throughout this Section 5.5, Sunflower employs a complete Contracting and Network Development team (Network Team) that includes the Provider Relations staff who conduct assertive outreach to recruit and retain providers on a routine basis. The Network Team works closely with all contracted providers to build trust and establish long-standing relationships with them, while also constantly monitoring network adequacy, including that for rural and frontier areas.

As a current KanCare MCO, Sunflower is currently a leader in supporting Kansas and our providers to enhance and expand the BH capacity across the KanCare network in response to identified network gaps and member needs. In the past, this has included paying specialty providers, such as those serving members living with autism, an enhanced rate to serve an area outside of their targeted geographic zone. In addition, Sunflower collaborated with the State to develop statewide policies and procedures for Medication Assisted Treatment (MAT) for individuals living with SUD. We have also engaged primary care providers in training and education to support them to become more confident in prescribing the full suite of available MAT treatments, including vivitrol, buprenorphine, naloxone, and other addiction medications for tobacco cessation. To date, we have provided training related to MAT best practices to more than 75 providers across the State.

In 2017, Sunflower trained 300 law enforcement officers and first responders in Crisis Intervention Training (CIT). Under KanCare 2.0, Sunflower will continue working with law enforcement officers, first responders, and other stakeholders across the State to provide this kind of education and consultation in order to enhance their ability to respond to members experiencing a behavioral health crisis.

Under KanCare 2.0, Sunflower will further support the expansion of BH capacity in Kansas through our telehealth strategies. For example, we are currently in the process of developing a telepsychiatry program, supported by the Kansas Health Care Association, to expand the availability of psychiatric medication management to members in nursing facilities in rural, frontier, and underserved regions of the State (anticipated implementation of 2018). Through this program, psychiatrists will ensure appropriate prescribing of psychotropic medications in

collaboration with the nursing facility, the nursing facility's Medical Director, the member, and the member's family. To date, in support of this initiative's development, Sunflower has identified and begun conversations with five nursing facilities across the State where members have limited access to BH prescription services. In addition to this telepsychiatry initiative, Sunflower's parent company recently executed a national contract with Project ECHO. Through this national contract, Sunflower will offer our BH provider network access to the worldwide Project ECHO database of trainings and programs, including many related to best practices in BH and integrated care.

To further support access to BH care in rural areas, Sunflower, in partnership with the Centene Foundation for Quality Health Care, provided Rural Health Grant in the amount of $110,000 to two agencies: the Center for Counseling & Consultation and the Pawnee County Health Department. The purpose of the grant funds was to broaden access to BH services through technological solutions, including mental health kiosks and telemedicine screening capabilities. The funding helped the two agencies purchase the software and equip 11 mental health screen kiosk stations, at which members can engage in mental health self-screenings and immediately receive relevant information on available local resources, both within Sunflower's network and in the community, based on the results of their screenings. Initially, the kiosk locations included the lobbies of the four county health departments, with the other kiosks being placed in community facilities, such as the six community hospitals, the area's family crisis center, libraries, high schools, and middle schools.

Sunflower's 2017 adult CAHPS survey, getting care quickly metric, met or exceeded the NCQA quality compass 90th percentile.

5.5.8. NETWORK MANAGEMENT

Sunflower's Contracting and Network Development department are dedicated to making each participating provider's experience with Sunflower a positive one. As a testament to our success in managing the provider network we are pleased to report that the latest CAHPS survey of member satisfaction demonstrates Sunflower's success in achieving top performance for both adults and children in getting access to care quickly.

Our contracting and management processes ensure that participating providers follow the criteria established by Sunflower, as well as government regulations and standards of accrediting agencies to provide good access to all covered services. The Contracting and Network Development department is responsible for oversight, coordination, and initiation of services for all providers. To ensure good access to all covered services the provider network includes the full range of covered PCPs, specialists, BH, LTSS, dentists, vision providers, pharmacies, hospitals, ancillary and transportation service providers.

We exceeded the All Plan Rate performance goals of 80.7% (adults) and 88.6% (children) with 87.8% and 92%, respectively reporting satisfaction, and exceeding the NCQA quality compass 90th percentile for adults.

TIMELY, COMPLETE NETWORK REPORT SUBMISSIONS TO STATE (5.5.2.H, 5.5.8.A AND 5.5.8.B)

Sunflower submits and will continue to submit network reports to KDHE quarterly, as otherwise defined by the Contract and upon request, to maintain and monitor compliance with KanCare 2.0's future Geo-Access distance standards and demonstrate network capacity including PCPs, BH, specialty, LTSS and pharmacy services. This includes at the time Sunflower enters into a Contract with the State, whenever there is a notable change to Sunflower's operations that could affect capacity and service access, or when there are changes in population, services, benefits or service areas (5.5.2.H.1-H.4). Our plan president reviews and signs all network report submissions to the State (5.5.2.I). In addition, as network access issues arise, Sunflower will report areas of network deficiency within 24 hours and plans for resolution to KDHE within five business days.

Sunflower uses and will continue to use Quest Analytics reports to highlight provider network adequacy issues at state, region, county, city, ZIP code and provider type level, for both graphical and thematic maps in place for KanCare and KanCare 2.0 and make the necessary updates to generate tables and maps plotting member and provider locations for each service area each month. In addition, we run and will run exception reports to look at the number, type, and location of providers compared to member residential locations, highlighting any variance to network access standards. Sunflower will provide a network adequacy report according to State requirements by member type, provider panel status (open, closed, open and closed) and other data points to assist with identifying network adequacy issues (5.5.2.F.4; 5.5.2.G.14). These reports are analyzed and compared against KDHE distance standards by provider type and urban vs. rural/frontier designations. We use a multi-tiered approach to assess adequacy that measures time and travel distances for designated provider types and work to address any network gaps, along with appoint time availability described in the Appoint Access paragraph below, and member feedback on appointment availability described further in the Member Grievances and Member Satisfaction paragraphs that follow (5.5.2.F.10, 5.5.8.B.2).

Our QIC reviews the provider network adequacy results at least annually for opportunities for improvement. They will issue internal and/or external long- term network gap strategies to address identified issues. Intermediate and short-term interventions are used when a network gap occurs and a member needs prompt access to specific services.

PROVIDER CREDENTIALS VERIFICATION (5.5.8.B.3)

As described further in Section 5.5.1, Sunflower has a process through our Credentialing department to review and verify the status of every provider's license, registration, certification and accreditation. This information is reviewed and verified during initial and ongoing provider credentialing.

ELIMINATION OF MEMBER ADVOCACY BARRIERS (5.5.8.C.1; 3)

Sunflower will in no way prohibit, or otherwise restrict, a provider, acting within the lawful scope of practice, from advising or advocating on behalf of a member, as described in Section

5.5.11. We will work closely will consumer and family-run organizations (5.5.2.G.6, 5.5.8.B.1) to review and provide input to all materials used to educate providers about provider rights and responsibilities during the initial orientation and quarterly orientation/refresher course webinars. We publish provider rights and responsibilities in the provider manual and on the Provider Portal. Included in provider responsibilities is information to remind and assure providers that they must maintain a relationship with members as advisor and advocate within the lawful scope of their practice concerning the member's health status, medical care, or treatment and non-treatment options, including risks or benefits and consequences of non-treatment, and any alternative treatments that may be self-administered. In addition, we use provider agreements which include specific requirements regarding respecting the preferences and will of the member.

In addition to educating providers about the importance of counseling and assisting members about their treatment options, including the right to refuse treatment, Sunflower also educates members about their rights for participating in decisions about their health care, seeking second opinions about their treatment, and for being informed of all treatment options and alternatives. We advise members to tell their PCP if they want a second opinion; the PCP or Sunflower's Customer Service department can help a member find a provider to give them a second opinion. Member rights information is available in the member handbook and in the member section of our website.

CONTINUALLY ASSESSING NETWORK SUFFICIENCY AND CAPACITY (5.5.8.D; G)

In addition to measuring network adequacy by time and distance standards, Sunflower measures capacity and will continue to do so using the following indicators:

- Member and provider complaints related to access
- Call center requests from members, providers, advocates and external organizations
- Reviewing access-related challenges voiced by Sunflower's Service Coordination teams
- Measuring the percentage of PCP panels open to both new and existing members (5.5.2.F.4)
- Obtaining provider feedback regarding difficulties with patient transitions
- Reviewing member satisfaction with providers through post visit surveys
- Measuring provider to member ratios and panel status (5.5.2.F.4)
- Primary Care Physician (PCP): 1 PCP : 2,500 members
- Primary Care Nurse Practitioner: 1 NP : 1,250 members
- Primary Care Physician Assistant: 1 PA : 1,250 members
- Reviewing member utilization (e.g., emergency room and non-network utilization)
- Members with special needs
- Tertiary care availability using travel distance standards of hospitals, availability of trauma centers, burn centers, high-risk nurseries, rehabilitation facilities, and of medical sub-specialties
- Home health, home care and nursing facility staffing capacity from State agency notifications

Implementing Long Term Solutions for Network Gaps

When the network gap analysis uncovers a network deficiency, Sunflower's network management and contracting team initiates various provider recruitment strategies, such as:

- Approaching PCPs and other providers with limited or closed panels, to request that they open their panels to new members or existing members (if applicable, to a family member of a member already on their panel) (5.5.2.F.4).
- Identifying prospective network providers in underserved counties from existing lists such as newly-licensed providers, other health plan provider directories, the local medical society, Kansas Board of Healing Arts, provider association lists, care manager records, MemberConnections representatives, established community relationships with hospitals and other provider organizations, Internet resources and personal recommendations from network providers in that county.
- Identifying a list of out-of-network providers previously used by Sunflower members
- Maintaining positive relationships with providers who have declined to join the Sunflower network

Provider retention strategies that stabilize the provider network

The best approach we've found for managing the ongoing stability of our provider network is being a supportive partner – we value their time and aim to simplify their interactions with the plan. We have found that providers respond favorably to our efforts to ease the administrative burdens that can occur under managed care. For example, Sunflower's staff members work conscientiously on these day to day activities to support network providers:

- Making on-time claims payments
- Simplifying administrative procedures
- Using non-bureaucratic preauthorization procedures
- Education and training for providers and office staff (initial orientations, provider meetings, customized trainings)
- Website support tools
- Quality Improvement Programs
- Annual provider satisfaction survey

ENSURING PROVIDER OFFICE PHYSICAL ACCESS AND ACCOMMODATIONS

As described in 5.5.2 above, Sunflower places high importance and value on ensuring our provider network can meet the physical access needs and accommodations of our members with physical or mental disabilities. This includes our Barrier Removal Fund (BRF) that will be implemented in 2019 to award provider grants for individualized technical and financial support in the form of:

- An on-site Accessibility Site Review (ASR) and Compliance Action Plan (CAP) conducted by a local Center for Independent Living (CIL) that includes recommendations for removal of accessibility barriers in priority order;
- Funding to remediate priority barriers; and
- Staff training to increase awareness.

APPOINTMENT ACCESS AND METHODOLOGY

Sunflower recognizes that our ability to implement comprehensive and effective monitoring practices regarding provider performance in the areas of appointment availability and wait times can have a positive impact on improving the healthcare experience from the member's perspective, improving healthcare outcomes from the provider's perspective, and reducing healthcare costs from the State's perspective. Our provider accessibility monitoring activities occur across our entire provider network. To ensure member access to care, in addition to our continuous monitoring practices, members are always given the option to change providers at any time or for any reason with the exception of members placed under an administrative lock-in arrangement (5.5.8.F)**.**

Sunflower monitors PCP and specialist appointment and after-hours accessibility annually against our standards, and initiates actions as needed to make improvements. For example, we contract with partner Altegra Health, to serve as a liaison between members and providers to assist with scheduling PCP appointments based on the identification of care gaps with higher risk members. Customer service telephone access is also monitored on a regular basis, and actions initiated when needed to improve performance.

As previously described in Section 5.5.3, Sunflower defines urgent care appointments as within 48 hours from the time of the request; routine appointment accessibility for PCPs as not to exceed three weeks from the date of member requests, and access to a specialty care appointment within 30 days of request.

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.

Appointment Availability and After-hours Access

In 2016 all high-impact specialists/oncologists and high-volume specialists/OBs were found to be compliant with wait time not to exceed 45 minutes. Sunflower improved access to urgent care appointments at 99% in 2016, up from 91.33% in 2015. The plan had excellent compliance with access to routine obstetrical care at 97% to 100%, depending upon trimester at the time of the appointment request.

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%). To respond to the lack of compliance with appointment access we determined that practitioners' lacked knowledge of Sunflower's appointment availability standards and the annual member experience survey (CAHPS) results. Sunflower followed up on these findings by providing education to network providers of the appointment access standards and expectations and educating them on member satisfaction with appointment access.

In 2016 Sunflower tracked our performance against 20 measures for provider accessibility through CAHPS and an appointment availability survey. The plan met the performance goals for 15 out of the 20 performance goals.

Member grievances information

Sunflower also monitors member grievances for access to care. Between July 2015 through June 2016 we met our established goal of less than .75 grievances per thousand members for the overall Access category with a rate of .01 per 1,000 grievances related to each area for accessibility of services. Given the minimal number of member grievances and appeals regarding accessibility of services received during the reporting period, Sunflower determined there were no issues specific to a particular geographic area or type of practitioner or provider.

Sunflower maintains an internal system for the identification, acknowledgement and prompt resolution of oral and written member grievances. Access to care is one of the coding categories for member grievances. The Sunflower Grievance and Appeal Committee and QIC review grievance data on a quarterly basis. Analysis performed by the QIC, which is composed of departmental leaders and network physicians, enables Sunflower to initiate quality improvement efforts to improve member satisfaction as needed.

As described in Section 5.5.5 transportations services were the most common grievance within the Access to Care and Services category, comprising 50% of the grievances in this category, and representing 22% of grievances overall. Access - other complaints were the next most common grievance in the Access to Care and Services category, at 36% of the grievances in this category, and representing 16% of grievances overall. In response we have worked closely with LogistiCare, our transportation provider to improve transportation access and decrease grievances related to transportation, and to identify trends with specific transportation providers.

Member satisfaction survey/CAHPS®

The results from the 2016 and 2017 CAHPS surveys indicate a general satisfaction of Sunflower members regarding accessibility of routine and urgent appointments. The *Getting Care Quickly* composite and individual question results for both the 2016 and 2017 Adult CAHPS surveys and Child CAHPS surveys met Sunflower's goal of meeting or exceeding the Quality Compass All Plan Rate.

Our 2017 LTSS member satisfaction survey revealed that over 95% of members receiving HCBS reported satisfaction with the help they receive from their Sunflower Service Coordinator and 99% indicated their Service Coordinator respects their beliefs and preferences.

Sunflower conducts member satisfaction surveys utilizing the CAHPS® 5.0H Medicaid Adult and Child Member Satisfaction Surveys to evaluate and compare health plan ratings by members. Sunflower strives to understand the problems members face to implement actions to achieve better performance on specific opportunities for improvement identified by CAHPS, including provider network adequacy and access. Sunflower contracts with SPH Analytics (formerly The

Myers Group), an NCQA-certified survey subcontractor, to conduct the CAHPS 5.0H Medicaid Adult and Child Satisfaction Surveys for Sunflower Medicaid members. A survey was conducted according to the survey methodology outlined in the 2016 HEDIS Specifications for Survey Measures. The Plan's performance for adults and children increased between 2015 and 2016 for all Child measures of provider access and for one of the three Adult measures of provider access, and between 2016 and 2017 for all the Child and Adult measures as provided in Table 5.5.8.A.

Table 5.5.8.A CAHPS Performance, 2015-2017, Provider Access Measures

CAHPS MEASURE	2015 RATE	2016 RATE	2017 RATE	2017 QUALITY COMPASS ALL PLANS PERCENTILE MET OR EXCEEDED 50TH PERCENTILE
ADULTS				
Getting Care Quickly	83.9%	83.4%	87.8%	YES
Obtaining needed care right away	88.6%	86.5%	87.7%	YES
Obtaining appointment for care as soon as needed	79.2%	80.3%	88.1%	YES
CHILDREN				
Getting Care Quickly	91.1%	90.0%	92%	YES
Obtaining needed care right away	92.6%	91.4%	95.8%	YES
Obtaining appointment for care as soon as needed	89.6%	88.5%	88.9%	YES

Sunflower analyzed the barriers and opportunities to improve member access to providers based on the CAHPS results, which were believed to be related to continued adjustment of members and networks providers adjusting to the changes brought forward in managed care with the implementation of KanCare in 2013. Thereafter the major sources of member dissatisfaction shifted from Access to Care (provider availability) to a focus on plan requirements, service of subcontractors, and distribution of information to promote wellness. To ensure members understand appointment standards on expected timeframes to obtain an appointment, Sunflower disseminated information to members and providers on standard timeframes to obtain appointments through our Provider Newsletter, hold voice recording, and member handbook.

After-hours survey. In 2016 Sunflower conducted a telephone survey with PCPs to determine provider accessibility and availability for member emergencies after hours. We set a goal that 90% or more PCPs must have acceptable after-hours coverage and the PCP sample performed at 100%.

Provider satisfaction survey

Sunflower uses provider satisfaction survey data to drive change. In 2017, Sunflower received the highest score (61.2%) of all Medicaid managed care payers in Kansas for overall provider satisfaction and ranks at or above the 75th percentile when compared to the SPH Analytics Book of Business benchmark for Medicaid plans (58 plans). Sunflower's overall satisfaction rate exceeded United Healthcare by 3.1% and Amerigroup by 21.2%. Sunflower's score represents a steady year over year increase in overall provider satisfaction of 2.3% from 2016 and of 8% from 2015. Moreover, 82.3% of surveyed providers would recommend Sunflower to other physicians practices. We have also seen an overall improvement in provider satisfaction with Sunflower from 2014 to 2015 of 9.4%. In addition, there were increases from 2015 to 2017 in provider satisfaction with timeliness and accuracy of claims payments, with being a BH network provider, and with courtesy extended by the Provider Relations department.

In 2017 61.2% of providers gave Sunflower high marks in Overall Satisfaction, the highest rating of any Medicaid plan in Kansas.

We will continue to conduct annual provider satisfaction surveys for KanCare 2.0 utilizing an approved tool that assesses satisfaction with overall satisfaction, finance issues, utilization and quality management, network/coordination of care, pharmacy, health plan call center, and provider relations. Sunflower contracts with a third-party subcontractor, SPH Analytics to conduct an annual provider satisfaction survey to review and apply for continuous improvement and to assist in identifying training opportunities for providers and staff.
In addition to the Provider Satisfaction Survey our Provider Relations specialists survey their assigned provider offices from time to time regarding their referral network and any preferences providers may have with regard to certain providers to target for participation in the Sunflower network.

Provider Quality Profiles (5.5.8.G.1)

Sunflower will regularly track provider and plan performance with provider quality profile reports for plan and provider use, Provider Portal accessibility and to monitor VBP initiatives and their relative progress in meeting performance benchmarks. Provider profiles also help to identify care gaps that could indicate a problem with appointment availability, and other network adequacy or access issues.

Sunflower just launched a Provider Analytics dashboard in July 2017, powered by Centelligence®. This is a health informatics platform that will give our staff and network providers timely, actionable quality information to support patient care and to optimize P4P arrangements. Upon full implementation the dashboard will bring together a collection of the most important medical cost and utilization, pharmacy, emergency room, potentially avoidable events, clinical, population health, and quality data to help providers form a cohesive understanding of provider and plan performance and member experience. We have also developed an LTSS Key Performance Indicators (KPI) dashboard that we will share with LTSS providers to support VBP arrangements, as further described in 5.7.1.

Available through our secure Provider Portal, provider analytics dashboards will offer varying levels of information to provider user groups and allow for, among other uses, provider performance analysis, cost and utilization trending, quality measure performance, active and non-active member pattern analysis, disease state prevalence, readmission analysis, and population health trend analysis. Provider groups will also be offered many of these metrics on a risk and severity adjusted basis. Authorized users will be able to interact with the dashboards through extensive custom selection, drill-down, and export capabilities, to identify factors behind clinical and cost performance. As providers increasingly shift to pay-for-performance and pay-for-outcome measures, the availability of such data to determine contract performance will become paramount. By using provider analytics, providers and Sunflower will be able to monitor their performance versus contractual or bonus goals.

For example, as a part of our ongoing efforts to support clinical quality improvement across the network at Sunflower, our QI department has run and sent our providers a HEDIS Physician Quality Report for the members either attributed to or assigned to their practice panel. This member-level report goes to both PCPs and specialty providers. The report is personalized to each provider and identifies patients shown as being out of date with specific HEDIS measures. This report helps providers identify members who are due for recommended screenings or who need additional services and initiate member outreach. When we identify an increasing trend of HEDIS non-compliance, we factor that information into our overall network development strategy.

Additional information about our provider profiling activities is described in Section 5.9.6.

IMPROVEMENTS TO NETWORK ANALYSIS ACTIVITIES

In response to a 2015 State audit of provider network data management Sunflower has taken practical steps to make improvements, for example:

- Improved audits of subcontractor data changes by enhancing the file management process to validate provider records in their files between quarters
- Guarantee that maps and network adequacy are using the same data 100% of the time for reporting purposes by merging the Geo mapping and network adequacy report generation process
- Replaced Geo-Access software with Quest Analytics to standardize addresses
- Created new internal data audits to review data validity and integrity to reduce duplications in network adequacy reports and provider directory
- Developing non-financial provider incentives (5.5.8.E)
- Through our value based payment initiatives Sunflower will incorporate non-financial incentives to PCPs as described further in Section 5.7. One non-financial provider incentive we have is Sunflower's Physician Summit Award for Excellence in Care. This annual award acknowledges healthcare professionals for their engagement with Sunflower members, as well as the exemplary care they deliver. Additionally, the providers are recognized for their clinical excellence (5.5.8.E).

- We are planning another non-financial provider incentive for providers with the best total performance outcomes for high quality care coupled with lower program costs who will receive preferential member assignment through our default assignment process (5.5.8.E).

5.5.9. NON-PARTICIPATING PROVIDERS

In the event the Sunflower network is unable to provide adequate and timely services as required by KanCare 2.0 established standards, we will arrange for the timely and adequate coverage of services through a licensed, qualified out-of-network (OON) provider until a network provider is available (5.5.9.A). Non-participating providers are paid 90% of the Medicaid fee schedule upon verification of their licensure and non-exclusion status (5.5.9.F) except for emergency service providers, non-participating Indian Health Care Providers (5.5.9.I) and OON family planning services providers who are paid at 100% of the Medicaid fee schedule (5.5.9.J.1). See Section 5.5.2 for further information about the family planning network. Sunflower will track and provide the State with documentation quarterly on our non-network provider-level utilization and claims paid experience (5.5.9.B).

PA PROCESSES FOR OUT-OF-NETWORK AND EXPEDITED REQUESTS FOR SERVICE (5.5.9.C; 5.5.9.G AND 5.5.9.J)

We will ensure coordination with respect to authorization and payment issues with OON providers. We will require prior authorization of all OON services prior to the provision of the services (except in an emergency or for certain post-stabilization services). This can occur when a member needs specialized, medically necessary services not otherwise available in the Sunflower network (5.5.9.G). OON providers may also be referred to for second opinion consultations (5.5.9.J.2). Utilization Management (UM) staff will review the request and supporting information against UR Criteria, and determine whether there is a more conservative or substantially less costly treatment, service, or setting available within the network to achieve the desired health outcome, and that is also appropriate for the member's needs. For new members already receiving ongoing services from on OON, a UM nurse outreaches to the provider, previous MCO, and others as necessary to request previous authorization and other information needed to enter an authorization for continuation of those services during the transition period.

For all non-emergency-OON requires, the UM nurse will generate an authorization, and communicate the determination to the requesting provider and member. UM staff will contact the OON provider to educate them on our UM policies, the scope of the authorization, and any requirements for submitting clinical information or collaborating with the Special Needs Unit care manager or other community-based care manager to manage transitions of care and/or update the care plan.

INFORMING OON PROVIDERS ABOUT STATE REQUIREMENTS (5.5.9.C AND 5.5.9.E)

We will routinely inform all OON providers about Sunflower's grievance and appeal and the State Fair Hearing process in the event of a dispute. The information is accessible to any

provider in our provider manual on the Sunflower website (5.5.9.C.1). In addition, Sunflower works closely to inform all providers about when it is inappropriate to bill members and to ensure that the cost for care is no greater than the cost of services from an in-network provider (5.5.9.E). Specifically, our Provider Manual's Billing and Claims Submission chapter includes a section about Billing the Member. We also educate members about their protections against balance billing in the Member Handbook in a section called What to Do if You Get a Bill and we advise them to inform all providers including any OON providers that they are a member of Sunflower under the Medicaid program.

OUT OF NETWORK CONTRACTING (5.5.9.D)

The Contracting and Network Development department will attempt to recruit non-participating providers serving our members into the network whenever possible. If an OON provider is required to fill a need but unwilling to contract, they will be asked to complete a single case agreement (SCA). SCAs solidify payment terms, authorization parameters, and treatment plans to ensure thorough service coordination of the member's care and appropriate transition to in-network services if warranted.

5.5.10. MATERIAL CHANGE TO PROVIDER NETWORK

In the past three years, the turnover rate for the network has been less than 3%. Sunflower has had a proven track record of successfully developing, maintaining, and managing a dedicated, stable provider network in support of the Kansas Medicaid managed care program since 2013. Because of the successful approaches we use to build and manage a statewide network, we do not expect to experience substantial or rapid network losses that could upset the balance of care provided to our members. Furthermore, the Sunflower Network Development team continuously reviews network stability by running monthly adequacy reports (5.5.10.A). Additional information on how Sunflower evaluates the network to identify unexpected or significant changes which may be material is detailed in Sections 5.5.2, 5.5.3 and 5.5.5. Although we have not experienced a material network change since we began operations in 2013, our network management process includes proactive risk management procedures and redundancies to address the loss of a material provider that could affect more than 5% of our membership in each service area.

MEETING CONTRACT REQUIREMENTS FOR TRANSITION OF CARE UPON A PROVIDER TERMINATION

Using the typical example based on our experience described above, Sunflower's hospital and physician agreements include language that would require a terminating group practice with empaneled members to coordinate with our care coordinators regarding the transition of care. Similarly, our agreements would require a terminating hospital to cooperate and assist with the transfer of care for inpatients to a contracted facility, and they would similarly require the PCP and a treating specialist to ensure that members receive continuity of care with respect to their course of treatment (such as chemotherapy). A member may remain with a terminating provider who is willing to continue care through a pregnancy or course of treatment, and assuming the

provider termination was not the result of quality issue, provider relocation or provider death. Sunflower will provide continuation of treatment with an OON provider for members previously approved by a previous MCO or Medicaid FFS for ongoing treatment for a chronic or acute medical condition for up to 90 days. For pregnant members past the first trimester, we will authorize services with the current OON OB/GYN through delivery and postpartum care. For persons in LTSS, we will authorize the existing services and units and complete our HRA, needs assessment and PCSP within 30 days. As described further in Section 5.4.12.E and 5.4.12.F, our Service Coordination (SC) or Utilization Management (UM) staff will obtain appropriate member consent, and contact the relinquishing entity and/or treating provider(s) to obtain current authorizations and related information. We will authorize existing services a new member is receiving, regardless of their provider's network status. We will then determine necessity of continuing OON services, and either authorize continued OON services or work with the member, family, existing provider, and other treating providers to develop a plan for safe transition to a network provider as appropriate. Our SC and UM team and the community service coordinators will work with the member to obtain copies of the member's medical records, as appropriate, in a manner that is compliant with Federal and State laws.
We have consistently demonstrated to NCQA through claims data that we have provided appropriate continuation of care.

Notification of Provider Plans to Exit the Sunflower Network

To anticipate changes to the provider network that could affect member access to care and continuity of care, in general Sunflower requires our contracted providers to give written notice to the plan of:

- Any event of which notice must be given to a licensing or accreditation agency or board, within 10 calendar days of the event
- Any change in the status of the provider's license, within 10 calendar days of the event
- Termination, suspension, exclusion, or voluntary withdrawal of the provider from any state or federal healthcare program, including the KanCare 2.0 program, within 10 calendar days of the event
- Any lawsuit or claim filed or asserted against the provider alleging professional malpractice involving a member, within 30 calendar days from the date the provider first has knowledge of the lawsuit or claim
- Cancellation, nonrenewal, lapse, or adverse material modification of insurance coverage, within 15 days of such notice, and
- Any change in provider panel status, at least 30 days prior to the effective date.

Addressing Network Adequacy Compliance

Sunflower has a contractually established timeframe of 90 days to respond to the prospect of planned provider terminations from our network. During this time, our staff perform the following actions to gain a clear understanding of provider community impact and to minimize access to care issues for members. These practices are far reaching and also apply to any delegated affiliate or subcontractor:

- Conduct a network adequacy analysis to identify alternate providers with the capacity to assume additional caseloads resulting from the termination/closure

- Gather claims data, including claims look back, to further quantify providers and patients that will be impacted by the change
- Notify KDHE through our compliance officer of the impending network change, and discuss any role KDHE could play in mitigating risks to health plan operations and quality of care delivered
- Attempt to negotiate terms that would retain the provider in the network, if appropriate, or to extend the contract end date or offer single-case agreements for members currently under care

Minimizing Disruption. When a provider termination occurs, impacted members are sent letters within 15 days informing them of the termination. Service Coordinators work directly with members to help them identify new providers who meet their needs. Sunflower staff support members with provider transitions using our automated technology systems, including the CRM, Member Portal, and online Provider Directory components. Our auto outbound option would be available to make calls to members as necessary.

Members whose PCP is terminated from the network are auto-enrolled with another provider. The Contracting and Network Development will immediately forward notification of the provider termination to our Service Coordination team. This will alert Service Coordination staff to outreach to affected members to notify them of the need to select a new provider and assist as needed. For example, Sunflower may assist members to arrange for the transfer of medical records to each member's new provider upon request. If the terminating provider is a specialist, Sunflower's Medical Management department will work to transition care and authorizations for services to another in-network specialist. Providers must continue to render covered services to members who are receiving care at the time of termination until a) completion of the treatment or b) Sunflower can arrange for appropriate healthcare for the member with a participating provider.

We obtain approval from KDHE regarding the written notice prior to sending the notice to members. The written notice includes:

- The provider's termination effective date
- The member's new PCP to which they have been assigned, along with a new ID card
- Instructions as to how members may select a new PCP if they would prefer a different PCP than the one to which they were auto-assigned
- Instructions for accessing care during transition to a new provider
- An offer to assist members in locating a new PCP
- The toll-free telephone number for Sunflower's Member Services team

We will determine whether pregnant members or those under a course of treatment would like to continue receiving care for their health condition from their terminating provider. If they do, and assuming the provider termination is not the result of a quality issue and the provider is still practicing in the member's service area, we will attempt to extend the terminating provider's contract or negotiate a single case agreement as appropriate (5.5.5.2.F). We follow up with members receiving a course of treatment (such as chemotherapy) from a terminating

provider to transfer their care to another appropriate provider in a safe and timely manner. We also personally follow-up with any pregnant woman whose care is impacted by a provider termination.

Ensuring a rapid return to compliance. In the event of the loss of a large provider, Sunflower will work to ensure both continued access and coordination of care for our members. We will use network assessment methods such as geo-mapping to measure the impact of the provider termination on compliance with geographic and appointment access standards. Our Quality Improvement Department and quality committee structure under our QIC Program will identify compliance issues based on this assessment and determine solutions, and our Contracting and Network Development team will incorporate the results into the Network Development Work Plan for implementation, reaching out to and attempting to recruit any non-participating providers that meet our quality standards. In addition, we may identify, and transition affected members to network providers willing to accept more members. Also, we may identify providers willing to travel to areas lacking access. If necessary, we may authorize care or contract with out-of-network providers located in the member's geographic area as well as providers located in other regions or out-of-state. We will also notify the State of any material changes to the network in advance for review and approval within 14 days of identifying the change, and include an impact analysis that assesses the delivery of covered services, plans for maintaining quality of care, and the communications schedule and correspondence to providers and members. (5.5.10.B, 5.5.10.C). Whenever possible, member and provider communications will be sent at least 30 days in advance of a material change to the network. If a material change to the network occurs without allowing for a minimum 30-day notice to members and providers we will notify the State within one business day of the material change for a notification requirements determination (5.5.10.D).

5.5.11. PROVIDER-MEMBER COMMUNICATION

Sunflower will in no way prohibit, or otherwise restrict, a provider, acting within the lawful scope of practice, from advising or advocating on behalf of a member, as described in Section 5.5.11 of the Scope of Work. Sunflower educates providers about provider rights and responsibilities during the initial orientation and quarterly orientation/refresher course webinars. We also publish provider rights and responsibilities in the provider manual and on the Provider Portal. Included in provider responsibilities is information to remind and assure providers that they must maintain a relationship with members as advisor and advocate within the lawful scope of their practice concerning the member's health status, medical care, or treatment options, including risks or benefits and consequences of non-treatment, and any alternative treatments that may be self-administered. In addition, we use provider agreements which include specific requirements regarding respecting the preferences and will of the member.

In addition to educating providers about the importance of counseling and assisting members about their treatment options, including the right to refuse treatment, Sunflower also educates

members about their rights for participating in decisions about their health care, seeking second opinions about their treatment, and for being informed of all treatment options and alternatives. We advise members to tell their PCP if they want a second opinion; the PCP or Sunflower's Customer Service department can help a member find a provider to give them a second opinion. Member rights information is available in the member handbook and in the member section of our website.

5.5.12. AVOIDING AND DISCLOSING POTENTIAL CONFLICTS OF INTEREST

ANTICIPATING, MONITORING AND PREVENTING POTENTIAL CONFLICTS OF INTEREST IN THE NETWORK (5.5.12.A; B)

Sunflower has a fiduciary responsibility to the State to protect against unjust enrichment that could occur through our provider network recruitment, contractual, financial, legal, provider referrals, provider reimbursement, service authorization practices, policies and procedures, monitoring and oversight or other practices (5.5.12.A). As an entity entrusted with State funds to administer covered services for Medicaid enrollees, Sunflower has procedures in place to prevent situations that may compromise the delivery or quality of health care services. Our compliance team monitors plan practices of the departments that engage with providers to enforce these protections. The Contracting and Network Development department, and the Medical Management department work closely with Sunflower's Compliance department and with corporate compliance to anticipate, mitigate, monitor and address potential conflicts of interest. Sunflower will notify KDHE timely about any legal, financial, contractual or related party interest that arrangement and the organizational structures for review and approval in keeping with Section (5.5.12.B).

Physician incentive plans and potential conflicts of interest

In January 2017 Sunflower initiated three P4P programs as a type of VBP with select providers to enhance quality of care with a focus on preventive and screening services that align with the State's and plan's goals. Complete details about our VBP programs are described in Sections 5.5.15 and 5.7. As we continue to grow the numbers of members served by providers paid under value based agreements we will ensure that these arrangements are structured and administered to reward quality performance and quality outcomes. Sunflower will make no payments under a performance incentive plan (PIP) to a provider or group as an inducement to reduce, limit or otherwise withhold medically necessary services to members. In addition, no physicians or provider groups engaged in PIP programs currently have or will have an organizational, employment or consulting relationship, or ownership interest with our plan.

ADDRESSING SITUATIONS THAT CAN RESULT IN A CONFLICT OF INTEREST (5.5.12.C; D)

The compliance team will update existing policies and procedures and conduct staff and provider training to educate responsible parties of the potential for conflicts of interest, how to identify and prevent common conflict of interest scenarios, and how to report possible conflicts of interest for remediation prior to implementation of KanCare 2.0. Training and education to prevent conflicts of interest will include all contracted providers including BH and LTSS

providers, and delegated entities and subcontractors who contract with providers to serve our members. The following situations will be given priority in our actions to avoid possible conflicts of interest:

- Changes to referral distribution patterns or reimbursement levels for providers within a level of care.
- In accordance with federal and state law, participating providers are prohibited from making referrals for designated health services to healthcare providers or entities with which the participating provider, the member, or a member of the participating provider's family or the member's family has a financial relationship.
- A disproportionate volume or exclusive referrals to providers who share an organizational relationship with Sunflower that occurs without State review and approval
- Preferred financial arrangements to providers who share an organizational relationship with Sunflower
- Preferential or otherwise separate and more favorable treatment of providers who share an organizational relationship with Sunflower during the credentialing, recredentialing, analytic profiling, admissions privileges, sanctions or other network management activities
- Substantiated complaints by members about difficulty in gaining access to network providers of their choice within an appropriate level of care

We will not delegate or subcontract with entities to perform needs assessments or person-centered service planning, or Plan of Service development on our behalf for our members if that entity is also a provider of service or conducts components of the HCBS program eligibility process. If after numerous documented attempts we are not able to contract with a conflict-free community-based organization in a certain geographic area, we will discuss and seek prior approval from the State before contracting with the entity. We are also committed to and will work with identified community-based organizations and the provider network to develop capacity to provide conflict-free case management services and the appropriate safeguards and mechanisms to protect against conflicts of interest. See Section 5.4.13 for further detail.

The compliance officer will document and disclose to the State any situation that may present as a conflict of interest within 10 days of identifying the event that gives rise to the potential for conflict and work with the State on an appropriate corrective action, if necessary.

CORPORATE OWNERSHIP AND MANAGEMENT DISCLOSURE MONITORING (5.5.12.E; F)

Sunflower and our parent company, Centene, will meet the State's ownership and management disclosure requirements as to Centene's, Sunflower's, and our subcontractor's ownership and control interest pursuant to 42 CFR 455.104, Form CMS 1513 and forms as required under KanCare 2.0.

Our compliance with disclosures includes business transactions, conviction of crimes, public entity crimes, and disbarment and suspension actions identified. The Centene Compliance team monitors and records all employee's ownership and controlling interest against the federal OIG's LEIE and System for Award Management (SAM) databases to identify any excluded individuals. Conflict of interest monitoring activities extend to all Centene contractors including those of Sunflower, its board of directors and any entities or individuals listed on the Business

Ethics and Conduct Policy (BECP) survey. When a match is made against the LEIE or SAM databases the names are reported to Centene's Human Resources department, and the vice president of ethics and compliance and the compliance officer at Sunflower.

Health plan ownership and management disclosure monitoring

Like corporate monitoring, the Sunflower compliance officer monitors and records all board members, contract employees and subcontractors' ownership and controlling interest against the OIG's LEIE and SAM databases to identify any excluded individuals. When a match is made against one of these databases the names are recorded in Compliance 360 and reported to the Human Resources department and corporate compliance. Sunflower requires our subcontractors to monitor employees and their subcontractors against the LEIE and SAM databases and report when this is complete, and any employees or subcontractors identified in the review.

Further, Sunflower requires our officers and directors to fully disclose ownership and/or controlling interests of 5% or more of the plan's capital or stock, or any situation where it receives 5% or more of its profits, or has a financial obligation secured in part or whole by the plan or by its property or assets of 5% or more of the total property or assets. Management disclosures are required when there are internal changes in management control of the plan or plans to contract out the operation of the plan to a management corporation. Sunflower will comply with all State reporting requirements as it concerns disclosures related to ownership and management and convictions of crimes for providers and other subcontractors.

5.5.13. DELEGATION RELATIONSHIPS

Sunflower uses a deliberative process to determine when to delegate functions to a subcontractor. Delegation decisions are based on the value that can be brought to our Members, Providers, and the State through engaging best in class, expert services in specialized areas of health plan operations. At the same time, we continuously evaluate opportunities to integrate the administration of delegated functions into Sunflower's health plan operations. This integration of subcontractors is facilitated by our affiliation with specialized vendors who are also owned by our parent company, Centene Corporation.

As an example, Sunflower is currently integrating the administration of the Behavioral Health benefit by shifting the expertise and resources previously provided by our affiliated subcontractor, Cenpatico, into our health plan operations with direct reporting to the Sunflower Kansas-based leadership team. Similarly, for the implementation of KanCare 2.0, we will integrate the specialty LTSS supports, currently provided by our affiliated subcontractor, LifeShare, into our health plan operations. These changes support better integration of services to Members across physical and behavioral health as well as Long Term Services and Supports. In both cases, the specialized expertise and experience of the current subcontractors is retained even as the functions are migrated into the Sunflower organizational structure. Our affiliation

with these nationally-recognized companies facilitates integration without requiring that new services be created, and expertise developed from scratch.

Below is a listing of the subcontractors that Sunflower will contract with for the purposes of this Agreement. All of these subcontractors have performed for us in multiple markets and we are confident in their ability to provide services for this Contract. Many of our subcontractors are affiliated with Sunflower through our parent company, Centene. Please note that the names of our affiliated subcontractors have changed to Envolve as part of our branding strategy, not a change in ownership. As mentioned above, use of affiliated subcontractors affords enhanced opportunities for collaboration and possible future administrative integration.

Sunflower-AFFILIATED Subcontractors

Envolve Dental, Inc. (Formerly Dental Health & Wellness)	**PRINCIPAL ADDRESS:** 5130 Sunforest Drive, 2nd Floor Tampa FL 33634 PHONE: 727-437-1701	Dental Benefit Management/Services
Envolve Vision Benefits, Inc. (Formerly OptiCare)	**PRINCIPAL ADDRESS:** 112 Zebulon Court Rocky Mount, NC 27804 PHONE: 252-544-9258	Vision Care Benefit Management
Envolve Pharmacy Solutions, Inc. (formerly US Script, Inc.)	**PRINCIPAL ADDRESS:** Envolve Pharmacy Solutions 8427 South Park Circle, Suite 400 Orlando, FL 32819 PHONE: 855-422-2742	Pharmacy Benefits Management including MTM services
Envolve PeopleCare (formerly Nurtur & NurseWise)	**PRINCIPAL ADDRESS:** 7700 Forsyth Boulevard St. Louis, MO 63105 **PHONE**: 844-331-6034	-Disease Management -Nurse Triage Phone Services providing 24-hour health care advice and assistance

In addition to the affiliated subcontractors listed above, Sunflower takes advantage of the specialized expertise of industry leading companies to manage specialized benefits and provide specialized services. The subcontractors listed below have served Sunflower Members for many years in addition to supporting Centene health plans across the country.

Sunflower Unaffiliated Subcontractors

LogistiCare	**PRINCIPAL ADDRESS:** 7275 Peachtree Street Atlanta, GA 30309	Non-Emergency Transportation including innovative transportation solutions such as a partnership with Lyft.
National Imaging Associates, In. (NIA)	**PRINCIPAL ADDRESS:** 6950 Columbia Gateway Drive Columbia, MD 21046	Outpatient Radiology Program Management, PT, OT and Speech Therapy and rehabilitative services program management.
Voiance	**PRINCIPAL ADDRESS:** 5780 Swan Road Tucson, AZ 85718	Phone and language interpretation services

ULTIMATE RESPONSIBILITY (5.5.13.A)

Sunflower understands that we are ultimately responsible for all products, services and obligations agreed to by the health plan and the State of Kansas and that we must certify and warrant all subcontractor work. Our subcontracts include appropriate provisions and contractual obligations to ensure the successful fulfillment of all contractual obligations. Sunflower will be subcontracting for: 24/7 nurse advice line, Radiology, Dental, Vision, Disease Management, Pharmacy benefit management and Non-emergency transportation services.

In addition, we will receive support from our corporate office for information system, claims processing, compliance/fraud and abuse detection and prevention, provider data management, human resources, and finance services through a separate Management Agreement.
To reinforce Sunflower's accountability for these services, our subcontractor agreements require that Member and Provider-facing communications are branded with Sunflower branding. These materials are submitted to KDHE through our standard materials submission process and are KanCare co-branded.

APPLICABLE MATERIAL TERMS AND CONDITIONS (5.5.13.B)

Sunflower's agreements with our subcontractors are subject to the applicable material terms and conditions of the contract between Sunflower and KDHE. These terms and conditions are incorporated into our subcontractor agreements via a template contract that is applicable to each subcontractor. When the contract between Sunflower and KDHE is amended, our Compliance Department works with Subcontractor Oversight staff to determine if material terms and conditions have changed in a way that requires modification of subcontractor agreements. Pursuant to Section 5.5.13.L, our subcontractor agreements are subject to the review and approval of the State.

Additionally, all subcontractor agreements will incorporate the requirements of 42 CFR 438.230 and 42 CFR 434.6. Our subcontractors will be required to include all required provisions in their network provider contracts as well and both monitor and enforce compliance with those provisions.

PRE-DELEGATION AUDIT (5.5.13.C)

Sunflower will not delegate any work performed under this Agreement without first ensuring the capability and responsibility of the potential subcontracted party through a Pre-Delegation Assessment. Building upon our best practice subcontractor pre-delegation audit process in 29 other states, we have developed a Subcontractor Oversight Program that supports high quality delivery of services. Pre-delegation audits are conducted using predetermined assessment tools which consider contractual, NCQA, CMS, and state requirements. During an assessment, noncompliant findings result in a Quality Improvement Plan or Corrective Action Plan for the subcontractor and may result in the subcontractor not being awarded a contract.

The pre-delegation assessment process consists of reviews of the policies and procedures specific to the delegated activities, staffing capabilities and the overall organizational

performance record in the following areas, depending on the functions delegated. Some of the areas that are reviewed during a pre-delegation include, but are not limited to, the following:

- Utilization Management files (denials and appeals for members/providers);
- Claims payment;
- Member grievances and appeals, claims disputes, and provider complaints;
- Provider contracting, network accessibility and availability;
- Provider training, including provider manuals;
- Credentialing and re-credentialing practices; Call Center stats for member/provider;
- Quality improvement;
- Encounters;
- Compliance; and
- Finance (solvency, P/L)

Pre-delegation assessments are requested up to 60 days prior to the execution of an agreement with a subcontractor. In the event that a subcontractor is currently utilized by Centene and an annual or pre-delegation assessment was performed within the prior 12 months that assessment will serve as the pre-delegation assessment. All participants in an on-site assessment will be trained prior to participating in the assessment. Our policy ensures that during the on-site assessment, no Sunflower participants will engage in any outside meetings with the subcontractor or bring other day to day operational issues or questions to the subcontractor in order to retain the focus of the on-site review. All assessment tools, results and CAPs from the pre-delegation assessments are maintained in our compliance management system, an enterprise-wide software utilized to manage our compliance with KDHE and other State regulatory requirements.

Our Subcontractor Oversight Program incorporates CMS' approach to creating a Subcontractor risk assessment methodology where the level of risk determines the format of the annual and pre-delegation assessment. A high-risk subcontractor, for example, may warrant a comprehensive on-site assessment, while a more consistently performing subcontractor may complete a questionnaire, a desktop policy review or focused file review to evaluate their performance in identified risk areas. The on-site review could include a policy review, in-depth file reviews of delegated services like utilization management/authorization, credentialing and claim files. In addition, the on-site team will review the organization's operations, interview managers or observe live incoming member and provider calls to ensure that the subcontractor remains fully compliant in the provision of services on behalf of Sunflower. All subcontractors that pay claims are required to submit a SAS 70, or similar SOC report, to demonstrate the organization meets rigorous Statement on Accounting Standards No. 70.

Prior to delegating any work performed as part of Kansas Sunflower's contract, we also ensure that the Subcontractor has not been excluded from participation in any Federal or State health care programs including exclusions issued by the Officer of the Inspector General (OIG) under Section 1128 of the Social Security Act, or by KDHE from participating in the Kansas Medicaid Program for fraud or abuse. Our Subcontractor Oversight Program includes a regular check of these databases every thirty-calendar days. In addition, during the pre-delegation and annual

assessment of the subcontractor, we ensure the subcontractor is performing a similar check on their employees, subcontractors and provider network. Prior to entering into any agreement with a subcontractor, we will also check:

- The Social Security Administration's Master Death File
- The National Plan and Provider Enumeration System (NPPES
- The System for Award Management (SAM
- The Medicare Exclusion Database (the MED)
- Any other databases prescribed by the Secretary of KDHE

All of our Subcontractors are required to complete a Conflict of Interest Disclosure and Financial Interest Disclosure Statement as outlined in our Subcontractor Oversight Program Description. In addition, our Subcontractor Service Agreement includes a requirement that they immediately report any legal proceedings that might occur after the effective date of our Agreement.

CONTRACT PROVISIONS SPECIFYING DELEGATED ACTIVITIES AND REPORTING RESPONSIBILITIES (5.5.13.D)

All Sunflower subcontractors with delegated services will enter into a written agreement that includes, but is not limited to:

- Responsibilities of Sunflower and the subcontractor;
- Specific delegated activities, required business and regulatory reporting requirements;
- Explicit statement of consequences, corrective action process if the subcontractor fails to meet the agreement terms, up to, and including revocation of the delegation agreement.

Sunflower's Subcontractor Oversight Staff, in collaboration with the Sunflower Compliance, Quality, other Business Area Departments and Corporate Compliance Performance Office, will ensure subcontractors are trained and understand all Subcontractor Agreement requirements and tracking Subcontractor completion of required training, including but not limited to, annual Compliance and Fraud, Waste and Abuse training. This training will also include information regarding KDHE policies and procedures.

Sunflower will not subcontract any portion of the services to be performed under our KDHE contract without the prior written approval of KDHE. We shall continue to notify KDHE in advance of our desire to subcontract.

MONITORING SUBCONTRACTOR PAYMENTS TO PARTICIPATING PROVIDERS (5.5.13.E)

Sunflower requires any subcontractor that is paying provider claims to reimburse providers at levels that are no less than the Fee-for-Service fee schedule. This requirement is included in our contracts with subcontractors. Sunflower maintains ultimate accountability for complying with provider payment requirements and takes our responsibility for monitoring subcontractor payments to providers seriously.

Centene Corporate conducts on-site audits for all Centene owned subcontractors and sample claims at the on-site to ensure claims are paying accurately. During annual rate setting with the

State, utilization is reviewed for accuracy levels to set appropriate rates going forward. Additionally, internal audit spot checks claim set-up and payment for specialty companies, like Envolve Dental, against their contracts to validate payment methodologies. Sunflower also leverages annual Centene Corporate audits of non-affiliated subcontractors, such as LogistiCare, to validate appropriate provider payments at levels consistent with Fee-for-Service Fee Schedules.

ONGOING MONITORING OF SUBCONTRACTORS (5.5.13.F)

Multi-Layer Risk Management Approach

Sunflower will implement a multi-layer risk management approach to monitoring and evaluating our subcontractors' performance. Following KDHE approval, Sunflower will utilize the Subcontractor Oversight Program of our parent company, Centene, with monitoring and oversight processes are built upon lessons learned and proven practices of other Centene health plans. Cross-functional teams at Sunflower and Centene Corporate will monitor subcontractor adherence to performance standards and reporting accuracy. Our Subcontractor Oversight Program has several components to promote communication and collaboration and ensure subcontractor adherence to agency, state, federal and NCQA requirements. Key to our oversight model is dedicated Subcontractor Oversight staff located at the Sunflower office. Prior to contracting with any subcontractor, Sunflower will perform a pre-delegation assessment and check to ensure no proposed subcontractor has been excluded from participation in federal or State healthcare programs.

Annual Subcontractor Audits. With the support of the Centene Corporate Compliance Performance Office, Sunflower conducts annual audits of subcontractor performance. The annual audits include a questionnaire, comprehensive desk audit and file review. As appropriate the annual audit also includes an onsite visit at the subcontractor's offices. Areas reviewed during the annual audit mirror the areas reviewed during a pre-delegation audit as described above. Findings from the annual subcontractor audits may result in the issuance of a Corrective Action Plan or the imposition of penalties or other remedies. Observations from the annual audit will also inform the subcontractor monitoring plans described in further detail below.

Staffing for Monitoring and Oversight. Sunflower takes full accountability for the monitoring and continuous evaluation of subcontractor compliance and performance through our multi-layer risk management approach. A Cross-Functional team including Sunflower and Corporate Compliance staff; National Contracting; Information Technology staff; Sunflower and Corporate Quality Improvement staff; Sunflower Subcontractor Oversight Staff and functional business area staff, will carry out the mission of our Subcontractor Oversight Program led locally by the Subcontractor Oversight Manager. The team will use principles of risk management, compliance and continuous quality improvement to ensure performance in accordance with Sunflower and KDHE requirements.

On an ongoing basis, Sunflower's Subcontractor Oversight staff will work in collaboration with the respective Sunflower business counterparts to monitor the day-to-day operations of the delegated subcontractor. Depending on the delegated activities, the subcontractor reports and engages in routine conversations with respective Sunflower business counterparts to ensure our members receive services as outlined in the subcontractor agreement. In addition, they will conduct Joint Oversight Committee (JOC) meetings with the subcontractor and Sunflower representatives at least quarterly, or more frequently if necessary, to review the overall performance of the subcontractor and document activities in the compliance management system. JOC meetings include a focused review of performance dashboards, reports, member/provider complaints, upcoming business process changes, quality improvement initiatives or other pertinent regulatory updates. Minutes are recorded and approved at each meeting.

Subcontractor Oversight staff, subsequent to JOC meetings, reports the status of each subcontractor to the Quality Improvement Committee. In addition, we will maintain a written Subcontractor Monitoring Plan that clearly defines the type and frequency of reporting and other monitoring to be carried out throughout the contract period. We will have established specific criteria and will report against such criteria to ensure that the subcontracted entity continues to have the ability to handle its responsibilities. The reports will be submitted to Sunflower monthly and/or quarterly and will provide information in areas such as:

- Authorization approvals and denials
- Call center volume and accessibility
- Service utilization, claims processing
- Member or provider inquiries, grievances, appeals, claims disputes, and provider complaints

On a monthly basis, QI staff from both Sunflower and Corporate will review required reports to ensure compliance with performance standards, and, on a quarterly basis, provide performance reports to the Quality Improvement Committee (QIC) for review and recommendations as needed. Annually, Sunflower will submit a Subcontractor Monitoring Plan that reflects the health plan's monitoring activities for the subsequent year for each healthcare service subcontractor. The subcontractor monitoring plans are described further below.

Through our robust oversight processes, we accept our accountability for subcontractor performance and ensure that our subcontractors are not only compliant with contractual requirements, but actively contributing to quality improvement. Subcontractor activities are incorporated into Sunflower's quality improvement strategy, and our subcontractors are helping us achieve outcomes. Some examples of improved outcomes supported by subcontractors are listed on the table below.

Table 5.5.13.F Subcontractor Performance

Subcontractor	Outcome Measure	Improvement
Envolve Vision	CDC Diabetic Eye Exams (HEDIS)	15.11% improvement from 2014-2016
Envolve Dental	Annual Dental Visit (HEDIS)	5.52% improvement from 2014-2016

Monitoring Technology. Sunflower uses a compliance management system to automate and manage compliance with KDHE contractual requirements. Any contract compliance issue identified with a subcontractor is tracked in the system along with progress on any corrective action plan. Sunflower staff will generate status reports from the system for quarterly review by the Quality Improvement Committee and Board of Directors.

Through the use of our compliance management system, all parties have immediate access to critical information such as:

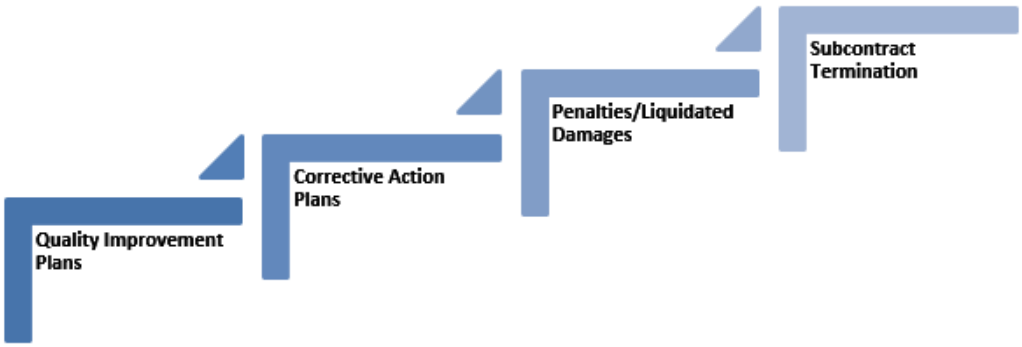
- Subcontractor Oversight Program Descriptions and corresponding Policy & Procedures;
- Assessment reports;
- Evidence of subcontractor adherence to performance standards (i.e. Dashboards);
- Minutes from key meetings (i.e. Joint Oversight Committee);

REPORTING SUBCONTRACTOR NONCOMPLIANCE (5.5.13.G)

If a subcontractor is non-compliant to the extent that its ability to perform the duties and responsibilities of the Subcontract, the Sunflower Compliance Officer and the Sunflower Senior Executive will notify KDHE in writing. The notice will include a description of the corrective actions that have been taken and Sunflower's plan to ensure minimal impact to program operations with no adverse impact to our Members. Sunflower will notify the State within 5 business days of discovering any such non-compliance.

REMEDIES FOR SUBCONTRACTOR PERFORMANCE ISSUES (5.5.13.H)

Sunflower will employ a progressive discipline approach with our subcontractors which involve early communication of a deficiency related to reporting requirements, performance, or other contract noncompliance or service issues. It is our intent to maintain quality service levels for our providers and members and, in that effort; we strive to ensure positive results and correction at the earliest possible stage. Our subcontractor agreements outline our ability to enforce performance requirements. Our escalating enforcement activities are shown below.



In addition, we include language requiring our subcontractors to self-disclose if they are aware of any areas where they are not meeting requirements. We require monthly and quarterly dashboard reports from our subcontractors demonstrating compliance with required performance metrics. We expect all subcontractors to meet the same performance and service levels as outlined in the contract with KDHE.
Through these reports, as well as through routine calls and Joint Oversight Committee meetings, we can identify concerns at an early stage and immediately and clearly communicate our concerns and our expectations for how to correct concerns within a 30-day timeframe. If we do not see a correction of the deficiency within that 30-day timeframe, we will then implement a Quality Improvement Plan (QIP).

Quality Improvement Plans

Sunflower's Subcontractor Oversight staff will review the performance issue and will request a QIP, in collaboration with the Corporate Compliance Performance Office, which includes:

- A summary of the performance issue or contract noncompliance that triggered the QIP;
- The expected, measurable result indicating acceptable evidence for completion of the QIP;
- Detailed action plan, including monitoring timeframes to complete activities required by the QIP; and
- Due date for completion of the QIP.

In addition to formally providing this request to the subcontractor, this information is also communicated to the Sunflower President, National Contracting and the Quality Improvement Director. Upon acceptance of the subcontractors proposed QIP, the QIP will be loaded into our compliance management system. This innovative software stores contract requirements as well as documents to demonstrate compliance, audit results, meeting minutes and relevant policies and procedures. Any contract compliance issue identified with a subcontractor is tracked in the compliance management system along with progress on any QIP. Sunflower staff will generate status reports from the system for quarterly review by the Compliance Committee, QIC and Board of Directors.

Corrective Action Plans

If the QIP requirements are not met by the timeframe required, Sunflower will issue a formal request for Corrective Action Plan (CAP) to the subcontractor and immediately notify KDHE of the CAP. The CAP issued will formally define the standards that were violated or the service issue necessitating the creation of the CAP, the expected measurable result, a detailed action plan and due date for completion of the CAP. Details of the CAP are captured within the compliance management system so that progress can be monitored and shared among all appropriate parties. In the event of significant and ongoing performance issues or due to a request by KDHE, Sunflower will bypass the QIP and immediately request a CAP from the subcontractor. Similar to a QIP, a CAP is monitored and tracked through the compliance management system and ongoing updates are provided to Sunflower's President, QIC, Compliance Committee and Board of Directors.

Penalties/Termination of Contract

In most instances, performance deficiencies are corrected through our regular communications and detailed plans for performance improvement. Should a deficiency persist with a subcontractor, our subcontractor agreements include language that will allow for the enforcement of penalties if performance is not corrected via a formal CAP. The Subcontractor Oversight Manager will track and document subcontractor performance results against required standards. Subcontractor Oversight staff will discuss the nonperformance issue with the subcontractor and notify the subcontractor of any decision to invoke either a financial penalty or at times, a termination of the subcontractor agreement. All penalties or requests to terminate Subcontractor Agreements will be reported promptly to KDHE. In the event of a termination, Sunflower will provide details of the transition plan for the services and new subcontractor arrangement.

Example of Addressing Subcontractor Performance Issues: Transportation Grievances

Through our subcontractor oversight and quality improvement programs, Sunflower identified a persistent issue with the volume of Member Grievances related to transportation services managed by our subcontractor, LogistiCare. Although grievances were filed on less than one half of one percent of the trips furnished by LogistiCare providers, Sunflower was receiving hundreds of transportation-related grievances. Our Quality Improvement and Subcontractor Oversight staff addressed the issue with LogistiCare during JOC meetings, and recommended that LogistiCare re-visit the use of gas/mileage reimbursement as an alternative to brokered door to door transportation. LogistiCare modified their processes to offer gas/mileage reimbursement when appropriate which resulted in higher Member satisfaction and a decrease in grievance volume. Also, because gas/mileage reimbursement is less costly than brokered trips, cost savings were achieved. From 2015 to 2016, based on changes implemented by our subcontractor, we had a 31% reduction in grievances.

SUBCONTRACTOR GRIEVANCE AND APPEALS REQUIREMENTS (5.5.13.I)

Upon executing agreements with our subcontractors, our subcontractor oversight and compliance staff will provide information about the Grievance and Appeal System. The requirements included in 42 CFR 438.10(g)(2)(xi) will be reviewed with subcontractor points of content. Key elements of the Grievance and Appeal System include:

- Grievance, appeal, and fair hearing procedures and timeframes.
- Member and provider right to file grievances and appeals
- Availability of assistance in the filing process
- The State Fair Hearing process
- Continuation of services during an appeal
- Potential financial liability of Members for the cost of services if the final decision is adverse to the enrollee.

NOTIFICATION OF SUBCONTRACTORS WHEN PROGRAM MODIFICATIONS ARE MADE (5.5.13.J)

Through our subcontractor oversight process, Sunflower promptly notifies subcontractors of program modifications, contract amendments, manual updates and other changes that impact delegated activities. To streamline the process of our subcontractors receiving notification of

program modifications, our Subcontractor Oversight team has arranged for our subcontractors to be added to the State's email distribution list that is used to announce program changes. When a policy or program change is announced, Subcontractor Oversight staff contact the impacted subcontractor to gather information about their response.

Sunflower participates in weekly calls with the State to learn of policy and program changes. The day following the weekly State policy calls, a Sunflower internal workgroup meets to review the policy and program changes that were announced the day before. During this meeting, the Subcontractor Oversight team reports on any anticipated impact to subcontractor processes, policies or procedures.

RESTRICTION ON THE DELEGATION OF KEY OPERATIONAL FUNCTIONS (5.5.13.K)

Sunflower agrees that outsourcing key operational functions may present a barrier to achieving integrated health care service delivery. As a result, management of physical health, behavioral health and long-term services and supports are all retained within our organization. Our systems and organizational structure are also optimized to support fully integrated services. Where subcontractors play a role, their role is fully transparent to the State through our subcontractor monitoring reports. Sunflower's approach is designed to bring the best available subject matter expertise, industry knowledge and tools together into a single, seamless experience for our Members and Providers.

STATE REVIEW AND APPROVAL OF SUBCONTRACTS (5.5.13.L)

Sunflower is fully transparent when it comes to the functions being delegated to subcontractors. We acknowledge that our subcontracts, and further delegation by our subcontractors is subject to the review and approval of the State. Sunflower, through our management and oversight of best in class subcontractors, supports our ability to deliver high quality services to our members.

5.5.14. MINIMUM SUBCONTRACT PROVISIONS

USE OF KANSAS SUBCONTRACTORS AND REQUIRED SUBCONTRACT PROVISIONS (5.5.14.A)

Sunflower will consider qualified Kansas-based subcontractors when making decisions related to delegation. While our current list of subcontractors does not include other Kansas-based businesses, we are open to contracting with Kansas subcontractors, and in particular small and emerging businesses and small entrepreneurships based in Kansas. Beyond our subcontracting decisions, Sunflower seeks opportunities to partner with Kansas-based organizations. An example of this is our partnership with the Kansas Health Information Network (KHIN) for Health Information Exchange. We selected KHIN in part because they are based in Kansas, unlike LACIE-HIE which is based in Missouri.

Minimum Subcontract Provisions

As mentioned above, Sunflower uses a template contract for subcontractor agreements. In addition to material terms and conditions, this template includes all required subcontract

provisions listed in Section 5.5.14.A.1-25. The required provisions in the template are non-negotiable and are regularly updated in accordance with program modifications and state and federal regulatory changes.

SUBCONTRACTOR MONITORING PLANS (5.5.14.B)

Sunflower has used monitoring plans with subcontractors to address deficiencies and respond to trends in complaints and grievances related to subcontractor performance. We will build upon this approach to develop annual monitoring plans for each of our subcontractors. These monitoring plans will be created and maintained by our Subcontractor Oversight team and will be shared with the State at least annually. Customized monitoring plans will be informed by the following inputs:

- Trends in grievances and appeals
- SLA performance (as applicable)
- Quality Program priorities (including performance improvement plans
- Sunflower and KDHE initiatives.

The Subcontractor Monitoring plans will be updated each year following our annual subcontractor performance review. The monitoring plan will be reviewed with our subcontractors on an ongoing basis during the JOC meetings described above. Sunflower will modify and/or augment our monitoring plans based on feedback from the State.

SUBCONTRACTOR TRANSITION PLAN (5.5.14.C)

Sunflower has a Subcontractor Transition Plan which ensures continuity of care for members, appropriate notification to the State and prompt identification of a new subcontractor to provide services when it is necessary to terminate or change a provider of subcontracted services. This Transition Plan includes:

- A requirement that Sunflower Compliance staff, Subcontractor Oversight Staff and Contracting staff be notified within two business days of receipt of a subcontractor termination notice or a decision to change subcontractors.
- A requirement that Subcontractor Oversight staff will immediately notify Medical Management and the CMD to develop a Coordination of Care plan to outline the process to ensure the subcontractor adheres to contractual requirements for continuity of care for members. The Coordination of Care Plan will also include activities for the new subcontractor to ensure a smooth transition for members.
- A process for the Subcontractor Oversight staff, in coordination with other health plan staff, to promptly begin the pre-contracting assessment for the new subcontractor.
- A process for Subcontractor Oversight staff to coordinate with all appropriate health plan staff to efficiently complete the implementation plan.
- Notification to KDHE within the required timeframe of the change in subcontractor, including any issues of breach of contract; and provide KDHE with a copy of the transition plan for review.
- Communication of all subcontractor changes throughout the appropriate health plan and corporate functions including, but not limited to, Compliance, Encounters, Finance,

Eligibility, IT, Medical Management, Claims, Member Services and other Subcontractors as impacted.

5.5.15. PROVIDER PAYMENT

Sunflower has extensive experience reimbursing the variety of provider types noted in the KanCare 2.0 scope of work. We processed over five million provider claims in 2016 and over 4.5 million claims year-to-date consistent with Contract requirements across the full complement of provider types; we also have successfully processed 99.98% of all clean claims within 30 days of receipt year-to-date, and at a rate of 99.93% in 2016. We will adhere to the State's minimum published Medicaid fee-for-service (FFS) rates as required under the Contract by provider type, as well as build on our existing foundation of innovative, value-based provider payment and incentive models, such as pay for performance and risk-sharing. Based on our substantial experience with both volume and variation in provider payments, Sunflower will continue to invest in and expand upon a continuum of payment models that will support providers at various levels of capability and readiness to pay for value as described further in Section 5.7

Year to date we successfully processed over 4.5 million claims with 99.98% of all clean claims adjudicated within 30 days of receipt.

Alternative reimbursement arrangements proposed by Sunflower or initiated by providers will be submitted to the State for advance review and approval, inclusive of LTSS and BH service arrangements (5.5.15.A.2).

ENSURING PROVIDERS UNDERSTAND BILLING AND PRIOR AUTHORIZATION PROGRAMS

Sunflower continues to make a significant investment of time, energy, and resources in provider engagement, education, and training, with extra support being offered to those providers new to managed care. We help providers understand billing and prior authorization policies through the following: at the time of initial orientation; ongoing webinars and other periodic training; additional face-to-face meetings; regular provider newsletters; emails; and tools and bulletins on the website and Provider Portal. For example, providers can check claims adjudication logic prior to submission through the Provider Portal, a tool particularly useful for onboarding providers new to managed care.

"This is amazing! Just wanted to share with you. I have not been able to get through the other half of my billing... It's been extremely difficult and frustrating, but Sunflower has been my bright light."

Mom's Meals, HCBS Provider

Ongoing, provider relations specialists meet with providers as requested by the provider -- weekly, bi-weekly, monthly, and quarterly -- to resolve issues and ensure providers are being paid timely and accurately. Staff monitor claims and authorization trends to identify provider billing and authorization issues. Once identified, the dedicated provider relations specialist outreaches to reinforce education on billing and prior authorization. Post outreach, we monitor claims and authorization activities to ensure resolution.

Claims Filing Assists

Sunflower received our highest scores on the 2017 Provider Satisfaction Survey on our timeliness and accuracy of claims processing and ability to answer questions and resolve problems. We have over five years of experience with agency programs in Kansas with a provider claims adjudication rate of 85%. Our secure Provider Portal is a web-based platform that supports "self-service" capabilities for various administrative tasks including those associated with provider payment: claim submission, claim status inquiry, and claim payment history. Most providers certify for direct electronic data interchange (EDI) submission of claims. We offer providers individual and HIPAA EDI batch file claim submission, and the ability for providers to request adjustment to claims online, search for claim status using member information, claim information, and/or provider name, and view and download payment history information. Providers can submit claim reconsiderations through the Provider Portal and view the status/outcome of reconsideration requests. We also offer the LTSS Claims Wizard, a specialized version of our online Direct Data Entry (DDE) feature on the Provider Portal, designed specifically for LTSS providers with no coding experience to submit accurate and complete claims through a step-by-step claim entry process, with validation assists and online help, driving down errors and ensuring providers receive more timely payment for their services. The secure Provider Portal will also provide access to Sunflower claims adjudication logic using our Clear Claim Connection software. This software allows our providers to understand our administrative and clinical claim edits at a detailed coding level, to offer claim processing transparency and ensure claim coding accuracy. See Section 5.14 for further details about Sunflower's claims management process.

A SNAPSHOT OF PAYMENT METHODS BY PROVIDER TYPE (5.5.15.A – 5.5.15.G)

Provider payment methodologies align with the KanCare 2.0 Contract requirements by provider type. We acknowledge and will adhere to Medicaid FFS rate variations by provider type as set forth by the State under KanCare 2.0. We summarize the provider payment methods and claims experience in place with Sunflower network providers for most contracted provider types in Table 5.5.15.A.

Table 5.5.15.A Sunflower Payment Methods and 2016 Claims Experience by Provider Type

#	Provider Type	Description of Payment Method *Clean Claims Volume and Turnaround Time*
MEDICAL | 1,422,235 claims | 8.97 days		
1	Primary Care Providers (PCP)	Medicaid FFS, Enhanced Medicaid FFS, Episode based payment (contract specific), Quality based P4P incentive models 1 and 2
2	Specialists	Medicaid FFS, Enhanced Medicaid FFS, Episode based payment (contract specific), Quality based P4P incentive model timeliness of prenatal care
3	OB/GYNs and other prenatal care practitioners	P4P based on timeliness of prenatal care and volume of members entering prenatal care, or Negotiated rate
4	FQHCs and RHCs	Encounter Rate (FQHCs paid at 100% for both in and out-of-network per federal regulations), Quality based P4P incentive model 1
5	Indian/Tribal/Urban Indian Health Providers	Encounter Rate (paid at 100% for both in and out-of-network)

#	Provider Type	Description of Payment Method *Clean Claims Volume and Turnaround Time*
	(I/T/U) (in-network and out-of-network)	
HOSPITALS | 329,800 claims | 9.85 days		
1	Acute Care Hospitals	Medicaid FFS, Enhanced Medicaid FFS, percent of billed charges
2	Critical Access Hospitals (CAH)	Medicaid FFS (with applicable CAH Add on), Enhanced Medicaid FFS (with applicable CAH Add on)
3	State Hospitals	Per diem as of 01/01/2018 per KS policy, billed charges prior to 01/01/2018
LONG TERM SERVICES AND SUPPORTS | 116,889 claims | 9.21 days		
1	Nursing Facilities (NF)	Medicaid FFS per diem rates
2	Intermediate Care Facilities for Individuals w/Intellectual Disabilities (IID)	Medicaid FFS per diem rates
3	Nursing Facilities for Mental Health (NFMH)	Medicaid FFS per diem rates
BEHAVIORAL HEALTH | 671,234 claims | 9.36 days		
1	Psychiatric Residential Treatment Facility (PRTF)	Medicaid FFS, Enhanced Medicaid FFS
2	Behavioral Health Providers	Medicaid FFS, Enhanced Medicaid FFS, Episode based payment, Quality based P4P incentive CMHC model (CMHCs)
HOME AND COMMUNITY BASED SERVICES | 552,741 claims | 8.69 days		
1	HCBS providers	Medicaid FFS, Enhanced Medicaid FFS
OUT OF NETWORK | 191,959 claims | 9.33 days		
1	Out-of-Network Providers	As noted in KMAP bulletin 12099: Non-participating providers are reimbursed at 90% of the Medicaid Fee schedule.
2	Emergency care	100% the Medicaid Fee schedule, configured based off of the participating status indicator within Amisys configuration.

The plan will adhere to all updates and revisions to provider payment policies according to the State Contract where necessary in accordance with the implementation of KanCare 2.0.
Our provider contracts will specify our expectation for accuracy in filing claims, including use of appropriate billing codes. We will support provider compliance in claims filings with information in our Provider Manual on the Provider Portal, in provider orientations and other trainings to ensure claims accuracy and to also support timely payments.

PROHIBITING PAYMENT OF PROVIDER PREVENTABLE CONDITIONS (5.5.15.H)

As a condition of payment Sunflower will require that providers comply with the prohibition against payment for an inpatient hospital health-care acquired preventable condition (e.g., falls, infection, Stage III and IV pressure ulcers) and other provider preventable conditions for any health care setting (e.g., wrong surgical procedure performed, procedure performed on the wrong body part) as set forth in federal law 42 CFR § 434.6(a)(12) and 447.26.

EDUCATING LTSS AND BEHAVIORAL HEALTH PROVIDERS WITH BILLING CHALLENGES (5.5.15.I)

Sunflower's Provider Relations Specialists provide dedicated billing guidance to any provider who needs assistance in the submission of claims. We find that LTSS and BH providers benefit from this assistance as they often have less experience submitting claims under managed care. Additionally, for LTSS providers, our provider relations specialists (including those hired from within the LTSS industry) provide specialized training on billing practices. We recognize that LTSS providers work with limited cash flow and we want to ensure they are paid timely. To that end, we also deploy our LTC Wizard, which streamlines LTSS billing. We support providers to use Kansas' EVV system and offer a dedicated contact for resolving any authorization issues within the EVV system.

Under KanCare 2.0 we will continue to provide periodic training sessions for LTSS and BH providers to address common claims submission challenges, including but not limited to:

- Use of a claims submission form
- Electronic claims submission procedures
- Uniform billing codes
- Coordination of benefits
- Timely claims submissions schedule
- Patient liability
- How to research claims status information on the Provider Portal
- How to appeal claims determinations

The trainings will also be available to LTSS and BH providers and their administrative staff on the Provider Portal as an ongoing information resource.

SUNFLOWER SUCCESS STORIES ABOUT HELPING PROVIDERS WITH BILLING CHALLENGES

HCBS provider, Country Club Estates

Sunflower recently responded to a request from HCBS provider, Country Club Estates to help them achieve a more consistent revenue stream. The Provider Relations team studied this provider's billing patterns and claims consistency to determine an optimal day in which to submit claims to optimize payment turnaround time. Country Club Estates revised their submission timing accordingly and saw immediate improvements. Provider Relations' dedication to helping this HCBS provider, continual monitoring and good communications made a significant impact on their financial well-being.

Hospital provider, Lawrence Memorial Hospital (LMH)

In late 2015, Provider Relations in partnership with Sunflower's Claims Director initiated monthly meetings with the hospital's business office manager and billing staff to research and resolve a series of unresolved claims payment issues. Sunflower ran a Top 10 Claims Denial report to identify the most frequent reasons for claims denials and to determine process changes needed to prevent repeat occurrences. This presented an opportunity for Sunflower to point out ways for LMH to increase revenue by correcting claim submission errors, and reduce

overall administrative costs by reducing the number of appeals caused by common billing errors.

Hospital and physician practice, Salina Regional Health Center (SRHC)

In 2016 Sunflower began monthly meetings with SRHC hospital billing staff to address and resolve claim concerns. This led to a discussion with a SRHC physician who was concerned because all his claims to Sunflower were being denied. Provider Relations researched the denials and determined that these were due to a credentialing delay. Sunflower corrected the physician's network status, and all previously denied claims were reprocessed and paid. The monthly meetings produced positive results for the hospital and collateral benefits for their physician practice and have transitioned from claims resolution into meetings for updates and education.

5.5 Attachments

Attachment 5.5 Provider Network, Appointment Accessibility and Wait Times

Sunflower follows the accessibility and appointment wait time requirements set forth by KanCare and applicable regulatory and accrediting agencies. Sunflower monitors participating provider compliance with these standards at least annually and will use the results of appointment standards monitoring to ensure adequate access to care and to reduce inappropriate emergency room utilization.
The table below depicts the appointment accessibility and wait time standards for Sunflower members:

TYPE OF PROVIDER	APPOINTMENT STANDARDS
PRIMARY CARE PROVIDERS	
Regular Appointments	Not to exceed 3 weeks from date of member request
Urgent Care	48 hours
SUBSTANCE USE DISORDER (SUD) PROVIDERS	
Emergent	On demand service. No prior authorization is required and members go directly to an emergency room. Members are seen immediately.
Urgent	Assessment conducted within 24 hours of the initial contact and services delivered within 48 hours from initial contact.
IV Drug Users	Within 14 days of initial contact.
Routine	Members assessed within 14 days of initial contact and treatment services are delivered within 14 days of assessment.
MENTAL HEALTH ACCESS STANDARDS	
Post-Stabilization Services	Referral within 1 hour. Assessment and/or Treatment within 1 hour from referral for post-stabilization services (both inpatient and outpatient) in an emergency room.
Emergent	Referral immediately. Assessment and/or Treatment within 3 hours for an outpatient Mental Health service, and within 1 hour from referral for an emergent concurrent utilization review screen.
Urgent	Referral within 24 hours. Assessment and/or Treatment within 48 hours from referral for outpatient Mental Health services, and within 24 hours from referral for an urgent concurrent utilization review screen.
Planned inpatient psychiatric	Referral within 48 hours. Assessment and/or Treatment within 5 working days from referral.

sunflower health plan
8325 Lenexa Drive
Lenexa, KS 66214

Routine Outpatient	Referral within 5 days. Assessment and/or Treatment within 9 working days from referral; 10 working days from previous treatment.
Pregnant Women	Treatment within 24 hours of an assessment. IV drug users shall be admitted no later than 14 calendar days after an assessment or 120 calendar days after the date of such request. Interim services shall be made available no later than 48 hours after such request.
SPECIALTY AND URGENT CARE (INCLUDES SPECIALTY PHYSICIAN SERVICES, HOSPICE CARE, HOME HEALTHCARE, SUD TREATMENT, REHABILITATION SERVICES, ETC.)	
Routine Care	Not to exceed 30 days.
Urgent Care	Not to exceed 48 hours.
EMERGENCY CARE	
Emergency Care	Immediate, at the nearest facility available, regardless of participation status with Sunflower.
HOSPITALS	
Hospitals	Transport time not to exceed 30 minutes
GENERAL OPTOMETRY SERVICES	
Routine Care	Not to exceed 3 weeks for regular appointments
Urgent Care	Not to exceed 48 hours
LAB AND X-RAY SERVICES	
Routine Care	Not to exceed 3 weeks for regular appointments
Urgent Care	Not to exceed 48 hours

WAIT TIME STANDARDS FOR ALL PROVIDER TYPES
Office waiting time for scheduled appointments Not to exceed 45 minutes. If a provider is delayed, patients shall be notified immediately. If the wait is anticipated to be more than 90 minutes, the patient shall be offered a new appointment.

Sunflower requests that PCPs inform our Customer Service department (1-877-644-4623) when a Sunflower member misses an appointment so we may monitor that in our system and provide outreach to the member on the importance of keeping appointments. This will assist our providers in reducing missed appointments and reduce the inappropriate use of Emergency Room services.

5.6 Provider Services

5.6. PROVIDER SERVICES

SUNFLOWER DEMONSTRATED SUCCESS

Sunflower Health Plan (Sunflower) views the relationship with our providers of covered KanCare services as essential to assuring our members receive access to quality services and supports. The mission of our Provider Engagement and Support model is to educate, train, and coach participating providers with an emphasis on improving quality of care and controlling healthcare costs. Since 2013 we have demonstrated our success in supporting our KanCare providers in numerous ways, as evidenced by the following examples:

- Since the beginning of the KanCare program, we have employed regional, field based provider relations staff or representatives supporting providers in their local communities
- Recognizing the specialized requirements and needs of providers of long term services and supports and behavioral health (BH), we created and staffed designated provider representatives for these providers. This will now be a requirement under KanCare 2.0 for All MCOs.
- Over the course of 2016, Sunflower conducted 25 community trainings reaching over 1700 participants assuring that providers had the information and knowledge to provide quality care and receive timely payment.
- We currently meet or exceed every customer service center metric related to provider services, including 100% of all inquiries being resolved within two business days.
- Our 2017 provider phone call quality average based on regular call center audits that track compliance with quality through nationally recognized standards is 96.9%.
- Continued expansion of information sharing and valuable functionality in our secure Provider Portal, resulting in an increase in Provider Portal users from 700 in December 2012 to over 13,800 registered users as of December 2017.

Compliance with Scope of Work (SOW)

Sunflower complies with all contractual requirements described in Section 5.6 of the RFP for the KanCare 2.0 program. Below we describe in detail our overall provider engagement and support process including accountability, oversight, and evaluation for complying with each element of the RFP/SOW. For ease of review we have included SOW references in headers and within the narrative.

OVERVIEW OF SUNFLOWER'S PROVIDER ENGAGEMENT AND SUPPORT MODEL

Sunflower operates a comprehensive Provider Engagement and Support program, ensuring appropriate provider training and education, answering provider inquiries, addressing provider concerns, and improving the provider experience. The mission of our model is to educate, train, and coach participating providers with an emphasis on improving quality of care and controlling health care costs. Our best-practice Provider Engagement Model is designed to be:

- ***Provider-Centric.*** We meet providers where they are and take them where they want to go.
- ***Regional, Local, and Individualized.*** Since the beginning of KanCare, Sunflower has utilized a regional approach to increase the opportunity to engage providers over the phone and face-to-face. Sunflower supports providers through provider relations functions in the field

as well as provider service functions which are part of the Customer Service Center. The provider services included in the Customer Service Center are described in detail below in response to sub-section 5.6.5.

- ***Supportive.*** We equip providers to be successful while reducing burden through:
  - Providing meaningful and actionable data sharing including drill-down reports
  - Bi-directional communication
  - Value-based purchasing (VBP) and incentive programs
  - Access to a secure Provider Portal for administrative self-service capabilities, clinical applications, drill-down dashboards and reports, and educational tools and resources.
  - Specialized expertise with an identified provider representative solely devoted to providers of Intellectual and Development Disabilities (/IDD) and BH services.

PROVIDER TRAINING AND EDUCATION (5.6.A-G)

Over the course of 2016, Sunflower conducted 25 community trainings reaching over 1700 participants.

Our overarching training program is designed to shape a comprehensive, integrated care system that partners with providers/practitioners to offer a variety of resources, information, and tools to build strong working relationships, resolve operational issues, share best practices, promote mutual values and goals, improve health care delivery, and understand unique health care communities. As we do today, Sunflower will develop and submit an annual schedule of participating provider training sessions for State approval, followed by an annual report which reflects the completion of training sessions over the calendar year. For example, our 2017 KanCare schedule for education and outreach includes training sessions covering pre-enrollment education, initial provider orientation, ongoing and targeted education, and ongoing provider communications.

Implementing a Comprehensive Provider Education and Training Plan

From pre-enrollment to initial provider orientation to ongoing training, Sunflower is committed to ensuring our providers are aware of all KanCare, State, and Sunflower guidelines. We hold both in-person and web-based trainings. During provider orientation training, we provide education that addresses aspects of plan operations, the KanCare program and KDHE requirements. These sessions offer an opportunity for providers to ask questions and become familiar with Sunflower forms and materials. We provide office-based and group training for primary care providers (PCPs), specialists, hospitals, ancillary providers, LTSS providers, and all other provider types serving the needs of our membership. In addition to the written materials sent to all new providers, Sunflower Provider Network Specialists conduct office orientations with providers and their office staff within 30 days of the contract effective date. Orientations may be conducted in various ways, including but not limited to:

- Individual meetings in the provider's office according to the provider's availability (the most common means for completing orientations following program implementation)

- Group workshops in a community location such as a local hospital, Federally Qualified Health Center (FQHC), primary care association or community center during several days and different times
- Webinars offered at various dates and times

We also provide e-learning, including on-demand web-based training and webinars conducted by our Provider Relations team and other members of our contracting and network development team. Sunflower's provider education and outreach program meets providers where they are by offering trainings based on provider feedback or identified needs, encompasses components of the KanCare program, and complies with KDHE requirements. We offer ongoing trainings to addresses new requirements or initiatives, program priorities such as physical/BH coordination requirements, and compliance issues. Ongoing and targeted provider education is and will be conducted in various modes including office-based and group training, **semi-annual provider forums** chaired by the CEO or designee, and workshops.

All contracted providers are invited to attend our statewide provider workshops which are held at various locations around the State. Topics include Sunflower billing and claims processing, authorizations and utilization management, provider tools and resources, and general feedback on Sunflower policies and procedures. Information presented and shared during forums, workshops, and community meetings will be reported and discussed with the Sunflower Senior Leadership team and approved by KDHE prior to distribution.

Topics include:

- Prior authorization and referral guidelines
- Billing and reimbursement
- General claims submission guidelines and timelines
- Member outreach services
- Credentialing and re-credentialing
- Disease Management Program (population-based interventions, case management)
- Coordination of care
- Sunflower website, including Find a Provider (FAP) and other web functionality
- Secure provider web portal, including security enhancements
- Specialty Services with Vendors
- Retro Eligibility
- Quality improvement
- Program goals and objectives
- Covered services and populations
- Program Eligibility and Benefits
- Accountable quality care and the unique safety and Wellness issues associated with HCBS Waiver services (HCBS Waiver service providers)
- Provider satisfaction survey results
- Trends in provider call center inquiries
- Trends in member grievances and provider complaints
- Changes in KDHE or Sunflower policies and procedures
- Sunflower quality improvement initiatives
- Sunflower priorities such as cultural competency and incentives

Provider Training Schedule. We will ensure that all training is provided to participating network providers, including network providers that delivery HCBS Waiver services. As part of the initial schedule for KanCare 2.0, we will specifically address the requirements for HCBS Waiver service providers to be done at various cities throughout Kansas. We recognize that will have at least one in-person HCBS training and two general provider session per year and will notify the State within 30 days of any scheduled trainings.

Ongoing Provider Communications

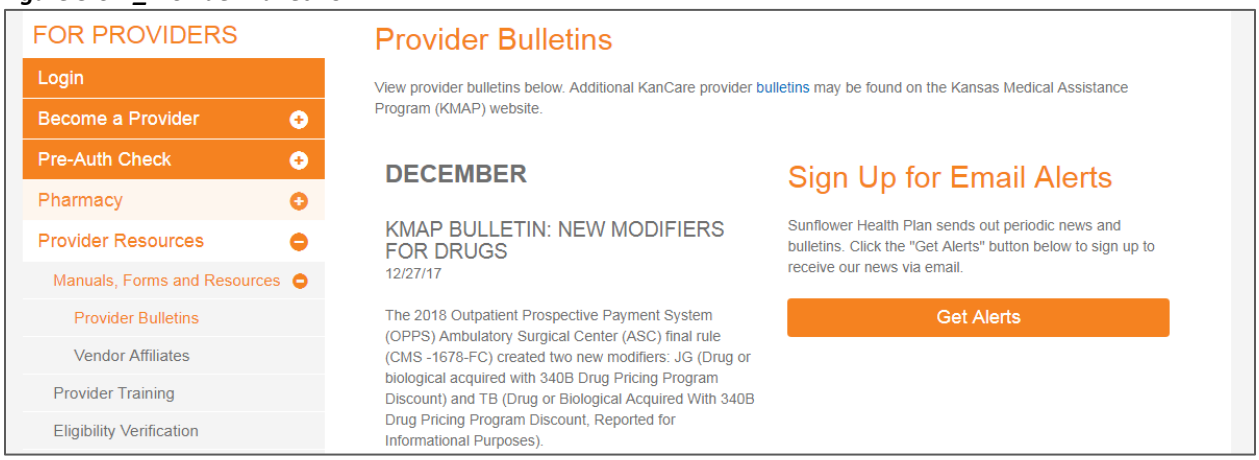
Sunflower uses a variety of communication mechanisms, coupled with carefully developed, well-tested content, to manage our provider network and ensure that providers receive the information needed to successfully and fully implement KanCare contract requirements, maintain high performance standards, and achieve optimal outcomes for our members. Sunflower's main communication method "subscription email alerts" has more than 4,000 providers signed up. The feature allows providers to self-service their preference with an easy unsubscribe option. This ensures that providers who no longer wish to receive the alerts can quickly remove themselves thus avoiding unwanted communication. This self-service functionality is unique to email and is not available in traditional fax blast communication.

Sunflower's main communication method "subscription email alerts" has more than 4,000 providers signed up.

Sunflower offers training that covers a variety of informational and clinical topics brought to providers through a variety of mechanisms:

- Webinars, tutorials and other we-based training available via our website and web portal
- Bulletins and other materials posted to our website (see ***Figure 5.6.A_Provider Bulletins*** for an example of our provider bulletins posted on our website)
- Personal, face to face training that may be tailored to the provider's needs
- Additionally, we send our provider communication materials (e.g., bulletins, news releases, policies, etc.) to provider associations for inclusion in their respective publications and newsletter.

Figure 5.6.A_Provider Bulletins



Examples of Provider Trainings Conducted. Our commitment to provider education and training is demonstrated through our 2016 Annual Training Report statistics. These trainings consisted of webinars, face to face workshops, and a small number of phone trainings. For example:

- Sunflower participated in both the summer and fall **All MCO Trainings**. Approximately 450 providers attended the spring trainings in Overland Park and Wichita. Approximately 150 providers attended each of the fall trainings in Topeka and Wichita.
- Sunflower offered **provider workshops** from mid-2016 to the end of 2016. Workshops were presented in eight cities across Kansas: Colby, Emporia, Garden City, Hays, Manhattan, Pittsburg, Pratt, and Salina Kansas. The provider workshops focused on claims topics including, Third Party Liability, Claims Submission and Payment Timelines, Present on Admission Indicators, Billing and Modifiers, Billing with Encounter Coders and top claim denial issues.
- Sunflower offered new and existing providers a **quarterly orientation**. Attendance was strong; 97 providers attended the 1st quarter training with no less than 49 providers at the subsequent orientations. Sunflower Provider Orientation trainings covered topics such as; Waste, Fraud and Abuse, Web Portal Tools, Website Resources and Information, Updating Provider and Practitioner Information, Connecting with Your Network Specialist, Sunflower Partners, Covered Benefits and Value-Added Services, Medical Management and Case Management, Claims Submission Guidelines, Grievance and Appeals, Quality Programs.
- Sunflower has received positive feedback from many providers regarding the web portal. Sunflower Provider Relations/Representatives **trained providers on the portal in person, via webinar, and on the phone.** Sunflower encourages providers to use the web portal for self-service with eligibility, claims, authorizations, patient lists for PCPs, and secure messaging with Customer Service.
- In addition, Sunflower conducted trainings consisting of:
  - National Imaging Associates, INC. (NIA) Refresher Training, Co-occurring disorder training, Psychotropic Medications training and DSM 5 training
  - Annual Cultural Competency Training was offered in December 2016 with 13 providers
  - One-on-one HEDIS training for a provider in January 2016

All 2016 training sessions were promoted in advance of the training dates via the Sunflower website, distributed via the Sunflower email alerts, and sent to Associations for posting in their bulletins and online materials. 2017 training sessions will be posted in the same manner.

Tracking, Trending, and Following Up on Provider Inquiries, Requests and Issues

All provider facing Sunflower staff use our Customer Relationship Management (CRM) platform (described in detail below in Section 5.6.5 below) to document and track provider inquiries/complaints/requests for information and confirm systemic action is taken to assure resolution. Sunflower currently meets existing contract requirements for KanCare and is developing a mechanism within our CRM platform to address the KanCare 2.0 requirement that calls are acknowledged within three business days and the result communicated to the provider

within 30 days. Trends are tracked and analyzed through our Quality Improvement infrastructure. Daily, weekly, monthly, and quarterly reporting is reviewed by the Senior Managers for Provider Network and Contracting and Provider Relations and reported to the Vice President for Provider Contracting and Network Development who discusses with the Performance Improvement Team. Based upon their review and discussion, appropriate actions will be taken to improve the provider experience. Any negative trends are reported up to the Quality Improvement Committee for intervention and follow up as appropriate.

5.6.1. REQUIREMENTS FOR A PROVIDER MANUAL

5.6.1. REQUIREMENTS FOR A PROVIDER MANUAL (5.6.1.A.1-5)

Sunflower's process and current provider manual meets all requirements contained in the SOW and assures its continued compliance under the KanCare 2.0 program. The Sunflower KanCare Provider Manual is posted on the provider section of Sunflower's website.

The KanCare 2.0 **Provider Manual** will describe the way we manage our Medicaid program as well as operational procedures and requirements, in accordance with the KanCare 2.0 Contract. Our current Provider Manual covers a broad array of topics, including:

- Credentialing and re-credentialing criteria
- Billing and Payment procedures
- A description of the Medicaid Care Management program
- Member and provider grievance and appeal process
- Medical necessity standards Medical record standards
- Provider rights and responsibilities
- Member rights and responsibilities
- Care Team core benefits and services
- Cultural competency information
- Value added services and benefits
- Primary Care Physician responsibilities
- Utilization Management policies and procedures
- Network Management requirements
- Prior authorization and referral procedures
- Prompt pay requirements
- Medical Management programs (including guidelines for treating chronic and complex conditions)
- Eligibility verification process
- EPSDT standards
- Quality Improvement program and requirement
- Waste, Abuse, and Fraud

Using Sunflower's provider email alert system, in place since 2013, the approved KanCare 2.0 Provider Manual will be distributed electronically no later than 30 days following the contract effective date and then to both participating and non-participating providers upon request thereafter.

Sunflower considers the Provider Manual to be a living document, which evolves as the program and its related policy requirements change. Our Manager of Marketing and Communications is responsible for assuring the manual is current and consistent with State Medicaid Provider Manuals regarding services covered and who can provide the services. The

Manager assures that any required changes/updates are reviewed weekly, that the changes are posted to the website and that bulletins are sent to providers via our email alert system. Substantive changes to the provider manual will be submitted to the State for approval prior to distribution. Whenever possible, these communications are sent to providers at least 30 calendar days in advance unless otherwise specified in the Provider Participating Agreement of a policy effective date. However, federal or state changes sometimes do not allow that much time. In those instances, Sunflower sends the information to providers within two business days of State approval. Appendix XII of Sunflower's Provider Manual provides list of all revisions to the manual for historical reference.

Provider Welcome Packet and Reference Materials. Sunflower offers providers several written resources that provide information about Sunflower and the KanCare Program. We distribute these materials in our Provider Welcome Packet and/or make available on our website. During initial orientation and subsequent trainings providers are informed of the information that is available and how to obtain copies through our website.

The following are included in the **Provider Welcome Packet**:

- Welcome Cover Letter
- Provider Manual
- Participating Provider Agreement
- Quick Reference Guide
- Prior Authorization Guide
- Electronic Funds Transfer Setup Guide
- Secure Web Portal Setup Guide
- Sunflower window decal

The **Provider Manual** is distributed electronically to all new network providers with the welcome packet within 10 business days of the committee clean date, well within the State requirement of within 30 days of the contract effective date. Sunflower will update the Manual regularly and distribute it electronically to participating providers at least 30 days in advance of any policy or procedure change, and include an updated copy on the Sunflower website.

- The **Provider Billing Manual** is a guide for providers that describes the way providers are expected to bill for services covered by our program. The Billing Manual is comprehensive and addresses all aspects of claims submission and billing requirements.
- The **Provider Quick Reference Guide** is a cheat sheet summarizing the operational policies and procedures that govern our program including information about billing requirements, claims, interpreter services, medical management and the member identification card.

Sunflower educates providers on **clinical practice guidelines (CPG)**, how our Care and Disease Management Programs support use of CPGs and how these guidelines dovetail with ongoing clinical initiatives such as NCQA (National Committee for Quality Assurance). CPGs and related educational materials are available on our website and upon request. Examples of clinical practice and preventive guidelines we provide include ADHD, adult preventive care, asthma, bipolar disorder, diabetes, major depressive disorder, pediatric preventive care, schizophrenia, sickle cell and congestive heart failure.

5.6.2. STATE APPROVAL PROCESS OF PROVIDER MATERIALS

5.6.2 STATE APPROVAL PROCESS OF PROVIDER MATERIALS (5.6.2.A-E)

Sunflower is fully compliant with existing KanCare contract requirements and has reviewed, understands, and assures compliance with the Scope of Work requirements in Section 5.6.2. Sunflower is a committed partner of the State, and we are diligent in sharing with the State all member and provider materials for approval before distribution to providers. This includes provider manuals and guides, bulletins, training materials, letters, forms, and member related materials such as the Member Handbook and Provider Directory. Sunflower is conscientious in providing electronic files, redlining changes in revisions, and making all efforts to assist the State in its review process.

Our Manager for Marketing and Communications is responsible for working with internal business owners, such as the Director, Provider Relations; Senior Manager, Provider Relations; Manager, Contracting and Network Development; and Director, Contracting and Network Development, to identify and prepare provider materials as described. The Marketing and Communications Manager will submit required items, including the items listed in Section 5.6.2.D, to the State 45 calendar days prior to printing, posting, or distribution, except for materials requiring expedited review, as allowed for and in accordance with Section 5.6.2.D. Materials are submitted in electronic file media, along with a description of the intended purpose for the material. The manager maintains a tracking system to monitor the status of each document or communication assuring that nothing is distributed prior to the State's approval. Sunflower understands and accepts that State reserves the right to notify it to discontinue or modify written Provider materials.

5.6.3. ELECTRONIC SPECIFIC AND WEBSITE REQUIREMENTS FOR PROVIDER INFORMATION (5.6.3.A-E

DESCRIPTION OF WEBSITE (5.6.3.A-B)

Sunflower has achieved the first eight NCQA Member Connections (MEM) standards on our public website and Member Portal. NCQA MEM standards are a nationally recognized gold standard for MCO websites, and span an array of interactive health management tools (including Health Appraisals and self-management health tools) to actively engage members in their care and ongoing wellness.

Sunflower currently hosts and maintains a public website in compliance with Section 5.6.3 of the SOW. Our website offers full functionality to both members and providers, under separate, easy to navigate sections of the website, providing information, resources, and tools to improve member health, access to care, and reduce provider burden. Our website provides accurate, up-to-date information about the Medicaid program and Sunflower. Key information provided includes: eligibility requirements, how to sign up for the Medicaid program, complete benefits information, services we provide (e.g., Nurse Advice Line, Service Coordination), how to access free interpreter services and the TTY/TDD number for those who have a hearing or speech impairment, frequently asked questions, hot links to subcontractors websites, and contact

phone numbers, among other information and links as required under Section 5.6.3.D of the SOW. In addition to KanCare and Sunflower information, our website also features educational resources, including an extensive online health library. We also provide access to online member and provider materials, including a searchable Member Handbook; an interactive and searchable online provider directory; the Provider Manual, Billing Manual, and quick reference guides; and the ability to register and login to our secure Member Portal and secure Provider Portal.

Website Specifications (5.6.3.C-D)

We design our websites and portals for seamless integration of content, with navigation attuned to, and authorized for, specific user types, including providers and members. Our public website has minimal end user technical requirements, with no specific browser prerequisites. It's accessible on all popular web browsers, including Google Chrome, Internet Explorer, Firefox, and Safari. It's designed using a mobile first strategy, so that all content is viewable on smartphones and tablets. Our website is also designed so that users do not require significant memory, disk resources, or special software beyond a web browser. It is also time stamped with date last updated, and is fully compliant with Federal Section 508 standards. The website currently contains all the required elements in section 5.6.3.D of the scope of work and the requirement for a separate posting for our cultural competency policy will be completed in 2018.

Our website and electronic materials are easy to search and navigate. Our website is available in two contrast levels and three font sizes and in multiple languages including English and Spanish. The Sunflower website search function is customizable. Sunflower has revised the site's search terms, with the help of the marketing team, based on provider feedback of their searches. Customizing search results for our website is local, completed by our Marketing and Communications team. Sunflower maintains separate and secure portals for providers and members. It is compliant with the Americans with Disability Act (ADA) Title III website accessibility requirements and the State of Kansas Information Technology Office (KITO) Executive Council Accessibility Requirements. (5.6.3.C.1-4)

Practice Improvement Resource Center (PIRC). Our provider website will also offer providers access to our PIRC, a searchable compendium of educational information and trainings on evidence-based practices, practice guidelines, multi-media content, and interactive tools to help Sunflower's team and our network providers support member care.

Maintaining Current and Up to Date Information (5.6.3.C.5)

Timely and accurate information is critical to ensuring an effective website and promoting a positive member and provider experience. With our use of industry standard web technologies such as HTML5, and best in class web content management systems such as Adobe Experience Manager (AEM), we can rapidly update content on our websites while maintaining a consistent user experience. Our implementation of AEM and our web content versioning capabilities, along with a best practices approach to change management, allows us to prepare new and modified web content to be approved by the State prior to posting on the web, ensuring all

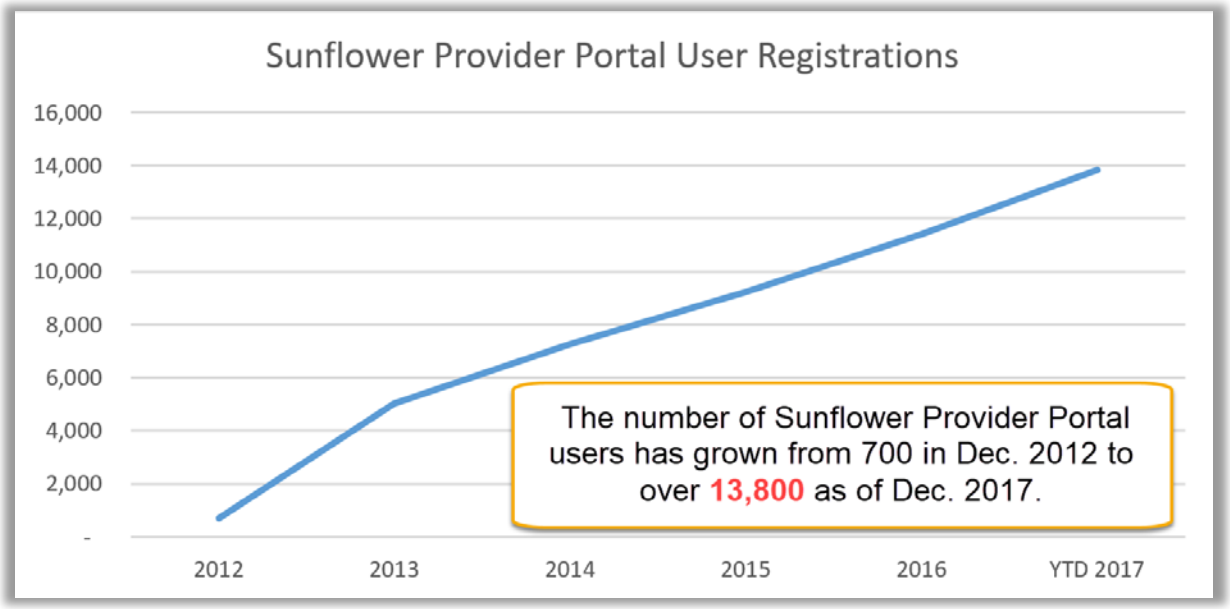
content is up-to-date and accurate. We also include HIPAA compliant controls to ensure web content is appropriately secured and are audited regularly to ensure ongoing compliance. Driven by the Manager of Marketing and Communications, we have a working team of cross-functional directors, including member services, provider services, marketing and outreach, operations, medical management, and quality, that are accountable for reviewing web content and making appropriate recommendations for change. This team identifies new content to promote seasonal activities or educational opportunities, such as announcements and tips. Likewise, these team members identify obsolete content.

A Secure Provider Portal that Exceeds Requirements (5.6.3.E)

Our web based secure Provider Portal is an enterprise scalable, standards based platform that is fully HIPAA security and HIPAA transaction compliant and available 24 hours a day, seven days a week. Sunflower's Provider Portal offers administrative "self-service" capabilities including eligibility inquiry, authorization submission and status, claim submission, claim status inquiry, and claim payment history. As we have continued investing in our Provider Portal with new interactive functions and targeted analytics for our providers, we have seen significant growth in the number of users of our Provider Portal. See ***Figure 5.6.B_Sunflower Provider Portal User*** Registrations below.

In 2018, we are enhancing our Provider Portal to include all physical and behavioral health (BH) functions on one secure platform – further enabling BH and physical health care coordination, and expanding the health information we exchange with all providers via this online presence.

Figure 5.6.B_Sunflower Provider Portal User Registrations



Much of the growth in our Provider Portal's user base is due to a growing number of clinical applications with health information presented in a meaningful, impactful manner. These

clinical functions include: online care gap notifications (alerting providers to health alerts and care gaps), emergency room high utilizer flag (alerting providers if a member has had three or more emergency room visits in 90 days), and an online Member Health Record (MHR) delivering advanced capabilities for service coordination. Please see ***Table 5.6.A_Secure Provider Portal Features*** for a detailed description of the information, applications, and functionality of our Provider Portal.

Table 5.6.A_Secure Provider Portal Features

Secure Provider Portal Features	Description
Provider Practice Information	Providers have the option of updating their contact information, including addresses, on our secure Provider Portal.
Member Search and Check Member Eligibility	Search for member by last name, date of birth, date of service, or by KanCare member ID and date of service. See ***Figure 5.6.C_Provider Portal Member Eligibility*** below.
Secure Messaging	Users can securely message with Customer Service Representatives (CSRs) and other staff.
Claims Submission, Status, Payment History	We offer providers individual and HIPAA EDI batch file claim submission, and the ability for providers to request adjustment to claims online, search for claim status using member information, claim information, and/or provider name, and view and download payment history information. Provider can submit claim reconsiderations through the portal and view the status/outcome of reconsideration requests.
LTSS Claims Wizard	We offer the LTSS Claims Wizard, a specialized version of our online Direct Data Entry (DDE) feature on the Provider Portal, designed specifically for LTSS providers with no coding experience to submit accurate and complete claims through a step-by-step claim entry process, with validation assists and online help, driving down errors and ensuring Providers receive more timely payment for their services.
Claims Audit Tool	The secure Provider Portal will also provide access to Sunflower claims adjudication logic using our Clear Claim Connection software. This software allows our providers to understand our administrative and clinical claim edits at a detailed coding level, to offer claim processing transparency and ensure claim coding accuracy.
InterQual SmartSheets	We offer Single Sign On (SSO) to InterQual SmartSheets for providers to view the criteria for adult and pediatric procedures, home health, durable medical equipment, and imaging. SmartSheets offers providers a checklist customized for each service, including procedure code, which allows Sunflower to share key aspects of our criteria and reduce denials due to incorrect or missing information.
Prior Authorization (PA)/Referral Status	We offer providers the ability to look up whether a PA is required through our PA tool on Sunflower's public website. If needed, providers can use the Provider Portal to submit PA requests and supporting information via our PA request tool. Providers can also use the secure Provider Portal to enter and view authorization requests and status. A prior authorization report is exportable into Excel format and includes the procedure code, modifier, service start date and other information.
ED Notification	This functionality allows facilities to indicate, in the secure Provider Portal, if a member is in the ED. If the facility activates the ED notification, the data is automatically transmitted to TruCare for follow up by our care team and utilization management team allowing us to provide timely notification to PCPs and other relevant providers, as needed.

Secure Provider Portal Features	Description
Member Panel Roster including care gap alerts and reports	Through the member panel roster, providers can quickly review and filter on detail level information and can export and print a care gap report. These alerts notify a provider about the potential need for interventions, diagnostic tests, and labs for certain conditions, or for EPSDT and preventive services. Care alerts are generated for disease management and an ER flag is generated for any member that has been to the ER more than three times in a 90-day period.
Member Health Record (MHR)	The MHR offers actionable information in a manner and format that allows providers to view clinical history and current interventions on their members. Providers can view member contacts, utilization history (derived directly from physical, behavioral, and pharmacy claims data), lab test results, care plans (when applicable), allergies, eligibility history, participation in Sunflower Service Coordination programs, and more to assist providers in their practice of coordinated care delivery. The clinical data provided on the MHR is supplied through our Centelligence® platform, which integrates administrative, demographic, and clinical data from multiple sources, making our MHR a secure, web-based clinical data home. In 2018, we are enhancing our MHR with additional tools to support our 5,500 members in Foster Care and other child members with features such as contact information of the member's Integrated Care Team (e.g., caregiver, caseworker, PCP), completed EPSDT assessments, immunization schedules, and growth charts. See ***5.6.D_Provider Portal Member Health Record*** below.
Patient Analytics Dashboard	The patient analytics dashboard, part of our Centelligence® capabilities, allows practice managers or individual providers to access their patient disease registries (at the PCP or practice level) to view critical information including evidence-based care gaps, identify quality improvement opportunities, and improve their care coordination functions. The patient analytics dashboard offers providers physical and BH diagnoses, and medication, lab, and care team data, on a member level. The patient analytics dashboard offers easy to build reports, allowing providers and their care team to view care gaps and compliance status for patients. Patient Analytics puts *predictive* measures of health care costs at the primary care provider's fingertips by including a risk score and an inpatient probability score. The risk score identifies the likelihood that the member will incur cost and services in the next 12 months compared to an average member. The inpatient probability score is a percentage indicating the likelihood that a member will have one or more inpatient confinements in the next 12 months.
Provider Analytics Dashboard	The provider analytics dashboard, part of our Centelligence® capabilities, offers varying levels of information to provider user groups and allows for, provider performance analysis, cost and utilization trending, quality measure performance, active and non-active member pattern analysis, disease state prevalence, readmission analysis, and population health trend analysis. Users are also offered many of these metrics on a risk and severity adjusted basis. Authorized users can interact with the dashboards through extensive custom selection, drill-down, and export capabilities, to help identify potential casual factors behind clinical and cost performance. As providers shift to pay-for-performance and pay-for-outcome measures, the availability of such data to determine contract performance will become paramount. By using the provider analytics dashboard, providers will be able to monitor their performance versus contractual or bonus goals. See ***Figure 5.6.E_Provider Portal Reporting Dashboard*** below.

Secure Provider Portal Features	Description
Web-based Authorization (McKesson's InterQual (IQ) Connect)	In advance of the scope of work requirement of July 1, 2019, we are enhancing our web-based authorization capability through the implementation of IQ Connect point-of-care solution. IQ Connect incorporates InterQual® Criteria in an automated, and supports real-time medical appropriateness review and determination for key services and uses auto-determination rules to approve prior authorization (PA) and provide timely response to providers via our secure Provider Portal.

Figure 5.6.C_Provider Portal Member Eligibility

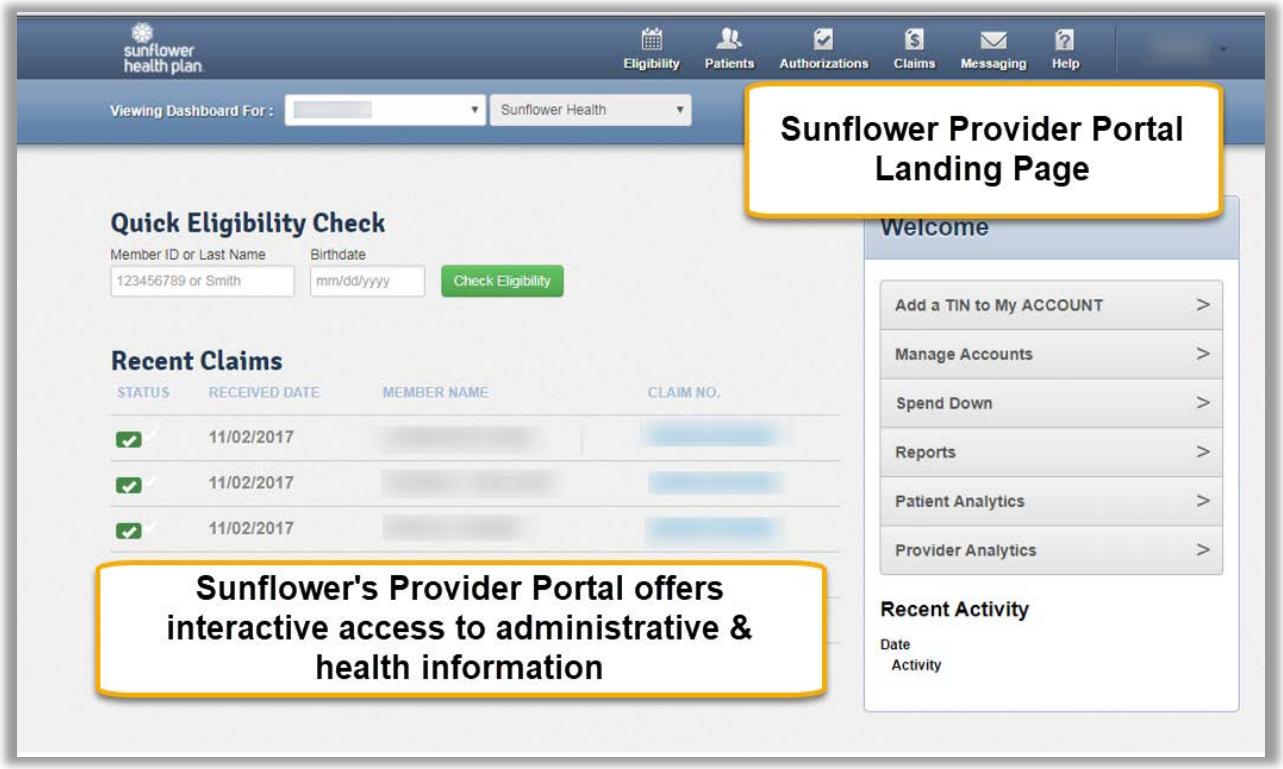


Figure 5.6.D_Provider Portal Member Health Record

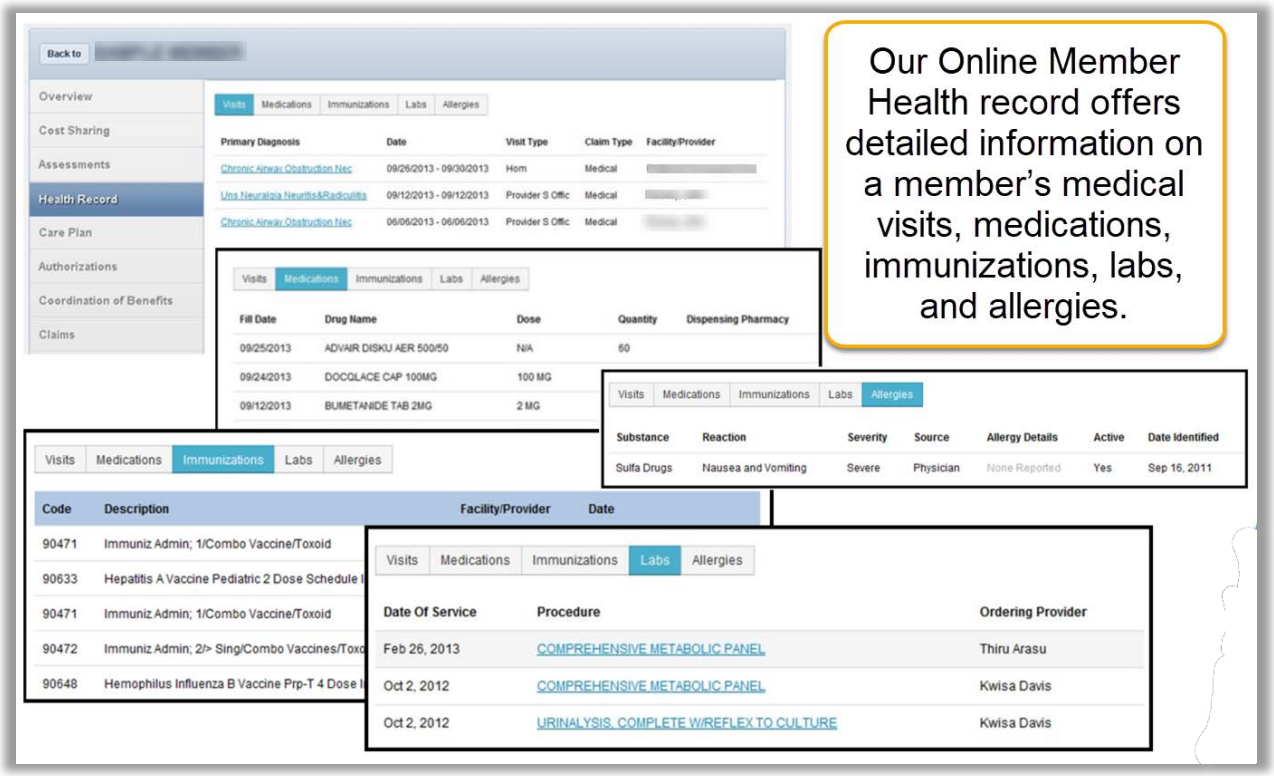
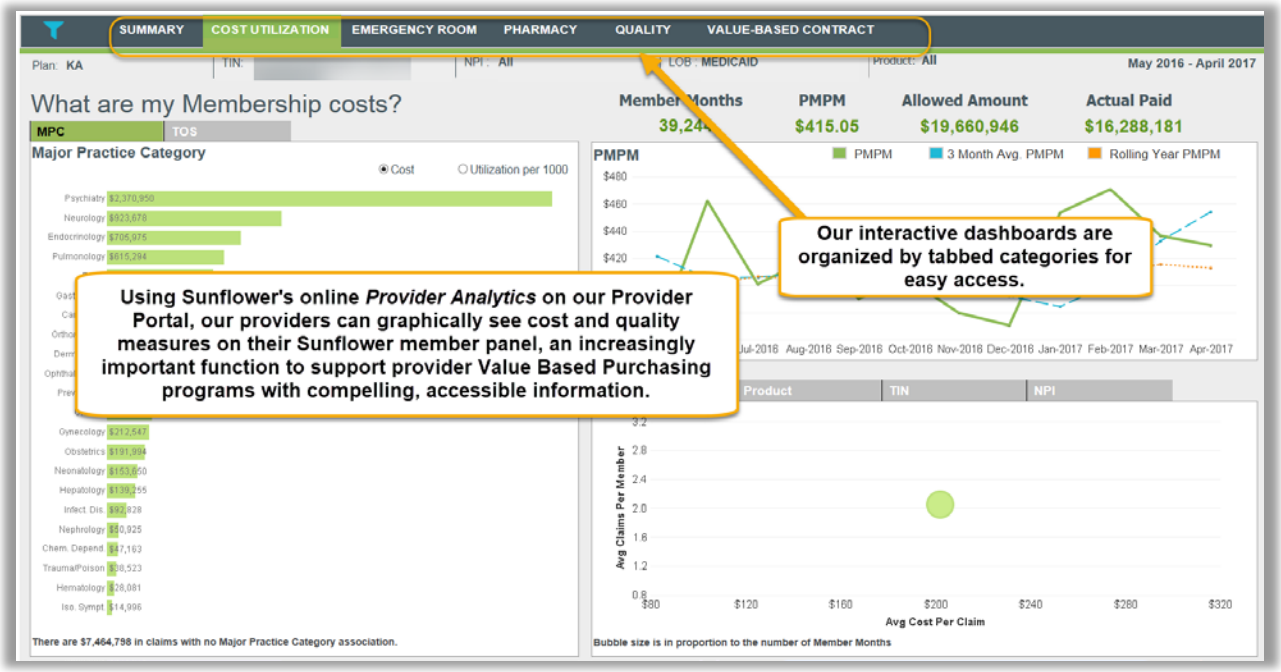


Figure 5.6.E_ Provider Portal Reporting Dashboard



5.6.4. WRITTEN PROVIDER MATERIALS REQUIREMENTS (5.6.4.A-F)

Sunflower complies with all existing KanCare requirements for provider and member materials, including those items requiring State approval and those requiring Bulletin distribution. For more information on our member materials, please see Section 5.10.

We acknowledge KDHE 2017 policy change related to the distribution of State policy changes outlined in 5.6.4.C. Our Marketing and Communications Manager is responsible for receiving the State's provider bulletin, posting it to Sunflower's website, and distributing via email in advance of effective date to providers. Our Marketing and Communications Manager distributes to all providers a weekly KMAP Round Up Bulletin that includes a summary of and links to all State Bulletins via email. KDHE is on the email distribution which serves as notification that the publication process is complete.

Any change in process that impacts providers will also be communicated via bulletin after State approval. The responsible Sunflower business owner alerts the Marketing and Communications Manager to a need for the communication. The Manager submits the request to the State and tracks it for completion. Once approval is received, the Manager is responsible for posting to the website and communicating through email. A common example would be the Manager, Claims & Contract Support Services might identify a process change. They work with Marketing and Communications to draft the bulletin. Most recently a bulletin was submitted for approval related to a change in the check run schedule due to holidays.

Sunflower does not and will not distribute any marketing materials without first obtaining State approval. Those materials that are distributed are always co-branded. A recent example is the NCQA Postcard, approved by the State. See ***Figure 5.6.F_NCQA Postcard*** below.

Figure 5.6.F_NCQA Postcard

Sunflower Health Plan encourages you to visit our website at **SunflowerHealthPlan.com** to find information and resources.

KanCare | sunflower health plan.

Programs:
- Information about Sunflower Health Plan
- Pharmaceutical Management Procedures, Pharmaceutical Restrictions/Preferences (annual/ updates), and Other Pharmacy information
- Sunflower's Quality Program
- HEDIS Program and Data Collection Process
- Staff Availability
- Appeal & Grievance Information

Documents:
- Current Provider Manual
- Preferred Drug List (PDL)
- Provider & Member Rights and Responsibilities
- Adopted Preventive and Clinical Practice Guidelines
- Availability of Criteria / Utilization Management Criteria
- Affirmative Statement about Incentives

Secure Portal Resources:
- Check or Submit Prior Authorization Requests
- Check Prior Authorization Requirements
- View, Adjust or Submit Claims
- Complete Assessments and View Cost Sharing, Care Plans and Coordination of Benefits
- View Your Patient Roster
- Check Patient Care Gaps
- Access to Case Management and Behavioral Health Referrals

Additional provider resources are also available – including forms, helpful links, FAQs, quarterly provider newsletters, fax blasts, E-blasts and other provider updates and much more. If you would like us to provide a printed copy of the Provider Manual, Provider Newsletters or any other document found on our website, please call Customer Service at

1-877-644-4623

SunflowerHealthPlan.com

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5.6.5. CUSTOMER SERVICE CENTER – PROVIDER ASSISTANCE

OVERVIEW OF SUNFLOWER'S CUSTOMER AND PROVIDER SERVICE CENTER (5.6.5.A - 5.6.5.D)

Sunflower provides 24 hour/7 day per week access to customer service. Our local customer and provider service center, responsible for handling and responding to inquiries or correspondence concerning KanCare programs, is located at 8325 Lenexa Drive, Lenexa, Kansas. The center has capability to receive inquires via telephone, fax, written, in-person or electronic means. Our established toll-free telephone service (877-644-4623) available to members, providers, and all community stakeholders is answered 8:00 am until 5:00 pm CST, Monday through Friday, except for State approved holidays (5.6.5.A, 5.6.5.B). Sunflower does utilize an Automated Voice Response System (AVRS) which includes separate queues for persons speaking English or Spanish; is capable providing information such as the hours of operation and fax number; or allowing immediate access to a CSR.

All calls are handled by highly competent staff trained to handle member and provider calls. Collectively throughout this proposal, these staff are referred to Customer Service Representatives (CSRs). All CSRs are trained locally to assure specific KanCare knowledge. Under

the Senior Director's leadership, the Customer Service Team is responsible to research, resolve and respond to all received inquiries by providers, members and other parties utilizing our Customer Relationship Management (CRM) Platform that provides an integrated approach to member and provider service response, enabling the CSR to resolve inquiries in a single call (first call resolution). This CRM Platform is highlighted further below.

Service Center Staffing Model (5.6.5.C)

Sunflower's customer and provider service center is a separate, identifiable and centralized unit under the direction of the Senior Director, Customer Service. To maintain appropriate staffing that will meet or exceed KanCare performance standards, Sunflower uses our innovative IEX Workforce Management System (IEX) to create a responsive, scalable call center. Based on years of call data analyses from Kansas, IEX factors in historical call duration, call patterns, seasonal variations, market maturity, and program features specific to Kansas to adjust staffing. Our IEX model also accounts for variations in call-type complexity, allowing us to create better service performance to standards than using static provider service representatives to provider ratios or member service representatives to member ratios. This predictive modeling capability allows us to forecast staffing needs and maintain standards, adjusting for both the size and type of membership and size of network, even during rapidly changing situations, such as during open enrollment and network expansion. Because the same CSRs follows a member or provider call to resolution, we use IEX to predict staffing needed for shrinkage caused by follow-up, post-call documentation, and staff training.

Highly Trained Customer Service Representatives (5.6.5.E, 5.6.5.O)

Our local call center is staffed with highly trained CSRs. In coordination with our Human Resources Department, our CSR Trainers have designed comprehensive, Kansas specific courses, using instruction, role-playing, hands-on demonstrations, and interactive online modules to ensure our staff are best equipped to serve KanCare 2.0 members and providers. Sunflower has an existing Training Plan that is reviewed each year and the plan and training will be adjusted as required for the new contract beginning in 2019. That updated training plan, evaluation standards, and tools will be submitted to the State for approval 90 days after contract award.

Initial Training. All CSRs will be trained locally which will include a three-week core Member and Provider Services course. After completion of core training, the new CSR takes calls side-by-side with an experienced staff person or supervisor who monitors for competency, accuracy, consistency and appropriate use of all documentation and desktop tools. Call monitoring continues until they consistently demonstrate accuracy and proficiency on live calls. After training, a Team Lead is always available for calls requiring escalation or special handling. Sample training topics include:

Sunflower in Action…

…kudos for Jacque (CSR)…pleased to see how Jacque took the time to ensure that she provided the most accurate information…went above and beyond and was thankful that she called back when more information was needed instead of closing the request.

Joanne from Newman Regional Health

- **Fundamentals** such as customer and provider service tools, including active listening and use of the language line; conflict resolution; detailed review of internal departments and appropriate warm transfers; claims and prior authorizations; web tools and mobile apps; roles and responsibilities of subcontractors; and emergency management protocols.
- **Program information,** including Medicaid 101 and introduction to KanCare; accessing appropriate services; review of benefits, including self-direction; provider and member materials and education; provider and member appeal and grievance processes; overview of Provider Engagement Model; integrated service coordination and other clinical programs, including how members can access ICC services and how providers can refer members for those services.
- **Job functions** including how to serve as subject matter experts; following protocol and escalating urgent or emergent situations; protocols for prior authorization; helping members select a PCP/medical home; and how to conduct claims-look up, gather information for coordination of benefits, and explain the prior authorization process.
- Upon hire and annually, we require all CSRs to complete training based on the Enhanced National Standards for **culturally and Linguistically Appropriate Services** in Health Care (CLAS Standards). We require disability sensitivity training, including People-First Language, Americans with Disabilities Act, misconceptions about persons with physical and behavioral disabilities and those receiving Medicaid, and how to accommodate specific communications needs.

Ongoing Training. Sunflower's Customer and Provider Service team meets weekly to cover new procedures and technologies, current policy changes and/or issues, and online modules on topics like Conflict Resolution. Weekly staff meetings/training also cover subjects such as appropriate transfers for ICC services, performance issues, and State issued bulletins. Ad hoc training huddles include Medicaid and KanCare 2.0 updates, "Late Breaking News" articles, network changes, and member outreach programs, such as our annual Fluvention flu prevention program. Annually, Compliance, Appeals/Grievance and Cultural Competency training is conducted with the staff. We provide targeted training for all member- and provider-facing department staff through our Corporate Learning modules and in-house training conducted by the Customer Service management team.

Advanced Automation to Support First Call Resolution. (5.6.5.I)

Customer Relationship Management (CRM). CRM enables Sunflower to identify, engage, and serve our members, providers, and State partners in a holistic and coordinated fashion across the breadth of their wellness, clinical, administrative, and financial matters. Through its integration with our Management Information System (MIS), CRM affords a 360-degree view of our relationship with members and providers for our CSRs. CRM provides an integrated approach to service management enabling our CSRs to resolve most call inquiries in one call (first call resolution). Additionally, CRM helps CSRs facilitate and coordinate communication between Sunflower staff, our members, and providers (including support-a-user capability to help members and providers navigate our secure web portals) and collect and update member and provider demographic data. Our CRM provides an integrated approach to service management including, but not limited to, the following capabilities:

- ***Workflow Capabilities.*** CRM ensures that CSRs can route any inquiry-related task requiring follow-up to appropriate staff such as eligibility specialists, claims processors, or clinical staff while also enabling CSRs and their supervisors to manage all tasks to successful completion in the fastest possible timeframe.
- ***Dynamic User Interface.*** CRM features task lists and work queues that rapidly communicate to all CSRs and supporting staff on the prioritization and urgency of any member or provider follow-up actions.
- ***Inquiry Tracking.*** CRM tracks all service inquiries to enable unified communications (phone, e-mail, fax, mobile device, web and interactive messaging). All interactions, whether by phone, e-mail, etc., with a member or provider become part of that member or provider's online CRM record.
- ***Complaints, Grievances, and Appeals Application.*** CRM captures, tracks, reports and manages complaints, grievances, and appeals as well as reasons for termination of enrollment other than loss of eligibility.
- ***Whole Member and Provider Service View.*** CRM provides CSRs with access to the most up-to-date information on our members and providers through integration with the member and provider data management components of our Management Information System (MIS). This ensures that our CSRs have access to the information they need to support and assist members and providers. For example, CSRs can view a calling member's information across all historic and current (longitudinal) Sunflower eligibility spans, view any care gaps, and assist members with their health risk assessment.

CRM Platform Enhancements

In Q1 of 2018, we are enhancing our CRM platform with expanded automation capabilities to further increase our first call resolution rate, help our CSRs follow State mandated procedures and HIPAA-compliant caller validation protocols, systematically prompt CSRs with specific questions germane to each caller's situation, and automatically create work tasks when appropriate. Our CRM platform guides our CSRs through each step of a customer interaction, driven by the caller's interests and questions, while minimizing manual and duplicative workflows that often burden CSRs. For example, our CRM intelligently guides CSRs with call scripting, including questions to ask the caller based on their interests. Further, our CRM features educational dialog that provides opportunities for CSRs to inform members of pertinent information that may impact their health situation, such as care gaps.

In Q1 of 2018, we are enhancing our CRM platform with expanded automation capabilities to further increase our first call resolution rate.

CRM also provides instructions to the CSR based on the caller's needs and automatically builds a task and routes it based on call information. For example, if a caller supplies us with new third-party liability or Coordination of Benefits (COB) information, the CSR collects that information in CRM, which automatically constructs a task for our COB Specialists to validate and update our member records, contained in our enrollment and eligibility system. Our enhanced CRM also offers CSRs suggested tasks or 'next best actions'

to initiate with the caller and/or supporting Sunflower staff. Through an array of automation enhancements to our CRM, CSRs will have improved capacity to streamline issue resolution, tasks, and interactions resulting in fewer errors and duplication associated with manual intervention. Our CRM enhancements equip our CSRs with the tools to provide smarter and more agile customer service, and exemplifies our commitment to excellence in customer service for Sunflower members and providers.

In addition to CRM, Sunflower staff utilize the following technology tools:

Support-A-User. For personalized assistance and customer service, Sunflower integrates our secure Member and Provider Portals with a Support-a-User capability for CSRs to view what the provider or member is viewing (with caller's permission). This feature bolsters customer service excellence and member satisfaction by enabling CSRs to be faster at visualizing, understanding, and resolving barriers to care.

Customer Service Optimization Tool. The Customer Service Optimization Tool (CS Optimization Tool) is our quality evaluation software system, to record, review, and evaluate customer service calls. The CS Optimization Tool records all audio calls handled by CSRs during normal business hours and all after hours Nurse Advice Line calls. In addition to call recording, the CS Optimization Tool has the capability for phonetics-based speech analytics, which detects key words and phrases as well as silence detection for both English and Spanish speaking callers. Speech analytics can be used to proactively identify CSRs who may need coaching to more closely follow best practices.

Telephony and Voice Portal Platform. This platform enables seamless and efficient call answering, monitoring, and reporting capabilities. Our telephony platform, along with call manager system software provides automatic call distribution (ACD) across our member call queues. Our call manager system software tracks and reports information processed through the ACD and enables seamless and efficient call answering, monitoring, and reporting capabilities.

Interactive Voice Response. CRM is integrated with our telephony and voice portal platform for Interactive Voice Response (IVR) support with phone keypad capability. Our IVR allows self-service options and live person assistance.

Proactive Outreach Manager (POM). This application is integrated with our CRM system, enables Sunflower to create and execute automated outbound voice, email, or SMS text campaigns providing valuable information and enabling members to take immediate action with our live CSRs or via self-service on the web.

Call Flow and Warm Transfers (5.6.5.M, 5.6.5.N, and 5.6.5.O)

Providers and members need to call only one phone number and place only one call. Sunflower tracks the talk time for a call, but does not have a requirement for staff regarding call duration

so that the CSR can focus on first call resolution and meeting the member or provider's need. CSRs have immediate access to subject matter experts across the organization.

For example, in the event a provider inadvertently chooses the member option and the call is directed to a member-focused CSR, the CSR obtains the reason for their call and offers support, if possible, and transfer only those issues requiring the expertise of a provider-focused CSR. Should there be a need to transfer a caller to an outside entity, such as the member's PCP, the CSR will warm transfer the call. In other words, the CSR calls the appropriate individual for the member, stays on the line, and verbally introduces the caller to ensure continuity, and remains in touch with and transparent to the caller. These warm transfer processes include the transfer from Help Lines when the crisis cannot be resolved by the Help Line.

Sunflower provides ease of service and will not re-direct callers to call another number unless that is the caller's choice. For urgent and non-urgent matters, they will warm transfer to a Service Coordinator or to the member's assigned Services Coordinator if available, including Community Service Coordinators. Should a CSR receive an inquiry regarding a complex claims issue, they advise the caller of the need for research and provide an estimate for when the caller can expect a call back regarding the outcome of the review. Our CSRs have access to our local Claims Liaisons who are experts in claims billing, adjudication and payment, and they complete the research and provide feedback to the CSR regarding necessary next steps. This arrangement offers two benefits:

- 1. Assigning the complex research to staff not responsible to service inbound calls allows us to focus on quickly servicing our callers
- 2. The caller receives a return call from the same person they initially spoke with, and the person most familiar with the case.

This approach holds the CSR accountable for the entire inquiry, from receipt, through research and finalization, offering a seamless customer service experience for our members and providers. For more complex provider claims issues, a Senior CSR will make the provider callback to ensure the provider is satisfied with resolution, or to provide education regarding the provider concern.

Integrated Service Lines. Finally, our Nurse Advice Line and BH line share the same telephone platform and calls are easily transferred to ensure that callers are not lost or required to call a separate telephone number. As in all situations, the CSR warm transfers the call to the appropriate individual. All call information is documented by the CSR in our CRM System, including any transfers. This information can then be reported on, trended and analyzed to determine the nature of calls and incorporate related improvements into our training programs.

After Hours Calls. After hours, our 24/7 Nurse Advice Line answers our toll-free line to ensure members can always get the assistance they need. No matter when they call, callers never receive a busy signal, every call is answered, and every caller may speak with a courteous,

Sunflower resolves 100% of provider inquires within 2 business days, far exceeding KDHE's requirement of 95%.

knowledgeable representative. For convenience, our IVR system responds to push button prompts and includes many self-service features. This automated system provides callers with operating instructions on what to do in case of an emergency and provides the option for callers to speak with our Nurse Advice Line or leave a voice message. All voicemail messages are returned by a CSR within one business day. Through the Nurse Advice Line, registered nurses are available, to issue medical advice and instruct members/providers on how to access urgent and emergent services. Members will also have access to licensed providers through the Nurse Advice Line and our telemedicine tele-video partner.

Call Distribution System

Avaya, our state of the art automated call distribution system, is designed to complement our service model and meet or exceed this contract's requirements for managing, measuring, assessing, and recording calls. Sunflower ensures that the voice mailbox has adequate capacity to receive all messages. All voice mails are now sent through the exchange server so there is only the limit of the email mailbox. The current capacity is 35 GB which would store 1 day, 11 hours and 23 min of audio recordings. Each day the recordings are saved for auditing purposes and then cleared. The capacity is monitored and the capacity can be expanded beyond 35 GB. Callers are also given the option to talk with our Nurse Advice Line for prior authorizations and confirmation of covered services.

Call Quality - Tracking, Monitoring, Improvement to Deliver Excellent Provider Performance Service (5.6.5.L, 5.6.5.J, 5.6.5.K, 5.6.5.Q)

Sunflower has diligent and methodical monitoring and reporting processes described in policy to ensure accuracy, responsiveness, and continuous quality improvement. The Avaya Call Management System (CMS) and Quality Monitoring Systems (QMS) delivers call routing, advanced vectoring, messaging and information tracking to allow for seamless, efficient call answer/service capabilities, monitoring and reporting. CMS/QMS enables the Customer Services Manager (herein known as Manager) or designee to conduct real-time monitoring and captures call activity by time, date, queue and CSR. This combined with on-screen call queue monitoring tools mangers to immediately adjust staffing to ensure timely handling of all calls per KanCare standards.

Our 2017 provider phone call quality average based on regular call center audits that track compliance with quality through nationally recognized standards is 96.9%.

For internal quality monitoring and performance, Sunflower monitors and reports key elements and maintains compliance with the service levels as required in RFP section 5.6.5.K and 5.6.5.Q. Our Avaya system also provides historical reports so management staff can analyze trends that allow us to act to maintain service levels. For example, we can analyze and trend phone statistics in half hour increments by queue to initiate any changes in work distribution among queues. Electronically documenting incoming calls in CRM enables easy follow-up and promotes response accuracy. We further evaluate each CSR's interactions with our members as

well as the effectiveness of our training programs by silent monitoring 10 live calls per month per representative. Call audit criteria include evaluating the accuracy and effectiveness of the interaction; accuracy of call documentation; and cultural appropriateness. Supervisors document the audit results in each CSR's monthly performance cards. This industry *best practice* compares individual performance to predefined performance goals, including measures for number of calls handled; average talk time; percentage of documentation compared to calls taken; and attendance. The Supervisor reviews the performance report card monthly with each CSR, except in cases where immediate correction is warranted. This monthly performance review provides an opportunity to discuss the CSR's strengths, deficiencies, and specific training needs. Follow up activities may include informal coaching, retraining, a Performance Improvement Plan (PIP), or corrective action initiated to correct performance. All calls are also recorded and audit staff and supervisors routinely review calls based on live audit results and other observations or feedback. Each CSR is required to read and sign the company's Call Monitoring Acknowledgment form upon hire. Trends across multiple CSRs are promptly addressed at department-wide training sessions or biweekly staff meetings, and if appropriate, reminders are displayed on our visual display boards.

In compliance with Sections 5.6.5.J and 5.10.10.J, Sunflower currently provides monthly performance reports to the State using its specifications and definitions. Our reporting for Service Center elements will be adjusted to accommodate KanCare 2.0 adjustments to standards related to hold time and quality.

Demonstrated Excellence in Provider Service (5.6.5.K, 5.6.5.Q)

Sunflower has demonstrated consistent excellence in meeting Customer Service Standards established by KDHE. ***Table 5.6.E_Sunflower Customer Service Standards Performance*** below demonstrates our superior performance utilizing our most recent report.

Table 5.6.E_Sunflower Customer Service Standards Performance

Performance Standard	KanCare 2.0 Standard	Sunflower Performance
Incoming and outgoing calls must be documented and recorded	100%	100%
Calls answered without receiving busy signal	99%	100%
Calls will be answered within 30 seconds or less	80%	87%
Average Speed of Answer	30 seconds or less	Provider: 20 Seconds
Average Abandonment Rate	4% or less	Provider 1.7%
Calls answered resolved during initial contact	90%	100%
100% calls recorded and retained	100%	100%
100% calls left on voice mail returned within 1 business day	100%	100%
95% of inquires resolved within 2 business days	95%	100%
98% of all inquiries resolved within 5 business days	98%	100%
100% of all inquiries resolved within 15 business days	100%	100%
Email inquiries will be answered within 1 business day	100%	100%
Quality monthly average fully trained staff	90% (NEW)	NA
Hold times equal to or less than 1 minute for inbound and outbound calls	95% (NEW)	NA

Fully Compliant with Technical Specifications (5.6.5.G, 5.6.5.H, 5.6.5.N, 5.6.5.R, 5.6.5.S)
Sunflower currently has sufficient in-bound toll-free lines to meet and exceed the performance standards (5.6.B) along with dedicated Provider lines (5.6.5.G) Provider calls enter a designated queue. Sunflower currently records all in-bound and outbound calls and voice mail (5.6.5.H). Sunflower's voicemail system allows messages to be left during and after business hours. (5.6.5.N). Sunflower currently has a toll-free fax line HIPAA compliant, secure fax system that has sufficient capacity to handle incoming volume. (5.6.5.P) Sunflower's existing HIPAA-compliant email system that allows us to receive materials from providers is our Secure Messaging feature which resides within our secure Provider Portal. We publish the availability of this system through provider trainings and in our on-line Provider Manual. (5.6.5.R). Finally, Sunflower is currently compliant and will remain so for KanCare 2.0 by assuring that all fax, written communication, and similar documents received are imaged/scanned into electronic files for documentation and retrieval purposes, and stored using HIPAA-compliant methods (5.6.5.S)

5.6.6. PROVIDER REPRESENTATIVES

Sunflower operates a comprehensive Provider Engagement and Support program, ensuring appropriate provider training and education, answering provider inquiries, addressing provider concerns, and improving the provider experience. The mission of our model is to educate, train, and coach participating providers with an emphasis in improving quality of care and controlling health care costs.

PROVIDER RELATIONS AND REPRESENTATIVES STRUCTURE

Sunflower has dedicated provider relations staff who act as representatives that are regionally based and are responsible for meeting the needs of our providers through training, education, conducting office visits, and serving as the liaison between our provider network and health plan associates to help remediate provider hardships. Sunflower has an internal Provider Relations support team responsible for responding to member complaints regarding providers, leading provider engagement initiatives, and the pay for performance program (P4P). This team is responsible for leading provider education and training through the development of the State approved annual provider training plan, delivering quarterly orientation/refresher and other provider training in conjunction with Sunflower departments and vendors, and developing communications so that messaging is consistent when delivered by field staff. This team will be expanded to assure accountability for new provider representatives KanCare 2.0 requirements of which Sunflower acknowledge and will comply.

Dedicated Provider Representatives. Sunflower is fully supportive of the proposed changes in KanCare 2.0 for provider representatives focused on providers of specialty services, such as LTSS and BH. Sunflower already recognized this need in the makeup of the current team. Sunflower has regionally based Provider Relations representatives who focus on providers of all types of services. Consistent with future requirements and exceeding current contractual requirements, Sunflower already has a team dedicated to support BH providers. In addition, also exceeding current requirements, is Sunflower's dedicated representative for providers of

IDD services. Because of the special characteristics of those providers, as well as the need to address all other populations served by providers of LTSS services, we will add a new LTSS provider representative, bringing our total field based team to ten staff. These representatives are external-facing, spending the majority of their time at local provider offices. All the current staff have prior customer service experience and insurance claim experience with training in billing and we will ensure this to be the case for the new LTSS representative.

As described in Section 5.6.5 above, our CSRs in our customer service center also support our provider engagement model and our field based provider relations representatives. For example, CSRs receive continuous operational training to offer assistance with member eligibility, benefits, and claims inquiries; assistance identifying and locating network providers; grievances and appeals; and assistance and guidance with administrative tasks such as EDI claims submissions and payment procedures. CSRs work to achieve first call resolution and when additional technical claims assistance is needed, the caller is warm-transferred to the assigned provider relations representative for resolution.

Provider Relations/Representative Staff Roles

Sunflower's Provider Relations/representative staff are accountable for the day to day relationship management and service administration with community based providers and strategic 'premier' provider systems. They work in conjunction with the Plan Contracting and National Contracting teams providing support for contracted, participating providers. Essential Responsibilities include:

- Accountable for the daily maintenance of strategic provider relationships and other community based providers.
- Implements and leads joint operations committee meetings with Sunflower administration and provider leadership to improve ongoing working relationships and effectiveness of contract administration.
- Accountable for maintaining a service administration model that supports hospital, skilled nursing, hospice, ambulance and other community based providers necessary to deliver services to our members.
- Working in collaboration with Sunflower administration to facilitate the process for issue resolution which enable timely and accurate payment of claims.

Provider Representatives Focused on Increasing Provider Satisfaction. The primary focus of our provider representatives is provider support, education, quality outcome and VBP measures, billing and claim submission accuracy, problem resolution and overall provider satisfaction. Provider representatives are the single point of contact for their assigned providers, taking in all questions, issues, recommendations and concerns, resolving internally as appropriate, and closing the loop back with the provider. Provider relations representatives meet with all network providers at least annually. Larger volume providers are visited at least quarterly or as the provider determines is the best meeting schedule.

Our Provider Engagement team establishes strong relationships with our providers through face-to-face engagement that is key to establishing long-term partnerships. They are responsible for training providers on claim billing, Medicaid benefits, authorization requirements, Grievance, Appeal, and State Fair Hearing rights and procedures, recoupments explanation of benefits, claim reconsiderations, and claim payment/denial. They are also responsible for documenting and tracking all provider interactions, training, and technical assistance provided. Provider relations representatives will be located in or near the communities they serve, and are directly responsible for provider network retention, provider compliance, provider satisfaction through relationship building and customer service, soliciting feedback from providers, and relaying information to them on proposed and implemented process and operational improvements.

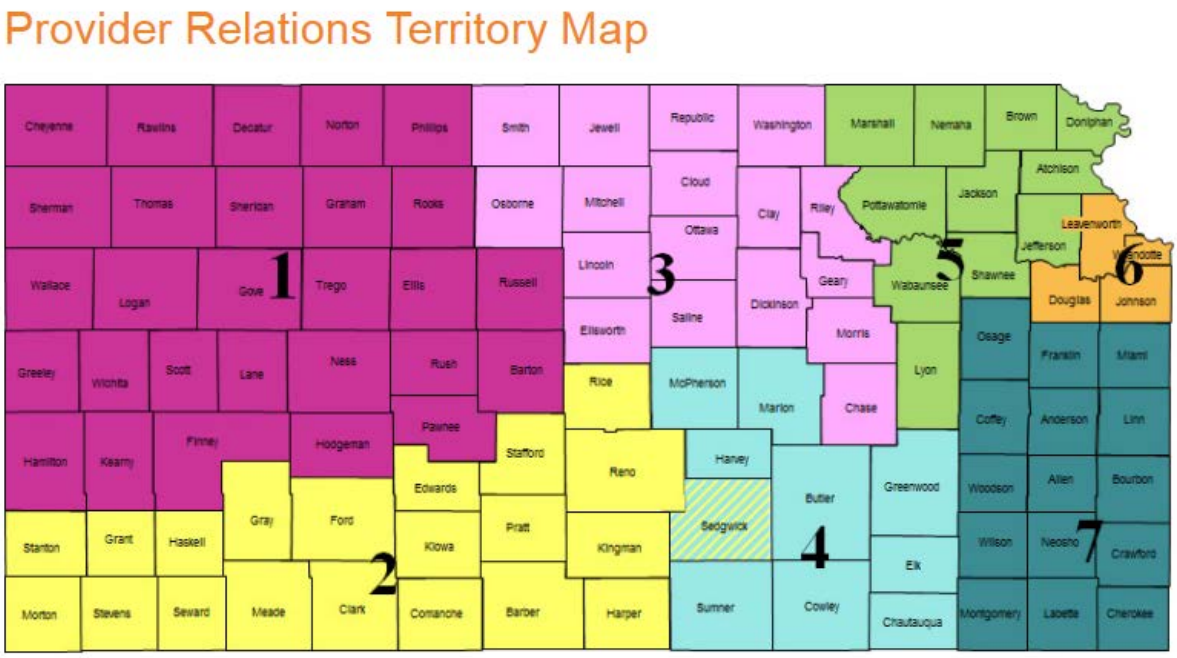
Provider Engagement through MCO Collaboration…

Sunflower is an active partner with the State and the other MCOs serving KanCare members. During 2017, Sunflower participated in all MCO training Wichita and Topeka. More than 300 providers participated in each location. Sunflower also participated on a webinar focused on Federally Qualified Health Centers and Rural Health Clinics in November 2017 with the two other MCOs. We will build upon this experience to work with other MCOs and the State to create and present approved trainings at least quarterly.

Our provider representatives currently attend all major provider association meetings and at least one all-MCO meeting. These meetings include but are not limited to the Kansas Hospital Association Technical Assistance Group (KHA-TAG), Kansas Hospital Authority All Payer Meeting, Kansas Medical Society biller meeting, Health Department biller meeting, KAMU/Primary Care Association conference, Leading Age and Kansas Health Care Association conferences.

Regional Provider Relations Team. See ***Figure 5.6.G_Provider Relations Territory Map*** for a state map with provider representative regions outlined. This map is available on our website and includes the full name/contact information for provider representatives is provided on our website, ensuring providers always know who to call for full resolution of any issue.

Figure 5.6.G_Provider Relations Territory Map



5.7 Contractors Proposals for VBM and Purchasing Strategies

5.7. CONTRACTOR(S) PROPOSALS FOR VALUE BASED MODELS AND PURCHASING STRATEGIES

SUNFLOWER DEMONSTRATED SUCCESS

Since 2013, Sunflower Health Plan (Sunflower)'s has been a leader in designing and administering effective Value Based Models and Purchasing Strategies that contribute to a variety of outcomes, including:

- 48% of our members attributed to a Value Based Payment (VBP) arrangement as of November 2017
- Significant year-over-year improvements in quality Outcomes among our members in Foster Care. Outcomes for more than 85% of the HEDIS measures captured for Sunflower's Foster Care membership in 2015 and 2016 improved during that period.
- A greater than 20% increase from 2015 to 2016 in discussions between members and Sunflower's Service Coordination staff about Social Determinants of Health and Independence (SDOHI) such as employment status
- Sunflower's VBP and quality initiatives engage a wide variety of health systems and provider types including Primary Care Providers (PCPs), specialists, pharmacists, LTSS, and behavioral health (BH). For example, we engage all 26 of Kansas' community mental health centers (CMHCs) in an innovative pay-for-performance incentive program that rewards them for success in HEDIS measures that span physical health (PH) and BH, demonstrating Sunflower's commitment to PH/BH integration.
- Repatriating more than 500 LTSS members from Nursing Facilities (NFs) to Home and Community Based Services (HCBS) since 2014
- Early indications of success in a Congestive Heart Failure (CHF) Telemonitoring Program. In July 2017, Sunflower partnered with Windsor Place's in-home telemonitoring program to offer services to our high-risk members with CHF. Preliminary results over the last five months show a reduction in hospital outpatient care primary and specialty care visits producing an overall member per month spend reduction and over 10% savings for the 35 member cohort.
- ***Sunflower Health Plan has provided this information in our Proprietary Proposal.***

Compliance with Scope of Work

Sunflower will comply with all requirements set forth in Scope of Work (SOW) Section 5.7 CONTRACTOR(S) PROPOSALS FOR VALUE BASED MODELS AND PURCHASING STRATEGIES of the Kansas Medicaid Managed Care Request for Proposal for KanCare 2.0 (RFP). Below we describe in detail our overall approach including accountability, oversight, and evaluation for complying with each element of Section 5.7 of the SOW. For ease of review we have included SOW references in headers and within our narrative response.

OVERVIEW

Sunflower shares Kansas Department of Health & Environment (KDHE)'s commitment to impacting the delivery system. We have translated KDHE's 1115 Demonstration Waiver

hypotheses into the following mission, which is supported by the Value Based Models and Purchasing Strategies proposed throughout our response to Section 5.7:

- Sunflower will continue expanding Service Coordination to include strategies that solve for Social Determinants of Health and Independence (SDOHI), such as access to affordable housing, food security and employment
- Sunflower will continue working to increase employment and independent living supports for members with Behavioral Health (BH) needs and those with intellectual, developmental or physical disabilities or Traumatic Brain Injury (TBI)
- Sunflower will continue providing Service Coordination for all youth in Foster Care to decrease the number of placements and reduce psychotropic medication

Over the past five years, Sunflower has driven successful outcomes in each of these objectives using a variety of Value Based Models, programs and initiatives, as demonstrated below.

Experience Impacting SDOHI through Service Coordination

- Sunflower recognizes that nearly 500,000 Kansans experience food insecurity, or inconsistent access to enough food. In response, Sunflower is proud to sponsor the 2018 Double Up Food Bucks (DUFB) program in Wichita, with the intent and option to sponsor the program in the two subsequent years (2019 and 2020) based on outcomes from the 2018 program year. The DUFB program allows Supplemental Nutrition Assistance Program (SNAP) beneficiaries to receive a match of $1 for every $1 (up to $25, for a total of $50 with the match) redeemed from their Kansas Benefits card exclusively for fresh fruits and vegetables at a participating farmers market. Sunflower's Service Coordination team will actively promote the DUFB program among members. Sunflower's $15,000 sponsorship will allow local leaders to serve an expanded population within the so-called food desert and further demonstrates our commitment to impacting SDOHI across the state.

> ***Sunflower understands the impact that addressing SDOHI has on whole-person member health. Working to resolve members' SDOHI is a fundamental tenet of Sunflower's Service Coordination model.***

- As part of our processes for completing Health Screenings, Health Risk Assessments and Needs Assessments, Sunflower captures a variety of member SDOHI information including employment status, food security status and independent living status. Such data allows our Service Coordination staff insight into the whole-person, 360-degree view of our members and informs referrals to community-based services and other resources to address SDOHI at the individual member level. To complement our SDOHI data collection processes, Sunflower uses SAMHSA National Outcomes Measures (NOMs) SDOHI data, such as employment and homelessness status. This supplementary information, provided by KDHE to update Plans of Service and Person Centered Service Plans in TruCare. This member-centric health management platform is used for Service Coordination and case, behavioral health (BH), disease, LTSS, and utilization management.

Experience Increasing Employment and Independent Living Supports

- Sunflower actively participates in the Governor's Behavioral Health Services Planning Council Vocational Subcommittee, which is committed to coordinating supported employment activities and reviewing statewide infrastructure in promoting and sustaining supported employment for Kansans. In response to the Subcommittee's recommendation to sustain supported employment through expanding the use of the Individual Placement and Support (IPS) model, an evidence-based approach to supported employment for individuals with mental illness, by community mental health centers (CMHCs), Sunflower promoted IPS model adoption among CMHCs through face-to-face meetings and provider education. In addition, Sunflower supported a payment model to encourage CMHCs to use the IPS model with an enhanced payment rate, for which 11 CMHCs have billed. In 2015, 261 unique members received 16,620 units (1 unit = 15 minutes) of supported employment services. In 2016, the number of unique members steadily increased to 268, and the number of supported employment service units increased to 17,298. Two Sunflower staff members have been trained to audit member records for fidelity to the IPS model in conjunction with KDADS staff. Two sites have been audited by these trained auditors to date, and Sunflower continues to support the IPS model through collaboration with KDADS to ensure continued commitment to supported employment.

> ***Sunflower regularly collaborates with State and local health officials to address barriers and increase opportunities that would improve its members' health and quality of life.***

- Sunflower actively engages Kansas providers that deliver supported employment services, conducted through in-person meetings during which the provider's service delivery methods, rates of employment for members within their catchment area, and data integrity with submission of employment data through the State of Kansas Automated Information System (AIMS) are reviewed. In 2016, Sunflower made on-site visits to Pawnee Mental Health Services, Johnson County Mental Health Center, Four County Mental Health Center, Prairie View Mental Health and the Mental Health Association of South Central Kansas. During these visits, the partners reviewed employment data, specifically comparing the data collected and reported by the State to what is submitted by the CMHCs. There was increased awareness by the partners that CMHC data related to employment had multiple options to describe employment that ultimately translated to either employed or unemployed status when received by Sunflower. During these discussions, the facilitator and providers took away a better understanding of the intent of employment data submission and better define employment classification. For instance, it was discovered that members who volunteered or worked in a shelter were classified as unemployed. Ultimately, remediation for appropriate employment tracking allowed providers to submit more accurate member employment data and preserve data integrity.

- Sunflower has operated a robust Work Opportunities Reward Kansans (WORK) program since 2013. Currently, 125 I/DD, PD, and TBI waiver members participate in our program, and Sunflower continuously works to identify additional eligible individuals for participation.

Sunflower members who participated in the WORK program in 2014, 2015, and 2016, remained in the program an average of almost four years (45+ months).

- Early on in Sunflower's history, we recognized the data challenges in identifying members that were diagnosed with SPMI and/or SUD for employment services. To address these challenges, Sunflower's Service Coordination work processes were updated to include questions related to the member's employment status. Depending on the member's need, support for employment status change comprises developing the care plan goals, advocating and coordinating with appropriate parties on behalf of the member for employment status change, and providing employment resources. To measure the work processes' effectiveness, Sunflower reviewed 2015 and 2016 behavioral health case notes for any notes that referenced employment or job. Sunflower's revised Service Coordination work processes resulted in an increase of 24.21% unique members whose employment status was discussed with them by a Sunflower staff member in 2016 compared to 2015.
- In 2016, Sunflower conducted a training session with our BH Service Coordination staff to stress the need to discuss employment with each member contact. The training also discussed barriers for employment, employment strategies and employment resources available for Kansans. The ultimate intent was to engage all members to ensure the unidentified members diagnosed with SPMI and/or SUD were offered employment resources.
- The State of Kansas provided employment related data for members with SPMI on multiple occasions to Sunflower in 2016. The condensed set of employment data represented information submitted by CMHCs through AIMS, which indicated whether members were employed or unemployed. Sunflower utilized the data provided by the State to identify members with SPMI to conduct employment related outreaches. In 2016, Sunflower identified 909 unemployed Sunflower members within the State's dataset, and subsequently outreached to these members through informational mailings on employment resources.

Experience Impacting Outcomes for Youth in Foster Care

- Through our **Psychotropic Medication Utilization Review (PMUR) Program**, Sunflower actively supports best practices in prescribing psychotropic medications for children in Foster Care and persons with I/DD. This program uses a retrospective claims review process to compare a member's medication regimen to a set of prescribing parameters. When medications are outside of parameters, a review of medical records is conducted, and in some cases a peer to

Sunflower is well positioned to continue improving Outcomes among the Foster Care population in support of KDHE's KanCare 2.0 goals.

peer discussion occurs between a Sunflower Behavioral Health Medical Director and the prescriber. Recommendations of the review are shared with the prescriber and the assigned Foster Care Contractor. Sunflower's diligence has resulted in an overall reduction in psychotropic medications utilized by members in Foster Care from 33.5% in 2013 to 28.9% in 2016. 60+ day psychotropic medication utilization among Sunflower's Foster Care membership decreased from 13.4% in 2013 to 11.6% in 2016.

- Sunflower utilizes predictive modeling software to assess our highest-risk members in Foster Care, including those who are likely to experience a disruption in placement. We conduct interdisciplinary team reviews on these members and submit appropriate referrals based on identified need. In 2016, 56 such referrals were submitted for members in Foster Care who were identified as likely to experience placement disruption.
- In July 2017, Sunflower launched a Foster Care Transitioning Youth Program, designed to identify those youth who are approaching their 18th birthday and who would benefit from support as they age out of Foster Care eligibility. Sunflower's goal is to improve outcomes for youth as they transition into adulthood by providing education about our health plan and the youth's benefits under Medicaid. While still in its infancy, to date we have engaged 16 Foster Care members in the program.
- In addition to 100% of Sunflower's Foster Care team completing annual training in Trauma Informed Care, 248 of Sunflower's providers have been trained in Trauma Focused Cognitive Behavioral Therapy (TF-CBT)
- Sunflower's Online Member Health Record, our secure, web-based clinical data home will be expanded to further support our Foster Care population and children through features such as contact information of the member's integrated care team (e.g., caregiver, caseworker, PCP), completed EPSDT assessments, immunization schedules, and growth charts among other information to assist providers in their practice of coordinated care delivery.
- Sunflower takes pride in the year-over-year improvements in quality outcomes among our members in Foster Care. As demonstrated in ***Table 5.7.A HEDIS Measures***, outcomes for more than 85% of the HEDIS measures captured for Sunflower's Foster Care membership in 2015 and 2016 improved during that period.

Table 5.7.A HEDIS Measures

HEDIS Measure	2015	2016
Well Child Visits for 3, 4, 5, and 6 year olds	71%	73%
Immunizations for Adolescents	63%	69%
Annual Dental Visits	68%	70%
Medication Management for those with Asthma	46%	52%
7 day follow up after ED visit for mental health	N/A	79%
30 day follow up after ED visit for mental health	N/A	88%
Use of multiple anti-psychotics	8%	5%
Metabolic monitoring for those on anti-psychotics	30%	41%
Diabetes screening for those on anti-psychotics	66%	74%

Value Based Purchasing (VBP) Program Strategies

We discuss the following tenets that contribute to the historic and ongoing success of Sunflower's VBP Program, which is comprised of a variety of VBP arrangements, below:

- Sunflower's five years of experience allow us to tailor new VBP arrangements based on continuous feedback received from Kansas' provider community
- Sunflower's thoughtful processes for designing VBP arrangements result in a variety of options available to providers of all size, specialty and geographic location
- Sunflower's approach to promoting data sharing with providers participating in VBP arrangements ensures transparency, efficiency and maximized quality of care
- Sunflower's commitment to supporting VBP-participating providers through technical assistance promotes understanding, accuracy, and high levels of engagement among our provider community
- Sunflower's processes for continuously evaluating the effectiveness of our VBP arrangements ensure our incentives align with State outcomes including P4P at-risk dollars, complement provider capabilities, reward providers in the most meaningful ways, and allow Sunflower the flexibility to adjust arrangements as needed
- Sunflower's VBP performance evaluation criteria are closely aligned with KDHE's P4P objectives

Sunflower Health Plan has provided this information in our Proprietary Proposal.

Sunflower's parent company, Centene Corporation (Centene), is the industry leader in designing and implementing impactful VBP arrangements, with more than 30 years' experience rewarding providers for improving member health outcomes. Where successful, these programs have demonstrated a significant impact at the national level, such as 25% higher

Quality Scores; 1-2% lower costs: 10-15% lower IP admissions; ~20% lower ED rates; and up to 30% in additional provider payouts. We will continue to build on this local and national momentum to successfully transition additional providers to the innovative VBP arrangements described throughout our response to Section 5.7.

VBP Program Design. Woven throughout the wide variety of models Sunflower and Centene have developed over the years is a set of core values and guiding principles. The following concepts will continue to serve as the foundation for Sunflower's VBP Program design:

Providers are Essential to Successful Payment Transformation. Sunflower's VBP models are designed with providers and their workflows in mind. Even when working with hospital-based systems, we work closely with their contracting and quality staff to ensure the provider's member assignment is accurate, thereby maximizing incentive earnings. Sunflower maintains long-standing relationships with highly-satisfied provider partners, in part, by ensuring that providers are empowered as part of the VBP model design process.

Our VBP Arrangements are Fair and Transparent. Trust-based relationships between providers and Managed Care Organizations (MCOs) serve as a cornerstone for success in any VBP program. As VBP arrangements are implemented, Sunflower ensures that all eligible providers are invited to participate. Additionally, we provide full transparency into any benchmarks and targets established and assure providers their dedicated PR staff are available to offer additional information or consultative support. Sunflower's secure Provider Portal includes a VBP Scorecard, which offers providers a snapshot of their VBP performance on an ongoing basis.

VBP Models are Offered Only When Providers Have a Reasonable Chance to Succeed. Early provider success in VBP programs is critical for sustainable, long-term delivery system transformation. As a general rule, we require that only those providers who have consistently demonstrated success with gain share-based arrangements are invited to engage in risk-based programs.

Sunflower Complies with Physician Incentive Plan (PIP) Regulations. Across our risk-sharing models, Sunflower's affiliate health plans have experience offering Stop Loss in accordance with PIP regulations. Sunflower remains open to Stop Loss or other market-based options that providers may choose to pursue.

Sunflower Requires Minimum Eligibility Criteria for Participation in Our VBP Program. Sunflower contractually requires the following minimum requirements for provider participation in our VBP Program:

- Providers must maintain an open panel and/or commit to maintain historical panel sizes
- Providers engaged in cost of care based models must meet minimum quality standards before earning incentives through cost savings
- Providers must make EMR and/or Medical Records access available at Sunflower's request
- Providers must participate in all performance-related meetings (e.g., Joint Operating Committees)
- Providers must have an established process to verify member and provider rosters on an ongoing basis

Additionally, Sunflower's VBP arrangements are developed using the following key design features:

- **Prospective Member Attribution:** Attribution remains the most challenging aspect of many VBP models, particularly those providers whose practitioners include employed physicians. We simplify our models through a prospective attribution model (based on PCP assignment) to provide clarity to our providers on attributable members. We also work with providers on an ongoing basis to verify members and make necessary changes to the model.
- **Acuity Adjustment:** In any of our VBP models where we measure utilization or cost, we acuity-adjust these targets to ensure provider performance is fairly and accurately measured.
- **Minimum Panel Size:** In order to maximize participation in VBP arrangements, Sunflower invites those providers with the highest panel volumes to participate in VBP arrangements in an effort to maximize the number of members impacted through such programs.
- **Rational Targets and Benchmarks:** Most of programs feature multiple target thresholds (low, medium and high) to ensure all providers, irrespective of their starting point, have a reasonable chance and motivation to succeed. In designing such tiered targets we also ensure that providers who are performing on the higher tiers are eligible to earn greater rewards compared to providers operating on lower tiers. For instance, in our cost of care models, providers who deliver 1% cost savings may be eligible for 25% of the savings while providers who deliver greater than 5% savings may be eligible for 50% shared savings.
- **Integrated Alignment in Measures:** Sunflower shares KDHE's belief that MCOs have an opportunity to maximize PH/BH integration through VBP arrangements. To that end, Sunflower promotes integrated care by identifying and including performance measures across multiple provider types. For example, depression screening is a measure set across PCP and BH providers and pre-natal and post-partum visits are measured across PCPs and OB/GYNs.

Continuous Data Sharing with Providers. Each of Sunflower's VBP arrangements is built on a foundation of measurable performance metrics supported by provider quality, utilization, cost, and outcomes data. Data is compiled, analyzed and shared with providers on an ongoing basis to track performance against established goals and benchmarks. Provider feedback indicates that data is valuable only if it is delivered timely and consistently, customized by provider type, and above all provide easily-digestible, actionable insights. For providers participating in the Kansas Health Information Network (KHIN) or the Lewis and Clark Information Exchange (LACIE), Sunflower shares eligibility and utilization data with the Health Information Exchange (HIE).

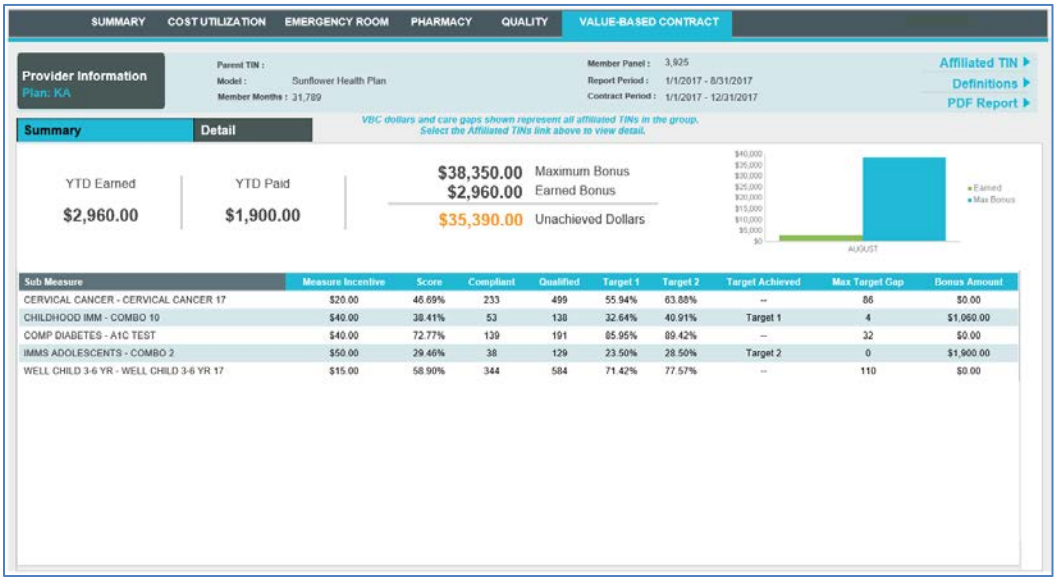
Powered by Centelligence®, Sunflower generates and distributes a variety of report packages made available at point-of-service as well as at monthly and quarterly meetings with Provider Relations (PR) staff. PR staff works shoulder-to-shoulder with providers to guide them through

the information packages we prepare for them, and coach them when opportunities for improvement exist. Each of the report packages described below is intended to allow providers transparency into the measures that ultimately influence their success in Sunflower's VBP Program.

Point-of-Service Report Package. Point-of-Service Report Packages are generated through Sunflower's secure Provider Portal, which houses comprehensive Member Health Records (MHRs) for each provider's assigned membership. In addition to member Plans of Service, Person Centered Service Plans and Service Coordination Team contacts, this report package communicates data such as members' identified risk level; care gaps; recent preventive and primary care services; ED and inpatient history; nursing facility admissions; current medications list; detailed medical, BH, and pharmacy utilization data such as lab test results; and utilization of specialty services, home health, durable medical equipment (DME), community benefits and other services.

Quarterly Report Package. To complement PR outreach initiatives, Sunflower's Quarterly Report Package includes a quality and financial snapshot of the provider's VBP arrangement; a prioritized list of measures aligned with their VBP arrangement; a prioritized list of member care gaps that require closure within the next three months; a detailed, panel-level list of all member care gaps; a list of members not engaged in primary care; a list of members with complex needs; a summary of their members' ED and inpatient stays; a breakdown of the provider's financial performance; risk-adjusted member cost and utilization reports; episode-based panel outcomes stratification; and peer comparisons organized at the enterprise, practice, provider, and member levels. Quarterly Report Packages may be delivered as part of a quarterly Joint Operating Committee (JOC) meeting, and includes a customized VBP Scorecard (see ***Figure 5.7.A_Sample VBP Scorecard***) for those providers participating in VBP arrangements.

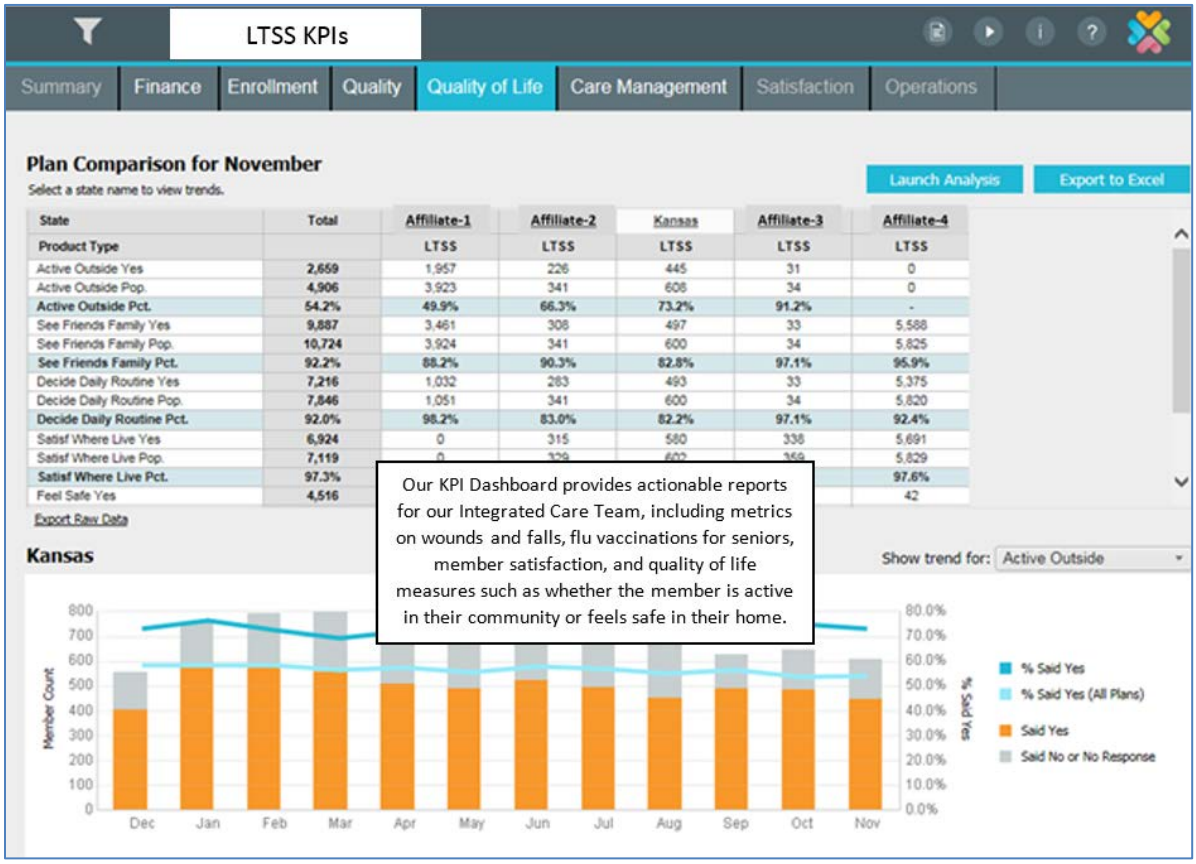
Figure 5.7.A_Sample VBP Scorecard



Sub Measure	Measure Incentive	Score	Compliant	Qualified	Target 1	Target 2	Target Achieved	Max Target Gap	Bonus Amount
CERVICAL CANCER - CERVICAL CANCER 17	$20.00	46.69%	233	499	55.94%	63.88%	--	86	$0.00
CHILDHOOD IMM - COMBO 10	$40.00	38.41%	53	138	32.64%	40.91%	Target 1	4	$1,060.00
COMP DIABETES - A1C TEST	$40.00	72.77%	139	191	85.95%	89.42%	--	32	$0.00
IMMS ADOLESCENTS - COMBO 2	$50.00	29.46%	38	129	23.50%	28.50%	Target 2	0	$1,900.00
WELL CHILD 3-6 YR - WELL CHILD 3-6 YR 17	$15.00	58.90%	344	584	71.42%	77.57%	--	110	$0.00

LTSS Dashboards. LTSS providers benefit from a customized reporting suite designed to reflect the nuances of their services and members supported. While participating in measure development work underway at the national level, Sunflower and its affiliates have partnered with Centene's Corporate LTSS Team, which is at the forefront of meaningful member measurement, and continues to engage in a variety of activities to inform this effort. For example, we are actively collaborating with the National MLTSS Health Plan Association to develop standard MLTSS quality measures, which will be integrated into our LTSS/MMP KPI Dashboard (see ***Figure 5.7.B_Sample LTSS Dashboard***). Our measures are derived, where possible, from recognized and validated national assessment tools such as the Home and Community-Based Services Consumer Assessment of Healthcare Providers & Systems (HCBS CAHPS) surveys and National Core Indicators-Aging and Disabilities (NCI-AD). Sunflower's LTSS KPI Dashboard includes both clinical quality metrics more likely to lead to institutionalization (such as wounds, falls, incidences of Urinary Tract Infection, and flu vaccinations) as well as quality of life metrics (such as member satisfaction with living arrangement, employment status, member participation in the community, and control over daily routine), in addition to other categories (e.g., enrollment, financial/utilization, satisfaction). Centene is currently building the capability to connect metric performance with each member's key providers, and will make performance reports available to providers who serve a significant number of Sunflower LTSS members.

Figure 5.7.B_Sample LTSS Dashboard



State	Total	Affiliate-1	Affiliate-2	Kansas	Affiliate-3	Affiliate-4
Product Type		LTSS	LTSS	LTSS	LTSS	LTSS
Active Outside Yes	2,659	1,957	226	445	31	0
Active Outside Pop.	4,906	3,923	341	608	34	0
Active Outside Pct.	54.2%	49.9%	66.3%	73.2%	91.2%	-
See Friends Family Yes	9,887	3,461	308	497	33	5,588
See Friends Family Pop.	10,724	3,924	341	600	34	5,825
See Friends Family Pct.	92.2%	88.2%	90.3%	82.8%	97.1%	95.9%
Decide Daily Routine Yes	7,216	1,032	283	493	33	5,375
Decide Daily Routine Pop.	7,846	1,051	341	600	34	5,820
Decide Daily Routine Pct.	92.0%	98.2%	83.0%	82.2%	97.1%	92.4%
Satisf Where Live Yes	6,924	0	315	580	338	5,691
Satisf Where Live Pop.	7,119	0	329	602	359	5,829
Satisf Where Live Pct.	97.3%					97.6%
Feel Safe Yes	4,516					42

Interactive Performance Dashboards. Sunflower recognizes that providers benefit from the convenience of on-demand, self-service data reporting to complement our suite of Report Packages. Through our secure Provider Portal, in addition to the Report Packages described above, providers have access to our Interactive Performance Dashboard. This tool reports medical cost and utilization, pharmacy, lab results, ED, population health, and quality outcome data to help providers understand trends and supports custom selection, drill-down, and export capabilities.

Technical Assistance Offered to VBP-Participating Providers. Sunflower is developing a variety of education and other supports to help providers navigate the often complex nuances of VBP structures while maximizing performance. Our PR staff go beyond just provider relations, serving as the central conduit for delivering VBP technical assistance. With all our contracts, we will guarantee assignment of a single, dedicated PRS, who support their assigned providers' progression along the VBP continuum. We see every interaction with our providers as a means to educate them on our VBP Program. All provider-facing staff (Sunflower's Network Contracting (NC) Team and PR staff will complete rigorous training on our VBP Program and are our first line to support and educate providers on our VBP arrangements. On an ongoing basis, PR staff will educate providers on the calculations used to determine bonus/incentive amounts; incentive payment schedules; and concepts such as Total Cost of Care, Outcomes/Quality Scores, Shared Savings/Share Losses payments, and Risk Tracks using the various training modalities described below.

Dedicated Provider Relations Specialist (PRS) Support. For providers participating in a VBP arrangement, Sunflower will assign a PRS to serve as the provider's primary point of contact for VBP technical assistance and moving providers along the continuum. The provider's assigned PRS, in collaboration with the NC Team, conduct comprehensive orientation training, in-person whenever possible, covering all core topics essential to VBP performance success.

Quarterly Meetings. Sunflower's PR Team, in collaboration with the NC Team, host quarterly scheduled meetings with providers participating in a VBP arrangement to review performance and discuss opportunities for improvement. PR staff have access to clinical, financial, relative practice and individual provider performance reports and innovative tools to support these efforts. For example, Shadow Reports provide a gain/risk share performance evaluation, before taking risk, educating providers on model mechanics and opportunities. We conduct both qualitative and quantitative evaluations to determine a provider's level of readiness, consistently supporting progress along the VBP continuum. Sunflower's PR staff develop a customized plan that provides a path to VBP success that meets the needs of the providers, supports the goals of KDHE, and improves the outcomes and experience of members and providers. Quarterly Meeting agendas are structured to discuss clinical and financial performance opportunities, gaps in care, trends in clinical gap findings across the provider's panel, and trend mitigation strategies to support VBP performance management.

Joint Operating Committees (JOCs). Through our JOCs, Sunflower's Contracting and Network Development team regularly meets with Tier 1 providers, including those participating in VBP models, to provide technical assistance in areas such as improving access and capacity, enhancing the patient and provider experience, impacting healthy outcomes, and collaborating to design and implement the most effective delivery system model to serve the needs of the KanCare population while managing VBP performance.

Ad Hoc/Customized Training. Sunflower provides tailored, ad hoc VBP training when requested by a provider, as well as when we identify issues through training evaluations, provider analysis, and analysis of claims submission errors or member complaints that may be contributing to unfulfilled VBP performance potential. Our PR staff proactively outreach to schedule individualized in-person or telephonic training to address identified issues.

Access to Project ECHO Curricula. Access to Project ECHO, to be implemented during the upcoming Contract period, will equip Sunflower's PCPs with education, mentoring opportunities, and support in managing specialty conditions, including improving access to treatment and appropriate prescribing. These curricula will serve as an additional training resource intended to promote the right care, in the right place, at the right time, thereby improving provider VBP performance results. Sunflower intends to also implement training with Community Service Coordinators (CSCs) through Project ECHO to enhance their skills and ability to offer integrated coordination of care.

Practice Transformation. In partnership with the Kansas Association for the Medically Underserved (KAMU), Sunflower will fund a Practice Transformation Specialist (PTS) at KAMU to support Community Health Centers and providers to be successful in their practice transformation goals.
Additional Education Offerings. Sunflower provides training and educational materials on a variety of our VBP arrangements electronically to providers. In addition to our comprehensive Provider Manual, online written resources such as Provider Newsletters feature information related to our VBP Program.

Continuous Evaluation of VBP Program Effectiveness. Sunflower embraces the Quadruple Aim as a yardstick for measuring successful health care delivery transformation within our VBP Program. We firmly believe that delivering on the Triple Aim (Enhanced patient experience, improving population health, and reducing costs) requires achieving a fourth aim of provider engagement, a sustainable work life balance, and viable and satisfactory business models for providers. Sunflower measures VBP Program effectiveness based on our network's delivery of higher quality care, cost management and earning of VBP reimbursement over the course of the Contract Period. We utilize the following criteria when evaluating our VBP Program success:

- **The percentage of VBP-participating PCPs' members that are loyal.** Sunflower measures the strength of member-PCP relationships and how this correlates with healthcare outcomes. Our observations suggest that members who exclusively seek care from their assigned PCPs have 25% higher quality and lower ED and IP-stay rates compared to

members who switch between PCPs and members who have not established a relationship with their assigned PCP.

- **The percentage of providers in VBP arrangements that have exceeded Kansas quality performance targets.** Quality results are perhaps the most direct indication of our VBP Program's effectiveness. Sunflower tailors our VBP arrangements at the provider level to include quality measures that support individual provider goals.
- **The percentage of providers in VBP arrangements that are successful in achieving 2% or greater reduction in costs.** For those providers participating in Sunflower's cost of care models, potential rewards are tiered based on performance. For example, providers participating in a shared savings model who deliver 1% cost savings based on evaluation of ED, IP, Specialist, Ancillary, and total PMPM cost may be eligible for 25% of the savings, while providers who deliver greater than 5% savings may be eligible for 50% of the savings.
- **Whether VBP reimbursement constitutes at least 5% of total medical spend.** Sunflower recognizes that one of the most effective ways to impact member care quality is to support provider success, and that having sufficient cash flow to provide optimal service delivery is pivotal to such success.
- **The percentage of Sunflower's members who are served by a provider who is successful in VBP**

Ongoing Monitoring and Addressing Improvement Opportunities. Sunflower regularly monitors and evaluates the effectiveness and results of our VBP arrangements discussed to ensure our VBP Program remains relevant, viable and sustainable. If a VBP arrangement is found to be less effective than expected, we will determine whether improvement is needed, and take appropriate action at the provider and/or arrangement level. Sunflower employs a variety of continuous VBP Program monitoring/adjustment efforts, such as:

- At the **individual provider level**, facilitating regular JOC meetings between providers and their PRS and Sunflower's leadership team. JOC meetings are intended to serve as a multi-disciplinary approach to monitoring VBP model success at the provider level, with staff representing Sunflower teams such as Quality Improvement, Medical Management and Behavioral Health in attendance to discuss the provider's VBP performance and improvement opportunities. If improvement is needed at the provider level, the provider's PRS works with them hand-in-hand to improve results.
- At the **VBP Program level**, a quarterly and annual review of effectiveness performed by Sunflower's Quality Improvement Committee and Physician Advisory Committee. In the event it is determined that a VBP arrangement as a whole is not achieving the anticipated level of effectiveness, we may refine or adapt the model or begin planning for a replacement model.
- At the **enterprise level**, Centene's senior leadership team is making a $41 million investment in 2017 and 2018 to support a single, enterprise wide quality platform across our affiliate health plans in support of VBP operations. Centene's corporate Provider Network Performance team analyzes the performance of VBP models across all affiliate health plans through three lenses for evaluating contract performance - quality, cost and

member engagement - to identify trends that may help to inform broad-based model refinement. For example, as a result of evaluating the outcomes of our Upside Quality P4P model across all affiliate health plans, we have made adjustments to maximize model effectiveness.

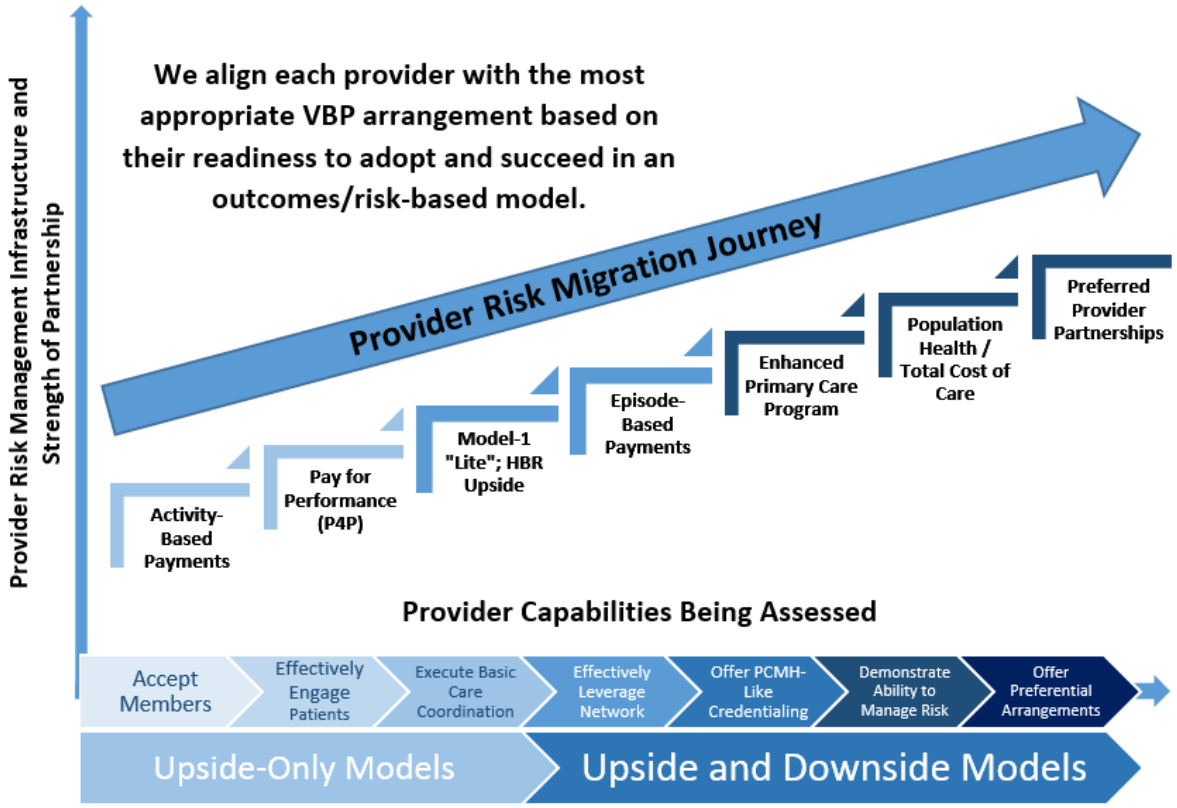
Approach to Meeting KDHE's Goals for Value Based Models and Purchasing Strategies.

Sunflower is committed to supporting the achievement of KDHE's VBP objectives. As described under each Topical Area (Alternative Payment Models (APMs), Social Determinants of Health and Independence, Behavioral Health Services, Long-Term Supports and Services, Physical and Behavioral Health Integration Strategies and Telehealth Projects) below, we will build upon our existing portfolio of innovative, successful VBP arrangements by further empowering our provider community to impact Outcomes for the KanCare population.

ALTERNATIVE PAYMENT MODELS (APMS) (5.7.1.A.1)

Each of Sunflower's proposed APMs described below include quality and/or outcome measures as part of the proposed reimbursement strategy. In alignment with KDHE's example APMs set forth in the RFP, our list of proposed APMs includes episodic bundled payments, shared savings arrangements, and risk-based strategies for providers equipped with the necessary infrastructure to support advanced APMs. Additionally, our APMs extend beyond participation among traditional provider types to include Nursing Facilities (NFs), Psychiatric Residential Treatment Facilities (PRTFs), and providers that serve members with intellectual and developmental disabilities (I/DD). In accordance with RFP requirements, all quality-based evaluation criteria associated with our proposed APMs are primarily based on nationally accepted measure sets (e.g., HEDIS measures). Over the past five years, Sunflower has observed a shift in the Kansas provider community's perception of activities once considered low-priority. With the introduction of APMs, providers now perceive activities such as care gap closure, HEDIS score monitoring and improvement, and data integrity monitoring with increased precedence as these efforts directly align with incentive reimbursement opportunities. As demonstrated in ***Figure 5.7.C_Continuum of APMs that Evolve with Provider Capabilities***, Sunflower will continue to meet providers where they are with the most appropriate initial APM and move them along the below continuum over time to where they want to go by consistently supporting progress toward increased accountability for assigned members.

Figure 5.7.C_Continuum of APMs that Evolve with Provider Capabilities



Experience Implementing APMs. Sunflower's current inventory of piloted and/or implemented APMs is described below:

Adult and Pediatric Quality-Based Pay for Performance (P4P) Program. Sunflower targeted seven large health systems including Salina Regional Health Center, University of Kansas Health System, and Via Christi for participation in this program, which extends to more than 50,000 eligible adult and pediatric Sunflower members. Participating providers are rewarded through bonus reimbursement for achieving target quality results in the following five HEDIS measures, comprised of three pediatric-focused measures and two adult-focused measures, which are aligned with KDHE's P4P program: Well-Child Visits 3-6, Immunizations for Adolescents (IMA) Combo 2, Childhood Immunization Status (CIS) Combo 10, Cervical Cancer Screening and Comprehensive Diabetes Care (CDC) A1C Testing.

Sunflower Health Plan has provided this information in our Proprietary Proposal.

Sunflower Health Plan has provided this information in our Proprietary Proposal.

Timeliness of Prenatal Care Incentive Program. This upside-only, VBP program allows Sunflower to increase member access to timely prenatal care and early identification of risk factors impacting pregnancy. Currently, six of our OB/GYN providers, covering approximately 1,000 members, participate in this program. OB/GYNs and their support teams are financially incented upon successful completion of the Notice of Pregnancy (NOP) during an office visit in the first trimester of pregnancy or within 42 days of enrollment. The NOP is a comprehensive screening tool developed by Centene as part of Start Smart for Your Baby (SSFB) program aimed at reducing pregnancy complications, premature deliveries and infant disease. Timely access to prenatal care and electronic submission of risk screening is coupled with a component to increase the number of Sunflower deliveries over the OB/GYN's prior year delivery rate by 10%. For example, if an OB/GYN practice delivered 170 Sunflower babies the previous year, the practice would be eligible to receive an enhanced payment for increasing that number of deliveries by at least 17, for a total of 187, during the evaluation year.

BH P4P Program for Community Mental Health Centers (CMHCs). All 26 of Kansas' CMHCs participate in this upside-only, VBP program, impacting more than 20,000 members across the State. This program reimburses CMHCs a bonus payment when they achieve target quality results in the following four HEDIS measures, which are aligned with KDHE's Physician Incentive Plan (PIP): APM – Metabolic Monitoring for Children & Adolescents on Antipsychotics, SAA – Adherence to Antipsychotic Medications for Individuals with Schizophrenia, SSD – Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic medications, and FUH-7 day -7 day follow up visit post discharge for mental health hospitalization visit ages 6 years and above. The program also evaluates and rewards providers on impacting Reduction of IP Readmissions rates that occur within 30 days of discharge for a psychiatric condition. A second component of this program involves Sunflower incentivizing CMHCs serving members who are on a waitlist for Psychiatric Residential Treatment Facility (PRTF) admission. CMHCs are eligible to receive an enhanced payment for successful completion of post-admission follow-up activities.

Pharmacy Incentive Program. In order to impact Outcomes through member access to high-quality services from pharmacists, in 2016 Sunflower became one of the first health plans in the nation to develop and implement an innovative, pharmacist-focused VBP strategy. For network pharmacy practices that become accredited by the Center for Pharmacy Practice Accreditation (CPPA), Sunflower reimburses an enhanced professional fee added to each claim paid to the pharmacy. Sunflower has been in discussions with the Kansas Pharmacists Association regarding possible evolution of this VBP program for pharmacists and pharmacies. As such, we are investigating options for modifying this program to include recognizing pharmacies

participating in an enhanced pharmacy services network. The enhanced pharmacy services network could include pharmacies that offer specialized adherence packaging, medication reconciliation, and other enhanced services.

As described in the tables below, our proposed APMs to be implemented during the upcoming Contract Period for KDHE's consideration include four expanded and four new models:

- Proposed APM #1: (Expanded) Adult and Pediatric Quality-Based P4P Program (***Table 5.7.1.A.1_A***)
- Proposed APM #2: (Expanded) Pediatric Quality and Loyalty-Based P4P Program (***Table 5.7.1.A.1_B***)
- Proposed APM #3: (Expanded) Timeliness of Prenatal Care Incentive Program (***Table 5.7.1.A.1_C***)
- Proposed APM #4: (Expanded) BH P4P Program for CMHCs (***Table 5.7.1.A.1_D***)
- Proposed APM #5: (New) Extraordinary Funding Innovative Payment Program (***Table 5.7.1.A.1_E***)
- Proposed APM #6: (New) LTSS Transition Coordination Incentive Program (***Table 5.7.1.A.1_F***)
- Proposed APM #7: (New) Community Service Coordinator (CSC) Enhanced Payment Program (***Table 5.7.1.A.1_G***)
- Proposed APM #8: (New) Bundled Payments for Post-Acute and Rehabilitation Services (***Table 5.7.1.A.1_H***)
- Proposed APM #9: (New) Enhanced Primary Care Program (***Table 5.7.1.A.1_I***)

Table 5.7.1.A.1_A: Expanded Adult and Pediatric Quality-Based P4P Program

Proposed APM #1: Expanded Adult and Pediatric Quality-Based P4P Program	
1. Topical Area addressed	APMs
2. Description of arrangement and objectives	**Description of Model** Sunflower's existing Adult and Pediatric Quality-Based P4P Program enhances quality of care through a focus on preventative and screening services which align with State P4P and Sunflower goals. Sunflower proposes to increase the number of large provider systems participating in our Adult and Pediatric Quality-Based P4P Program from seven to 25 by end-of-year 2019. Participating providers are rewarded through bonus reimbursement for achieving predetermined, KDHE-aligned quality target results. **Alignment with State Hypotheses** Sunflower's objective for the Expanded Adult and Pediatric Quality-Based P4P Program is to further impact KDHE's overall quality of care goals, thereby improving Outcomes for KanCare members.
3. Identify specific populations and services included in the arrangement	**Populations Impacted** Geographically Isolated Populations: By expanding Sunflower's Adult and Pediatric Quality-Based P4P Program to include three to four times the number of providers participating today, the program will impact geographically isolated members living in Ellis and Reno counties.

Proposed APM #1: Expanded Adult and Pediatric Quality-Based P4P Program	
	Specified Populations and Subpopulations: Sunflower's Expanded Adult and Pediatric Quality-Based P4P Program will reach a variety of adult and pediatric members categorized within multiple subpopulations. **Services Included in the APM** Services proposed to be included in Sunflower's Expanded Adult and Pediatric Quality-Based P4P Program are adult and pediatric physician-provided primary care services. **Providers Included in the APM** Sunflower proposes that a mix of adult and pediatric primary care physicians located throughout Kansas be included in the Expanded Adult and Pediatric Quality-Based P4P Program.
4. Identify role of Service Coordination strategies, as applicable	**Role of Service Coordination Strategies** Our PR staff's regular engagement with participating providers, in collaboration with Sunflower's SCs, includes a variety of activities intended to maximize provider incentive reimbursement. Such efforts include training providers on the Provider Portal tools available to close care gaps and reviewing individual member care gaps that require closure. PR staff, in collaboration with SCs, also work with providers to identify why member care gaps remain open and take action toward care gap resolution. For example, if the member has started seeing a different PCP, we work with the provider to have them reassigned; in the event we discover a member could benefit from community-based services, we work to connect members with appropriate resources. Sunflower also works to identify those providers with significant open care gaps among their panels to build staff capacity for supporting outreach to members. For example, GraceMed employs a dedicated team of 10 staff that review member care gaps and make phone calls to schedule appointments. We recognize that not all providers have the infrastructure to support such efforts, so Sunflower embeds Service Coordination staff at targeted providers such as Wesley Medical Center in Wichita and Stormont Vail in Topeka several hours each week to extend the provider's ability to increase care gap closures, thereby promoting APM performance success.
5. Identify role of health information technology/health information exchange (HIT/HIE), as applicable	**Role of HIT/HIE** Sunflower requires that providers participating in an APM utilize our secure Provider Portal, through which they may access and export information necessary for closing care gaps and other activities tied to APM performance. For providers participating in the Kansas Health Information Network (KHIN) or the Lewis and Clark Information Exchange (LACIE), Sunflower shares eligibility and utilization data with the Health Information Exchange (HIE).
6. Coordination and collaboration with existing Value Based Purchasing and Quality Initiatives	**Coordination with Existing VBP/Quality Initiatives** This proposed program is a direct extension/expansion of Sunflower's existing Adult and Pediatric Quality-Based P4P Program. **Collaboration with Existing VBP/Quality Initiatives** Each of the six proposed quality measures associated with the Expanded Adult and Pediatric Quality-Based P4P Program is aligned with those of KDHE's P4P Program.
7. Identify if the model would be implemented statewide or would be a pilot proposal and if the	**Proposed APM Scope** Sunflower proposes that the Expanded Adult and Pediatric Quality-Based P4P Program be implemented statewide to maximize participation in an already successful APM. **Existing Experience with Similar APMs** The following seven providers currently participate in Sunflower's Adult and Pediatric Quality-Based P4P Program (non-Expanded): Via Christi Health, Stormont Vail Health

Proposed APM #1: Expanded Adult and Pediatric Quality-Based P4P Program	
CONTRACTOR(S) has existing experience with the initiative in Kansas or in another state.	System, University of Kansas (KU, KUPI), GraceMed Health Clinic, Hutchinson Clinic, Olathe Medical Services, and Salina Regional Health Center. Sunflower has identified a number of interested providers, including Wesley Medical Center, Community Health Center of Southeast Kansas, and Swope Health Services. In 2016, Sunflower's providers who participated in APMs compared to providers not participating in an APM achieved higher HEDIS quality scores in 14 out of 20 measures which correspond with 2016 state withhold HEDIS categories. **Stakeholder Engagement Strategy** Sunflower is currently soliciting feedback on our proposed Expanded Adult and Pediatric Quality-Based P4P Program from targeted providers. If approved, we anticipate focused provider APM education efforts to extend from August through December 2018. Once deployed, Sunflower's PR staff will frequently engage with APM-participating providers throughout the implementation process with continuous education, training, and technical support to maximize provider success.
8. Identify the proposed metrics, Outcomes or other measurements that the CONTRACTOR(S) will use to (i) determine the payment methodology, if applicable; and (ii) evaluate the effectiveness of the arrangement.	**Proposed APM Metrics** Sunflower will use the following five HEDIS metrics to evaluate provider performance in our Expanded Adult and Pediatric Quality-Based P4P Program: Well-Child Visits 3-6, Immunizations for Adolescents (IMA) Combo 2, Childhood Immunization Status (CIS) Combo 10, Cervical Cancer Screening, and Comprehensive Diabetes Care (CDC) A1C Testing. **Proposed APM Outcomes** Sunflower's proposed outcomes related to this program are expanded provider performance that meets established NCQA HEDIS guidelines for achieving 50th percentile (low tier) or 75th percentile (high tier) guidelines within each of the HEDIS measures listed above. **Proposed APM Measurements** Each measure will be assigned an incentive dollar amount and target percentage. Each performance threshold (low tier; HEDIS 50th percentile and high tier; HEDIS 75th percentile) pays an increased percentage of the potential incentive dollar amount (providers meeting the low tier threshold are eligible to receive 50% of the incentive dollar amount; those meeting the high tier threshold are eligible to receive 100% of the incentive dollar amount). Incentives will be paid on each compliant member event once the target has been met. **Measurement Selection Methodology** Sunflower selected these measurements to align with KDHE's PIP, motivate providers currently scoring below the HEDIS 50th percentile in the selected metrics to improve quality Outcomes, and to incentivize providers currently scoring within the HEDIS 50th percentile in these selected measures to strive for HEDIS 75th percentile quality performance. **Monitoring Provider APM Performance** Sunflower's data analytics team, with support from Centene, continuously monitors provider APM performance against predetermined performance objectives. Sunflower facilitates regular JOC meetings between providers and their PRS and Sunflower's leadership team. JOC meetings are intended to serve as a multi-disciplinary approach to monitoring APM success at the provider level, with staff representing Sunflower teams such as Quality Improvement, Medical Management and Behavioral Health in attendance to discuss the provider's APM performance and improvement opportunities. If improvement is needed at the provider level, the provider's PRS works with them hand-in-hand to improve results.

Proposed APM #1: Expanded Adult and Pediatric Quality-Based P4P Program	
	Impact of Proposed APM on Members A significant number of additional Sunflower members will receive services from providers participating in an APM that offers a concerted focus on improving member care and quality Outcomes, aligned with KDHE's PIP. **Providing APM Data to the State?** Sunflower proposes a similar reporting structure and timeframes to those currently in place for reporting APM-related data to KDHE. Sunflower will comply with all reporting requirements set forth in the RFP. **Stakeholder Engagement Plan** Sunflower seeks every opportunity to empower providers in key decision making processes, such as APM development and associated performance metrics. We have sought feedback from the seven providers currently participating in the Adult and Pediatric Quality-Based P4P Program and will consider provider-suggested adjustments as we continue to design the Expanded Adult and Pediatric Quality-Based P4P Program. Additionally, we will engage those providers that Sunflower has targeted for participation in the Expanded Adult and Pediatric Quality-Based P4P Program for feedback on our proposed design.
9. Identify the total number of Members expected to participate in the arrangement and when the arrangement is expected to start.	**Anticipated Member Participation** Sunflower projects that, by end-of-year 2020, at least 60,000 of Sunflower's members will be assigned to a provider participating in the Expanded Adult and Pediatric Quality-Based P4P Program. **Implementation Timeline (Key Milestones)** Research and Development Activities: Present – 7/2018 Provider Engagement in APM Design: Present – 7/2018 APM Provider Education Efforts: 8/2018 – 12/2018 APM Deployment Phase 1 (to include at least 50% of targeted providers): 1/2019 – 6/2019 APM Deployment Phase 2: 7/2019 – 12/2019

Table 5.7.1.A.1_B: Expanded Pediatric Quality and Loyalty-Based P4P Program

Proposed APM #2: Expanded Pediatric Quality and Loyalty-Based P4P Program	
1. Topical Area addressed	APMs
2. Description of arrangement and objectives	**Description of Model** Sunflower's existing Pediatric Quality and Loyalty-Based P4P Program rewards pediatric care providers for maintaining loyalty among Sunflower's membership while enhancing quality of care through a focus on preventative and screening services. Sunflower proposes to increase the number of large provider systems participating in our Pediatric Quality and Loyalty-Based P4P Program from one to six by end-of-year 2019. Participating providers are rewarded through bonus reimbursement for achieving predetermined, KDHE-aligned quality target results. **Alignment with State Hypotheses** Sunflower's objective for the Expanded Pediatric Quality and Loyalty-Based P4P Program is to further impact KDHE's overall quality of care goals while rewarding providers who maintain loyal panels, thereby improving Outcomes for KanCare members.
3. Identify specific populations and services included in the arrangement	**Populations Impacted** By expanding Sunflower's Pediatric Quality and Loyalty-Based P4P Program to include six times the number of providers participating today, the program will impact members living in Riley, Wyandotte, Shawnee and Barton counties and surrounding areas. **Services Included in the APM**

Proposed APM #2: Expanded Pediatric Quality and Loyalty-Based P4P Program	
	Services proposed to be included in Sunflower's Expanded Pediatric Quality and Loyalty-Based P4P Program are pediatric physician-provided primary care services. **Providers Included in the APM** Sunflower proposes that a mix of pediatric primary care physicians located throughout Kansas be included in the Expanded Pediatric Quality and Loyalty-Based P4P Program.
4. Identify role of Service Coordination strategies, as applicable	**Role of Service Coordination Strategies** Our PR staff's regular engagement with participating providers, in collaboration with Sunflower's Service Coordinators (SCs), includes a variety of activities intended to maximize provider incentive reimbursement. Such efforts include training providers on the Provider Portal tools available to close care gaps and reviewing individual member care gaps that require closure. PR staff, in collaboration with Service Coordinators, also work with providers to identify why member care gaps remain open and take action toward care gap resolution. For example, if the member has started seeing a different PCP, we work with the provider to have them reassigned; in the event we discover a member could benefit from community-based services, we work to connect members with appropriate resources. Sunflower also works to identify those providers with significant open care gaps among their panels to build staff capacity for supporting outreach to members. For example, GraceMed employs a dedicated team of 10 staff that review member care gaps and make phone calls to schedule appointments. We recognize that not all providers have the infrastructure to support such efforts, so Sunflower embeds Service Coordination staff at targeted providers such as Wesley Medical Center in Wichita and Stormont Vail in Topeka several hours each week to extend the provider's ability to increase care gap closures, thereby promoting APM performance success.
5. Identify role of health information technology/health information exchange (HIT/HIE), as applicable	**Role of HIT/HIE** Sunflower requires that providers participating in an APM utilize our secure Provider Portal, through which they may access and export information necessary for closing care gaps and other activities tied to APM performance. For providers participating in the Kansas Health Information Network (KHIN) or the Lewis and Clark Information Exchange (LACIE), Sunflower shares eligibility and utilization data with the Health Information Exchange (HIE).
6. Coordination and collaboration with existing Value Based Purchasing and Quality Initiatives	**Coordination with Existing VBP/Quality Initiatives** This proposed program is a direct extension/expansion of Sunflower's existing Pediatric Quality and Loyalty-Based P4P Program. **Collaboration with Existing VBP/Quality Initiatives** Each of the six proposed quality measures associated with the Expanded Pediatric Quality and Loyalty-Based P4P Program is aligned with those of KDHE's P4P Program.
7. Identify if the model would be implemented statewide or would be a pilot proposal and if the CONTRACTOR(S) has existing experience with the initiative in Kansas or in another state.	**Proposed APM Scope** Sunflower proposes that the Expanded Pediatric Quality and Loyalty-Based P4P Program be implemented statewide to maximize participation in an already successful APM. **Existing Experience with Similar APMs** Topeka Pediatrics currently participates in Sunflower's Pediatric Quality and Loyalty-Based P4P Program (non-Expanded). Sunflower has identified a number of interested providers, including Pediatric Associates of Manhattan and Pediatric Associates of Topeka, LLC. In 2016, Sunflower's providers who participated in APMs compared to providers not participating in an APM achieved higher HEDIS quality scores in 14 out of 20 measures which correspond with 2016 KDHE PIP HEDIS categories.

Proposed APM #2: Expanded Pediatric Quality and Loyalty-Based P4P Program	
	Stakeholder Engagement Strategy Sunflower is currently soliciting feedback on our proposed Expanded Pediatric Quality and Loyalty-Based P4P Program from targeted providers. If approved, we anticipate focused provider APM education efforts to extend from August through December 2018. Once deployed, Sunflower's PR staff will frequently engage with APM-participating providers throughout the implementation process with continuous education, training, and technical support to maximize provider success.
8. Identify the proposed metrics, Outcomes or other measurements that the CONTRACTOR(S) will use to (i) determine the payment methodology, if applicable; and (ii) evaluate the effectiveness of the arrangement.	**Proposed APM Metrics** Sunflower will use the following five HEDIS metrics to evaluate provider performance in our Expanded Pediatric Quality and Loyalty-Based P4P Program: Well-Child Visits 3-6, Immunizations for Adolescents (IMA) Combo 2, Childhood Immunization Status (CIS) Combo 10, Medication Management for Asthma 12- 18 year olds - 75% of Treatment Period, and Medication Management for Asthma 5- 11 year olds - 75% of Treatment Period. **Proposed APM Outcomes** Sunflower's proposed outcomes related to this program are expanded provider performance that meets established NCQA HEDIS guidelines for achieving 50th percentile (low tier) or 75th percentile (high tier) guidelines within each of the HEDIS measures listed above. **Proposed APM Measurements** Each measure will be assigned an incentive dollar amount and target percentage. Each performance threshold (low tier; HEDIS 50th percentile and high tier; HEDIS 75th percentile) pays an increased percentage of the potential incentive dollar amount (providers meeting the low tier threshold are eligible to receive 50% of the incentive dollar amount; those meeting the high tier threshold are eligible to receive 100% of the incentive dollar amount). Incentives will be paid on each compliant member event once the target has been met. **Measurement Selection Methodology** Sunflower selected these measurements to align with KDHE's PIP, motivate providers currently scoring below the HEDIS 50th percentile in the selected metrics to improve quality Outcomes, and to incentivize providers currently scoring within the HEDIS 50th percentile in these selected measures to strive for HEDIS 75th percentile quality performance. **Monitoring Provider APM Performance** Sunflower's data analytics team, with support from Centene, continuously monitors provider APM performance against predetermined performance objectives. Sunflower facilitates regular JOC meetings between providers and their PRS and Sunflower's leadership team. JOC meetings are intended to serve as a multi-disciplinary approach to monitoring APM success at the provider level, with staff representing Sunflower teams such as Quality Improvement, Medical Management and Behavioral Health in attendance to discuss the provider's APM performance and improvement opportunities. If improvement is needed at the provider level, the provider's PRS works with them hand-in-hand to improve results. **Impact of Proposed APM on Members** A significant number of additional Sunflower members will receive services from providers participating in an APM that offers a concerted focus on member-PCP loyalty and improving member care and quality Outcomes, aligned with KDHE's PIP. **Providing APM Data to the State?**

Proposed APM #2: Expanded Pediatric Quality and Loyalty-Based P4P Program	
	Sunflower proposes a similar reporting structure and timeframes to those currently in place for reporting APM-related data to KDHE. Sunflower will comply with all reporting requirements set forth in the RFP. **Stakeholder Engagement Plan** Sunflower seeks every opportunity to empower providers in key decision making processes, such as APM development and associated performance metrics. We have sought feedback from the seven providers currently participating in the Pediatric Quality and Loyalty-Based P4P Program and will consider provider-suggested adjustments as we continue to design the Expanded Pediatric Quality and Loyalty-Based P4P Program. Additionally, we will engage those providers that Sunflower has targeted for participation in the Expanded Pediatric Quality and Loyalty-Based P4P Program for feedback on our proposed design.
9. Identify the total number of Members expected to participate in the arrangement and when the arrangement is expected to start.	**Anticipated Member Participation** Sunflower projects that, by end-of-year 2020, at least 7,500 of Sunflower's pediatric members will be assigned to a provider participating in the Expanded Pediatric Quality and Loyalty-Based P4P Program. **Implementation Timeline (Key Milestones)** Research and Development Activities: Present – 7/2018 Provider Engagement in APM Design: Present – 7/2018 APM Provider Education Efforts: 8/2018 – 12/2018 APM Deployment Phase 1 (to include at least 50% of targeted providers): 1/2019 – 6/2019 APM Deployment Phase 2: 7/2019 – 12/2019

Table 5.7.1.A.1_C: Expanded Timeliness of Prenatal Care Incentive Program

Proposed APM #3: Expanded Timeliness of Prenatal Care Incentive Program	
1. Topical Area addressed	APMs
2. Description of arrangement and objectives	**Description of Model** Sunflower's existing Timeliness of Prenatal Care Incentive Program rewards providers for successful completion of the Notice of Pregnancy during the first trimester of pregnancy or within 42 days of enrollment, coupled with a component to increase the number of Sunflower deliveries over the OB/GYN's prior year delivery rate by 10%. Sunflower proposes to include six participating providers in our Timeliness of Prenatal Care Incentive Program. Participating providers are rewarded through bonus reimbursement for achieving predetermined, KDHE-aligned quality target results and increasing year-over-year delivery volume. **Alignment with State Hypotheses** Sunflower's objective for the Expanded Timeliness of Prenatal Care Incentive Program is to further impact KDHE's overall quality of care goals, thereby improving Outcomes for KanCare members, while rewarding providers for increasing year-over-year delivery volume.
3. Identify specific populations and services included in the arrangement	**Populations Impacted** By expanding Sunflower's Timeliness of Prenatal Care Incentive Program to include additional providers, the program will the program will impact members living in Shawnee, Johnson, Riley, Wyandotte, Shawnee and Sedgwick counties and surrounding areas. **Services Included in the APM** Services proposed to be included in Sunflower's Expanded Timeliness of Prenatal Care Incentive Program are pre- and post-natal services.

Proposed APM #3: Expanded Timeliness of Prenatal Care Incentive Program	
	Providers Included in the APM Sunflower proposes that a mix of pre- and post-natal service providers located throughout Kansas be included in the Expanded Timeliness of Prenatal Care Incentive Program.
4. Identify role of Service Coordination strategies, as applicable	**Role of Service Coordination Strategies** Sunflower's experience with Kansas' OB/GYN community reveals that they are generally less open to embedding Service Coordination staff in their practices. In light of this, Sunflower invests in comprehensive training among OB/GYNs related to the multiple programs Sunflower offers, such as Start Smart® for Your Baby, to be discussed with their pregnant members at the time they submit a Notification of Pregnancy to Sunflower.
5. Identify role of health information technology/health information exchange (HIT/HIE), as applicable	**Role of HIT/HIE** Sunflower requires that providers participating in an APM utilize our secure Provider Portal, through which they may access and export information necessary for closing care gaps and other activities tied to APM performance. For providers participating in the Kansas Health Information Network (KHIN) or the Lewis and Clark Information Exchange (LACIE), Sunflower shares eligibility and utilization data with the Health Information Exchange (HIE).
6. Coordination and collaboration with existing Value Based Purchasing and Quality Initiatives	**Coordination with Existing VBP/Quality Initiatives** This proposed program is a direct extension/expansion of Sunflower's existing Timeliness of Prenatal Care Incentive Program. **Collaboration with Existing VBP/Quality Initiatives** The proposed quality measure associated with the Expanded Timeliness of Prenatal Care Incentive Program is aligned with those of KDHE's PIP.
7. Identify if the model would be implemented statewide or would be a pilot proposal and if the CONTRACTOR(S) has existing experience with the initiative in Kansas or in another state.	**Proposed APM Scope** Sunflower proposes that the Expanded Timeliness of Prenatal Care Incentive Program be implemented statewide to maximize participation in an existing APM. **Existing Experience with Similar APMs** The following providers currently participate in Sunflower's Timeliness of Prenatal Care Incentive Program (non-Expanded): Lincoln Center OBGYN (Shawnee County), Mid America Physicians (Johnson County), Associates in Women's Health (Sedgwick County), KU/Saint Francis Physician (Shawnee, Riley Counties), College Hill OB/GYN (Sedgwick County), and The Women's Health Group (Riley County). In 2016, Sunflower's providers who participated in APMs compared to providers not participating in an APM achieved higher HEDIS quality scores in 14 out of 20 measures which correspond with 2016 KDHE PIP HEDIS categories. **Stakeholder Engagement Strategy** Sunflower is currently soliciting feedback on our proposed Expanded Timeliness of Prenatal Care Incentive Program from targeted providers. If approved, we anticipate focused provider APM education efforts to extend from August through December 2018. Once deployed, Sunflower's PR staff will frequently engage with APM-participating providers throughout the implementation process with continuous education, training, and technical support to maximize provider success.
8. Identify the proposed metrics, Outcomes or other measurements that	**Proposed APM Metrics** Sunflower will continue to measure provider performance against the Timeliness of Prenatal Care HEDIS measure, coupled with percentage of year-over-year delivery increase.

Proposed APM #3: Expanded Timeliness of Prenatal Care Incentive Program	
the CONTRACTOR(S) will use to (i) determine the payment methodology, if applicable; and (ii) evaluate the effectiveness of the arrangement.	**Proposed APM Outcomes** Sunflower's proposed outcomes related to this program is an activity-based incentive resulting in increased timely NOP submission facilitating appropriate case management and improved perinatal outcomes coupled with OB/GYN practice growth providing improved member access to comprehensive OB services. **Proposed APM Measurements** In addition to measuring providers' year-over-year increase in delivery volume, HEDIS measures will be assigned an incentive dollar amount and target percentage. An activity-based incentive is paid for each NOP that is submitted electronically during the member's first trimester of pregnancy or within 42 days of enrollment. **Measurement Selection Methodology** Sunflower selected these measurements to align with KDHE's PIP, reduce preterm deliveries, low birth weight and other poor birth outcomes in babies. **Monitoring Provider APM Performance** Sunflower's data analytics team, with support from Centene, continuously monitors provider APM performance against predetermined performance objectives. Sunflower facilitates regular JOC meetings between providers and their PRS and Sunflower's leadership team. JOC meetings are intended to serve as a multi-disciplinary approach to monitoring APM success at the provider level, with staff representing Sunflower teams such as Quality Improvement, Medical Management and Behavioral Health in attendance to discuss the provider's APM performance and improvement opportunities. If improvement is needed at the provider level, the provider's PRS works with them hand-in-hand to improve results. **Impact of Proposed APM on Members** A significant number of additional Sunflower members will receive services from providers participating in an APM that offers a concerted focus on improving pre- and post-natal care and quality Outcomes, aligned with KDHE's PIP. **Providing APM Data to the State** Sunflower proposes a similar reporting structure and timeframes to those currently in place for reporting APM-related data to KDHE. Sunflower will comply with all reporting requirements set forth in the RFP. **Stakeholder Engagement Plan** Sunflower seeks every opportunity to empower providers in key decision making processes, such as APM development and associated performance metrics. We have sought feedback from the six providers currently participating in the Timeliness of Prenatal Care Incentive Program and will consider provider-suggested adjustments as we continue to design the Expanded Timeliness of Prenatal Care Incentive Program. Additionally, we will engage those providers that Sunflower has targeted for participation in the Expanded Timeliness of Prenatal Care Incentive Program for feedback on our proposed design.
9. Identify the total number of Members expected to participate in the arrangement and when the arrangement is expected to start.	**Anticipated Member Participation** Sunflower projects that, by end-of-year 2020, at least 1,500 of Sunflower's pregnant members will be assigned to a provider participating in the Expanded Timeliness of Prenatal Care Incentive Program. **Implementation Timeline (Key Milestones)** Research and Development Activities: Present – 7/2018 Provider Engagement in APM Design: Present – 7/2018 APM Provider Education Efforts: 8/2018 – 12/2018 APM Deployment Phase 1 (to include at least 50% of targeted providers): 1/2019 – 6/2019 APM Deployment Phase 2: 7/2019 – 12/2019

Table 5.7.1.A.1_D: Expanded BH P4P Program for CMHCs

Proposed APM #4: Expanded BH P4P Program for CMHCs	
1. Topical Area addressed	APMs, Behavioral Health Services
2. Description of arrangement and objectives	**Description of Model** Sunflower's existing BH P4P Program for CMHCs rewards providers for impacting quality of BH care through four BH-focused HEDIS measures while reducing IP Readmission following discharge for a psychiatric condition. Sunflower proposes to increase the member populations participating in our BH P4P Program for CMHCs to include members with SUD by end-of-year 2019. To account for this additional population, Sunflower will add the following three HEDIS measures against which CMHCs will be evaluated: Initiation and Engagement of Alcohol and other Drug Dependence Treatment (IET), Follow-up after Emergency Department Visit for Alcohol and other Drug Dependence (FUA), and Follow-up after Emergency Department visits for Mental Illness (FUM). Participating providers are rewarded through bonus reimbursement for achieving predetermined, KDHE-aligned quality target results and reducing IP Readmission rates following discharge for a psychiatric condition. CMHCs serving members who are on a waitlist for Psychiatric Residential Treatment Facility (PRTF) admission would continue to be eligible to receive an enhanced payment for successful completion of post-admission follow-up activities. **Alignment with State Hypotheses** Sunflower's objective for the Expanded BH P4P Program for CMHCs is to further impact KDHE's overall quality of care goals, thereby improving Outcomes for KanCare members, while rewarding providers for improving IP Readmission rates.
3. Identify specific populations and services included in the arrangement	**Populations Impacted** a. Geographically Isolated Populations: By expanding Sunflower's BH P4P Program for CMHCs to include additional member populations, the program will impact geographically isolated members living in rural counties throughout the state served by CMHCs. b. Specified Populations and Subpopulations: Sunflower's Expanded BH P4P Program for CMHCs will reach members categorized within multiple subpopulations, including members with SUD. **Services Included in the APM** Services proposed to be included in Sunflower's Expanded BH P4P Program for CMHCs are SUD treatment services in addition to those BH services currently in our existing BH P4P Program for CMHCs. **Providers Included in the APM** Sunflower proposes that each of the 26 CMHCs located throughout Kansas be included in the Expanded BH P4P Program for CMHCs.
4. Identify role of Service Coordination strategies, as applicable	**Role of Service Coordination Strategies** Sunflower piloted a dedicated CMHC Service Coordinator assignment process with one of our network CMHCs in 2017. The process increased collaboration and streamlining of communication and processes so much so that we expect to assign dedicated virtual or co-located Service Coordinators to additional network CMHCs in 2018 and beyond. The dedicated Service Coordinator takes the time to fully understand their assigned CMHC's workflows and data gaps to create synergies while building a trusting relationship between Sunflower and provider. This model allows Sunflower's data to impact the CMHC's ability to maximize whole-person member care. For example, the dedicated Service Coordinator regularly shares insights such as member physical health (PH) treatment, changes in prescription medication utilization and care gap alerts to help

Proposed APM #4: Expanded BH P4P Program for CMHCs	
	inform the member's BH treatment and support KDHE's goal of increased PH/BH integration.
5. Identify role of health information technology/health information exchange (HIT/HIE), as applicable	**Role of HIT/HIE** Sunflower requires that providers participating in an APM utilize our secure Provider Portal, through which they may access and export information necessary for closing care gaps and other activities tied to APM performance. For providers participating in the Kansas Health Information Network (KHIN) or the Lewis and Clark Information Exchange (LACIE), Sunflower shares eligibility and utilization data with the Health Information Exchange (HIE).
6. Coordination and collaboration with existing Value Based Purchasing and Quality Initiatives	**Coordination with Existing VBP/Quality Initiatives** This proposed program is a direct extension/expansion of Sunflower's existing BH P4P Program for CMHCs. **Collaboration with Existing VBP/Quality Initiatives** Each of the proposed quality measures associated with the Expanded BH P4P Program for CMHCs is aligned with those of KDHE's PIP.
7. Identify if the model would be implemented statewide or would be a pilot proposal and if the CONTRACTOR(S) has existing experience with the initiative in Kansas or in another state.	**Proposed APM Scope** Sunflower proposes that the Expanded BH P4P Program for CMHCs be implemented statewide to maximize participation in an existing APM. **Existing Experience with Similar APMs** All 26 of Kansas' CMHCs currently participate in Sunflower's BH P4P Program for CMHCs (non-Expanded). **Stakeholder Engagement Strategy** Sunflower is currently soliciting feedback on our proposed Expanded BH P4P Program for CMHCs from our existing network of CMHCs. If approved, we anticipate focused provider APM education efforts to extend from August through December 2018. Once deployed, Sunflower's PR staff will frequently engage with APM-participating providers throughout the implementation process with continuous education, training, and technical support to maximize provider success.
8. Identify the proposed metrics, Outcomes or other measurements that the CONTRACTOR(S) will use to (i) determine the payment methodology, if applicable; and (ii) evaluate the effectiveness of the arrangement.	**Proposed APM Metrics** In addition to expanding this APM to evaluate CMHC performance against IET, FUH and FUM HEDIS measures, Sunflower will continue to measure provider performance against those HEDIS measures currently evaluated, coupled with IP Readmission rates following discharge for a psychiatric condition. **Proposed APM Outcomes** Sunflower's proposed outcomes related to this program are expanded provider performance that meets established NCQA HEDIS guidelines for achieving 50th percentile (low tier) or 75th percentile (high tier) guidelines within the defined HEDIS measures. **Proposed APM Measurements** In addition to measuring providers' IP Readmission rates, HEDIS measures will be assigned an incentive dollar amount and target percentage. Each performance threshold (low tier; HEDIS 50th percentile and high tier; HEDIS 75th percentile) pays an increased percentage of the potential incentive dollar amount (providers meeting the low tier threshold are eligible to receive 50% of the incentive dollar amount; those meeting the high tier threshold are eligible to receive 100% of the incentive dollar amount). Incentives will be paid on each compliant member event once the target has been met. **Measurement Selection Methodology**

Proposed APM #4: Expanded BH P4P Program for CMHCs	
	Sunflower selected these measurements to align with KDHE's PIP, motivate providers currently scoring below the HEDIS 50th percentile in the selected metrics to improve quality Outcomes, and to incentivize providers currently scoring within the HEDIS 50th percentile in these selected measures to strive for HEDIS 75th percentile quality performance. **Monitoring Provider APM Performance** Sunflower's data analytics team, with support from Centene, continuously monitors provider APM performance against predetermined performance objectives. Sunflower facilitates regular JOC meetings between providers and their PRS and Sunflower's leadership team. JOC meetings are intended to serve as a multi-disciplinary approach to monitoring APM success at the provider level, with staff representing Sunflower teams such as Quality Improvement, Medical Management and Behavioral Health in attendance to discuss the provider's APM performance and improvement opportunities. If improvement is needed at the provider level, the provider's PRS works with them hand-in-hand to improve results. **Impact of Proposed APM on Members** A significant number of additional Sunflower members will receive services from providers participating in an APM that offers a concerted focus on improving BH care provided by CMHCs and quality Outcomes, aligned with KDHE's PIP. **Providing APM Data to the State** Sunflower proposes a similar reporting structure and timeframes to those currently in place for reporting APM-related data to KDHE. Sunflower will comply with all reporting requirements set forth in the RFP. **Stakeholder Engagement Plan** Sunflower seeks every opportunity to empower providers in key decision making processes, such as APM development and associated performance metrics. We have sought feedback from our network of CMHCs and will consider provider-suggested adjustments as we continue to design the Expanded BH P4P Program for CMHCs.
9. Identify the total number of Members expected to participate in the arrangement and when the arrangement is expected to start.	**Anticipated Member Participation** Sunflower projects that, by end-of-year 2020, at least 26,000 of Sunflower's members will be assigned to a provider participating in the Expanded BH P4P Program for CMHCs. **Implementation Timeline (Key Milestones)** Research and Development Activities: Present – 7/2018 Provider Engagement in APM Design: Present – 7/2018 APM Provider Education Efforts: 8/2018 – 12/2018 APM Deployment Phase 1 (to include at least 50% of targeted providers): 1/2019 – 6/2019 APM Deployment Phase 2: 7/2019 – 12/2019

Table 5.7.1.A.1_E: Extraordinary Funding Innovative Payment Program

Proposed APM #5: Extraordinary Funding Innovative Payment Program	
1. Topical area addressed	APMs, LTSS
2. Description of arrangement and objectives	**Description of Strategy** Providers of I/DD Services can currently apply for higher tier rate payments for persons with extraordinary health and behavioral health needs. These rates are called Extraordinary Funding. To date, Sunflower has identified four I/DD providers which account for approximately 48% of Sunflower's members with Extraordinary Funding. These providers have been identified as having more specialized health and behavioral health services teams, and are typically sent referrals by Sunflower for persons with more challenging/higher risk needs. Sunflower has offered the four providers a contract

Proposed APM #5: Extraordinary Funding Innovative Payment Program	
	for a higher regular tier rate payment for all members they serve as an alternative to requesting Extraordinary Funding. The goal of these contracts is to sustain the specialty services offered by the four providers. All four providers have accepted the contract terms and rates proposed. Sunflower is currently finishing the contract amendments to submit to the State for approval. Additional providers are eligible to apply for this supplemental funding. To qualify, a provider would need to demonstrate they are serving a higher percentage of our members with I/DD who are high risk, have an extraordinary spending rate, and offer more specialized services to support these members, such as nursing supports, therapies and behavioral health supports incorporated into their program. This program offers a higher reimbursement for providers who can demonstrate they are providing services to persons with I/DD with extraordinary health and behavioral health needs with the goal of ensuring they continue to offer these services and can continue to provide and enhance the specialized services required to best care for these high cost, high risk members. **Strategy Goals** The goal is to increase access to these services and maintain the ability of these providers to serve persons with I/DD who have the most complex behavioral and health needs, and to reduce the current administrative burden for the providers and Sunflower. **Alignment with KanCare 2.0 Objectives** This strategy directly aligns with KanCare 2.0 goals by improving access to quality providers that support greater independence for our members; improving coordination and integration of PH, BH, and LTSS, including social determinants of health and independents; promoting wellness and healthy lifestyles; and lowering costs via competitive contracting.
3. Identify specific populations and services included in the arrangement	**Populations Impacted** Members with I/DD **Services Included in the Arrangement** I/DD Services **Providers Included in the Arrangement** Providers of I/DD Services
4. Identify role of Service Coordination strategies, as applicable	**Role of Service Coordination Strategies** Service Coordinators are educated on the availability of I/DD providers across the network that have specialized services, skills, or training. Through this program, Service Coordinators have greater access to these specialized providers to whom they can refer members who have a higher level of need and may be requesting institutional care. **Potential Synergies** Service Coordinators provide feedback on the program and services to support continuous quality improvement.
5. Identify role of health information technology/health information exchange (HIT/HIE), as applicable	**Role of Health Information Technology/Health Information Exchange (HIT/HIE)** Not applicable

Proposed APM #5: Extraordinary Funding Innovative Payment Program	
6. Coordination and collaboration with existing Value Based Purchasing and Quality Initiatives	**Coordination with Existing Relevant VBP and Quality Initiatives** Our goal is to expand our current contracts to incorporate quality based measures and payments in connection with the enhanced reimbursement. As provider partners, we will also continue to support these specialized providers in expanding capacity and competency through statewide and other initiatives, such as Project ECHO, and trainings we and other providers offer on Trauma Informed Care, Chronic Conditions, the Charting the LifeCourse Framework, Positive Behavioral Support strategies and others that are most applicable to this population.
7. Identify if the model would be implemented statewide or would be a pilot proposal and if the CONTRACTOR(S) has existing experience with the initiative in Kansas or in another state.	**Proposed APM Scope** Sunflower proposes that the Extraordinary Funding Innovative Payment Program be implemented statewide. **Existing Experience with Similar APMs** Sunflower has offered contract terms and rates to four providers, of which all four have accepted. We are finalizing the contract amendments to send to the State for approval. Future anticipated outcomes may include ER and inpatient utilization, member quality and quality of life metrics and member satisfaction. **Stakeholder Engagement Strategy** We have provided and will continue to provide education and training on the availability of these providers and services to Service Coordinators, and engaged the four providers in the development of the contract terms.

8. Identify the proposed metrics, Outcomes or other measurements that the CONTRACTOR(S) will use to (i) determine the payment methodology, if applicable; and (ii) evaluate the effectiveness of the arrangement.	**Proposed APM Metrics, Outcomes and Measurements**
	Based on the goals of the strategies described, the following measures will be used to evaluate effectiveness:
	• Member access to HCBS I/DD Services
	• Member Satisfaction
	• Provider Satisfaction
	• Utilization (for members receiving I/DD services, broken out by provider)
	  ◦ IP Admissions and Readmissions/1000
	  ◦ ED visits/1000
	• LTSS Key Performance Indicators for Quality and Quality of Life within our dashboard
	• Ability for members to remain and reside safely in the home
	APM Measurement Selection Methodology
	Measures described were selected as a consistent method of evaluation as used across clinical and quality programs, and are indicators of the success of achieving the goal of this program.
	Monitoring Provider APM Performance
	Sunflower will regularly monitor through our Quality Improvement Program using standardized reporting and report up through our LTSS Quality Assurance Committee.
	Impact of Proposed APM on Members
	The anticipated impact to members is improved access to community services which meet their individual needs, leading to improved health outcomes and continued independence.
	Providing APM Data to the State
	Sunflower will submit relevant monthly, quarterly, and annual reporting, as requested by the State.
	Stakeholder Engagement Plan
	Sunflower will utilize our Member and LTSS advisory committees to review program outcomes and adjust evaluation metrics as appropriate.

Proposed APM #5: Extraordinary Funding Innovative Payment Program	
9. Identify the total number of Members expected to participate in the arrangement and when the arrangement is expected to start.	**Anticipated Member Participation** Sunflower expects that approximately 50% of Sunflower's I/DD membership will participate in this APM. **Implementation Timeline (Key Milestones)** Research and Development Activities: Present – 1/2018 Provider Engagement in APM Design: Present – 1/2018 APM Provider Education Efforts: Present – 1/2018 APM Deployment Phase 1: 2/2018; Additional providers will be considered for participation at the time of request.

Table 5.7.1.A.1_F: LTSS Transition Coordination Incentive Program

Proposed APM #6: LTSS Transition Coordination Incentive Program	
1. Topical Area addressed	APMs, LTSS
2. Description of arrangement and objectives	**Description of Model** Sunflower is in the process of implementing an LTSS Transition Coordination Incentive Program to provide transition coordination services for members moving out of nursing facility (NF) or other institutional level of care to the community. Community providers have the opportunity to earn up to three payments from the time of referral to the time a member has successfully repatriated in the community, two of which are contingent upon certain outcomes. Providers with whom we contract for Transition Coordination will receive an initial payment upon referral to provide a defined set of transition activities. A second incentive payment is made when a member is successfully placed in the community and the provider furnishes a defined set of post-placement activities. Providers receive a third incentive payment when the member has remained in the community for 30 consecutive days without institutional readmission or IP hospitalization. **Alignment with State Hypotheses** Sunflower's objective for the LTSS Transition Coordination Incentive Program is to increase independent living opportunities for LTSS members residing in NFs and other institutional settings.
3. Identify specific populations and services included in the arrangement	**Populations Impacted** a. Geographically Isolated Populations: Providers located in all geographic areas throughout Kansas, including geographically isolated counties, would be eligible to participate in this Program. Sunflower is in the process of contracting with providers who agree to jointly cover all counties in Kansas. b. Specified Populations and Subpopulations: Sunflower's LTSS Transition Coordination Incentive Program will apply to institutionalized LTSS members. **Services Included in the APM** Services proposed to be included in Sunflower's LTSS Transition Coordination Incentive Program include finding housing and household items, locating community providers, assisting with the setup of self-direction (when chosen), in home risk assessment, identification of community and natural supports, initial visits to confirm services have started, DME is delivered and working, as applicable, and initial medical appointments are kept. **Providers Included in the APM** Sunflower's list of providers targeted for participation in the LTSS Transition Coordination Incentive Program include Topeka Independent Living and Resource Center and MindsMatter.
4. Identify role of Service	**Role of Service Coordination Strategies**

Proposed APM #6: LTSS Transition Coordination Incentive Program	
Coordination strategies, as applicable	Sunflower recognizes the significant opportunities for synergies that exist among institutional providers at the community level as they complement MCO Service Coordination activities for LTSS members. Our proposed LTSS Transition Coordination Incentive Program would enhance the hands-on transitional supports that members receive, and post-placement checks for success. This support is in alignment with KDHE's objective to increase independent living opportunities for LTSS members.
5. Identify role of health information technology/health information exchange (HIT/HIE), as applicable	**Role of HIT/HIE** Sunflower requires that providers participating in an APM utilize our secure Provider Portal, through which they may access and export information necessary for closing care gaps and other activities tied to APM performance. For providers participating in the Kansas Health Information Network (KHIN) or the Lewis and Clark Information Exchange (LACIE), Sunflower shares eligibility and utilization data with the Health Information Exchange (HIE).
6. Coordination and collaboration with existing Value Based Purchasing and Quality Initiatives	**Collaboration with Existing VBP/Quality Initiatives** Sunflower's LTSS Transition Coordination Incentive Program is aligned with KDHE's goal to improve quality Outcomes and expand independent living opportunities for LTSS through innovative contracting strategies.
7. Identify if the model would be implemented statewide or would be a pilot proposal and if the CONTRACTOR(S) has existing experience with the initiative in Kansas or in another state.	**Proposed APM Scope** Sunflower is in the process of contracting with two providers who have agreed to jointly offer Transition Coordination Program statewide. **Stakeholder Engagement Strategy** Sunflower has an LTSS Advisory Committee comprised of associations, providers and advocacy groups representing members in LTSS. This group meets quarterly. We shared our plans for continuation of Transition Coordination services, following the end of MFP. The Advisory Committee recommended incentive-based contracts for assisting persons with successful transition out of institutions. We have continued to update the Advisory Committee with our progress on implementation.
8. Identify the proposed metrics, Outcomes or other measurements that the CONTRACTOR(S) will use to (i) determine the payment methodology, if applicable; and (ii) evaluate the effectiveness of the arrangement.	**Proposed APM Metrics** Sunflower will determine provider eligibility to receive incentive payments based on completion of defined transition coordination services, and LTSS member stability in the community for 30 days following date of discharge from an institutional setting. **Proposed APM Outcomes** Sunflower's proposed outcomes related to this program is an increase in successful transitions among LTSS members from an institutional to community setting as evidenced by the following: • % of members in NF who engage in Transition Coordination and move out of the facility into a community-based setting • % of members in NF who engage in Transition Coordination post placement and remain living 30 consecutive days in a community setting without an inpatient hospitalization stay **Measurement Selection Methodology** Sunflower selected these measurements to align with KDHE's objective to impact quality of care and increase independent living opportunities for LTSS members through innovative solutions. **Monitoring Provider APM Performance**

Proposed APM #6: LTSS Transition Coordination Incentive Program	
	Sunflower's Provider Relations team, in conjunction with our Service Coordination team, will continuously track which providers have completed each incentive-qualifying level of outcomes. We have received permission to utilize the MFP TCS service billing code to authorize the Transition Coordination payments. Therefore, we will be able to track the incentive payments authorized for each provider at the member level. **Impact of Proposed APM on Members** LTSS members transitioning from an institutional to community setting will experience improved Service Coordination, in concert with Sunflower's Service Coordination, and Community Service Coordination activities, delivered by a network of engaged community providers in alignment with KDHE's objectives for serving this complex member population. **Providing APM Data to the State** Sunflower proposes a similar reporting structure and timeframes to those currently in place for reporting APM-related data to KDHE. Sunflower will comply with all reporting requirements set forth in the RFP. **Stakeholder Engagement Plan** Sunflower seeks every opportunity to empower providers in key decision making processes, such as APM development and associated performance metrics. We will continue to engage our LTSS Advisory Committee and individual providers that Sunflower has targeted for participation in the LTSS Transition Coordination Incentive Program for feedback on our proposed design.
9. Identify the total number of Members expected to participate in the arrangement and when the arrangement is expected to start.	**Anticipated Member Participation** Sunflower has an average of approximately 130 persons per year that transition from an institutional setting to the community. We have submitted the Scope of Work to KDHE for approval and anticipate implementing this program by 2/1/2018. **Implementation Timeline (Key Milestones)** Provider Engagement in APM Design: 4/1/2017 to 7/31/2017 APM Provider Education Efforts: 8/1/2017-9/30/2017 Scope of Work State Approval: Anticipated 1/15/2018 APM Deployment: 2/1/2018

Table 5.7.1.A.1_G: Community Service Coordinator (CSC) Enhanced Payment Program

Proposed APM #7: Community Service Coordinator (CSC) Enhanced Payment Program	
1. Topical Area addressed	APMs
2. Description of arrangement and objectives	**Description of Model** Sunflower proposes to pilot a CSC Enhanced Payment Program intended to reduce behavioral health inpatient stays and out-of-home placement related to behavioral health needs among the membership served by targeted network CSCs who complete Positive Behavioral Support (PBS) training offered by Sunflower through our LifeShare program. CSCs will be rewarded through an enhanced payment for reducing BH service utilization. Sunflower proposes that CSCs who qualify for the enhanced payment would also receive preferred referrals for members with I/DD, TBI, SED and children in Foster Care. **Alignment with State Hypotheses** Sunflower's objective for the CSC Enhanced Payment Program is enhance the capabilities of our CSCs to provide supports to persons who exhibit challenging behavior, and to fill the need in Kansas for greater access to persons with knowledge about Positive Behavioral Supports strategies.

Proposed APM #7: Community Service Coordinator (CSC) Enhanced Payment Program	
3. Identify specific populations and services included in the arrangement	**Populations Impacted** a. Geographically Isolated Populations: CSCs located in all geographic areas throughout Kansas, including geographically isolated counties, would be eligible to participate in this Program. b. Specified Populations and Subpopulations: Sunflower's CSC Enhanced Payment Program will apply to those members receiving service coordination services from CSCs. **Services Included in the APM** Services proposed to be included in Sunflower's CSC Enhanced Payment Program include the services required to be provided by Community Service Coordinators (Attachment L) plus functional behavioral assessment, Quality of Life assessment, specialized PCSP/Plan of Service development including positive behavioral support planning, monitoring and review of the support plan, linkage to the Sunflower clinical team for medication review and peer-to-peer contacts, and community behavioral health resources. **Providers Included in the APM** Sunflower's list of CSCs targeted for participation in the CSC Enhanced Payment Program is to be determined.
4. Identify role of Service Coordination strategies, as applicable	**Role of Service Coordination Strategies** Sunflower recognizes the significant opportunities for synergies that exist among CSCs at the community level as they complement BH services utilized by members. Our proposed CSC Enhanced Payment Program would motivate CSCs to play a more active role in impacting the access to and success of behavioral health services for the members they serve, developing relationships with physicians and BH providers, encouraging interdisciplinary team participation between BH, I/DD, Foster Care and other providers, and utilizing Sunflower's clinical team for provider peer support, in alignment with KDHE's objective to increase access to BH supports across Kansas.
5. Identify role of health information technology/health information exchange (HIT/HIE), as applicable	**Role of HIT/HIE** Sunflower requires that providers participating in an APM utilize our secure Provider Portal, through which they may access and export information necessary for closing care gaps and other activities tied to APM performance. For providers participating in the Kansas Health Information Network (KHIN) or the Lewis and Clark Information Exchange (LACIE), Sunflower shares eligibility and utilization data with the Health Information Exchange (HIE).
6. Coordination and collaboration with existing Value Based Purchasing and Quality Initiatives	**Collaboration with Existing VBP/Quality Initiatives** Sunflower's CSC Enhanced Payment Program is aligned with KDHE's goal to provide greater access to Service Coordination and to improve quality Outcomes and expand access to BH supports through innovative contracting strategies.
7. Identify if the model would be implemented statewide or would be a pilot proposal and if the CONTRACTOR(S) has existing experience with the	**Proposed APM Scope** Sunflower proposes that the CSC Enhanced Payment Program be initially implemented as a pilot with selected CSC providers. **Stakeholder Engagement Strategy** Sunflower will solicit feedback on our proposed CSC Enhanced Payment Program from potential CSC providers, including CMHCs, and from our LTSS Advisory Committee. If approved, we anticipate focused provider APM education efforts to extend from August through December 2018. Once deployed, Sunflower's LifeShare staff who are certified

Proposed APM #7: Community Service Coordinator (CSC) Enhanced Payment Program	
initiative in Kansas or in another state.	PBS trainers will engage with targeted CSCs to provide our PBS strategies curriculum, and test for competency.
8. Identify the proposed metrics, Outcomes or other measurements that the CONTRACTOR(S) will use to (i) determine the payment methodology, if applicable; and (ii) evaluate the effectiveness of the arrangement.	**Proposed APM Metrics** Sunflower will determine provider eligibility to receive the enhanced payment based on successful PBS training completion, including testing for competency, and reduction in BH service inpatient utilization among members served by participating CSCs. **Proposed APM Outcomes** Sunflower's proposed outcomes related to this program is a reduction in BH service inpatient utilization among our members receiving services provided by CSCs, reduced transitions for children in Foster Care, and reduced transitions of persons with I/DD and/or TBI from HCBS to institutional settings **Measurement Selection Methodology** Sunflower selected these measurements to align with KDHE's objective to impact quality of care and expand access to BH supports through innovative contracting solutions. **Monitoring Provider APM Performance** Sunflower's Provider Relations team, in conjunction with our Service Coordination team, will continuously track which CSCs have completed each incentive-qualifying level of outcomes. **Impact of Proposed APM on Members** Members receiving services provided by a CSC who has successfully completed the training will have greater access to more specialized quality of life assessment, functional behavioral assessment, positive behavioral supports plan development and review, and PBS strategies that have been shown to decrease challenging behavior for children with behavioral challenges, and adults with I/DD and/or TBI. It is anticipated that by having greater access to persons trained in PBS strategies, children and adults with challenging behavior will have a reduction in inpatient utilization and community living transitions to higher levels of care. **Providing APM Data to the State** Sunflower proposes a similar reporting structure and timeframes to those currently in place for reporting APM-related data to KDHE. Sunflower will comply with all reporting requirements set forth in the RFP. **Stakeholder Engagement Plan** Sunflower seeks every opportunity to empower providers in key decision making processes, such as APM development and associated performance metrics. We will engage those CSCs that Sunflower will target for participation in the CSC Enhanced Payment Program for feedback on our proposed design, as well as our LTSS Advisory Committee.
9. Identify the total number of Members expected to participate in the arrangement and when the arrangement is expected to start.	**Anticipated Member Participation** Based upon current membership, Sunflower projects having approximately 24,000 members who participate in CSC. Sunflower further projects that, by end-of-year 2020, at least 25% of Sunflower's members receiving services from a CSC will receive such services from a CSC participating in the CSC Enhanced Payment Program. **Implementation Timeline (Key Milestones)** Research and Development Activities: Present – 7/2018 Provider Engagement in APM Design: Present – 7/2018 APM Provider Education Efforts: 8/2018 – 12/2018 APM Deployment Phase 1 (to include at least 50% of targeted providers): 1/2019 – 6/2019 APM Deployment Phase 2: (to include remaining targeted providers) 7/2019 – 12/2019

Table 5.7.1.A.1_H: Bundled Payments for Post-Acute and Rehabilitation Services

Proposed APM #8: Bundled Payments for Post-Acute and Rehabilitation Services	
1. Topical Area addressed	APMs
2. Description of arrangement and objectives	**Description of Model** For targeted high-volume hospitals that have historically achieved favorable quality and cost performance outcomes, Sunflower proposes to offer Bundled Payments for Post-Acute and Rehabilitation Services following inpatient stays for conditions such as congestive heart failure (CHF), renal failure, and joint replacement surgery. Instead of paying separate rates for associated hospital, physician and other services, Sunflower would bundle together the payments for those services provided to targeted members. The provider would be eligible to retain the savings generated through reduced spending for defined components of care included in the bundle. **Alignment with State Hypotheses** Sunflower's objective for Bundled Payments for Post-Acute and Rehabilitation Services is to offer an innovative approach to maximizing coordination of services across the system of care for members whose conditions would benefit from an increased level of engagement from multiple providers.
3. Identify specific populations and services included in the arrangement	**Populations Impacted** a. Geographically Isolated Populations: Providers located in all geographic areas throughout Kansas, including geographically isolated counties, would be eligible to participate in this Program. b. Specified Populations and Subpopulations: Sunflower's Bundled Payments for Post-Acute and Rehabilitation Services will apply to members requiring higher levels of cross-system provider engagement for seamless treatment of multiple concurrent conditions. **Services Included in the APM** Services proposed to be included in Sunflower's Bundled Payments for Post-Acute and Rehabilitation Services include post-acute and rehabilitation services provides to members following inpatient stays for conditions such as CHF, renal failure, and joint replacement surgery. **Providers Included in the APM** Sunflower's list of providers targeted for participation in Bundled Payments for Post-Acute and Rehabilitation Services include KU, Children's Mercy and Stormont Vail.
4. Identify role of Service Coordination strategies, as applicable	**Role of Service Coordination Strategies** Our PR staff's regular engagement with participating providers, in collaboration with Sunflower's Service Coordinators, includes a variety of activities intended to maximize provider incentive reimbursement. Such efforts include training providers on the Provider Portal tools available to close care gaps and reviewing individual member care gaps that require closure. PR staff, in collaboration with Service Coordinators, also work with providers to identify why member care gaps remain open and take action toward care gap resolution.
5. Identify role of health information technology/health information exchange (HIT/HIE), as applicable	**Role of HIT/HIE** Sunflower requires that providers participating in an APM utilize our secure Provider Portal, through which they may access and export information necessary for closing care gaps and other activities tied to APM performance. For providers participating in the Kansas Health Information Network (KHIN) or the Lewis and Clark Information Exchange (LACIE), Sunflower shares eligibility and utilization data with the Health Information Exchange (HIE).

Proposed APM #8: Bundled Payments for Post-Acute and Rehabilitation Services	
6. Coordination and collaboration with existing Value Based Purchasing and Quality Initiatives	**Collaboration with Existing VBP/Quality Initiatives** Sunflower's Bundled Payments for Post-Acute and Rehabilitation Services is aligned with KDHE's goal to improve quality Outcomes through innovative contracting strategies.
7. Identify if the model would be implemented statewide or would be a pilot proposal and if the CONTRACTOR(S) has existing experience with the initiative in Kansas or in another state.	**Proposed APM Scope** Sunflower proposes that Bundled Payments for Post-Acute and Rehabilitation Services be implemented as a pilot with select hospital providers. **Stakeholder Engagement Strategy** Sunflower is currently soliciting feedback on our proposed Bundled Payments for Post-Acute and Rehabilitation Services from targeted hospitals. If approved, we anticipate focused provider APM education efforts to extend from August through December 2018. Once deployed, Sunflower's PR staff will frequently engage with APM-participating providers throughout the implementation process with continuous education, training, and technical support to maximize provider success.
8. Identify the proposed metrics, Outcomes or other measurements that the CONTRACTOR(S) will use to (i) determine the payment methodology, if applicable; and (ii) evaluate the effectiveness of the arrangement.	**Proposed APM Metrics** Sunflower will determine provider eligibility to receive bonus payments based on cost performance against defined components of bundled care. **Proposed APM Outcomes** Sunflower's proposed outcomes related to this program is an improvement in coordinated service delivery among providers of varying specialties for members receiving post-acute and rehabilitation services following inpatient stays for defined conditions. **Measurement Selection Methodology** Sunflower selected these measurements to align with KDHE's objective to impact quality of care for members through innovative solutions. **Monitoring Provider APM Performance** Sunflower's data analytics team, with support from Centene, continuously monitors provider APM performance against predetermined performance objectives. Sunflower facilitates regular JOC meetings between providers and their PRS and Sunflower's leadership team. JOC meetings are intended to serve as a multi-disciplinary approach to monitoring APM success at the provider level, with staff representing Sunflower teams such as Quality Improvement, Medical Management and Behavioral Health in attendance to discuss the provider's APM performance and improvement opportunities. If improvement is needed at the provider level, the provider's PRS works with them hand-in-hand to improve results. **Impact of Proposed APM on Members** Members receiving post-acute or rehabilitation services will benefit from a more seamless service delivery experience from a network of engaged providers. **Providing APM Data to the State** Sunflower proposes a similar reporting structure and timeframes to those currently in place for reporting APM-related data to KDHE. Sunflower will comply with all reporting requirements set forth in the RFP. **Stakeholder Engagement Plan** Sunflower seeks every opportunity to empower providers in key decision making processes, such as APM development and associated performance metrics. We will

Proposed APM #8: Bundled Payments for Post-Acute and Rehabilitation Services	
	engage those institutional providers that Sunflower has targeted for participation in Bundled Payments for Post-Acute and Rehabilitation Services for feedback on our proposed design.
9. Identify the total number of Members expected to participate in the arrangement and when the arrangement is expected to start.	**Anticipated Member Participation** Sunflower projects that, by end-of-year 2020, at least 10% of Sunflower's membership requiring post-acute and rehabilitation services following an inpatient hospital stay for CHF, renal failure or joint replacement will have received care from a provider participating in Bundled Payments for Post-Acute and Rehabilitation Services. **Implementation Timeline (Key Milestones)** Research and Development Activities: Present – 7/2018 Provider Engagement in APM Design: Present – 7/2018 APM Provider Education Efforts: 8/2018 – 12/2018 APM Deployment Phase 1 (to include at least 50% of targeted providers): 1/2019 – 6/2019 APM Deployment Phase 2: 7/2019 – 12/2019

Table 5.7.1.A.1_I: Enhanced Primary Care Program

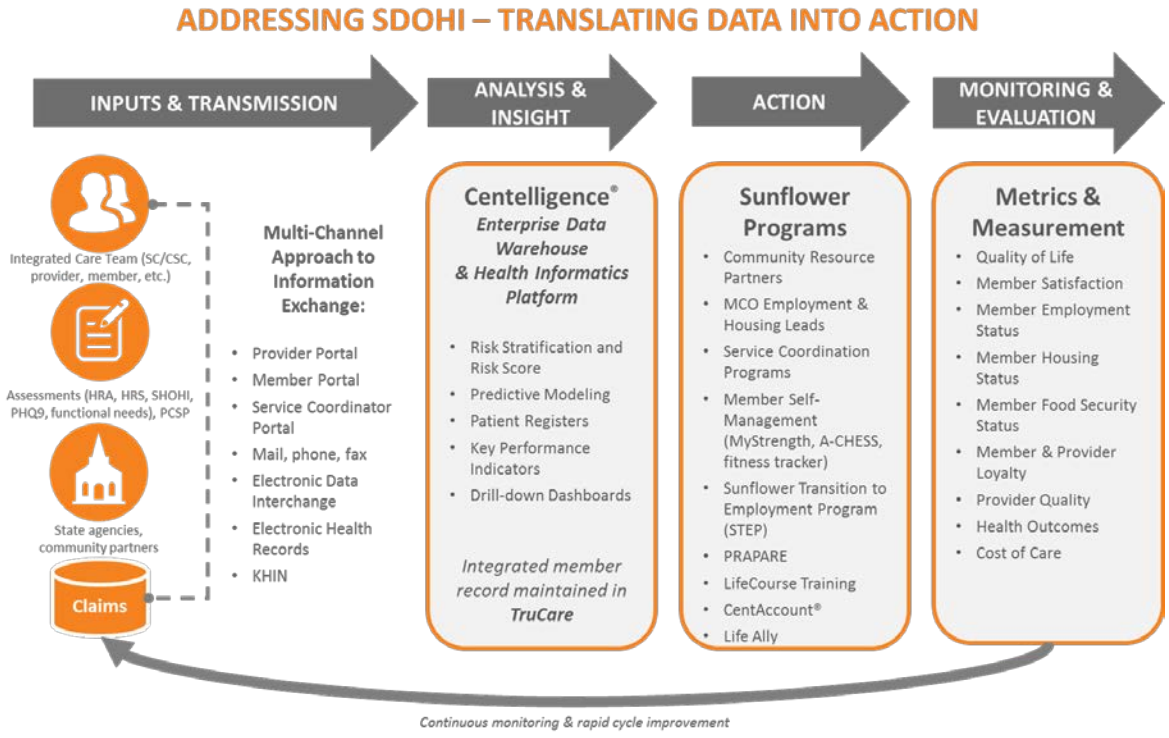
Proposed APM #9: Enhanced Primary Care Program	
1. Topical Area addressed	APMs
2. Description of arrangement and objectives	**Description of Model** Sunflower proposes to implement an Enhanced Primary Care Program with targeted providers who have demonstrated prior success in achieving positive member Outcomes. Modelled after CPC + and recommendations from the American Medical Association, this program will offer PCPs a capitation rate with the opportunity to earn upside and downside shared savings based on performance against defined HEDIS measures, partially delegated Service Coordination responsibilities, and contributions to reductions in ED and IP costs. The enhanced capitation rate would account for team-based care costs, and would be prorated based on variables including the PCP-Member Loyalty Rate and the PCP's acuity mix. Capitation rates would be adjusted annually to account for cost and quality performance. **Alignment with State Hypotheses** Sunflower's objective for the Enhanced Primary Care Program is to offer an innovative approach to engaging PCPs capable of assuming risk for cost of care and quality Outcomes among their member panels.
3. Identify specific populations and services included in the arrangement	**Populations Impacted** a. Geographically Isolated Populations: Providers located in all geographic areas throughout Kansas, including geographically isolated counties, would be eligible to participate in this Program. b. Specified Populations and Subpopulations: Sunflower's Enhanced Primary Care Program will not be limited by member population or sub-population. **Services Included in the APM** Primary care services are proposed to be included in Sunflower's Enhanced Primary Care Program. **Providers Included in the APM** Sunflower's list of providers that will be targeted for participation in the Enhanced Primary Care Program is to be determined.
4. Identify role of Service Coordination	**Role of Service Coordination Strategies** Our PR staff's regular engagement with participating providers, in collaboration with Sunflower's Service Coordinators, includes a variety of activities intended to maximize provider incentive reimbursement. Such efforts include training providers on the

Proposed APM #9: Enhanced Primary Care Program	
strategies, as applicable	Provider Portal tools available to close care gaps and reviewing individual member care gaps that require closure. PR staff, in collaboration with Service Coordinators, also work with providers to identify why member care gaps remain open and take action toward care gap resolution.
5. Identify role of health information technology/health information exchange (HIT/HIE), as applicable	**Role of HIT/HIE** Sunflower requires that providers participating in an APM utilize our secure Provider Portal, through which they may access and export information necessary for closing care gaps and other activities tied to APM performance. For providers participating in the Kansas Health Information Network (KHIN) or the Lewis and Clark Information Exchange (LACIE), Sunflower shares eligibility and utilization data with the Health Information Exchange (HIE).
6. Coordination and collaboration with existing Value Based Purchasing and Quality Initiatives	**Collaboration with Existing VBP/Quality Initiatives** Sunflower's Enhanced Primary Care Program is aligned with KDHE's goal to improve quality Outcomes through innovative contracting strategies.
7. Identify if the model would be implemented statewide or would be a pilot proposal and if the CONTRACTOR(S) has existing experience with the initiative in Kansas or in another state.	**Proposed APM Scope** Sunflower proposes that the Enhanced Primary Care Program be implemented as a pilot with select PCPs. **Stakeholder Engagement Strategy** Sunflower is currently soliciting feedback on our proposed Enhanced Primary Care Program from targeted PCPs. If approved, we anticipate focused provider APM education efforts to extend from August through December 2018. Once deployed, Sunflower's PR staff will frequently engage with APM-participating providers throughout the implementation process with continuous education, training, and technical support to maximize provider success.
8. Identify the proposed metrics, Outcomes or other measurements that the CONTRACTOR(S) will use to (i) determine the payment methodology, if applicable; and (ii) evaluate the effectiveness of the arrangement.	**Proposed APM Metrics** Sunflower will determine provider eligibility to receive shared savings payments based on performance against defined HEDIS measures, delegated Service Coordination outcomes, and cost of care metrics. **Proposed APM Outcomes** Sunflower's proposed outcomes related to this program is an improvement in defined HEDIS measures, Service Coordination outcomes, and cost of care metrics. **Measurement Selection Methodology** Sunflower selected these measurements to align with KDHE's objective to impact quality of care for members through innovative solutions. **Monitoring Provider APM Performance** Sunflower's data analytics team, with support from Centene, continuously monitors provider APM performance against predetermined performance objectives. Sunflower facilitates regular JOC meetings between providers and their PRS and Sunflower's leadership team. JOC meetings are intended to serve as a multi-disciplinary approach to monitoring APM success at the provider level, with staff representing Sunflower teams such as Quality Improvement, Medical Management and Behavioral Health in attendance to discuss the provider's APM performance and improvement opportunities. If improvement is needed at the provider level, the provider's PRS works with them hand-in-hand to improve results.

Proposed APM #9: Enhanced Primary Care Program	
	Impact of Proposed APM on Members Members receiving primary care services from providers participating in this Program will benefit from a high level of quality care delivered by a network of engaged PCPs. **Providing APM Data to the State** Sunflower proposes a similar reporting structure and timeframes to those currently in place for reporting APM-related data to KDHE. Sunflower will comply with all reporting requirements set forth in the RFP. **Stakeholder Engagement Plan** Sunflower seeks every opportunity to empower providers in key decision making processes, such as APM development and associated performance metrics. We will engage those institutional providers that Sunflower has targeted for participation in Bundled Payments for Post-Acute and Rehabilitation Services for feedback on our proposed design.
9. Identify the total number of Members expected to participate in the arrangement and when the arrangement is expected to start.	**Anticipated Member Participation** Sunflower projects that, by end-of-year 2020, at least 10% of Sunflower's members will have received care from a PCP participating in the Enhanced Primary Care Program. **Implementation Timeline (Key Milestones)** Research and Development Activities: Present – 7/2018 Provider Engagement in APM Design: Present – 7/2018 APM Provider Education Efforts: 8/2018 – 12/2018 APM Deployment Phase 1 (to include at least 50% of targeted providers): 1/2019 – 6/2019 APM Deployment Phase 2: 7/2019 – 12/2019

SOCIAL DETERMINANTS OF HEALTH AND INDEPENDENCE (5.7.1.A.2.)

Sunflower uses a whole person, relationship centered approach to identify and support member needs, lifestyle preferences and goals which includes assistance with addressing SDOHI that impact their overall health and well-being, and result in decreased medical expenditures.



Assessing and addressing SDOHI are key functions of Sunflower Service Coordination and will be an expectation of Community Service Coordinators. All Sunflower members receive Service Coordination which supports connection with local resources that can help with employment, housing, food security, transportation, education and advancement in education, as well as other social factors relating to SDOHI. Approaches and programs are tailored to specific Sunflower member subpopulations, as appropriate and through our Centelligence® health informatics platform, Sunflower continuously monitors program outcomes as graphically depicted in ***Figure 5.7.1.A.2 Sunflower Approach to Addressing SDOHI*** below.

Figure 5.7.1.A.2 Sunflower Approach to Addressing SDOHI

To support the goals of KanCare 2.0, we propose the following delivery system innovations and strategies that address SDOHI, as fully described in the tables below:

- Proposed SDOHI Strategy #1: Partner with the Kansas Association for the Medically Underserved (KAMU), the Primary Care Association of Kansas, on the use of Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE) at community health centers (***Table 5.7.1.A.2_A: PRAPARE***)
- Proposed SDOHI Strategy #2: LifeCourse Framework Training for Service Coordinators, Community Health Workers and Community Service Coordinators (***Table 5.7.1.A.2_B: LifeCource Training***)
- Proposed SDOHI Strategy #3: Sunflower Transition to Employment Program (STEP) (***Table 5.7.1.A.2_C: Sunflower Transition to Employment Program (STEP)***)

Table 5.7.1.A.2_A: PRAPARE

Proposed SDOHI Strategy #1: Partner with KAMU, the Primary Care Association of Kansas, on use of PRAPARE at community health centers	
1. Topical Area addressed	SDOHI
2. Description of arrangement and objectives	**Description of Strategy** PRAPARE is a National Association of Community Health Centers (NAC), Association of Asian Pacific Community Health Organizations, and the Oregon Primary Care Association effort to help health centers and other providers collect the data needed to better understand and act on their patients' SDOHI. PRAPARE is both a standardized patient social risk assessment tool consisting of a set of national core measures as well as a process for addressing the SDOHI at both the patient and population levels. PRAPARE helps community health centers and other providers define and document the increased complexity of their patients, transform care with integrated services and community partnerships to meet the needs of their patients, advocate for change in their communities, and demonstrate the value they bring to patients, communities, and payers. PRAPARE supports providers as they are increasingly held accountable for reaching population health goals while reducing costs by giving them a tool to identify upstream socioeconomic drivers of poor outcomes and higher costs. PRAPARE tool data collection establishes standardized SDOHI data collection across health centers and providers that may be used to identify interventions to address population health. PRAPARE emphasizes measures that are actionable and cover the following: Core Measures - Race and ethnicity - Employment

Proposed SDOHI Strategy #1: Partner with KAMU, the Primary Care Association of Kansas, on use of PRAPARE at community health centers	
	• Farmworker status • Neighborhood • Housing status • Stress • Insurance status • Social integration and support • Language preference • Material security (food, utilities, clothing) • Education <u>Optional Measures</u> • Safety • Domestic violence • Incarceration history • Refugee status **Differs from Traditional Service Delivery and/or Payments** Sunflower partnership with KAMU on the use of the PRAPARE tool by community health centers supports member-level SDOHI interventions, as well as population health interventions at the state and local community levels. Traditional service delivery does not routinely identify and address individual patient or population health needs regarding SDOHI. **Strategy Goals** Strategy goals include: • Increase member satisfaction, quality of life and independence • Support providers in achieving better health outcomes for patients and quality goals • Reduce health care costs by addressing SDOHI upstream that may reduce or eliminate the need for medical services downstream (i.e. prevent health service utilization) **Alignment with State Hypotheses and KanCare 2.0** KanCare 2.0 aims to help members achieve healthier, more independent lives by providing services and supports that address SDOHI. To support this goal, PRAPARE will assist providers who serve our members move towards transformed, integrated care and demonstration of value. PRAPARE aligns with the State's hypothesis that expanding Service Coordination to include assisting members with accessing affordable housing, food security, employment and other SDOHI will increase independence and stability, and improve health outcomes.
3. Identify specific populations and services included in the arrangement	**Populations Impacted** Use of the PRAPARE tool and process for addressing SDOHI will impact all Sunflower member populations accessing community health centers in Kansas. KAMU member community health centers operate in urban, rural and frontier areas. KAMU member health center and clinic map showing geographic areas served is on the KAMU website at https://www.kamuonline.org/information-for-consumers/members-clinic-map/ Of Sunflower members accessing community health center services, subpopulations impacted include but are not limited to members who are in Foster Care, pregnant, managing chronic diseases and conditions, experiencing transient housing status,

Proposed SDOHI Strategy #1: Partner with KAMU, the Primary Care Association of Kansas, on use of PRAPARE at community health centers	
	showing high ER utilization, served under the HCBS waivers, jail involved individuals, and individuals impacted by trauma. **Services Included in the Arrangement** In partnership with KAMU, Sunflower will support the use of the PRAPARE tool and process by funding a Practice Transformation Specialist (PTS) at KAMU to provide information to community health centers and promote PRAPARE training for community health center staff. Sunflower will additionally promote the use of PRAPARE through established communication channels with its providers, such as Sunflower provider enewsletters. KAMU, in consultation with NAC, will provide community health center staff training on the use of the PRAPARE tool. **Providers Included in the Arrangement** Kansas community health center professional and non-professional staff. Staff trained to use PRAPARE will be dependent upon individual health center workflows and resources.
4. Identify role of Service Coordination strategies, as applicable	**Role of Service Coordination Strategies** PRAPARE supports Service Coordination activities to assist members with accessing employment, affordable housing, food security, and other SDOHI. **Potential Synergies** PRAPARE aligns with the Sunflower Service Coordination SDOHI data collection through current HRA screening which covers 50% or more of PRAPARE tool core measures including race, ethnicity, employment, insurance status, language, transportation, veteran status and social integration/support. Information captured by the PRAPARE tool for Sunflower members accessing services at community health centers will be made available to Service Coordinators, Community Health Workers and Community Service Coordinators enhancing their ability to address member's SDOHI. (See 5. Identify role of health information technology/health information exchange (HIT/HIE), as applicable below) PRAPARE supports the connection of local community health center resources with Service Coordination activities. Community health centers that administer the PRAPARE tool may also have onsite services to assist with addressing SDOHI.
5. Identify role of health information technology/health information exchange (HIT/HIE), as applicable	**Role of Health Information Technology/Health Information Exchange (HIT/HIE)** Sunflower's goal is to use PRAPARE data with claims data to identify high-cost, high-need patients for customized interventions to address SDOHI. PRAPARE data may additionally be used in the aggregate by geography to identify service shortages such as transportation, and the need for focused interventions. Sunflower will partner with KAMU and community health centers to identify and establish data collection, exchange and integration to inform our Service Coordination activities. HIE/HIT for PRAPARE will support continual sharing of meaningful information in a bidirectional way. Avenues for capturing and sharing data include: • PRAPARE data can be collected in electronic health records (EHRs). PRAPARE EHR templates exist for eClinicalWorks, Epic, GE Centricity, and NextGen. • KAMU may establish a central data warehouse to capture and provide centralized PRAPARE data with functionality to provide supporting reports and analytics. Sunflower would facilitate data exchange with KAMU to import PRAPARE data into Sunflower internal HIT/HIE systems. Data outputs will be used for reports and data stratification. Data will be shared with the State for reporting and Service Coordinators, Community Health Workers and Community Service Coordinators to ensure the members they serve have SDOHI needs addressed at the community health center, and if not, directly assist members with identified SDOHI needs.

Proposed SDOHI Strategy #1: Partner with KAMU, the Primary Care Association of Kansas, on use of PRAPARE at community health centers	
	• Provide access to the PRAPARE tool via the Sunflower provider portal. Placing the PRAPARE tool on the Sunflower provider portal will support the spread of use of PRAPARE to additional provider types. • Add SDOHI domains/questions from the PRAPARE tool to the HRA currently used by Service Coordinators and will be used by Community Service Coordinators to expand collection of PRAPARE data for our members who do not access community health center services.
6. Coordination and collaboration with existing Value Based Purchasing and Quality Initiatives	**Coordination with existing relevant VBP and quality initiatives** The use of PRAPARE is new to the way SDOHI data are collected. Currently, providers do not collect SDOHI through use of a uniform screening tool. PRAPARE implementation positions Sunflower for collection and establishment of baseline PRAPARE SDOHI data to incorporate into relevant VBP strategies and quality initiatives.
7. Identify if the model would be implemented statewide or would be a pilot proposal and if the CONTRACTOR(S) has existing experience with the initiative in Kansas or in another state.	**Statewide or Pilot** The model will cover Kansas community health center service areas. KAMU has identified member community health centers interested in PRAPARE. **Existing Experiences** Sunflower has extensive experience assessing, documenting and addressing SDOHI through its Service Coordination activities. PRAPARE builds and expands upon this experience by using a tool uniquely dedicated to collecting SDOHI member level data and expands impact using aggregated member data to inform population health initiatives. Partnering with our providers to use a tool uniquely tailored to SDOHI is new. **Stakeholder Engagement Strategy** Sunflower will partner with KAMU on stakeholder engagement strategy for community health center service areas, including leveraging existing Sunflower and KAMU forums for information sharing and engagement with community health centers and the individuals they serve. Sunflower will work with KAMU and the community health centers to establish VBP strategies to support the tool. Sunflower will also engage providers to evaluate what incentives would help facilitate expansion of PRAPARE tool in a clinical setting.
8. Identify the proposed metrics, Outcomes or other measurements that the CONTRACTOR(S) will use to (i) determine the payment methodology, if applicable; and (ii) evaluate the effectiveness of the arrangement.	**Proposed Metrics, Measurements and Outcomes** Sunflower will provide a payment incentive to community health centers for accurately collected and submitted PRAPARE tool data. Paper results may be submitted by community health centers with limited capacity/infrastructure with migration to electronic submission in the future. The PRAPARE system generates reports to establish a baseline for measuring outcomes going forward relative to housing, employment, food security, education and other SDOHI. (ex: data to show community tenure in a stable housing situation for six months) **Measurements Selection Methodology** This measurement was selected to incentivize accurate use of the PRAPARE tool and submission of results to Sunflower to inform individual member and population health interventions. **Monitoring** Sunflower will track submission of PRAPARE data via our information technology systems. We will identify the number of unique Sunflower members seen by community health centers and the number of unique PRAPARE tool submissions. We will compare to claims data for unique individuals receiving the PRAPARE tool to identify high utilizers in need of focused interventions. **Impact to Members**

Proposed SDOHI Strategy #1: Partner with KAMU, the Primary Care Association of Kansas, on use of PRAPARE at community health centers	
	Members accessing community health center services will experience increased satisfaction with care, quality of life and independence and better health outcomes. The next phase is to provide an incentive for members that complete the recommended activity to address the SDOHI identified. Each member that acts upon linkages and referrals to services addressing SDOHI may be rewarded with a financial incentive for healthy behavior in their CentAccount®. Sunflower will work with KAMU and providers to identify a way to capture this information. **Providing Data to the State** Sunflower, in partnership with the State will define reports that demonstrate the progress made through the use of the PRAPARE tool and collection of SDOHI data and demonstrated outcomes. Through our Centelligence® analytics and reporting platform, Sunflower can submit program outcome reports to the State, as requested. **Stakeholder Engagement Plan for Receiving Input in the Development of Performance Metrics** In partnership with KAMU, Sunflower will engage community health centers and our members in the development of performance metrics through existing KAMU and Sunflower forums and venues for obtaining stakeholder input. Engagement will include identification of metrics, outcomes or other measures available to community health centers, Sunflower and the State and not be administratively burdensome.
9. Identify the total number of Members expected to participate in the arrangement and when the arrangement is expected to start.	**Number of Members Expected to Participate** 17,244 Sunflower members received care at community health centers in 2016. **Start Date** PRAPARE use by community health centers will start in 2018. **Implementation Timeline and Rollout** • Q2 2018: Begin practice transformation activity through use of KAMU Practice Transformation Specialist (PTS) • 1/1/2019: HIE infrastructure in place to facilitate collection of PRAPARE information for use by Service Coordinators, Community Health Workers, Community Service Coordinators, providers and other stakeholders

Table 5.7.1.A.2_B: LifeCource Training

Proposed SDOHI Strategy #2: LifeCourse Training for Service Coordinators (SCs), Community Health Workers (CHWs) and Community Service Coordinators (CSCs)	
1. Topical Area addressed	SDOHI
2. Description of arrangement and objectives	**Description of Model** LifeShare and Sunflower participate in the Community of Practice that is moving towards integrating *Charting the LifeCourse*, a person-centered framework that highlights Person-Centered Thinking (PCT), into the Kansas system. *Charting the LifeCourse* (LifeCourse) is a framework created to help individuals and families of all abilities and all ages develop a vision for a good life, think about what they need to know and do, identify how to find or develop supports, and discover what it takes to live the lives they want to live. Individuals and families may focus on the current situation and stage of life but may also find it helpful to look ahead to think about life experiences that will help move them toward an inclusive, productive life in the future. Even though it was originally created for people with disabilities, this universally-designed framework may be used by any person or family making a life plan, regardless of life circumstances. The core belief for the LifeCourse framework is that all people have the right to live, love, work, play and pursue their life aspirations. The framework was developed by Missouri Family to Family at the University of Missouri, Kansas City, Institute for Human Development/ *University*

Proposed SDOHI Strategy #2: LifeCourse Training for Service Coordinators (SCs), Community Health Workers (CHWs) and Community Service Coordinators (CSCs)	
	Centers for Excellence in Developmental Disabilities (UCEDDs). The LifeCourse framework takes the person-centered thinking model a step further, encouraging focus on the family and supports surrounding the individual and the family. It offers tools to help individuals and families think about what a good life looks like for them and how to get there. **Differs from traditional service delivery and/or payments** In-person LifeCourse training for Service Coordinators (SCs), Community Health Workers (CHWs) and Community Service Coordinators (CSCs) will support use of person centered thinking to identify the strengths, capacities, preferences, needs and desired outcomes, including assistance with addressing SDOHI, of members and their families. Training covers the core principles and values that are important to think about what it means to support individuals and their families have good lives. Techniques and supporting tools will enable community service coordinators to help Sunflower members chart a life plan and course, and provide them the ability to self-direct and include family and caregivers. LifeCourse focuses on members' whole lives which are made up of specific, connected, and integrated life domains that are important to a good quality of life – daily living, community living, safety and security, healthy lifestyles, social and spirituality, and citizenship and advocacy. **Strategy Goals** LifeCourse training creates provider capacity to discover and build on members' strengths and preferences, increase independence, identify appropriate services and supports that improve health outcomes and quality of life, and provide an opportunity to realize associated cost savings and efficiencies. **Alignment with State Hypotheses and KanCare 2.0** LifeCourse training to SCs, CHWs and CSCs directly supports the State's hypothesis that expanding Service Coordination to include assisting members with accessing affordable housing, food security, employment and other Social Determinants of Health and Independence will increase independence and stability, and improve health outcomes. It also aligns with the hypothesis that providing Service Coordination for all youth in Foster Care will decrease the number of placements, reduce psychotropic medication use, and improve health outcomes for these youth. Members and families plan for present and future life outcomes that take into account all facets of life and have life experiences that build self-determination, social capital, economic sufficiency and community inclusion.
3. Identify specific populations and services included in the arrangement	**Populations Impacted** LifeCourse training will benefit all populations throughout Kansas - in urban, rural and frontier areas. Subpopulations impacted include but are not limited to members who are in Foster Care, pregnant, managing chronic diseases and conditions, experiencing transient housing status, showing high ER utilization, served under the HCBS waivers, jail involved individuals and individuals impacted by trauma. Member's family and caregivers will also be impacted when included as participants, as desired by the member, in the LifeCourse planning process through our Service Coordination activities. **Services Included in the Arrangement** SCs, CHWs and CSCs will receive in-person, interactive LifeCourse training with tools that support conversations with members about their life and assistance addressing SDOHI including employment, housing, food security, education and other SDOHI. Our members will receive Service Coordination from SCs, CHWs and CSCs skilled at eliciting what is important to individuals and their families and caregivers, and how to help set goals for healthy outcomes and community-based living. **Providers Included in the Arrangement**

Proposed SDOHI Strategy #2: LifeCourse Training for Service Coordinators (SCs), Community Health Workers (CHWs) and Community Service Coordinators (CSCs)	
	SCs, CHWs and CSCs will receive LifeCourse training. Sunflower supported LifeCourse training may serve as a platform for providing LifeCourse training to all KanCare 2.0 community service coordinators.
4. Identify role of Service Coordination strategies, as applicable	**Role of Service Coordination Strategies** LifeCourse training enhances the person centered approach to Service Coordination program activities linking members directly to services and supports related to employment opportunities, housing supports, food and nutritional security, education opportunities, and advancement in education levels. It provides member conversation tools to the SCs, CHWs and CSCs and builds member independence through tools that support self-direction accessing community resources addressing SDOHI and setting life goals. **Potential Synergies** LifeCourse training will engage SCs, CHWs and CSC in building working relationships with providers and community organizations to support member life goals. (Section 5.4.1.E.1) LifeCourse Training strengthens skills for discovery of members' needs for assistance with addressing SDOHI (Section 5.4.1). It also supports documentation of member's strengths, needs, goals, lifestyle preferences and other preferences in Plans of Service and development of the Person Centered Service Plan. (Section 5.4.4.1.A.)
5. Identify role of health information technology/health information exchange (HIT/HIE), as applicable	**Role of Health Information Technology/Health Information Exchange (HIT/HIE)** Sunflower will provide an external link to our Community Resource Database to support SCs, CHWs and CSCs in addressing member barriers to and support linkages to services that assist with addressing SDOHI. The Community Resource Database is a fluid database that would be continuously updated as we find additional resources.
6. Coordination and collaboration with existing Value Based Purchasing and Quality Initiatives	**Coordination with Existing Relevant VBP and Quality Initiatives** LifeCourse training complements Sunflower Person Centered Thinking (PCT) Training provided to service coordinators and community health workers using copyrighted training material developed by the Learning Community for Person Centered Practices started in 1989 by Michael Smull and Susan Burke-Harrison at the University of Maryland. PCT training instructs Sunflower SCs and CHWs on how to incorporate person centered thinking into all aspects of our Service Coordination program. As stated in the overview of the strategy above in the description of the model, the LifeCourse framework takes the person centered thinking model a step further, encouraging focus on the family and supports surrounding the individual and the family. LifeCourse training directly supports the proposed LTSS Transition Coordination Incentive Program. A person centered approach to nursing facility repatriation is essential to successful transitions. As members transition back into the community from nursing facilities SCs, CHWs and CSCs will assist with member access to housing, financial supports, eligibility for food assistance programs, transportation and other services that address SDOHI.
7. Identify if the model would be implemented statewide or would be a pilot proposal and if the CONTRACTOR(S) has existing experience with the	**Statewide or Pilot** LifeCourse training will be implemented statewide for SCs, CHWs and CSCs. **Existing Experience** Sunflower engaged in discussions with The Kansas Council for Developmental Disabilities and other LifeCourse stakeholders in Kansas during 2017. We are part of the Community of Practice learning the tools within the LifeCourse framework and producing a plan to implement the framework statewide, including development of training. The Kansas Council for Developmental Disabilities is working with KDADS to make this a universal

Proposed SDOHI Strategy #2: LifeCourse Training for Service Coordinators (SCs), Community Health Workers (CHWs) and Community Service Coordinators (CSCs)	
initiative in Kansas or in another state.	framework in programming for all KanCare members. Community of Practice meetings occurred on the following dates: • April 21, 2017 • May 17 & 18, 2017 • June 21, 2017 • August 16, 2017 • December 6, 2017 • December 7, 2017 **Stakeholder Engagement Strategy** Sunflower will solicit ongoing input on the LifeCourse training during Community of Practice meetings. Sunflower's representative for the Kansas Community of Practice for LifeCourse was named to the National LifeCourse Community of Practice subcommittee on support coordination. Our representative also chairs the support coordination subcommittee for LifeCourse Community of Practice in Kansas. We have also engaged the Sunflower LTSS Advisory Committee which is comprised of Sunflower leadership and the following organizations: • Disability Rights Center • InterHab- association for members with I/DD • Association for Area Agencies on Aging • Kansas Association for Centers of Independent Living • MindsMatter- a provider of TBI services • Topeka Independent Living and Resource Center • Community Living Opportunities • The Alliance for Kansans with Developmental Disabilities • Craig Homecare- A provider of Technology Assistance and IDD HCBS Services • Maxim- A provider of Technology Assistance and other HCBS attendant care • Johnson County Developmental Supports- a Community Developmental Disability Organization and provider of I/DD services
8. Identify the proposed metrics, Outcomes or other measurements that the CONTRACTOR(S) will use to (i) determine the payment methodology, if applicable; and (ii) evaluate the effectiveness of the arrangement.	**Proposed Metrics** Sunflower will use metrics gathered via the following evaluations and data to inform whether LifeCourse training and approaches enhance SC, CHW and CSC support addressing member SDOHI: • Quality of Life Metrics within the Sunflower parent corporation LTSS Key Performance Indicators (KPI) dashboard • Member satisfaction survey data (quality of life, coordination of care, and care management) • HEDIS data • Member employment data • Member food security data • Goal completion **Proposed outcomes** Sunflower's proposed outcomes related to providing LifeCourse training to SCs, CHWs and CSCs will result in identification of appropriate services and supports to address member SDOHI and increased member independence and quality of life. **Proposed Measurements**

Proposed SDOHI Strategy #2: LifeCourse Training for Service Coordinators (SCs), Community Health Workers (CHWs) and Community Service Coordinators (CSCs)	
	All contracted CSC entities will have their CSCs successfully complete LifeCourse training and submit documentation of 100% completion to Sunflower. Sunflower will monitor and document in its information system receipt of LifeCourse training by 100% of SCs and CHWs. **Measurement Selection Methodology** The proposed measurement reflects the implementation phase of the project. Future measurement may be tied to better quality of life outcomes and satisfaction for the members served by SCs, CHWs and CSCs. **Monitoring Outcomes** Sunflower will monitor trainings and outcomes through direct oversight of CSC contract requirements which will include reporting, and trainings for SCs, CHWs and CSCs via: • Provider Satisfaction Surveys • Member Satisfaction Surveys **Impact to our Members** Sunflower members will experience greater independence, increased member satisfaction and better quality of life. **Providing Data to the State** Sunflower will provide updates to the State regarding number and percentage of providers trained. Through our Centelligence® analytics and reporting platform, Sunflower can submit program outcome reports to the state, as requested. **Stakeholder Engagement Plan for Receiving Input in the Development of Performance Metrics** Sunflower will engage LifeCourse Community of Practice participants, as well as members of our LTSS Advisory Committee to ensure that the proposed outcomes and measurements are readily available to providers, Sunflower and the State and are not administratively burdensome.
9. Identify the total number of Members expected to participate in the arrangement and when the arrangement is expected to start.	**Number of Members Expected to Participate** All Sunflower members who are in Service Coordination will receive support from SCs, CHWs and CSCs who will have received LifeCourse Training. **Start Date** Training will begin July 2018 **Implementation Timeline and Rollout** • Quarter 2 2018: Completion of training and competency in the LifeCourse framework and tools by internal LifeShare staff • Quarter 3 2018 begin internal and external provider training Sunflower will continue to partner with the Kansas Council on Developmental Disabilities (KCDD) on regional conferences and activities they convene regarding LifeCourse. We will hold 6 regional trainings for Sunflower providers starting in July 2018. The training will be open to external providers and agencies.

Table 5.7.1.A.2_C: Sunflower Transition to Employment Program (STEP)

Proposed SDOHI Strategy # 3: Sunflower Transition to Employment Program (STEP)	
1. Topical area addressed	SDOHI
2. Description of arrangement and objectives	**Description of Model** Sunflower recognizes that part of our responsibility is to care for the "whole health" of our members. This includes empowering and supporting our members in reaching their health and life goals including education and employment goals. To address social determinants

Proposed SDOHI Strategy # 3: Sunflower Transition to Employment Program (STEP)	
	of health and in particular, independence, Sunflower proposes our new Sunflower Transition to Employment Program (STEP). STEP is a workforce development and employment support resource program to identify and remove employment barriers for all of our members within the communities we serve. STEP will provide employment resources and opportunities to achieve financial independence for our members and provide a connection for our members to existing community resources. The STEP program will offer job training opportunities including community job fairs, GED vouchers, referrals and assistance with career counseling services, transportation to/from job interviews and job fairs and financial management education. To support the STEP program in addition to other employment related initiatives, Sunflower will hire an Employment Specialist to help make employment a reality for members that choose to move back into the workforce. **Differs from traditional service delivery and/or payments** The STEP initiative described will enhance traditional service delivery by equipping members with the resources, tools, and supports needed to fulfill their employment goals – addressing SDOHI and lifting members out of poverty. Payment models used to support the STEP program and other employment initiatives will focus on outcomes and quality of life measures. For example, Sunflower will provide enhanced reimbursement for providers that provide supported employment. **Strategy Goals** The goals of the STEP program include: • Increase of eligible members with part or full time job status • Improved member satisfaction and quality of life • Identify and refer eligible members to the Kansas WORK program **Alignment with State Hypotheses** The STEP program directly aligns with the KanCare 2.0 goal of helping members address SDOHI. This program is designed to support and encourage member independence, improve member quality of life and help outcomes.
3. Identify specific populations and services included in the arrangement	**Populations Impacted** The STEP program will be offered to all Sunflower members as a Value Added Benefit. **Services Included in the Arrangement** STEP will be offered as a value added benefits for members and will include community job fairs, GED vouchers, referrals and assistance with career counseling services. As a Referral Resource, we will connect members with a benefits specialist to learn how their income may impact their benefits, refer members to various organizations such as End Dependence Kansas and Accelerating Opportunities in Kansas as well as assisting with completion of paperwork and follow-up. Components of STEP include: • ***GED Prep Test Vouchers.*** For Sunflower members who are interested in pursuing their GED (cost may be absorbed for the test as part of the AO-K pathways program), Sunflower will provide vouchers to purchase the GED prep test for each testing section (4 sections). • ***Scholarship Program.*** Sunflower members wanting to pursue a college degree would complete a STEP scholarship application. The scholarship will be funded by Sunflower employees through fundraising opportunities held throughout the year at the health plan. • ***Transportation.*** Sunflower will provide members an enhanced transportation benefit to support members needing transportation related to their job search. For example, to/from a job fair or job interview. • ***Job Fairs.*** Sunflower will explore partnerships with retailors such as Wal-Mart, FQHCs, CHCs, and other community organizations throughout Kansas to host job fairs and career counseling seminars. The job fairs will include local employers, career counseling, and job placement as well as support services.

Proposed SDOHI Strategy # 3: Sunflower Transition to Employment Program (STEP)	
	Supported Employment Incentive Program. Sunflower will provide enhanced reimbursement for providers that provide supported employment where members hold a successful job for six months at minimum wage or above for at least 25 hours a week.
4. Identify role of Service Coordination strategies, as applicable	**Role of Service Coordination Strategies** Sunflower's model of care is an integrated, community-anchored system which allows us to effectively address not only the clinical needs of the member, but also social determinants such as employment, transportation and other non-clinical needs that have an impact on health outcomes and quality of life. We put the member at the center of all service coordination activities. Our role is to facilitate collaboration and coordination as appropriate between the member, his/her family, providers, including HCBS providers, and other programs, services and agencies supporting the member. Through the STEP program, service coordination will play a critical role in assisting, educating, and connecting members toward their employment goals. **Sunflower Employment Specialist.** Sunflower's Employment Specialist will work proactively with Service Coordinators, Community Service Coordinators, and the Integrated Care Team to educate about available services and supports throughout the region that can be integrated into the person-centered care planning process. This education includes but is not limited to, engaging members in discussions about pursuing employment, increasing their motivation to work, and offering the full spectrum of employment services (e.g., identifying employment goals, skill development, job placement, and job coaching). **Potential Synergies** Potential synergies include the Kansas WORK and Working Healthy programs in addition to community organizations who support work and employment initiatives in the State. As part of this program, Sunflower will continue to be a referral source for identifying individuals who potentially meet the qualifications of the Kansas WORK and Working Healthy programs. We will refer Sunflower members, provide eligible members in WORK with the choice of Independent Living Counseling (ILC) providers, connection with our WORK FMS provider, and provide the needs assessment and approved member budget.
5. Identify role of health information technology/health information exchange (HIT/HIE), as applicable	**Role of Health Information Technology/Health Information Exchange (HIT/HIE)** Successful to the implementation of the STEP program is active member identification and employment status and the sharing employment data across organizations such as the State of Kansas Automated Information System (AIMS) across the continuum.
6. Coordination and collaboration with existing Value Based Purchasing and Quality Initiatives	**Coordination and Collaboration with Existing Relevant VBP and Quality Initiatives** Sunflower is committed to improving employment opportunities while supporting the health and wellness goals of its members. STEP will be offered as a value added benefits for Sunflower members. The STEP program will align with quality measures within the State's pay-for-performance program and will also provide enhanced reimbursement for providers that provide supported employment where members hold a successful job for six months at minimum wage or above for at least 25 hours a week.
7. Identify if the model would be implemented statewide or would be a pilot	**Statewide or Pilot** The framework of STEP will be implemented throughout the State and available to all Sunflower members. **Existing Experience and Outcomes**

Proposed SDOHI Strategy # 3: Sunflower Transition to Employment Program (STEP)	
proposal and if the CONTRACTOR(S) has existing experience with the initiative in Kansas or in another state.	Sunflower engages in a variety of employment initiatives which benefit our members, other Kansans, and Sunflower as an employer of persons with disabilities. For example: ***Project Search.*** As the Statewide Employment Coordinator for Project Search, Sunflower, has been a leader in providing employment assistance services for our members on the I/DD waiver. Project Search is a nationwide program which supports students with disabilities with obtaining competitive employment when graduating from high school. The project is designed to develop partnerships between school districts and local businesses to offer internship opportunities for students with disabilities who have an employment goal and are transitioning out of high school. Outcomes. In Kansas, Project SEARCH has experienced a 70% success rate. In addition to its statewide coordinator role, Sunflower is a business internship site for Project SEARCH interns and, to date, has hired two interns through a competitive interview process. As the Statewide Employment Coordinator for Project Search, Sunflower, has provided employment assistance to our members on the I/DD waiver for over three years. ***Member Contacts about WORK.*** KDHE has identified for Sunflower the members we have in HCBS, and members on the I/DD waiting list who are potentially eligible for the WORK program. Outcomes. Sunflower provides at least 2 contacts per year to our members who are on a waiting list for HCBS services. We provide education during these contacts about employment supports and opportunities, and about the WORK program. ***Other Employment Activities.*** Sunflower recently participated in a Reverse Job Fair organized by Johnson County Mental Health and Johnson County Development Supports. The job fair allowed persons with disabilities a location to display their employment information, and for businesses to come by and visit with them about their skills. In addition to participating in job fairs, Sunflower assisted in the dissemination of an online survey conducted by The Kansas Employment Systems Change Coalition. The intent of the survey was to identify barriers to employment for persons with disabilities. **Stakeholder Engagement Strategy** Sunflower recognizes that the success of the STEP program and helping members achieve independence is driven by a successful stakeholder engagement strategy. As part of the STEP program, Sunflower will leverage existing community partnerships where we administer our workforce development program for our members with developmental disabilities as part of our STEP program. Sunflower will continue participating and partnering with organizations such as the Transformers Group which provides a venue for various organizations such as Vocational Rehabilitation and the Department of Commerce to work together and provide education across the State for families and individuals interested in employment. Sunflower also participates on the planning committee for Disability Mentoring Days and participates on the Association of People Supporting Employment First (APSE) Kansas Chapter Board to further policy advocacy for Employment First and provide trainings across the State. Sunflower is a member of the Sedgwick County Business Leadership Network and the Greater Kansas City Business Leadership Network. Sunflower was presented the DisAbility Champion award in 2016 from the Greater Kansas City Business Leadership Network for our commitment to employing individuals with disabilities as well as noteworthy programs and initiatives that support their employment practices. Additional current and future partnerships include: **Project SEARCH.** Project SEARCH is a unique, business-led, one-year, school to work program that takes place entirely at the workplace. There are also adult programs assisting young adults to go from day services or home to work. Sunflower/LifeShare is currently the Statewide Coordinator for Project SEARCH. The Statewide Coordinator facilitates monthly phone calls with all the sites in Kansas. There is also a quarterly phone call with the state steering committee. The Statewide Coordinator assists new programs to generate interest in their communities and works with National Project SEARCH to train

Proposed SDOHI Strategy # 3: Sunflower Transition to Employment Program (STEP)	
	new programs across the state. Sunflower also services as a third rotation site for interns interested in employment at Sunflower. Sunflower has hired two individuals from this program. **Workforce Partnership.** Workforce Partnership is committed to building a workforce development system that meets the needs of job seekers and employers throughout the state of Kansas. They provide job search assistance, interviewing skills practice, resume assistance, trainings, and other supports. Sunflower will partner with this organization to provide services for our members. **Accelerating Opportunities in Kansas.** The Kansas Board of Regents, in partnership with the Kansas Department of Commerce, has implemented Accelerating Opportunity in Kansas (AO-K) to transform the delivery system for adult education in Kansas by delivering career and technical education at the same time as adult basic skills instruction within a career pathways framework. The KS Department of Children and Families supports AO-K with TANF funds to provide tuition scholarships for TANF-eligible students who enroll in approved AO-K pathways. Sunflower will identify and refer eligible Sunflower members to this pathways program and provide assistance with applying for scholarships, completing all paperwork and enrolling in the program. Once enrolled the Sunflower Employment Specialist would periodically follow up with the member to see if they need additional support to complete the program such as transportation or childcare services. **GOALS.** Generating Opportunities to Attain Lifelong Success: GOALS is a 3-year pilot project of the Kansas Department for Children and Families funded by the USDA. It provides eligible Kansans with employment assistance and career navigation. Sunflower will contract with GOALS to assign a GOALS Career Navigator with eligible Sunflower members. The GOALS Career Navigator provides guidance and support through four service phases – Stabilize, Train, Place and Sustain. The Career Navigator will be part of the care team for members in case management. The Career Navigator will work closely with the Sunflower Employment Specialist to identify eligible recipients and promote care coordination and data sharing to continue support for program recipients. Sunflower will also contract with GOALS to help recruit and retain skilled employees to work at Sunflower.
8. Identify the proposed metrics, Outcomes or other measurements that the CONTRACTOR(S) will use to (i) determine the payment methodology, if applicable; and (ii) evaluate the effectiveness of the arrangement.	**Proposed Metrics and Measurements** Based on the goals of the STEP program described, the following measures will be used to evaluate effectiveness: Member attendance at events (e.g., job fairs, financial management courses, clothing drives) Transportation utilization Number of interviews Completed job applications Registered and completed GED courses HEDIS measures **Proposed Outcomes** Proposed outcomes based on the metrics and measurement described above include: Improved quality of life as measured by member person centered planning goals Improved member satisfaction and level of independence **Measurement Selection Methodology** Measures described were selected as a consistent method of evaluation as used across clinical and quality programs. **Monitor Outcomes** We will regularly monitor through our Centelligence® data and analytics platform, our LTSS KPI Dashboard, and Quality Improvement Program using standardized reporting and report up through our Quality Improvement Committee.

Proposed SDOHI Strategy # 3: Sunflower Transition to Employment Program (STEP)	
	Impact to Members The anticipated impact on members is helping member achieve their employment goals, maintain their employment status thus improving member satisfaction and quality of life and addressing SDOHI, in particular Independence. **Provide Data to the State** Through our Centelligence® platform, Sunflower will provide data and reporting on a monthly, quarterly, and/or annual basis, as requested by the State. **Stakeholder Engagement Plan for Receiving Input in the Development of Performance Metrics** To develop the STEP performance metrics, Sunflower will seek input from our community partners, Member, Provider, and LTSS Advisory Committee.
9. Identify the total number of Members expected to participate in the arrangement and when the arrangement is expected to start.	**Number of Members Expected to Participate** There are nearly 173,000 adults between the ages of 18-64 in Kansas without a high school diploma or GED and over 700,000 adults between the ages of 25-64 without meaningful postsecondary credentials. **Start Date** 2018 **Implementation Timeline and Rollout** To implement STEP, Sunflower will follow the timeline below: <u>Research and Development:</u> Q1 2018 – Analysis currently available datasets to identify members who are unemployed. Additionally, Sunflower staff and/or Sunflower's Employment Specialists will identify and attend job fairs to develop network of employers across the state to participate in STEP. <u>Community Engagement:</u> Q2 2018 – Develop partnerships with existing community resources including employers, Circle USA, AO-K, and GOALS. As part of this search, we will utilize our Community Resource Database to identify additional organizations across the State to partner with for job clothing drives, job fairs, etc. <u>Training:</u> Q3 2018 – Train SCs and identified CSC partners on STEP. <u>Rollout:</u> Q4 2018 – Rollout program to all Sunflower members as a Value Added Benefit. Sunflower will make members aware of the program through our approved member communications including in the member welcome packet, member newsletter, and other communications via our website. <u>Post Rollout: Data Collection and Program Evaluation:</u> Collect baseline data on metrics identified above for comparative analysis of the STEP program.

BEHAVIORAL HEALTH SERVICES (5.7.1.A.3)

Sunflower coordinates behavioral health (BH) services for a diverse member population including members with co-occurring BH conditions, Serious and Persistent Mental Illness (SPMI) and/or Substance Use Disorders (SUD). Sunflower understands that member health outcomes are impacted by multiple factors beyond physical health and BH conditions, including environmental conditions and social determinants of health and independence (SDOHI). Our approach will include developing a comprehensive, holistic, and integrated approach to delivering BH services that focus on supporting and incentivizing providers that care for members. We will deliver BH services with an organizational commitment to supporting KDHE

goals to provide members with service coordination that will improve health outcomes. To achieve this objective, we propose the following delivery system innovations as outlined in the tables below:

- Proposed BH Services Strategy #1: Parent Management Training—Oregon Model (PMTO) (***Table 5.7.1.A.3_A: Parent Management Training-Oregon Model***)
- Proposed BH Services Strategy #2: Intensive Care Coordination (ICC) Services (***Table 5.7.1.A.3_B: Intensive Care Coordination Services***)
- Proposed BH Services Strategy #3: SUD Provider Quality-Based Pay for Performance (***Table 5.7.1.A.3_C: SUD Provider Quality-Based P4P***)
- Proposed BH Services Strategy #4: Individual Placement and Support (IPS) Model (***Table 5.7.1.A.3_D: Individual Placement and Support Model***)

Table 5.7.1.A.3_A: Parent Management Training-Oregon Model

Proposed BH Services Strategy #1: Parent Management Training--Oregon Model	
1. Topical area addressed	Behavioral Health Services
2. Description of arrangement and objectives	**Description of Model** The PMTO model is a parent training intervention that can be used in family contexts and as a preventative program as well as a treatment program. PMTO interventions can be delivered in multiple settings and focuses on enhancing stability in the home. PMTO interventions have been tailored for specific pediatric clinical symptoms such as conduct problems, externalizing/internalizing problems, acting out within the school setting, antisocial behavior, deviant peer association, theft, delinquency, SUD, and child neglect and abuse. **Differentiating Component from Traditional Service Delivery and/or Payments** Sunflower will offer an enhanced rate for family therapy which is intended to support the administrative costs associated with maintaining fidelity to this evidence-based model. Additionally, Sunflower will reimburse for family therapy without the child present as this is a key component of service delivery under the PMTO model. The PMTO model will be a collaborative effort between both participating providers and Sunflower, to determine membership and track outcomes for the program. **Strategy Goals** The strategy goal is to maintain members (including Foster Care children) in lower levels of care, decrease risk of placement disruption, and strengthen the member family to support high needs pediatric members. We hope to enhance the use of evidence-based practices within Foster Care through the use of PMTO. **Alignment with State Hypotheses** The PMTO model aligns with KDHE's goal of providing BH service coordination for members to decrease the number of placements to improve health outcomes.
3. Identify specific populations and services included in the arrangement	**Populations Impacted** a. Geographically Isolated Populations: For geographically isolated populations, we will offer an enhanced rate to support the cost of travel and support administrative costs. b. Specified/Subpopulations: Members in Foster Care, pediatric members with SUD, delinquency, police arrest history, out-of-home placements, and deviant peer association as well as families of the members expressing stress, depression, and/or BH symptoms will be included in the arrangement. **Services Included in the Arrangement** Services included are outpatient services and home-based services. **Providers Included in the Arrangement**

Proposed BH Services Strategy #1: Parent Management Training--Oregon Model	
	Providers included are providers who serve pediatric members in outpatient and/or community settings. Providers will be trained in delivering the PMTO model. Presently, we have two state contracted agencies who are trained in this model.
4. Identify role of Service Coordination strategies, as applicable	**Role of Service Coordination Strategies** The role of service coordination will be integral to the PMTO model. Service Coordinators will provide service coordination to members receiving treatment from providers using PMTO interventions. Service coordination strategies include providing resource linkage and ensuring members are connected to all needed services to ensure they remain in the least restrictive setting as it is appropriate. **Potential Synergies** Potential synergies with Service Coordinators are increased and in-depth understanding about a member's individual environment and how it impacts improved health outcomes. Specifically, parent therapeutic encounters may help expedite the treatment and personal growth of the member. These parental encounters provide the opportunity to identify and address potential barriers that exist not only for the member but for the family as a whole.
5. Identify role of health information technology/health information exchange (HIT/HIE), as applicable	**Role of HIT/HIE** The role of is HIT/HIE is to ensure access to up-to-date member information including but not limited to care gaps, pharmacy utilization, notification of ER visits, and BH admissions. HIT/HIE components that are necessary include access to the plan of service across systems, use of services, care gaps, and special health care needs.
6. Coordination and collaboration with existing Value Based Purchasing and Quality Initiatives	**Coordination with Existing VBP/Quality Initiatives** The Department of Children and Families (DCF) has provided support for the PMTO model. We coordinated with providers on behalf of the DCF funding as well as the Continuum of Care Grant to increase referrals for members who needed intensive intervention services. We learned of the need for PMTO expansion from visits with the contracted agencies who are part of the DCF funding of PMTO as well as participants of KDHE/DCF high utilizer workgroups that we were a part of. **Collaboration with Existing VBP/Quality Initiatives** Presently, contracted agencies receive DCF funding to serve a prescribed number of members each year. In response, we collaborated by working with providers on behalf of DCF funding of the PMTO model and in support of continuation of the research grant that was through University of Kansas.
7. Identify if the model would be implemented statewide or would be a pilot proposal and if the CONTRACTOR(S) has existing experience with the initiative in Kansas or in another state.	**Proposed Scope of Strategy** Sunflower proposes for the PMTO model to be implemented statewide to maximize participation by providers in urban and rural settings. **Existing Experience with Strategy** N/A **Stakeholder Engagement Strategy** We will include PMTO model information and the availability of this opportunity during provider orientation to increased PMTO opportunities. For providers that participate, we will offer case staffing support to assist them with the delivery of the PMTO model. Staffing support will be on a quarterly basis at minimum as the PMTO model runs for three to five months.

Proposed BH Services Strategy #1: Parent Management Training--Oregon Model	
8. Identify the proposed metrics, Outcomes or other measurements that the CONTRACTOR(S) will use to (i) determine the payment methodology, if applicable; and (ii) evaluate the effectiveness of the arrangement.	**Proposed Metrics/Measurements** Based on the goals of the strategies described, the following measures will be used to evaluate effectiveness: • Increased parent/child interactions • Decreased time in out of home placement • Improved child functioning scores (CAFAS) • Reduced acute hospital admissions and length of stay **Proposed Outcomes** Sunflower's proposed outcomes are based on the PMTO model's reported treatment group conducted by our two state contracted agencies that showed improved outcomes and cost savings when compared to children/families in the control group. Outcomes are a result of a five-year study that concluded in 2016. Results of the five-year study are as follows: • Increased parent/child interactions - Average of 34 interactions • Decreased time in out-of-home placement - Return home was significantly more common for families in the PMTO model treatment group (70% vs. 30%) - Families who completed PMTO model treatment were more likely to have their children return home (81% vs. 44%) • Improved child functioning scores (CAFAS) - PMTO model treatment completion was also associated with improvements in child functioning (CAFAS) (67 vs. 22 points) • Reduced acute hospital admissions/readmissions and length of stay - Hospitalization rates were lower for the treatment group (11.4% vs. 14.3%) - Average number of hospital admissions were lower for the treatment group (1.9 vs. 2.7) - Percent with readmissions was lower for the treatment group (37.9% vs. 47.9%) - The average days hospitalized across all admissions was lower for the treatment group (36.6 days vs. 57.8 days) - The cumulative total of days hospitalized was lower for the treatment group (2,124 days vs 2,774 days) **Measurement Selection Methodology** Our measurement selection methodology was based on the PMTO model treatment group experience that showed improved outcomes and a projected cost savings opportunity of more than $2.6 million per year. **Monitoring Provider Performance** We will monitor provider performance by monitoring outcomes through a quarterly report from providers to Sunflower. Specifically, we will monitor member reduced acute hospital admissions/readmissions, length of stay, improved CAFAS scores, and parent engagement. **Impact on Members** A significant number of additional Sunflower members will receive services from providers using PMTO interventions that will improve member care and quality outcomes by keeping members in lower levels of care, decreasing risk of placement disruption, and strengthening families to support high needs children. **Providing Data to the State**

Proposed BH Services Strategy #1: Parent Management Training--Oregon Model	
	Sunflower proposes a similar reporting structure and timeframes to those currently in place for reporting VBP data to KDHE. Sunflower will comply with all reporting requirements as described in the RFP. **Stakeholder Engagement Plan** Sunflower will engage contracted agencies to refer potential members for PMTO interventions; work with DCF on the members who are going into family preservation; and make referrals to providers delivering PMTO interventions; and engage families through service coordination to participate in the PMTO model. In order to maintain engagement, Sunflower will meet quarterly with providers to discuss program outcomes as well as any barriers to treatment. Sunflower will work to address any issues or barriers identified promptly.
9. Identify the total number of Members expected to participate in the arrangement and when the arrangement is expected to start.	**Anticipated Member Participation** Due to the intensity of the PMTO model, we anticipate limited member participation (approximately 30 members). PMTO model treatment sessions are weekly for a 16-week period. We will work with our providers trained in the PMTO model to refer members and ensure providers have the bandwidth to properly treat members based on the scope of the model. **Implementation Timeline** Research and Development Activities: Research and development activities have been completed. Provider Engagement and/or Enrollment: Sunflower has begun contracting and engagement processes. We have two providers in network trained in the PMTO model. Provider Education Efforts: We have begun provider education as we have two provider trained in PMTO interventions. We will continue to expand education efforts by assessing our members who may benefit from the PMTO model and refer them as needed to the appropriate providers. Deployment Phase 1 (30-45 days): • Receipt of approval from KDHE for enhanced rate service within 30 days • System configuration for the code to be used that will bill at the enhanced rate within 45 days Deployment Phase 2 (90 days): • Revising contracts with the providers identified • Rate configuration Deployment Phase 3 (Nine-month period) • Identifying families who would benefit from the service and engaging in treatment • Outcomes tracking and analysis • Quarterly meetings between Sunflower and providers Evaluation of cost savings

Table 5.7.1.A.3_B: Intensive Care Coordination Services

Proposed BH Services Strategy #2: Intensive Care Coordination Services	
1. Topical area addressed	Behavioral Health Services
2. Description of arrangement and objectives	**Description of Model** ICC services are designed to avoid unnecessary and inappropriate admissions to psychiatric units, state hospitals, inpatient SUD treatment, social detoxification, and/or the emergency room (ER) by connecting members receiving ICC services to resources in their home communities. ICC services reduce the number of admission days in a

Proposed BH Services Strategy #2: Intensive Care Coordination Services	
	psychiatric unit or state hospital and improve quality of life. Even though members may have access to services, the member population we will target often does not engage in needed services due to "burned bridges" with community providers and the inability to access needed services without assistance and/or intervention. **Differentiating Component from Traditional Service Delivery and/or Payments** ICC services for members who are without resources will be provided and/or purchased through partnerships with community agencies to coordinate physical health, safety, housing, employment, legal, and financial issues. We will purchase ICC administrative support services including: • Financial oversight and management of personnel expenses, subcontracts, client service dollars, accounting and reporting. • Technical resources including data base development, IT services, data tracking, reporting, and technical assistance to subcontractor(s). • Clinical Supervision of our staff and support to subcontractors. • Quality Improvement process including data utilization and review, corrective feedback, benchmark monitoring, and data entry oversight. **Strategy Goals** To link members to needed services within their communities, thereby improving health outcomes and reducing the potential use of inappropriate and costly services. **Alignment with State Hypotheses** ICC services align with KDHE's goal of expanding BH services and BH service coordination to improve health outcomes. We will work with members and their providers to determine individualized goals to increase member independence and stability to improve overall quality of life.
3. Identify specific populations and services included in the arrangement	**Populations Impacted** a. Geographically Isolated Populations: Purchased ICC services can be delivered in provider offices to reach members and their families even in rural settings as well as in community-based settings. b. Specified/Subpopulations: We will target members diagnosed with co-occurring SUD and BH issues who may not qualify or for whom SUD treatment or BH services may not be appropriate. This includes members who frequently appear at local social detoxification programs, local jails, and hospital ERs who are at-risk for being admitted to state or local hospitals due to co-occurring BH and SUD issues, multiple unsuccessful treatment episodes, health-related issues and/or the presence of SDOHI such as homelessness. **Services Included in the Arrangement** Services included are settings such as Federally Qualified Health Centers (FQHCs), Community Mental Health Centers (CMHCs), Health Homes, and other provider offices that offer needed services. **Providers Included in the Arrangement** Providers will include FQHCs, CMHCs, Health Homes, other primary care provider offices, physical health specialists, BH specialists, and SUD providers.
4. Identify role of Service Coordination strategies, as applicable	**Role of Service Coordination Strategies** We will establish relationships with local jails, police and sheriff departments to develop a strategy to reduce public nuisance violations involving members. This would allow for coordination with a Sunflower Service Coordinator in place of arrest for minor violations to avoid the use of costly resources such as transporting to, and services through, community or State Hospitals. We will work collaboratively with Osawatomie State Hospital and Larned State Hospital discharge planners, state and local hospital social workers, jails, police departments, sheriff departments, and CMHCs. Our Service

Proposed BH Services Strategy #2: Intensive Care Coordination Services	
	Coordinators will serve as a central point of contact and work to facilitate effective communication with the multiple stakeholders often involved with this population (Psychiatrists, CMHCs, DFC workers, Probation/Parole Officers, Disability Determination Services, local health departments, etc.). **Potential Synergies** Potential service coordination synergies include linking members to needed community resources. To achieve this effectively, we will continue to assess the whole person to determine individualized service needs such as, but not limited to, locating safe housing outside of State Hospitals and/or jails and by providing service coordination until the SUD assessment can be completed and an appropriate recovery plan is developed. ICC services help determine needs for resources such as permanent/transitional housing, access to healthcare, and providers that are having a positive impact on the member.
5. Identify role of health information technology/health information exchange (HIT/HIE), as applicable	**Role of HIT/HIE** The role of is HIT/HIE is to ensure access to up to date physical health and BH member information including but not limited to care gaps, pharmacy utilization, notification of ER visits, and BH admissions. A HIT/HIE component that is necessary is the ability to provide a "picture of the member" from a claims perspective.
6. Coordination and collaboration with existing Value Based Purchasing and Quality Initiatives	**Coordination with Existing VBP/Quality Initiatives** ICC services was similar to the Opioid Grant, in which we initiate and support member referrals to and from Sunflower. **Collaboration with Existing VBP/Quality Initiatives** We currently have a contract for ICC services with one provider. We will continue to work with this provider to expand ICC services. In addition, we have quality incentives with CMHCs and will incorporate ICCs services.
7. Identify if the model would be implemented statewide or would be a pilot proposal and if the CONTRACTOR(S) has existing experience with the initiative in Kansas or in another state.	**Proposed Scope of Strategy** This model will be implemented in Wyandotte, Johnson, Shawnee, Douglas, Sedgwick, Ellis, Barton, and Saline Counties. **Existing Experience with Strategy** Sunflower has experience with service coordination, however, does not possess the bandwidth to perform ICC services, which is more intensive than regular service coordination. As known and respected providers were identified, we recognized and understood the value of their ICC service experience to serve our members. **Stakeholder Engagement Strategy** Our stakeholder engagement strategy has been to support and recognize the potential achievements of ICC services and contract with our targeted counties as detailed in question seven. We understand that that the key to the success of this program is connecting members with needed services within the community through referrals and providing continued service coordination to address system barriers that present for members that we have referred for ICC services.
8. Identify the proposed metrics, Outcomes or other measurements that the CONTRACTOR(S) will use to (i) determine the	**Proposed Metrics/Measurements** Based on the goals of the strategies described, the following measures will be used to evaluate effectiveness: • Members will be assessed and have an appropriate recovery plan developed • Members will be in a transitional or permanent housing situation • Members will not be admitted or re-admitted to a state hospital after the initiation of ICC services

Proposed BH Services Strategy #2: Intensive Care Coordination Services	
payment methodology, if applicable; and (ii) evaluate the effectiveness of the arrangement.	• The number of hospitalization days will be reduced for necessary state hospital admissions that are necessary for stabilization **Proposed Outcomes** Our proposed outcomes related to ICC services are based on results from Heartland Regional Alcohol and Drug Assessment Center's semi-annual data review that shows the impact of Intensive Case Management services: • Total number of members served (33 in 2016) • Total/percentage of members who obtained or maintained permanent housing (percentage maintained at or above 40%) • Total/percentage of members who obtained or maintained transitional housing (percentage maintained at or above 40%) • Total/percentage of members who were engaged in Recovery Oriented Systems of Care (ROSC) services (percentage maintained at or above 80%) • Total/percentage of members who were engaged in BH services (percentage maintained at or above 65%) • Total percentage of members who were engaged in SUD treatment (100% of members were engaged) • Total of members who were assisted to secure primary medical care and the number of people who attained primary medical care (baseline) (percentage improved by 5%) • Total number of members who had an interest in seeking earned income and the number of people who attained earned income (baseline) (percentage maintained at or above 30%) • Total number of members who disengaged from ICC services (percentage maintained at or above 30%) **Measurement Selection Methodology** Our measurement selection methodology was based on our goal to reduce the use of inappropriate and costly services while improving the member's quality of life. **Monitoring Provider Performance** All services purchased are tracked and monitored on a quarterly basis. Provider performance will be monitored via data utilization and review, corrective feedback, benchmark monitoring, and data entry oversight. **Impact on Members** A significant number of additional Sunflower members will receive services from providers using ICC services that will improve member care and quality outcomes as described throughout Table 2. **Providing Data to the State** Sunflower proposes a similar reporting structure and timeframes to those currently in place for reporting VBP data to KDHE. We will comply with all reporting requirements as described in the RFP. **Stakeholder Engagement Plan** We will meet quarterly in each region with key collaborative providers to discuss service access and system barriers. During quarterly meetings, we will engage providers to receive input in the development of performance metrics.
9. Identify the total number of Members expected to participate in the arrangement and	**Anticipated Member Participation** Sunflower anticipates approximately 50 members to be referred throughout a calendar year for ICC services.

Proposed BH Services Strategy #2: Intensive Care Coordination Services	
when the arrangement is expected to start.	**Implementation Timeline** Research and Development Activities: Research and development activities have been completed. Provider Engagement and/or Enrollment for ICC Services: This will be completed by 12/31/17. Provider Education Efforts: Provider education efforts have been completed. Deployment Phase: Present--01/2018 (will be an ongoing and annual agreement)

Table 5.7.1.A.3_C: SUD Provider Quality-Based P4P

Proposed BH Services Strategy #3: SUD Provider Quality-Based Pay for Performance	
1. Topical area addressed	Behavioral Health Services
2. Description of arrangement and objectives	**Description of Model** We will offer a SUD Quality-Based P4P Program that enhances quality of care through a focus on SUD preventative and stabilization services. Services may include Medication-Assisted Treatment, Peer Mentoring, Recovery Coaching, Detoxification, Stabilization, and short-term residential services. Participating providers are rewarded through shared savings reimbursement for achieving predetermined, KDHE-aligned quality target results. **Differentiating Component from Traditional Service Delivery and/or Payments** The differentiating component will be our coordination and co-development approach with providers. Specifically, we will proactively involve select providers in the development of processes. For example, we have started to reach out to select SUD providers and members who may benefit from the provider's treatment. In addition, we have worked with Central Kansas Foundation around P4P and co-occurring BH conditions. We have also co-located service coordinators in high traffic areas such as but not limited to the ER to serve members. **Strategy Goals** To link members to needed services within their communities to improve health outcomes and reduce the potential use of inappropriate and costly services. In addition, we recognize that provider investment and member health are intrinsically connected the delivery of quality health care. **Alignment with State Hypotheses** This model aligns with KDHE's goal of expanding BH services and BH service coordination to improve health outcomes. We will work with members and their providers to determine individualized goals to increase member independence and stability to improve overall quality of life.
3. Identify specific populations and services included in the arrangement	**Populations Impacted** Geographically Isolated Populations: Preferred providers in rural and semi-urban areas will be selected to participate in this model. Specified/Subpopulations: We will target members who with co-occurring SUD and BH conditions. We will also target members who are at-risk for being admitted to state or local hospitals due to co-occurring BH and/or SUD, member who have multiple unsuccessful treatment episodes, and/or members with health-related conditions and/or are experiencing homelessness. Other populations include members who frequently show up in local social detoxification programs, local jails, and the ER. **Services Included in the Arrangement** Services included are settings such detoxification units and hospital settings. Other settings for service coordination may include provider offices, CMHCs, and FQHCs. **Providers Included in the Arrangement** Providers included in the arrangement will include SUD providers, psychiatrists with a

Proposed BH Services Strategy #3: SUD Provider Quality-Based Pay for Performance	
	focus in SUD, and professionals with a specialty of SUD such as Licensed Addiction Counselors, and/or Licensed Clinical Addiction Counselors.
4. Identify role of Service Coordination strategies, as applicable	**Role of Service Coordination Strategies** The role of service coordination will be integral to this model and participating providers. Service Coordinators will provide service coordination s to members receiving services from participating providers. Service coordination strategies include providing resource linkage and ensuring members are connected to all needed services to achieve member desired recovery goals. Service Coordinators will be the central point of contact and work to facilitate effective communication with the member's providers. **Potential Synergies** Potential synergies of a SUD Quality-Based P4P Program approach includes provider buy-in and investment to connect with other community providers to wrap services around the members who are high risk to address possible SDOHI and/or other barriers to care in order to share savings. Another potential synergy is through telemedicine. For example, a Sunflower Service Coordinator would coordinate with SUD providers (participating in this incentive) for a member to receive elements of medication-assisted treatment (MAT) services, such as a psychiatric evaluation, through telemedicine to treat their SUD and/or co-occurring BH condition. The Sunflower Service Coordinator would educate the member about what the telemedicine appointment would look like/what to expect before the appointment and would also follow up with the member and the provider after the appointment to ensure all needs are met and/or answer questions if needed.
5. Identify role of health information technology/health information exchange (HIT/HIE), as applicable	**Role of HIT/HIE** The role of is HIT/HIE is to ensure access to up to date physical health and BH member information including but not limited to care gaps, pharmacy utilization, notification of ER visits, and BH admissions/readmissions for SUD related events.
6. Coordination and collaboration with existing Value Based Purchasing and Quality Initiatives	**Coordination with Existing VBP/Quality Initiatives** Kansas was awarded a Substance Abuse and Mental Health Services Administration (SAMHSA) grant for opioid intervention and this VBP would enhance the range of services offered in that grant. Sunflower has a board certified addictionologist who can also assist with Project ECHO for opioid use. In addition, our parent company initiated an Opioid Prevention Program in 2016 with the goal of creating best practices to address the opioid epidemic. The Opioid Program approaches opioid use from three angles: pharmacy/policy, health care provider, and member. The first phase of the program includes the implementation of an updated narcotic analgesic pharmaceutical policy to reduce the amount of opioids that members can receive. Phase two of the program includes utilization of a proprietary predictive data science model to identify members at high risk for opioid use and intervene appropriately. **Collaboration with Existing VBP/Quality Initiatives** Four Sunflower providers were awarded the SAMHSA grant that centered on opioid intervention as described above. Sunflower will collaborate with the SAMHSA grant-awarded providers to focus the work of the Sunflower Service Coordinator and the Community Service Coordinator on members participating in the grant and provide additional resources not allocated in the grant such as but not limited to data sharing, SDOHI resources, and the expertise of our Sunflower Addictionologist.
7. Identify if the model would be implemented	**Proposed Scope of Strategy** Our proposed SUD Quality-Based P4P Program providers will be implemented statewide. **Existing Experience with Strategy**

Proposed BH Services Strategy #3: SUD Provider Quality-Based Pay for Performance	
statewide or would be a pilot proposal and if the CONTRACTOR(S) has existing experience with the initiative in Kansas or in another state.	Sunflower's current P4P program for CMHCs underscores our experience with the P4P model. All 26 of Kansas' CMHCs participate in our VBP program, which reimburses CMHCs a bonus payment when they achieve target quality results by measuring the following which includes but is not limited to: Follow-up after hospitalization for mental illness, reduction of psychiatric readmissions, and service of members' waitlisted for Psychiatric Residential Treatment Facility (PRTF) admission. **Stakeholder Engagement Strategy** To engage stakeholders, we have been working with the Kansas Association of Addiction Professions, Association of Kansas CMHCs, and the Behavioral Health Association of Kansas to identify gaps and areas of need as well as other grants that we can enhance. One example of our collaboration with these entities includes the Adult Continuum of Care which had representatives from CMHCs, SUD providers, state legislators, and other community providers. Sunflower is currently soliciting feedback SUD Quality-Based P4P Program to select providers who will be identified by the volume of members served, their location geographically in the state, and their participation in the current grants and quality initiatives. Once deployed, our Provider Relations team will engage with participating providers throughout the implementation process with continuous education, training, and technical support to maximize provider success.
8. Identify the proposed metrics, Outcomes or other measurements that the CONTRACTOR(S) will use to (i) determine the payment methodology, if applicable; and (ii) evaluate the effectiveness of the arrangement.	**Proposed Metrics/Measurements** Based on the goals of the strategies described, the following five measures will be used to evaluate effectiveness: • Reduction in ER utilization • Reduction in hospital admissions • Reduction in hospital readmissions • Initiation and Engagement of Alcohol and other Drug Dependence Treatment (IET) • Follow-up after Hospitalization for Mental Illness Each measure will be assigned an incentive dollar amount and target percentage. Each performance threshold (low tier; HEDIS 50th percentile and high tier; HEDIS 75th percentile) pays an increased percentage of the potential incentive dollar amount (providers meeting the low tier threshold are eligible to receive 50% of the incentive dollar amount; those meeting the high tier threshold are eligible to receive 100% of the incentive dollar amount). Incentives will be paid on each compliant member event once the target has been met. **Proposed Outcomes** For HEDIS measures, our proposed outcomes supports expanded provider performance meeting established NCQA HEDIS guidelines for achieving 50th percentile (low tier) or 75th percentile (high tier) guidelines within each HEDIS measure. For the measures below, we propose the following outcomes for this model to demonstrate a: • Reduction in ER utilization rates • Reduction in hospital admissions • Reduction in hospital readmission rates within 30 days of discharge **Measurement Selection Methodology** Our measurement selection methodology was based on our goal to reduce the use of inappropriate and costly services while improving the member's quality of life. **Monitoring Provider Performance** Provider performance will be monitored via data utilization and review, corrective feedback, benchmark monitoring, and data entry oversight. All services will be tracked and monitored on a quarterly basis. **Impact on Members**

Proposed BH Services Strategy #3: SUD Provider Quality-Based Pay for Performance	
	A significant number of Sunflower members will receive SUD services from select providers that will improve member care and quality outcomes. **Providing Data to the State** Sunflower proposes a similar reporting structure and timeframes to those currently in place for reporting VBP data to KDHE. Sunflower will comply with all reporting requirements as described in the RFP. **Stakeholder Engagement Plan** Sunflower will work with the CMHCs, SUD providers, and members to provide education about the importance of integrated care. Primary Care Physicians will be included in updates pending members sign a release of authorization to disclose their information based on CFR 42 requirements.
9. Identify the total number of Members expected to participate in the arrangement and when the arrangement is expected to start.	**Anticipated Member Participation** Anticipated member participation are members with SUD and co-occurring BH conditions. We anticipate beginning with a focus group of approximately 50 members. **Implementation Timeline** Research and Development Activities: Research and development activities have been completed. Provider Engagement and/or Enrollment: Present-90 days Provider Education Efforts: Present-90 days Deployment Phase 1: We will develop SUD Quality-Based P4P Program payment structure to be active by Q2 of 2018. Deployment Phase 2: SUD Quality-Based P4P Program contracts will be initiated and active in Q3 of 2018.

Table 5.7.1.A.3_D: Individual Placement and Support Model

Proposed BH Services Strategy #4: Individual Placement and Support Model	
1. Topical area addressed	Behavioral Health Services
2. Description of arrangement and objectives	**Description of Model** The IPS model is an evidence-based approach to supported employment for members with BH conditions and serious mental illness (SMI). The IPS model provides support to members who face hardships such discrimination, poverty, isolation, stigmatization, and demoralization due to their BH condition/SMI. Specifically, the IPS model works to achieve steady and meaningful employment for members in mainstream competitive part-time or full-time jobs. IPS model interventions focus on increasing member self-esteem and decreasing poverty, allowing them to become productive contributors within their communities. **Differentiating Component from Traditional Service Delivery and/or Payments** We will expand and incentivize providers by paying an enhanced rate for IPS services. Expanded services includes enhanced payment for present day non-participating CMHCs (beyond our current 12 participating CMHCs) that are currently in process of becoming certified in the IPS model. We will be providing additional fidelity review support for newly participating CMHCs. **Strategy Goals** To connect members with BH conditions to needed support in order to gain their desired employment. **Alignment with State Hypotheses** The IPS model aligns with KDHE's goal to increase employment for members with BH service needs. We will work with members to determine their individual goals as it relates to increasing their independence and improving health outcomes.

Proposed BH Services Strategy #4: Individual Placement and Support Model	
3. Identify specific populations and services included in the arrangement	**Populations Impacted** a. Geographically Isolated Populations: Members with SPMI, co-occurring BH conditions, and SUD in rural areas will be included in the arrangement. b. Specified/Subpopulations: Members with SPMI, co-occurring BH conditions, and SUD will be included in the arrangement. **Services Included in the Arrangement** All services within the scope of their practice and maintaining fidelity to the IPS model will be included in the arrangement. **Providers Included in the Arrangement** CMHCs who have been identified as certified in the IPS model will be included in the arrangement.
4. Identify role of Service Coordination strategies, as applicable	**Role of Service Coordination Strategies** The role of service coordination will be integral to this model and participating providers. Service Coordinators will provide service coordination to members receiving services from participating providers. Service coordination strategies include providing resource linkage and ensuring members are connected to all needed services to achieve member desired recovery goals. Service Coordinators will be the central point of contact and work to facilitate effective communication with the member's providers. **Potential Synergies** Potential synergies at the local level include the ability to have an approach that is Fidelity Model focused. In addition, Sunflower staff have been trained in the Fidelity Model to ensure comprehensive service coordination approaches. Additionally, our staff have been trained on inter-rater reliability (IRR) to ensure a consistent understanding of IRR as well as consistent application of IRR.
5. Identify role of health information technology/health information exchange (HIT/HIE), as applicable	**Role of HIT/HIE** The role of is HIT/HIE is to ensure access to up to date member information including but not limited to care gaps, pharmacy utilization, notification of ER visits, and BH admissions. HIT/HIE components that are necessary are the assurance of transparency related to member utilization information to inform providers of potential barriers to employment such as health conditions that may impact member treatment and positive outcomes.
6. Coordination and collaboration with existing Value Based Purchasing and Quality Initiatives	**Coordination with Existing VBP/Quality Initiatives** Our inclusion of the IPS model enhanced rate supports coordination and support of the existing IPS model that was established through a grant funded program. **Collaboration with Existing VBP/Quality Initiatives** We collaborated with the Kansas Department for Aging and Disability Services (KDADS) in terms of a technical assistance SAMHSA grant, which streams funding to IPS technical assistance. Specifically, we participated in KDADs training as well as follow-up activities for fidelity reviews. We will continue to support providers and organizations that are working towards fidelity.
7. Identify if the model would be implemented statewide or would be a pilot proposal and if the CONTRACTOR(S) has existing experience with the	**Proposed Scope of Strategy** Our proposed scope includes CMHCs who have gained certification and have met fidelity to the IPS model. **Existing Experience with Strategy** Sunflower staff have been trained in the IPS model. Our staff also conduct fidelity reviews with providers to ensure service delivery that is true to the model. **Stakeholder Engagement Strategy** We will encourage our members to participate in IPS interventions and we will educate members on how employment impacts their Medicaid benefits. To support this goal,

Proposed BH Services Strategy #4: Individual Placement and Support Model	
initiative in Kansas or in another state.	Sunflower staff were provided comprehensive education on matters related to members transitioning from Medicaid to employment.
8. Identify the proposed metrics, Outcomes or other measurements that the CONTRACTOR(S) will use to (i) determine the payment methodology, if applicable; and (ii) evaluate the effectiveness of the arrangement.	**Proposed Metrics/Measurements** Based on the goals of the strategies described, the following measures will be used to evaluate effectiveness: • Employment at any time • Tenure of longest held job • Total hours worked **Proposed Outcomes** Our proposed outcomes for the IPS model are described below. Percentages are based on the Supported Employment Fidelity Scale, which provides an approximate range of success for members to reach their work goals. • Total members to establish part-time and full-time employment within six months of interventions (outcome information is gathered on a one to five scale from less than 64% to 95% or more, to measure full time job status) • Total members who maintain employment for one year (outcome information is gathered on a one to five scale from less than 30% to 65% or more, to measure work hours in the community) **Measurement Selection Methodology** Measurement selection methodology was made through the IPS model and from information taken from automated information management system (AIMs). **Monitoring Provider Performance** We will monitor provider performance during fidelity audits as well as through AIMS data provided from the state. **Impact on Members** A significant number of additional Sunflower members will receive services from providers using IPS model interventions that will potentially increase a member's income, improve their self-esteem, and increase their social and quality of life. In addition, members may have increased control of their BH symptoms and reduced substance use. **Providing Data to the State** Sunflower proposes a similar reporting structure and timeframes to those currently in place for reporting VBP data to KDHE. Sunflower will comply with all reporting requirements as described in the RFP. **Stakeholder Engagement Plan** Sunflower will work with providers to maintain fidelity to the IPS model by offering refresher IPS trainings and we will work with members to engage IPS interventions at their respective CMHCs.
9. Identify the total number of Members expected to participate in the arrangement and when the arrangement is expected to start.	**Anticipated Member Participation** We anticipate approximately 100 members to participate. **Implementation Timeline** Research and Development Activities: Research and development activities have been completed. Provider Engagement and/or Enrollment: This has been completed. Provider Education Efforts: This has been completed. Deployment Phase: Presently ongoing.

LONG-TERM SUPPORTS AND SERVICES (LTSS) (5.7.1.A.4)

Sunflower draws on the experience, best practices, and innovations of our affiliates serving over 233,000 LTSS members in 8 states, as well as the expertise of our local staff who have extensive backgrounds in LTSS programs and our provider and service partners across the state. Highlighted in the table below are current and proposed LTSS delivery system innovations and best practices that will be enhanced and implemented for KanCare 2.0. Focused on quality and access across the LTSS delivery system, current and proposed initiatives include:

- Proposed LTSS and APM Strategy #1: LTSS Transition Coordination Incentive Program (Alternative Payment Model) (***Table 5.7.1.A.4_A: Alternative Payment Models***)
- Proposed LTSS and APM Strategy #2: Extraordinary Funding Innovative Payment Program (***Table 5.7.1.A.4_B: Extraordinary Funding Innovative Payment Program***)
- Proposed LTSS Strategy #3: Sunflower Select Nursing Home Partners (***Table 5.7.1.A.4_C: Sunflower Select Partners Nursing Facility Preferred Referrals Quality Program***)
- Proposed LTSS Strategy #4: Sunflower Select In Home Care Partners (***Table 5.7.1.A.4_D: Sunflower Select Partners In-Home Care Preferred Referral Quality Program***)
- Proposed LTSS Strategy #5: Fiscal Management Services (FMS) Quality Program (***Table 5.7.1.A.4_E: Fiscal Management Services (FMS) Self-Evaluation, Monitoring, and Quality Program***)
- Proposed LTSS Strategy #6: Home Modification Services (***Table 5.7.1.A.4_F: Improving the Value and Impact of Home Modification Services***)

Table 5.7.1.A.4_A: Alternative Payment Models

Proposed LTSS Strategy #1: Alternative Payment Models	
See 5.7.1.A.1, *Table 5.7.1.A.1_F* above, for full details	Sunflower proposes to implement a LTSS Transition Coordination Incentive Program to provide transition coordination services for members moving out of a nursing facility (NF) or other institutional level of care to the community. NFs and other institutional providers can earn up to three incentive-based payments from the time of referral to the time a member has successfully repatriated in the community. Providers are eligible to receive an initial payment upon referral for pre-placement transition activities which include finding and securing housing and household supplies, assisting with in-home safety assessments, helping confirm informal supports, helping find caregiver applicants for persons who choose to self-direct, and other more hands-on supports. A second incentive payment is made when a member is successfully placed in the community and the provider completes one or more follow up visits to ensure: 1) services and equipment are in place and meeting the member's needs, 2) that the member has an initial PCP visit scheduled, 3) to complete a follow up environmental risk assessment, and 4) any other tasks agreed upon in the transition plan. Providers receive a third incentive payment when the member has remained in the community for 30 consecutive days without institutional readmission or IP hospitalization.

Table 5.7.1.A.4_B: Extraordinary Funding Innovative Payment Program

Proposed LTSS Strategy #2: Extraordinary Funding Innovative Payment Program	
See 5.7.1.A.1, *Table 5.7.1.A.1_E* above, for full details	To improve access and quality of services for our members with I/DD, we offer high quality, qualified providers of I/DD services higher tier rate payments for persons with extraordinary health and behavioral health needs. These rates are called Extraordinary Funding. To date, Sunflower has identified four I/DD providers who quality for higher

Proposed LTSS Strategy #2: Extraordinary Funding Innovative Payment Program	
	payments based on having more specialized health and BH services teams, and accepting referrals by Sunflower for persons with more challenging/higher risk needs. These four providers account for approximately 48% of Sunflower's members receiving I/DD services. This program was developed and implemented in response to provider feedback on additional challenges in maintaining their specialized supports. This higher level of funding helps support their activities and, over time, increase their volume of members. To support and increase access to these specialized services, Sunflower has signed a contract with all four providers for a higher regular tier rate payment for all members they serve, as an alternative to requesting extraordinary funding for a subpopulation. The goal of these contracts is to sustain the specialty services offered by the four providers. Additional providers are eligible to apply for this supplemental funding. To qualify, a provider would need to demonstrate they are serving a higher percentage of our members with I/DD who have high risk needs, an extraordinary spending rate, and offer more specialized services to support these members, such as nursing supports, therapies and behavioral health supports incorporated into their program.

Table 5.7.1.A.4_C: Sunflower Select Partners Nursing Facility Preferred Referrals Quality Program

Proposed LTSS Strategy #3: Sunflower Select Nursing Home Partners	
1. Topical area addressed	LTSS

2. Description of arrangement and objectives	**Description of Strategy**
	Sunflower strives to offer a comprehensive, quality network of Nursing Facility providers to our membership. Nursing Facilities will become Sunflower Select Partners by meeting specific quality targets and requirements. Providers will earn credits based on participation, performance, and outcomes. At the outset of the program, these facilities will be shared with members by their Service Coordinators as high quality choices among our larger network, thus increasing the flow of referrals and potential revenue stream from Sunflower. Our goal is to limit the network to Sunflower Select Partners after at least one year of data collection and program evaluation. The final design and implementation of the Sunflower Select program for Nursing Facilities will be directly aligned with the Kansas Promoting Excellent Alternatives in Kansas Nursing Homes (PEAK) program, and the recommendations from the current State workgroup initiated to identify quality criteria which should be utilized to determine nursing home incentive payments. Examples of potential quality criteria include:
	• Staffing Ratios
	• PEAK Participation and Outcomes
	• Joint Commission Accreditation
	• Satisfaction
	  ◦ Nursing Home Compare: Quality of Patient Care rating and Patient Survey Summary Rating.
	  ◦ Member experience of care assessed through approved vendor using abbreviated (or full) Nursing Facility CAHPS.
	• Quality of Care
	  ◦ Member-reported fall rate below statewide average
	  ◦ Participation in Sunflower and/or State supported training in areas such as Person-Centered Care, Mental Health First Aid, Trauma Informed Care,

Proposed LTSS Strategy #3: Sunflower Select Nursing Home Partners	
	Community Transitions and Addressing Social Determinants of Health and Independence • Availability of a facility Care Transitions program or resources • % of members (with stays less than 6 months) transitioned home with community supports The program is designed to improve quality and accountability of our providers through non-financial incentives while improving information and transparency in provider quality to our members. Equipped with additional information and choice, this initiative supports the evolution of informed consumers and how they access the delivery system. The ultimate goal is a performance based network, as achieved through participation based on value. **Strategy Goals** The goals of the Sunflower Select Program are to improve member outcomes and reduce costs (via avoidance admits and ED utilization) through access to quality partners. The program is designed to improve quality outcomes and member satisfaction through a higher quality network, member choice, and greater transparency. We also anticipate increased provider satisfaction of our Sunflower Select Partners through increased member referrals. **Alignment with KanCare 2.0 Goals** This strategy directly aligns with KanCare 2.0 goals by improving access to quality providers.
3. Identify specific populations and services included in the arrangement	**Populations Impacted** All members eligible for and/or receiving Nursing Facility services. **Services included in the arrangement** Nursing Facility **Providers included in the arrangement** Nursing Facility
4. Identify role of Service Coordination strategies, as applicable	**Role of Service Coordination Strategies** Facilitating access to quality Nursing Facilities that promote holistic and quality health care, identify members for transition out of the Nursing Facility, and keep members out of the hospital and ED is a critical component of Service Coordination. Service Coordinators, including Community Service Coordinators, will be trained and educated on the Sunflower Select program and the providers that have achieved Sunflower Select Partner status, including specific training and/or special skills or services that are most relevant to each unique member they serve, for example, providers with expertise in members with Alzheimer's/Dementia. **Potential Synergies** The Sunflower Select program is designed to acknowledge and improve the quality of our Nursing Facilities through partnerships that reward quality and contribute to success through training and other support, including training on Person Centered Care and Transitions of Care.
5. Identify role of health information technology/health information exchange (HIT/HIE), as applicable	**Role of HIT/HIE** HIT and HIE may be a key resource in monitoring and measuring quality, as ultimately defined through our participating in Kansas PEAK and other stakeholder engagement. Information on our Sunflower Select program and partners will also be promoted through our Website, online Provider Search Function, and the Member and Provider Portals.

Proposed LTSS Strategy #3: Sunflower Select Nursing Home Partners	
6. Coordination and collaboration with existing Value Based Purchasing and Quality Initiatives	**Coordination with Existing Relevant VBP and Quality Initiatives** Sunflower currently participates in the Kansas nursing facility incentives workgroup and related workgroups and will use the input, feedback, and recommendations of this effort to inform and finalize the design of our Sunflower Select program. Project ECHO is an opportunity to improve training and consultation available to Nursing Facility providers in better caring for our members. For example, a Project ECHO on Patient Centered Care for Nursing Facility members.

7. Identify if the model would be implemented statewide or would be a pilot proposal and if the CONTRACTOR(S) has existing experience with the initiative in Kansas or in another state.	**Proposed Model Scope**
	Sunflower proposes that this proposed model be implemented statewide.
	Existing Experience with Similar Models
	Sunflower will build on the efforts of the Kansas nursing facility incentive program and leverage the experience of our affiliates, including our Ohio affiliate, Buckeye Health Plan. Buckeye has implemented a multi-faceted approach to improve the quality of care provided to members and to foster stronger relationships with individual facilities and some of Ohio's largest Nursing Facility Associations. Initiatives include pay for performance (shared savings) arrangements, establishment of a quality incentive program, a facility scorecard, and a gold-card program for high-performing facilities. For example, available to high-performing skilled nursing facilities, the gold card program removes prior authorization requirements for members being transferred to a skilled facility. This program was developed as a direct response to feedback from facilities. Retrospective audit ensures Gold Card facilities continue to meet InterQual and/or OAC criteria. A facility will lose Gold Card status after failing 4 consecutive quarterly retrospective audits. Buckeye also developed a scorecard to determine performance at both the facility and association level. The scorecard evaluates performance based on three categories (11 total metrics)
	• Quality/Performance (40% of overall score)
	  • Flu Vaccination
	  • Pneumonia Vaccination
	  • Members self-reporting pain
	  • Pressure ulcers
	  • Urinary tract infections
	  • Falls w/major injury
	  • Short stay transition to community
	  • Short stay readmission
	  • Long stay readmission
	• Member Satisfaction (30% of overall score)
	• CMS Star Rating (30% of overall score)
	Kansas PEAK 2.0 has reported positive health outcomes that Sunflower hopes to build on through the Sunflower Select program. For example: Major Depressive Symptoms declined by 42% from Stage 0 (non-participants) to Stage 4 (comprehensive person-centered care adoption) and Low-Risk Residents with Pressure Ulcers declined by 38% from Stage 0 to Stage 4. Our program in Ohio is new so has yet to reach the first evaluation period, therefore outcomes data is not currently available.
	Stakeholder Engagement Strategy
	As we continue to design and finalize the quality criteria, we will work directly with the State's nursing facility incentives workgroup and implement our program based on their recommendations, to ensure consistency across MCOs. We will also solicit direct input

Proposed LTSS Strategy #3: Sunflower Select Nursing Home Partners	
	from our Nursing Facility network providers, Member Advisory Committee, LTSS Advisory Committee, and referring providers. Once finalized, we will develop an educational campaign to be rolled out to all providers, training on the program, offering support, and sharing the value and benefit to the delivery system.

8. Identify the proposed metrics, Outcomes or other measurements that the CONTRACTOR(S) will use to (i) determine the payment methodology, if applicable; and (ii) evaluate the effectiveness of the arrangement.	**Proposed Metrics, Outcomes and Measurements**
	Based on the goals of the strategies described, the following measures will be used to evaluate effectiveness:
	• Member Satisfaction
	• Provider Satisfaction
	• Utilization (for members residing in Sunflower Select facilities versus members served by other facilities)
	  ◦ IP Admissions and Readmissions/1000
	  ◦ ED visits/1000
	• # of Members transitioned from Nursing Facility to home
	Measurement Selection Methodology
	Measures described were selected as a consistent method of evaluation as used across clinical and quality programs.
	Evaluating Program Effectiveness
	We will regularly monitor through our Quality Improvement Program using standardized reporting, as part of our LTSS Quality Assurance Committee that meets quarterly and reports up to the Quality Improvement Committee.
	Impact to Members
	The anticipated impact to members is greater choice and transparency leading to greater member satisfaction and health outcomes.
	Providing Data to the State
	Sunflower will submit quarterly reports reviewed and approved by our LTSS Quality Assurance Committee. Other monthly, quarterly, and annual reports will be provided as requested by the State.
	Stakeholder Engagement Plan
	In addition to a heavy reliance on the State's nursing facility quality incentives workgroup, we will utilize our advisory committees to receive direct input in the final development of and enhancements to the criteria. In addition, we will seek feedback from our Nursing Facility network providers through direct provider engagement.

9. Identify the total number of Members expected to participate in the arrangement and when the arrangement is expected to start.	**Projected Member Participation** Based on our data, 3,206 current members reside in a Nursing Facility. In the event, a member chooses to transition to a nursing facility, and for our current members who reside in nursing facilities, we want to ensure they are aware of and have access to quality facilities of their choosing, as measured by the Sunflower Select program. **Projected Implementation Date** Jan. 1, 2019 with members; preparation will begin in 2018 as indicated below. **Implementation Timeline** • Step 1 (January 1-June 31, 2018): Finalize criteria, measurement tools and educate Nursing Facilities and entire delivery system on program. • Step 2 (July 1, 2018-Sept. 31, 2018): Evaluate and rate Nursing Facilities using the identified measurement tools. • Step 3 (Oct. 1, 2018- Dec. 31, 2018): Provide more specific training to Sunflower SCs, and any contracted Community Service Coordinators on the results of evaluations and member education and choice process.

Proposed LTSS Strategy #3: Sunflower Select Nursing Home Partners	
	• Step 4 (January 1, 2019): Continue CSC training. Emphasizing member choice, during regular visits by CSCs, the CSC will education members and recommend these Sunflower Select facilities to any transitioning member first, but will honor all network agreements. Continue program, modify as necessary; hold conferences with facilities who may be excluded from the Sunflower Select program. Roll out to all Nursing Facilities in Q2 of 2018, with evaluation occurring in Q3 2018 and training to Service Coordinators on the education and referral process in Q4 2018. Information is planned to be provided to members in Q1 2019. After one year of data and experience, we will evaluate the impact of limiting the network to Sunflower Select Partners and incorporating value-based payments and implement as appropriate. The implementation and process is subject to State approval of the tools and processes developed.

Table 5.7.1.A.4_D: Sunflower Select Partners In-Home Care Preferred Referral Quality Program

Proposed LTSS Strategy #4: Sunflower Select In Home Personal Care Partners	
1. Topical area addressed	LTSS

2. Description of arrangement and objectives	**Description of Strategy**
	In Home Personal Care Service agencies will become Sunflower Select Partners by meeting specific quality targets and requirements. Agencies will earn credits based on participation, performance, and outcomes. At the outset of the program, these partners will be shared with members by their Service Coordinators as high quality choices among our larger network, thus increasing the number of referrals and potential revenue stream from Sunflower. Our goal is to develop a preferred network of Sunflower Select Partners. Examples of evaluation and quality criteria included:
	• Provision of agreed upon, authorized services
	• Integration with EVV
	  ◦ Provider scheduling integration to allow systematic tracking of visits (vendor permitted)
	  ◦ Compliance with use of EVV
	• Quality of Life Outcomes
	  ◦ As reported by members and captured within our LTSS Key Performance Indicators dashboard and LTSS Member Satisfaction Survey
	• Quality of Care
	  ◦ Protocols in place to communicate key information with Service Coordinators
	  ◦ Compliance with AIRs reporting
	  ◦ Number and severity of AIRs reports and Quality of Care incidents
	  ◦ Quality metrics as reported by members and captured within our LTSS Key Performance Indicators dashboard
	  ◦ Participation in Sunflower and/or State supported training in areas such as Person-Centered Care, Mental Health First Aid, Trauma Informed Care, and Addressing Social Determinants of Health and Independence
	The program is designed to improve quality and accountability of our providers through non-financial incentives while improving information and transparency in provider quality to our members. Equipped with additional information and choice, this initiative supports the evolution of informed consumers and how they access the delivery

Proposed LTSS Strategy #4: Sunflower Select In Home Personal Care Partners	
	system. The ultimate goal is a performance based network, as achieved through participation based on value. **Strategy Goals** The goals of the Sunflower Select In Home Personal Care Services Partners Program are to support independence through access to quality partners and to improve quality outcomes and member satisfaction through a higher quality network, member choice, and greater transparency. We also anticipate increased provider satisfaction of our Sunflower Select Partners through more referrals to our Sunflower Select agencies and through empowerment of In Home Personal Care Services workers. **Alignment with KanCare 2.0 Goals** This strategy directly aligns with KanCare 2.0 goals by improving access to quality providers that support greater and continued independence and wellness for our members.
3. Identify specific populations and services included in the arrangement	**Populations Impacted** All members eligible for and/or receiving in home personal care services. **Services Included in the Arrangement** In Home Personal Care Services for all HCBS waivers that include this service **Providers Included in the Arrangement** In Home Personal Care Service agencies and workers
4. Identify role of Service Coordination strategies, as applicable	**Role of Service Coordination Strategies** Facilitating access to quality In Home Personal Care Services that promote holistic and quality care while keeping members safely in their homes is a critical component of Service Coordination. Service Coordinators will be trained and educated on the Sunflower Select program and the agencies that have achieved Sunflower Select Partner status, including specific training and/or special skills or services that are most relevant to each unique member they serve. **Potential Synergies** The Sunflower Select program is designed to acknowledge and improve the quality of our In Home Personal Care Service providers through partnerships that reward quality and contribute to success through training and other support, including training on Social Determinants of Health and Independence, key communications with Service Coordinators, and identifying and reporting safety concerns; and access to resources such as our Community Resource Database that will be available to Service Coordinators and agency providers.
5. Identify role of health information technology/health information exchange (HIT/HIE), as applicable	**Role of HIT/HIE** Integrating with EVV can better support systematic oversight and monitoring. Based on the capabilities of the EVV vendor, it is our goal to encourage provider scheduling integration to allow systematic tracking of visits. Information on the member's PCSP, authorizations, and other health information will be available to PCS providers through our provider portal.
6. Coordination and collaboration with existing Value Based Purchasing and Quality Initiatives	**Coordination with Existing Relevant VBP and Quality Initiatives** Project ECHO is an opportunity to improve training and consultation available to In Home Personal Care Services in better caring for our members. For example, a Project ECHO on early identification of changing needs and risks; how symptoms, changing conditions, or other behaviors are observed on an individual member basis and population basis; improving person-centered care; identifying and reporting social determinants; and communication with Service Coordinators.
7. Identify if the model would be implemented statewide or would	**Proposed Model Scope** Sunflower proposes that the program be implemented statewide with the vision to limit the network to Sunflower Select Partners over time. **Existing Experience with Similar Models**

Proposed LTSS Strategy #4: Sunflower Select In Home Personal Care Partners	
be a pilot proposal and if the CONTRACTOR(S) has existing experience with the initiative in Kansas or in another state.	While we have had similar programs for physical health providers, such as Gold Carding (loosening prior authorization requirements) for high performing providers, expanding and enhancing this model of non-financial incentives is new for In Home Personal Care. Across Centene affiliates, Gold Carding has been associated with higher provider satisfaction through reduction in administrative barriers. With the Sunflower Select program we also strive to improve member satisfaction and directly improve quality outcomes. **Stakeholder Engagement Strategy** As we continue to design and finalize the quality criteria, we will work with our Member and LTSS advisory committees and solicit direct input from our In Home Personal Care Services agencies. Once finalized, we will develop an educational campaign to be rolled out to all agencies, training on the program, offering support, and sharing the value and benefit to the delivery system.

8. Identify the proposed metrics, Outcomes or other measurements that the CONTRACTOR(S) will use to (i) determine the payment methodology, if applicable; and (ii) evaluate the effectiveness of the arrangement.	**Proposed Metrics, Outcomes, and Measurements**
	Based on the goals of the strategies described, the following measures will be used to evaluate effectiveness:
	• Member Satisfaction
	• Provider Satisfaction
	• Utilization (for members receiving services by Sunflower Select providers versus members served by other network providers)
	  ◦ IP Admissions and Readmissions/1000
	  ◦ ED visits/1000
	• Provision of Authorized Services
	• AIRs and Quality of Care concerns
	• Ability to remain and reside safely in the home
	Measurement Selection Methodology
	Measures described were selected as a consistent method of evaluation as used across clinical and quality programs.
	Evaluating Program Effectiveness
	We will regularly monitor through our Quality Improvement Program using standardized reporting, as part of our LTSS Quality Assurance Committee that meets quarterly and reports up to the Quality Improvement Committee.
	Impact to Members
	The anticipated impact to members is greater choice and transparency leading to greater member satisfaction and health outcomes.
	Providing Data to the State
	Sunflower will submit quarterly reports reviewed and approved by our LTSS Quality Assurance Committee. Other monthly, quarterly, and annual reports will be provided as requested by the State.
	Stakeholder Engagement Plan
	We will utilize our Member and LTSS Advisory Committees to receive direct input in the final development of and enhancements to criteria. In addition, we will seek direct feedback from our network providers through provider engagement.

9. Identify the total number of Members expected to participate in the arrangement and when the	**Projected Member Impact** Based on our data, 1,728 current members are receiving agency-directed In Home Personal Care Services. Our goal is to ensure all of these members are aware of and have access to quality providers, as measured by the Sunflower Select program. **Proposed Implementation Date** Jan. 1, 2019?

Proposed LTSS Strategy #4: Sunflower Select In Home Personal Care Partners	
arrangement is expected to start.	**Implementation Timeline** • Step 1 (January 1-July 1, 2018): Finalize criteria and educate In Home Personal Care Services providers and entire delivery system on program. • •Step 2 (July 1, 2018-Sept. 31, 2018): Evaluate and rate Personal Care Services providers using the identified measurement tools. • Step 3 (Oct. 1, 2018- Dec. 31, 2018): Provide more specific training to Sunflower SCs, and any contracted Community Service Coordinators on the results of evaluations and member education and choice process. • Step 4 (January 1, 2019): Continue CSC training. Emphasizing member choice, during regular visits by CSCs, the CSC will education members and recommend these Sunflower Select providers as a first option, but will honor all network agreements. Continue program, modify as necessary; hold conferences with providers who may be excluded from the Sunflower Select program. Roll out to all In Home Personal Care Services providers through education in Q2 2018, evaluation and feedback to our providers and advisory committees in Q3 2018, training for Service Coordinators in Q4 2018 and member education of preferred providers beginning Jan. 1, 2019. After one year of data and experience, we will evaluate the impact of limiting the network to Sunflower Select Partners and incorporating value-based payments and implement as appropriate.

Table 5.7.1.A.4_E: Fiscal Management Services (FMS) Self-Evaluation, Monitoring, and Quality Program

Proposed LTSS Strategy #5: Fiscal Management Services (FMS) Quality Program	
1. Topical area addressed	LTSS
2. Description of arrangement and objectives	**Description of Strategy** Sunflower currently participates in the State's quarterly meetings with FMS providers. Supporting our participation and our service providers across the network, we will develop a FMS Quality Program in collaboration with Applied Self Direction. This includes development of a FMS quality auditing tool, compliance checklist and evaluation framework, based on national best practices. The purpose is to provide FMS Service Providers and Support Brokers self-assessment and technical assistance tools and to further enhance the state's auditing process of those providers. Our goal is to use the program to evaluate and narrow the network based on value and performance. The program is designed to improve quality and accountability of our providers through tools and technical assistance while improving information and transparency in provider quality to our members. This will include a "minimum standards" checklist that will be used initially as a self-assessment tool; a set of performance measures; and a framework for "best practice". This program will ultimately shape the network by recognizing current high performing providers, building the competency and capacity of lower performers, and improving the performance of the entire network, while maintaining the integrity of the Federal, state and HCBS Program requirements. **Strategy Goals** The goals of the FMS Quality Program are to support independence through access to quality partners and to improve quality outcomes and member satisfaction through a higher quality network, member choice, and greater transparency. We also anticipate increased satisfaction and competency of our FMS partners through increased support and collaboration. **Alignment with KanCare 2.0 Goals**

Proposed LTSS Strategy #5: Fiscal Management Services (FMS) Quality Program	
	This strategy directly aligns with KanCare 2.0 goals by improving access to quality providers that support greater independence for our members.
3. Identify specific populations and services included in the arrangement	**Populations Impacted** All LTSS members who choose to self-direct one or more of their services.. **Services Included in the Arrangement** FMS Services **Providers Included in the Arrangement** FMS Service Providers
4. Identify role of Service Coordination strategies, as applicable	**Role of Service Coordination Strategies** Supporting members in their choice to direct their HCBS services while keeping members independent is a critical component of Service Coordination. Service Coordinators are and will continue be trained and educated on the role of FMS Service providers, and how to engage these valuable resources in care planning. Sunflower has and will engage our FMS provider network in helping with this training. **Potential Synergies** The FMS Quality Program is designed to acknowledge and improve the quality of our FMS Service Providers through partnerships that recognize quality and contribute to success through training and other support, including training on Social Determinants of Health and Independence and access to resources such as our Community Resource Database that will be available to Service Coordinators and FMS Service Providers.
5. Identify role of health information technology/health information exchange (HIT/HIE), as applicable	**Role of HIT/HIE** Not applicable
6. Coordination and collaboration with existing Value Based Purchasing and Quality Initiatives	**Coordination with Existing Relevant VBP and Quality Initiatives** Sunflower will continue to participate in the Kansas statewide FMS quarterly meetings to listen to ongoing challenges and concerns to enhance and maximize the use of our FMS quality tools. Through this program we will also partner with the State to further enhance their auditing process of FMS providers.
7. Identify if the model would be implemented statewide or would be a pilot proposal and if the CONTRACTOR(S) has existing experience with the initiative in Kansas or in another state.	**Proposed Model Scope** Sunflower proposes that the program will be implemented statewide. **Existing Experience with Similar Models** We are currently working with Applied Self Direction to develop integrated FMS and Support Broker resources. **Stakeholder Engagement Strategy** As we continue to design and finalize the tools, we will work with the FMS workgroup and our Member and LTSS Advisory Committees, and solicit direct input from our FMS partners. Once finalized, we will develop an educational campaign to be rolled out to all providers, including training on the program, technical support, and sharing the value and benefit to the delivery system.
8. Identify the proposed metrics, Outcomes or other measurements that the CONTRACTOR(S) will use to (i) determine the	**Proposed Metrics, Outcomes, and Measurements** Based on the goals of the strategies described, the following measures will be used to evaluate effectiveness: • Member Satisfaction • Provider Satisfaction • Ability to remain and reside safely in the home

Proposed LTSS Strategy #5: Fiscal Management Services (FMS) Quality Program	
payment methodology, if applicable; and (ii) evaluate the effectiveness of the arrangement.	• Longevity of members' abilities to remain in self-direction • Outcomes from Self-Assessment tool metrics including both financial responsibilities and Information & Assistance supports offered **Measurement Selection Methodology** Measures described were selected as a consistent method of evaluation as used across clinical and quality programs, and reflect the responsibilities of Kansas FMS providers as well as the goal of measuring success of members who choose to self-direct. **Evaluating Program Effectiveness** We will regularly monitor through our Quality Improvement Program using standardized reporting, as part of our LTSS Quality Assurance Committee that meets quarterly and reports up to the Quality Improvement Committee. **Impact to Members** The anticipated impact to members is greater choice and transparency leading to greater member satisfaction, member success with self-direction and improved health outcomes. **Providing Data to the State** Results of FMS provider self-assessments, data reviewed by the Sunflower LTSS Quality Assurance Committee will be provided as well as any monthly, quarterly, and annual reporting, as requested by the State. **Stakeholder Engagement Plan** We will utilize the statewide FMS meetings (if agreed upon by the State), our Member and LTSS advisory committees, and our collaboration with Applied Self Direction to receive direct input in the final development of and enhancements to the program, including performance metrics. In addition, we will seek feedback from our FMS partners through direct provider engagement.
9. Identify the total number of Members expected to participate in the arrangement and when the arrangement is expected to start.	**Projected Member Participation** Based on our data, 3,303 current members have selected self-direction and are receiving FMS services. **Proposed Implementation Date** Jan. 1, 2019 **Implementation Timeline** • Step 1 (January 1-July 1, 2018): Share our FMS Evaluation tool with KDADS, finalize tools and educate FMS Service Providers on the program. • Step 2 (July 1, 2018): Distribute tools and resources to FMS providers and have them participate in a self-evaluation. • Step 3 (Nov. 1-Dec. 31, 2018): Share self-evaluation results with KDADs to determine further use of the tool to provide technical assistance or to use in conjunction with the State audit. • Step 4 (Jan. 1, 2019-Dec. 31, 2019) Continue program, modify as necessary, solicit ongoing input from KDADS, FMS providers, and our advisory committees. • Step 5 (by January 1, 2020) or after: Use evaluation criteria to narrow the network, incorporate into APM, and/or add in financial incentives as appropriate. Shared with KDADs in Q1 and Q2 2018, determine use in conjunction with the State FMS audit, and refine our tool as needed. Provide to FMS providers in Q3 2018 for self-evaluation. Provide results to KDADs in Q4 2018 to determine future use and purpose of the tool to determine technical assistance needed by providers or to potentially evaluate and narrow the network.

Table 5.7.1.A.4_F: Improving the Value and Impact of Home Modification Services

Proposed LTSS Strategy #6: Home Modification Services	
1. Topical area addressed	LTSS
2. Description of arrangement and objectives	**Description of Strategy** Sunflower wanted to ensure members receive access to the right modifications and assistive services at a reasonable cost. We solicited proposals and identified a statewide network provider with extensive experience and expertise in the area of Assistive Technology and Home Modifications and entered into a preferred contract. In our search, Sunflower was specifically looking to identify providers that employed an Occupational Therapist, as well as licensed contractors. The purpose of the effort was to create a more seamless in-home assessment and proposal process for our eligible LTSS members. In the process, we identified one provider had a more robust service array and could access equipment and perform contract work at a reduced rate, while demonstrating exceptional quality. This preferred provider also employs staff that are Certified Aging in Place Specialists, whose expertise is to eliminate environmental barriers for older adults and individuals with disabilities, offering members options to age in their home safely. Members still have access to their choice of in network providers as well as the preferred providers to compare cost, access, and quality of work. The value of the program is to assess the member's home to ensure safe, efficient, and effective home modifications and/or assistive services are being offered and/or installed, and to offer those services at a reduced rate, ensuring members receive appropriate services within their allowable benefits. **Strategy Goals** The goal of the initiative is to ensure members receive faster access to the right modifications and assistive services at a reasonable price. Access to home modifications and assistive services can support better independence and quality of life by keeping members safely in the community and offering a less costly option to institutionalization. **Alignment with KanCare 2.0 Goals** This strategy directly aligns with KanCare 2.0 goals by improving access to high quality providers that support greater independence for our members; improving coordination and integration of PH, BH, and LTSS, including social determinants of health and independence; promoting wellness and healthy lifestyles; and lowering costs against members' lifetime allowable amount via competitive contracting.
3. Identify specific populations and services included in the arrangement	**Populations Impacted** All members receiving or eligible for home modification and assistive services **Services Included in the Arrangement** Home modification and assistive services **Providers Included in the Arrangement** Eligible home modification and assistive services providers
4. Identify role of Service Coordination strategies, as applicable	**Role of Service Coordination Strategies** Through this program, we provide a valuable service and options for members needing home modification(s) and assistive services. Service Coordinators are educated on the availability of our preferred provider relationship and services offered, recognizing that members always have a choice. **Potential Synergies** Service Coordinators and members provide feedback on the program and services to support continuous quality improvement. Service Coordinators perform an on-site visit to follow up with the member regarding satisfaction and view the equipment or modification. We will develop a satisfaction survey that will be conducted by the Service Coordinator/Community Service Coordinator.

Proposed LTSS Strategy #6: Home Modification Services	
5. Identify role of health information technology/health information exchange (HIT/HIE), as applicable	**Role of HIT/HIE** Not applicable
6. Coordination and collaboration with existing Value Based Purchasing and Quality Initiatives	**Coordination with Existing Relevant VBP and Quality Initiatives** In combination with Sunflower's proposed initiatives for quality Personal Care Services and FMS, this will add to Sunflower's review and offering of a high quality, comprehensive LTSS service network.
7. Identify if the model would be implemented statewide or would be a pilot proposal and if the CONTRACTOR(S) has existing experience with the initiative in Kansas or in another state.	**Proposed Scope** Sunflower proposes that the model be implemented statewide. **Existing Experience with Similar Models** These preferred contracts have been in place since February 2017. We have experienced a faster turn-around time from assessment, to Sunflower authorization, to project completion with these two providers. Most are completed within 30-90 days depending on availability of project materials. We are also in the process of implementing a Post Satisfaction Survey to accompany our revised process. The survey will be completed by the Service Coordinator with the member and documented in TruCare, our case management system. **Stakeholder Engagement Strategy** We have provided education and training on the availability of these services to Service Coordinators, members, and their caregivers. We will provide future training to our Community Service Coordinators on our Home Modification/Assistive Service providers and approval process to allow members to access these preferred providers.
8. Identify the proposed metrics, Outcomes or other measurements that the CONTRACTOR(S) will use to (i) determine the payment methodology, if applicable; and (ii) evaluate the effectiveness of the arrangement.	**Proposed Metrics, Outcomes, and Measurements** Based on the goals of the strategies described, the following measures will be used to evaluate effectiveness: • Member Satisfaction • Member timely access to Home Modifications • Rate of member-reported falls • Ability of members to remain and reside safely in the home **Measurement Selection Methodology** Measures described were selected as a consistent method of evaluation as used across clinical and quality programs. Member timely access to contractors for completing Home Modifications, at a reasonable cost, has been a statewide challenge that we believe has been improved through these contracts. **Evaluating Program Effectiveness** We will regularly monitor through our Quality Improvement Program using standardized reporting, as part of our LTSS Quality Assurance Committee that meets quarterly and reports up to the Quality Improvement Committee. **Impact to Members** The anticipated impact to members is early intervention and risk mitigation leading to improved health outcomes and continued independence. **Providing Data to the State** Monthly, quarterly, and annual reporting, as requested by the State. **Stakeholder Engagement Plan**

Proposed LTSS Strategy #6: Home Modification Services	
	We will utilize our Member and LTSS Advisory Committees to review program outcomes and adjust evaluation metrics as appropriate.
9. Identify the total number of Members expected to participate in the arrangement and when the arrangement is expected to start.	**Projected Member Participation** Based on our data, Sunflower currently has an average of 2 to 3 members per month who are in HCBS or WORK and request home modification/assistive services. **Proposed Implementation Date** February 1, 2017 **Implementation Timeline** Implementation is complete, except that we will provide training to our future Community Service Coordination providers on this process. We also intend to implement the satisfaction survey with members who use this service by Q3 2018.

PHYSICAL AND BEHAVIORAL HEALTH INTEGRATION STRATEGIES (5.7.1.A.5)

Integration of physical health (PH) and behavioral health (BH) is a key element of our program design. To be successful, it is critical that we engage, incentivize, and align the delivery system in effectively and efficiently integrating services across disciplines and across the continuum. To achieve this objective, while supporting the goals of KanCare 2.0, we propose the following delivery system innovations and strategies, as fully described in the table below:

- Proposed Integration Strategy #1: Bi-Directional Integration and Practice Transformation to Promote Whole Person Health, the Collaborative Care Model, Telemedicine, Tele-Consults, and Project ECHO (***Table 5.7.1.A.5_A: Bi-Directional Integration and Practice Transformation***)
- Proposed Integration Strategy #2: Information Sharing Across Providers and Disciplines through Role-Based Web Portals and Provider Training (***Table 5.7.1.A.5_B: Information Sharing***)
- Proposed Integration Strategy #3: Improving Identification and Referral for BH Across the System (***Table 5.7.1.A.5_C: Improving Identification and Referral***)
- Proposed Integration Strategy #4: Addressing the Opioid Crisis (***Table 5.7.1.A.5_D: Addressing the Opioid Crisis***)

Table 5.7.1.A.5_A: Bi-Directional Integration and Practice Transformation

Proposed Integration Strategy #1: Bi-Directional Integration and Practice Transformation	
1. Topical area addressed	BH/PH Integration
2. Description of arrangement and objectives	**Description of Strategy** Sunflower will further facilitate the integration of PH and BH through a concerted effort overseen and managed by our Chief Medical Officer and BH Medical Director. Specific activities include implementation of new payment models to promote integrated, whole person health, coordination across disciplines, and quality outcomes (see 5.7.1.A.1 Alternative Payment Models); practice transformation support and technical assistance including onsite training, tools, and resources, for example training in Mental Health First Aid and SBIRT for PCPs; connecting FQHCs and CMHCs to facilitate provider consultations and seamless referral; implementation of evidence-based practices such as the Collaborative Care Model; and the use of Telemedicine, Tele-Consults, and Project ECHO to support bi-directional integration for both PH and BH providers. As part of the program, we will assess provider readiness, match interventions with their

Proposed Integration Strategy #1: Bi-Directional Integration and Practice Transformation	
	current capabilities and gaps, and develop a provider specific practice transformation plan to promote integrated service delivery, using the Integrated Practice Assessment Tool (IPAT) endorsed by SAMHSA. Sunflower is actively engaging our partners, including FQHCs, CMHCs, and other community providers and services, to understand how we can best work with our network providers and support the evolution of clinical integration through all these activities. From this direct input and building on successful strategies implemented in our affiliate plans, we will develop and implement an Integration Plan that will define specific strategies, tasks, and development efforts, including roles and responsibilities, timelines, and inter-dependencies. This effort will be led by our Chief Medical Officer and BH Medical Director with direct support from our Contracting and Network Development, and Quality Improvement departments and leadership. The strategy described will enhance traditional service delivery by improving coordination across provider disciplines and equipping providers and improving access to integrated training, tools, and resources. To help facilitate this, we will have Practice Transformation resources that can help assess provider practices for their level or readiness for integration and develop and help implement a path to integration, using the IPAT to assess and inform each provider specific plan. This will include a focus on social determinants of health and independence, leveraging the PRAPARE tools and integrated processes to address social determinants (see 5.7.A.2 Social Determinants of Health and Independence). Payment models used to support integration will focus on both process and outcomes. For example, value-based payments for PCPs and OBGYNs who complete depression and SUD screenings. In addition, we will educate on the use and availability of CPT codes to reimburse for services under the Collaborative Care Model. **Strategy Goals** The goals of bi-directional integration include improved member satisfaction due to more seamless and convenient care; improved PH and BH health outcomes; improved provider satisfaction based on the ability to better serve the holistic needs of members; and a reduction in costs due to improved access to services in ambulatory care settings and early identification. **Alignment with KanCare 2.0 Goals** This strategy directly aligns with KanCare 2.0 goals to improve integration, including addressing social determinants of health as part of our holistic model of care.
3. Identify specific populations and services included in the arrangement	**Populations Impacted** The activities described will be available to all members and providers. The specific interventions may differ based on variables such as geography. For example, members in geographically isolated areas may rely more heavily on telemedicine solutions to bring integrated services to members, such as tele-psych consults made available at an FQHC. We will identify provider shortage areas using provider density maps to determine the most appropriate strategies for each area, for example, use of tele-psychiatry in remote areas with limited BH access. **Services Included in the Arrangement** Services are focused on ambulatory settings such as FQHCs, CMHCs, and other provider offices, as well as in the emergency room. **Providers Included in the Arrangement** Providers will include FQHCs, CMHCs, Rural and Frontier Health Collaboratives, other primary provider offices, PH specialists, and BH specialists, as well as support staff such as Community Health Workers.
4. Identify role of Service Coordination	**Role of Service Coordination Strategies**

Proposed Integration Strategy #1: Bi-Directional Integration and Practice Transformation	
strategies, as applicable	Activities and strategies described will be directly integrated with our service coordination strategies, ensuring members are connected to the right services, at the right time, by the right provider. Sunflower and Community Service Coordinators will be trained on the availability of bi-directional integration care and services to appropriately match members with providers that can best meet their integrated needs. Service Coordinators will also provide feedback and input into the process by identifying areas of need across the delivery system, including providers and members needing additional support and working collectively to bring that support. **Potential Synergies** With a goal to support whole person health, all related trainings, screenings, tools, and resources identified will incorporate Social Determinants of Health and Independence, in addition to PH, BH, or LTSS services. For example, ensuring access to our Community Resource Database for members, providers, and Service Coordinators.
5. Identify role of health information technology/health information exchange (HIT/HIE), as applicable	**Role of HIT/HIE** Access to information across disciplines and across the continuum is critical to successfully integrating services. Key HIT/HIE elements for bi-directional integration include access to up to date PH and BH clinical information, including care gaps and pharmacy utilization, as well as timely notification of ED visits and IP admissions through Admissions, Transfers, and Discharge (ADT) transactions data.
6. Coordination and collaboration with existing Value Based Purchasing and Quality Initiatives	**Coordination with Existing Relevant VBP and Quality Initiatives** Sunflower will work with existing programs and initiatives to promote and augment all of our strategies. For example, in developing opportunities for transformation to improve bi-directional integration, we will work directly with the Practice Transformation Network to identify opportunities to support our providers through this initiative. We will also work directly with Project ECHO to support providers in our network on topics such as Service Coordination and Opioid Use and work through the Rural Health Initiative to identify areas of opportunity to improve access and services in rural areas. Internally, we will incorporate VBP incentives into our current and future VBP contracts that directly support bi-directional integration of PH and BH.
7. Identify if the model would be implemented statewide or would be a pilot proposal and if the CONTRACTOR(S) has existing experience with the initiative in Kansas or in another state.	**Proposed Scope** Our efforts to promote bi-directional integration will be statewide. Certain activities may be limited or adjusted based on variables such as patient load. For example, while in largely populated areas we can easily justify an on staff Behavioralist in a PCP practice or FQHC, these services may be more feasible through telemedicine in more remote areas. The capacity across the state will vary dependent upon the access to the spectrum of services available in that area. **Existing Experience with Similar Models** Integration has been a key strategy for Sunflower since inception. Part of our network strategy is the inclusion of providers able to serve the integrated needs of our membership. For example, Horizons Mental Health is a network CHMC co-located with primary care, including providing services in the jails. We will also apply our lessons learned from prior implementation of Health Homes. For example, the transition to Health Homes required a significant change in practice and approach, requiring additional training and workforce development. Equally important, the level of change of transformation varied by practice. In response, we have adopted the IPAT readiness assessment tool and will develop roles-based training, for example training for Service Coordinators to broaden their scope of how patients are viewed, ensuring a holistic view through a bio-psycho-social lens. Current initiatives we have in place to promote bi-directional integration include:

Proposed Integration Strategy #1: Bi-Directional Integration and Practice Transformation	
	• BH Consult Line – 800 number that goes to our BH Medical Director for non-BH provider support and questions • Provider and staff training on Treating Members with Co-Morbidities, Mental Health First Aid, Trauma Informed Care, and SBIRT, Motivational interviewing • MyStrength, a self-management, virtual mental health club that members access online including a personal home page, weekly plan, exercises, videos, articles and customizable tools; currently being expanded to include live health coaching • Sunflower initiated and recently concluded a workgroup with the CMHCs including assessment of how to integrate PH into the CMHC. We are also using our P4P with the CMHCs to introduce them to HEDIS measures that contain both a BH and PH component. We have one CMHC that we are working with that has a BH professional embedded in the local PCP clinic and will provide data to the case manager assigned to high risk cases with both BH and PH comorbidities. • Performance Improvement Project related to diabetic screening for members with schizophrenia and bipolar disorder who were dispensed antipsychotic medication Likewise, our affiliates across the country are actively engaged in new models and initiatives to promote bi-directional integration. For example, promoting, building, and providing technical assistance to integrated practices; implementing evidence-based models; and using telemedicine, tele-consults, and Project ECHO to support providers across the continuum. For example, our Illinois affiliate plan is in the process of implementing their ***Illinois Practice Transformation and Training (IPTT)*** Initiative. This included development of an IPTT Toolkit to: • Clarify terms, levels, types, and models for integration • Describe the technical support available and planned at the state and local level • Offer regional information and data to inform each provider's analysis of their own organization/practice This initiative also includes: ***Provider Level Support.*** Providers currently vary considerably in their degree of integration and capacity for further integration. Successfully building and sustaining integrated care at the provider level requires full information about available models and approaches, workforce assessment, HIT needs, practice transformation goals, and business projections to identify and sustain new activities and identify new partners and/or staff to meet evolving needs. We assist each provider to undertake a planning process informed by the IPTT, plus a thorough readiness self-assessment to consider the type and level of integrated care that best meets their population's needs and reflects their organization/practice's capacity for collaborative activities. For example, the ***Behavioral Health Integration Capacity Assessment (BHICA),*** which mirrors the six levels of integration and serves as a nationally recognized starting point. Workforce Training. Provide community training and technical assistance regarding appropriate use of screenings for BH conditions, appropriate referral for BH care, managing members with co-occurring conditions, crisis planning, person-centered care planning, trauma-informed care, recovery, and resiliency, use of peer supports, adherence to CLAS standards to improve care access and reduce health disparities, inclusion of natural supports, and more. The IPTT program offers tailored provider trainings, system-wide supports, and engagement strategies to fill identified gaps and move providers further along the integration spectrum relative to their goals and the needs of members.

Proposed Integration Strategy #1: Bi-Directional Integration and Practice Transformation	
	Training for Primary Care Providers. Provide primary care practices (PCPs and their clinical and administrative staff) with a customized array of trainings that are directly responsive to identified gaps and integration goals. For PCPs who are just beginning to think about integrating BH services, evidence based screening tools and local BH referral source identification education is a good starting place. Others, who are more prepared to integrate care may be ready to implement (or improve in the implementation of) an evidence based model of integration that meets the needs of the populations that they serve (i.e., Collaborative Care) or move towards becoming certified as an integrated Primary Care Medical Home (PCMH), as well as continuing education in managing basic BH conditions and developing processes to recognize and ensure members obtain appropriate support for more serious conditions. We also facilitate connections between PCPs who are at various stages of integration for peer-learning opportunities (i.e., Learning Collaboratives), and facilitate connections via teleconference, using specific patient case studies as a tool for discussion and group learning. Teach by example, including co-located health plan staff within offices to support development of integrated care infrastructure. Clinical Trainers also work with all health plan provider-facing staff to address integrated care during provider orientations, clinical rounds, and throughout ongoing education opportunities. Training for CMHC/BH Providers. Orient and train BH (including SUD) providers to screen and manage primary care and chronic disease for those with BH conditions, in collaboration with primary care colleagues. Includes programming to promote health literacy, smoking cessation, address stigma, ensure CLAS adherence, and implement the processes necessary to provide collaborative care (huddles, open access, etc.). A curriculum for licensed professional, such as LCSWs, LPCs, LACs, etc., includes specialty training on how to communicate effectively with primary care staff, including topics such as how to receive a Warm Handoff, how to write effective and efficient SOAP notes, how to best utilize the PCP's time, approach to the physical exam and health behavior change, and roles for PCPs in the BH environment. Other specific examples and related outcomes are included below. **Outcomes from Similar Models** Based on Sunflower integration activities, we have seen positive outcomes related to HEDIS for our members served by our CMHCs moved to VBP. For example: Metabolic Monitoring for Children and Adolescents on Antipsychotics 1 to 5 Compliant improved from 33.33% pre VBP (6/2017) to 40% post VBP (12/17) and Diabetes Screening for People with Schizophrenia or Bipolar Disorder improved from 54.05% to 55.04%. The study question from our Diabetes Screening PIP was "Do multifaceted education and outreach interventions which include person to person interventions, targeting both providers and Sunflower members improve the diabetic screening rate for Sunflower Medicaid members with schizophrenia and bipolar disorders who were dispensed an antipsychotic medication?" with a goal to increase compliance with glucose or HbA1c testing for members 18-64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication, leading to earlier identification and treatment of diabetes. The analysis originates with the HEDIS 2018 SSD measure results for baseline. Year-over-year comparisons will be completed upon validation of re-measurement year HEDIS data. Baseline rate is 75.37%; goal is 79.14%. Following are examples of specific activities that have been implemented in our affiliate plans, and related outcomes. Florida Affiliate: IMPACT Model (Collaborative Care Model). Our Florida affiliate implemented a Modified IMPACT (Improving Mood Providing Access to Collaborative Treatment) program that focuses on those who are newly diagnosed, undiagnosed or have an undertreated BH condition and are at risk of exacerbating a co-morbid medical

Proposed Integration Strategy #1: Bi-Directional Integration and Practice Transformation	
	illness such as sickle cell anemia, diabetes or heart disease. IMPACT is listed in SAMHSA's National Registry of Evidenced Based Programs and Practices. Participants are identified by the PCP based on predetermined criteria, such as an unmet BH need. Once identified, the member is assigned a BH Wellness Coach who meets with the member at the PCP location (embedded at the PCP location) to complete an initial needs assessment. The PHQ9 score is used to triage the appropriate risk level. Results demonstrate improvement in depression symptoms, increased engagement in BH services as well as overall health care cost reduction. The embedded BH Wellness Coach performs the following: • Educates the member about their behavioral health condition and treatment options available. • Coordinates BH care and community supports. • Supports antidepressant therapy prescribed by the member's PCP if appropriate. • Educates the member about self-management techniques • Meets regularly with the member to monitor for improvement or symptom exacerbation. • Completes caseload consultations with BH Medical Director on members who did not respond to PCP treatments as expected. • Offers feedback to PCP utilizing Best Practice Psychotherapeutic Medication Guidelines. Outcomes for our affiliate plan included the following after 12 months of engagement. • Patient Outcomes: 67% were connected to BH services, nearly double the rate of those identified but not engaged in the program. • Clinician Outcomes: Nearly 1 out of 3 members achieved the PHQ9 goal (50% improvement, or score less than 10), indicating a significant improvement in depression symptoms. • Community Impact: Family Care Partners as well as the patients they serve have benefited from seamless BH care coordination which improved access to care and minimized stigma. • Cost Savings: Average **overall health care cost approximately $2,000 lower** for members engaged in the program than members identified but not active. Texas Affiliate. One of our most established health plans, Texas offers several programs and lessons learned in BH integration. Following are two examples with associated outcomes. ***Bexar County CAT Therapy Initiative***. This initiative was launched as a pilot and continued as an ongoing program due to the positive results. The focus is to increase the use of Cognitive Adaptive Therapy (CAT) services to address readmission rates for high utilizing members and provides intensive behavioral-oriented community support, including accompanying members to medical appointments and environmental supports such as calendars, pillboxes, and alarms. CAT Therapy helps participating Bexar County Star Plus members maintain and increase community tenure. Data indicates decreased cost and usage for ER department and IP level of care, as well as increased outpatient usage/cost savings. The program has since been expanded to include members with SUD. Below are demonstrated outcomes pre- and post-implementation.

Proposed Integration Strategy #1: Bi-Directional Integration and Practice Transformation

Type	30 Day Pre	30 Day Post	90 Day Pre	90 Day Post	180 Day Pre	180 Day Post
BH Admits	19	12	47	27	74	46
OP Visits	22	8	36	9	47	12
ER Cost	$13,329	$12,081	$25,199	$20,804	$38,670	$35,839
IP Cost	$32,206	$18,818	$83,790	$35,044	$122,241	$82,369
OP Cost	$9,303	$8,834	$20,091	$19,711	$38,929	$31,860
Total Cost	*$54,838*	*$39,734*	*$129,081*	*$75,560*	*$199,841*	*$150,069*

Crystal Counseling Pilot. Bexar County is an area with many members struggling with SUD and frequent inpatient admissions. Crystal Counseling agreed to provide extensive discharge planning services for high utilizing members after inpatient psych admissions. Crystal Counseling provides intensive behavioral case management services for 30 days after discharge from an inpatient facility. This pilot went live in October of 2013 with demonstrated impact in 2014 as seen with the outcomes data below.

Type	30 Day Pre	30 Day Post	90 Day Pre	90 Day Post	180 Day Pre	180 Day Post
BH Admits	35	11	64	26	100	48
ER Cost	$16,128	$2,234	$37,291	$10,775	$65,837	$26,012
IP Cost	$97,334	$38,160	$171,831	$74,610	$278,215	$109,980

Stakeholder Engagement Strategy

We will include information on our programs to support bi-directional integration and practice transformation through our robust Provider Engagement Model, including information on the availability of these services and supports during provider orientation and Joint Operating Committee Meetings. In particular, we will proactively reach out to FQHCs and CMHCs that might benefit from these services. As part of contracting, we will ensure providers understand our related VBP initiatives and services offered to promote their success. We will also learn from successful engagement efforts in our affiliate plans. For example, in Illinois, they held a kick-off summit to convene providers across the state to discuss their definition of integration using the SAMHSA models as a guide.

In addition to engaging providers, we will engage Service Coordinators, providing training on provider capabilities, experience, and expertise serving holistic member needs. Training and information will be made available through in person and web-based trainings.

8. Identify the proposed metrics, Outcomes or other measurements that the CONTRACTOR(S) will use to (i) determine the payment methodology, if applicable; and (ii) evaluate the effectiveness of the arrangement.

Proposed Metrics, Outcomes, and Measurements

Based on the goals of the strategies described, the following measures will be used to evaluate effectiveness:

- Member Satisfaction
- Provider Satisfaction
- Utilization
  - IP Admissions and Readmissions/1000
  - ED visits/1000
  - PCP visits/1000
  - Psychotropic drug utilization with and without therapy
- Recidivism

Proposed Integration Strategy #1: Bi-Directional Integration and Practice Transformation	
	HEDIS Measures **Measurement Selection Methodology** Measures described were selected as a consistent method of evaluation as used across clinical and quality programs. **Evaluating Program Effectiveness** We will regularly monitor through our Quality Improvement Program using standardized reporting and report up through our Quality Improvement Committee. **Impact to Members** The anticipated impact to members is more seamless care delivery, improved access to timely services, and reduced stigma related to BH services, all leading to greater member satisfaction and health outcomes. **Providing Data to the State** Monthly, quarterly, and annual reporting, as requested by the State. **Stakeholder Engagement Plan** We will utilize our advisory committees to receive direct input in the development of performance metrics. In addition, we will seek feedback from our FQHCs, CMHCs, and other large provider groups through our Joint Operating Committees.
9. Identify the total number of Members expected to participate in the arrangement and when the arrangement is expected to start.	**Projected Member Participation** According to the Robert Wood Johnson Foundation (2/2011 report), more than 68 percent of adults with a mental disorder had at least one medical condition. For Medicaid specific populations, Medicaid.gov reported that more than half of the Medicaid-enrollees in the top five percent of expenditures who had asthma or diabetes also had a BH condition (2011). Based on our data, 2,793 of our current members identified as SMI and have a chronic health condition. This does not include those who fall outside the range of SMI but may have a BH diagnosis and physical health issue. We estimate 25,000 members will participate in or benefit from these programs. Our goal is to ensure all members have access to integrated care through more informed, educated, and better equipped providers. **Proposed Implementation Date** These efforts have already starting, as described under #7 above. **Implementation Timeline** Current P4P payment related initiatives went into effect in April 2017. Our goal is to have the additional capacity and competency to provide the described integration and transformation services and supports to providers starting in 2018. We will work with each individual provider on a timeline that meets them where they are and works within their current competencies and capacities. For payment related initiatives, we will continue our existing P4P with PH and BH providers and expand accordingly with each renewal. For integration and transformation initiatives, we will start with our FQHCs and CMHCs, as well as larger provider groups interested in moving toward a more integrated model. Based on success with these groups and lessons learned, we will roll out across the state, leveraging telemedicine and related solutions to reach rural and frontier areas. We will identify providers interested and ready to implement or expand their integration efforts through our regular Joint Operating Committee meetings with large provider groups, Physician Advisory Committee, Association meetings, and other direct provider outreach and workgroups.

Table 5.7.1.A.5_B: Information Sharing

Proposed Integration Strategy #2: Information Sharing	
1. Topical area addressed	BH/PH Integration
2. Description of arrangement and objectives	**Description of Strategy** To further support integration as described under Strategy #1, it is critical to have a secure method of information sharing and clear expectations for the information to be shared. While easily tied to Strategy #1, we have called out Information Sharing as a separate strategy as it expands beyond integration of PH and BH, and helps facilitate integration and coordination across all services, systems, and provider types. For example, child welfare, LTSS, justice, tribal nations, and veterans. Our strategy for information sharing is twofold. First is around setting expectations for providers with requirements for sharing chart notes, treatment plans, and participating in service planning activities and Care Teams. For example, we have implemented this on a small scale with one of our CMHCs, sharing information their Care Manager doesn't have access to and they share with us what they are seeing with our members that won't be reflected in claims, i.e. homeless, social stressors, etc. Our service coordinators will assist by providing additional view into the member's care alerts so that the Care Manager can incorporate PH needs into the plan of service/treatment plan. This information will be communicated through provider orientations and in our Provider Manual, and includes sharing information from PH providers to BH providers and BH providers to PH providers. The second strategy around information sharing is leveraging technology to promote coordinated and integrated care planning. Sunflower's technology solutions enhance our ability to integrate services by ensuring that all information about each member's needs and services is available to all staff, providers, and agencies interacting with the member. Our integrated care planning is supported by our state-of-the-art Centelligence® family of integrated decision support and healthcare informatics solutions. Our Centelligence enterprise platform integrates data from multiple sources and produces actionable information used organization-wide to monitor and improve outcomes. This includes, but is not limited to, Care Gap and Wellness Alerts, Key Performance Indicator (KPI) Dashboards, Provider Clinical Profiling analyses, population-level health risk stratifications, and standard and ad-hoc desktop reports. Key to external communications and coordination are our role-based Web Portals and Member Health Record. While these tools are used today, it is our goal to expand and enhance the use and functionality of these tools to improve information sharing across PH and BH providers. For example, all providers working off of a single, integrated Care Plan and having direct access to assessment data, including social determinants information that may be impacting patient compliance and outcomes. While not impacting payment, this strategy is intended to improve traditional service delivery by giving providers a secure and reliable means for sharing clinical information across disciplines. The Web Portal also provides a means to share provider performance information and bring actionable data and clinical information to the point of care. **Strategy Goals** The goals of improved information sharing include closing care gaps; improving care delivery and outcomes by treating the whole person and recognizing the impact PH conditions have on BH and vice versa; and improved provider satisfaction through the availability of actionable data, tools, and information to better care for their patients. **Alignment with KanCare 2.0 Goals** This strategy directly aligns with KanCare 2.0 goals to improve integration, including addressing social determinants of health as part of our holistic model of care. It also specifically supports the State's key focus area related to providing Service Coordination

Proposed Integration Strategy #2: Information Sharing	
	for all youth in Foster Care, helping to improve communication and coordination across the system.
3. Identify specific populations and services included in the arrangement	**Populations Impacted** The activities described will be available to and promoted for all members and all providers. **Services Included in the Arrangement** Primary information sharing is between professional providers and community agencies, although information is also available to emergency departments, including an ED flag that can be population by the ED and shared with authorized providers. **Providers Included in the Arrangement** All authorized providers and community agencies will have access to our Web Portals.
4. Identify role of Service Coordination strategies, as applicable	**Role of Service Coordination Strategies** Activities and strategies described will be directly integrated with our service coordination strategies, including improved communication and coordination. A key function of the Web Portals is to support care planning across disparate providers and systems and facilitate development, management, and monitoring of a single, integrated Care Plan. **Potential Synergies** Information sharing is a key success factor in many service coordination strategies. By supporting, promoting, and encouraging information sharing, we are improving service coordination and giving access to valuable clinical and member-specific information across the system.
5. Identify role of health information technology/health information exchange (HIT/HIE), as applicable	**Role of HIT/HIE** Access to information across disciplines and across the continuum is critical to successfully integrating services. Through our Centelligence platform, we can securely share information, pushing and pulling from existing HIE resources. The more information available, the more valuable our tools become.
6. Coordination and collaboration with existing Value Based Purchasing and Quality Initiatives	**Coordination with Existing Relevant VBP and Quality Initiatives** Our goal is to further support existing initiatives by bringing valuable information to make our providers and the delivery system more successful. For example, four of our BH providers were awarded a grant for Opioid interventions. Through our service coordination team, we will deliver member facing data to help these providers address whole person needs.
7. Identify if the model would be implemented statewide or would be a pilot proposal and if the CONTRACTOR(S) has existing experience with the initiative in Kansas or in another state.	**Proposed Scope** Information sharing is a statewide strategy. For providers in rural or frontier areas without internet access, we will run routine reports and provide information via phone, mail, and in person meetings, ensuring all providers have access to all information needed to effectively coordinate and integrate services. **Existing Experience with Similar Models** Sunflower has multiple tools available today to support information sharing. Through continuous enhancements based on provider input and best practices from across the country, we are improving these tools to support more timely and robust communications. For example, our secure Provider Portal is a web-based platform supporting provider administrative "self-service" capabilities including eligibility inquiry, authorization submission and status, claim submission, claim status inquiry, claim payment history, and a growing number of clinical applications. These clinical applications include: online care gap notifications (alerting providers to health alerts and care gaps), Emergency Department high utilizer flag (alerting providers if a member has had three or more emergency room visits in 90 days), the Online Member Health Record (delivering advanced capabilities for clinical service coordination), care and

Proposed Integration Strategy #2: Information Sharing	
	disease management referral, practice-level clinical quality & cost reports, patient analytics, provider analytics, and clinical practice guidelines. Our Provider Portal supports both our PH and BH providers in their practice of evidence-based medicine. Starting in Q2 2018, our suite of web portals will include a Community Partner Portal for community partners, service coordination agencies, and caseworkers. This portal promotes information sharing and collaboration across providers and the member's natural supports, while maintaining the security and privacy of the member's personal and protected information. The Community Partner Portal allows for the sharing of clinical information including completion and submission of assessments. Upon submission, results are loaded into our Centene Document Management System and accessible in TruCare. In addition, through the Community Partner Portal authorized users can check member eligibility, submit documents, view risk and care alerts, notify Sunflower if a member has been to the emergency room, view a member's care plan and submit and view associated notes, and access a member's health record. Based on the availability and current functionality of our Provider Portal, providers have expressed satisfaction, as evidenced through provider satisfaction survey results and feedback during statewide provider forums. **Stakeholder Engagement Strategy** We provide training on the Provider Portal during Provider Orientation, as well as re-introducing the portal during all interactions with Sunflower Service Coordinators, Member Services, and Provider Engagement to promote effective use, coordination, integrated and shared care planning, and data sharing.
8. Identify the proposed metrics, Outcomes or other measurements that the CONTRACTOR(S) will use to (i) determine the payment methodology, if applicable; and (ii) evaluate the effectiveness of the arrangement.	See response to Strategy #1 above as Information Sharing is part of our comprehensive strategy for improved integration. One addition to those measures described above is utilization of the Web Portals across the delivery system.
9. Identify the total number of Members expected to participate in the arrangement and when the arrangement is expected to start.	**Projected Member Participation** We expect 100% of our membership to benefit from the information sharing requirements and capabilities described. **Proposed Implementation Date** We anticipate all enhanced functions described within Information Sharing to be in place by the new Contract start date. **Implementation Timeline** Currently in process; complete by 1/1/2019. Full deployment by 1/1/2019.

Table 5.7.1.A.5_C: Improving Identification and Referral

Proposed Integration Strategy #3: Improving Identification and Referral	
1. Topical area addressed	BH/PH Integration

Proposed Integration Strategy #3: Improving Identification and Referral	
2. Description of arrangement and objectives	**Description of Strategy** Also supporting and directly related to Strategy #1, Strategy #3 is focused on ensuring the entire system is educated to promote early identification, referral, and treatment of BH. This includes not only the health care delivery system, but all systems that may interface with our members, such as child welfare, justice, social services, and first responders. Similar to other approaches, the strategy here is multi-faceted, including, but not limited to: • Provider, community, and first responder education on Mental Health First Aid, Trauma Informed Care, SBIRT, Depression and SUD Screening Tools, How and Where to Refer Members for BH Services, and Recovery and Resiliency • The use of Community Health Workers in hospitals, CMHCs, and social service agencies such as homeless shelters • Partnering with CMHCs and RADAC to meet members who present in the ED with signs of BH and screen and refer for appropriate follow up services • Value-Based Payments for BH Screening by PCPs Expanding our strategy to go outside of the traditional service delivery system promotes more timely identification and treatment. Members with complex BH conditions often have other social determinants that may present barriers or otherwise deter them from seeking services in the traditional manner. We don't want to wait for these members to show up in the ED, so we need to identify other system contacts or entry points we can coordinate with to get them in to appropriate care and service. This approach also leverages other resources that members may already have established and trusted relationships with. For example, using the State's provided list of families who are working with DCF to avoid disruption/removal of the child in the family through Family Preservation. This early identification can provide us with a method to activate our community service coordination to more intensive interventions, working alongside of Family Preservation with our enhanced tools and knowledge of what will assist the family to be successful. **Strategy Goals** Goals of Strategy #3 include improved coordination and knowledge and expertise across the entire system, leading to early identification and referral of BH conditions and improved health outcomes for these members. **Alignment with KanCare 2.0 Goals** This strategy directly aligns with KanCare 2.0 goals to improve integration, including addressing social determinants of health as part of our holistic model of care.
3. Identify specific populations and services included in the arrangement	**Populations Impacted** The activities described will be targeted for populations with potential BH conditions. **Services Included in the Arrangement** Services are administrative in nature and include education, training, and technical assistance and are focused on traditional and non-traditional contact and entry points. **Providers Included in the Arrangement** Providers will include all providers in the delivery system as well as systems and agencies outside of the health care delivery system that touch our members, such as justice, school systems, and homeless shelters.
4. Identify role of Service Coordination strategies, as applicable	**Role of Service Coordination Strategies** Activities and strategies described will be directly integrated with our service coordination strategies, ensuring members are connected to appropriate BH services, including Service Coordination. All Service Coordinators will be cross trained on PH and BH, so that even non-BH Service Coordinators can recognize and identify the signs and symptoms of potential BH conditions and pull in the appropriate BH resources to

Proposed Integration Strategy #3: Improving Identification and Referral	
	participate on Care Teams and connect members with BH services and supports. Service Coordinators will also provide feedback and input into the process by identifying areas of need across the delivery system, including opportunities to support and promote early identification and referral. **Potential Synergies** With a goal to support whole person health, all related trainings, screenings, tools, and resources identified will incorporate Social Determinants of Health and Independence, in addition to PH, BH, or LTSS services. For example, ensuring access to our Community Resource Database.
5. Identify role of health information technology/health information exchange (HIT/HIE), as applicable	**Role of HIT/HIE** Key HIT/HIE elements for early identification of BH conditions includes real time notification of ED visits and IP admissions allowing Sunflower to deploy staff to those locations. Clinical information at the point of service in the ED is also critical to support our EDs in better serving this membership.
6. Coordination and collaboration with existing Value Based Purchasing and Quality Initiatives	**Coordination with Existing Relevant VBP and Quality Initiatives** Sunflower continues to support the Kansas Healthcare Collaborative and current and future HIIN initiatives. Identification and appropriate referral of members with untreated or undertreated BH conditions can directly impact their goal of reducing readmissions. In addition, Project ECHO is an effective vehicle for system wide education and training, for example, we are looking at developing a Project ECHO specific to training and expanding the scope of Community Health Workers. Finally, we will work with Rural Health Initiative to identify opportunities for support stakeholders in our rural communities, including first responders. Internally, we will incorporate VBP around BH Screenings in PCP and OBGYN practices into our existing VBP arrangements.
7. Identify if the model would be implemented statewide or would be a pilot proposal and if the CONTRACTOR(S) has existing experience with the initiative in Kansas or in another state.	**Proposed Scope** Our efforts to support early identification and referral for BH will be statewide. Certain activities may be limited or adjusted based on variables such as local resources. For example, the availability of a partnering CMHC to meet members at the ED for screening and referral. Telehealth may be an alternative option for these communities. The co-location of Sunflower CHWs will also be focused on areas of higher membership density. Community trainings and education will be made available statewide, including rural and frontier areas. **Existing Experience with Similar Models** Early identification and referral for BH is a key strategy for Sunflower. Current initiatives we have in place to promote early identification, referral, and treatment include: • Co-location of CHWs, including two hospitals and two CMHCs • Provider and staff training on Mental Health First Aid, Trauma Informed Care, SBIRT, and Motivational interviewing • Availability of BH screening tools on our website • PCP Toolkits with screening tools • Support of law enforcement initiatives in the Crisis Intervention Teams model by providing BH focused training By placing CHWs in the community, Sunflower has expanded our reach and ability to identify and intervene early. For example, based on the work of our CHWs in these community sites we have completed: • 14,461 Resource Referrals • 2,129 Assessments

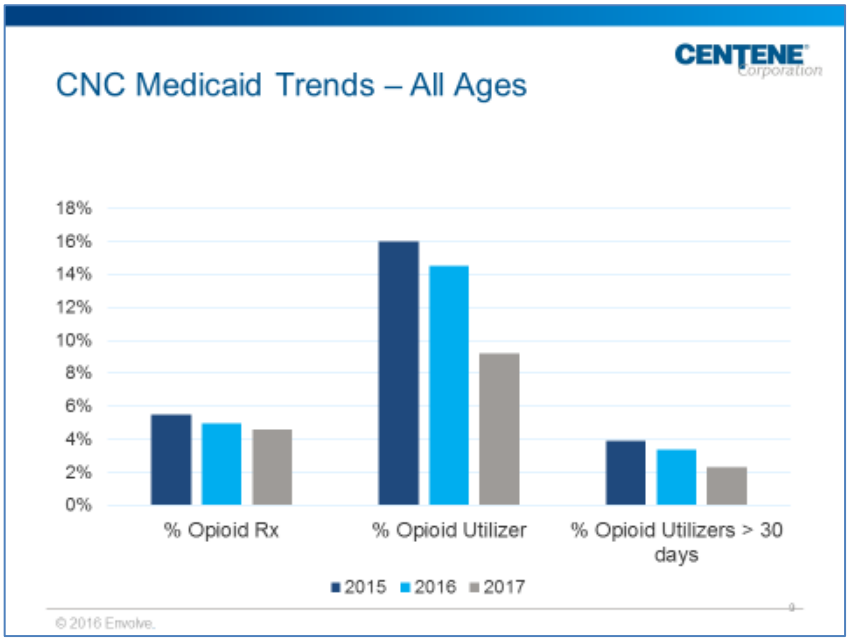
Proposed Integration Strategy #3: Improving Identification and Referral	
	To further promote early identification and screening, our Mississippi affiliate embeds Care Managers into high volume PCP practices and other care sites. For example, the Care Manager reviews member records, develops check lists for preventative measures the member may need, ensures they have their health risk screening, promotes the medical home concept, and performs ER Diversion activities. Since beginning this program, members with an assigned PCP at the clinics have seen a reduction in ER visits per 1000 members, from 1,171/1000 in 2013 to 747/1000 in 2016. A big area of focus in many of our affiliate plans is members experiencing homelessness. For example, our Washington affiliate has CHWs co-located at a local youth homeless shelter to engage, educate, and refer to providers and other allied and community services as needed. This is directly in line with their "We Care" pilot for transitioned foster youth homeless members and their Adopt-A-Shelter Program, which supports in shelter education, person-centered care planning, and coordination. They have also partnered with Downtown Emergency Services Center (DESC) to provide initial outreach to high-risk members living under bridges and in encampments. Through this partnership, DESC locates difficult to reach members and connects them directly to a health plan CHW to provide whole-health resource linkage. Their partnership with DESC has resulted in more than 100 successful member contacts in a 12-month period. Our Washington affiliate has also partnered with a number of Counties to use EMS utilization data from all participating fire agencies to generate reports that identify members who are "frequent utilizers" of 911 EMS services. The Care Management Team is then able to engage the member to address care coordination needs and connect the member to appropriate health care services and supports, including a whole person medical home and BH services as needed. **Stakeholder Engagement Strategy** To ensure comprehensive and widespread reach across local communities throughout the state, we will develop an outreach and engagement plan specific to providing education and identifying opportunities for co-location and BH screening and referral services. This will include working with providers, agencies, advisory committees, and associations to identify a list of stakeholders to engage and the most appropriate forums to provide training and education. For example, the Kansas Healthcare Association, Kansas Medical Society, Mother & Child Coalition, Kansas Association of Medically Underserved, the Kansas American Academy of Pediatrics, Independent Living Centers, and Homeless Shelters. Our education programs are community based and will be made available both in person and via web-based trainings.
8. Identify the proposed metrics, Outcomes or other measurements that the CONTRACTOR(S) will use to (i) determine the payment methodology, if applicable; and (ii) evaluate the effectiveness of the arrangement.	See response to Strategy #1 above as Identification and Referral is part of our comprehensive strategy for improved integration.

Proposed Integration Strategy #3: Improving Identification and Referral	
9. Identify the total number of Members expected to participate in the arrangement and when the arrangement is expected to start.	**Projected Member Participation** Over 13,400 of our members have a primary risk category of BH, representing approximately 11% of the population. Almost 20,000, or 16% of the population, are at risk for or have SUD. Our goal is to reach all members with an existing, at risk, or suspected BH condition, including hard to reach and engage members. **Proposed Implementation Date** We anticipate all enhanced functions described within Information Sharing to be in place by the new contract start date. **Implementation Timeline** Currently in process; complete by 1/1/2019. Training programs will be made available throughout the state on a quarterly basis starting in 2018. Efforts related to co-location and BH clinicians to support screening and referral in the ED will be rolled out based on those counties and facilities with an adequate membership base. Based on program success, we will expand through the use of telemedicine.

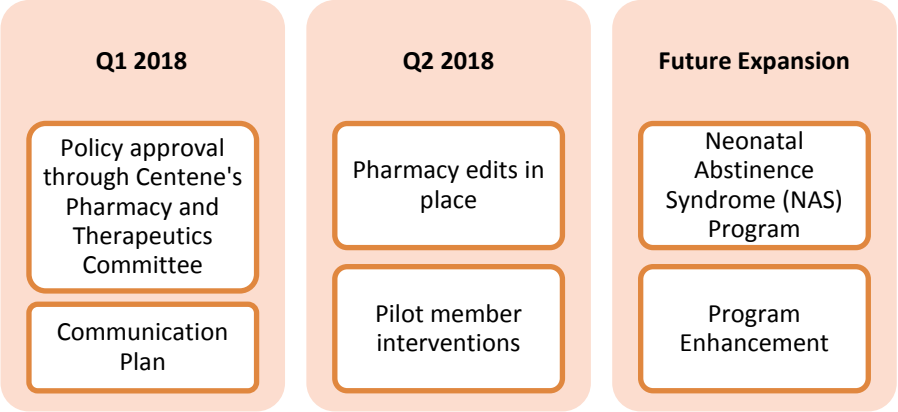
Table 5.7.1.A.5_D: Addressing the Opioid Crisis

Proposed Integration Strategy #4: Addressing the Opioid Crisis	
1. Topical area addressed	BH/PH Integration
2. Description of arrangement and objectives	**Description of Strategy** Centene Corporate Medical Affairs initiated an enterprise-wide Opioid Prevention Program in 2016 with the goal of creating standard guidance for Centene's health plans to address the opioid epidemic. The comprehensive Opioid Program approaches opioid abuse from three angles within Centene: pharmacy/policy, health care provider, and member. The first phase of the program includes the implementation of an updated narcotic analgesic pharmaceutical policy to reduce the amount of opioids that opioid naïve members can receive. Phase 2 includes utilization of a proprietary predictive data science model to identify members at high risk for opioid abuse and intervene appropriately. ***Pharmacy/Policy Recommendations*** • We are working directly with KDHE to align our pharmacy policies around opioid use and opioid naïve members (fewer than 28 days of opioids supplied in last 90 days). For example limiting chronic daily morphine milligram equivalent (MME) dose to 90 MME to be aligned with the CDC (Center for Disease Control and Prevention) Guideline for Prescribing Opioids for Chronic Pain. ***Provider Recommendations*** • Standardize process around profiling reports • Promote education about guidelines and appropriate prescribing • Generate Provider Engagement templates for health plans to implement • Promote use of states' Prescription Drug Monitoring Program (PDMP), K-TRACS • Expand access to Medication Assisted Treatment (MAT) ***Member Recommendations*** • Identify high risk members using the SUD Segmentation Model and Centene's Opioid Risk Classification Algorithm Model • Develop work process to outreach appropriately Our Opi-End Program is designed to approach the opioid crisis in a more targeted fashion, developing and implementing specific policies and protocols to improve the way opioids are prescribed. This is coupled with alternative pain management strategies to support opioid naïve members.

Proposed Integration Strategy #4: Addressing the Opioid Crisis	
	Strategy Goals Goals of the Opi-End program include: Preventing opioid misuse and abuse; Identifying and treating opioid use disorder; Preventing deaths from overdose; and effectively using data to detect opioid misuse/abuse. **Alignment with KanCare 2.0 Goals** The Opi-End programs supports integration by recognizing the abuse of prescription opioids is often caused by pain, which is typically a result of a PH condition. The opioid epidemic is a system-wide issue that must be resolved through an integrated effort, leveraging experts across the PH and BH system.
3. Identify specific populations and services included in the arrangement	**Populations Impacted** Opioid naïve members and members abusing or at risk of abusing prescription opioids. **Services Included in the Arrangement** Services include pharmacy, pain management, and education, training, and segmentation. **Providers Included in the Arrangement** Providers across the health care system are targeted for education, with particular focus on PCPs, prescribers and alternative pain management providers.
4. Identify role of Service Coordination strategies, as applicable	**Role of Service Coordination Strategies** Activities and strategies described will be directly integrated with our service coordination strategies, ensuring members are connected to the right services, at the right time, by the right provider. Service Coordinators and Community Service Coordinators will be trained on the Opi-End program to ensure members are using opioids appropriately and/or otherwise receiving alternative pain management services. Service Coordinators will also engage providers and pharmacists in care planning to appropriately design interventions for members at risk. **Potential Synergies** We are connected closely to the four entities that received the SAMSHA Opioid grant and continue to explore our collaboration with these entities (Four County, KU, RADAC and CKF). While the described program focuses on prescription opioid addiction, there are synergies with other SUD interventions, and many members may have co-occurring substance use disorders, such as opioids and alcohol. We also have specific programs for pregnant members abusing opioids and other SUDs. We work to identify pregnant members through various means, including referral, notice of pregnancy (NOP), and state assessment for SUD. We assign a service coordinator upon notification and they work with that member throughout their treatment. We also refer members to our Start Smart for Your Baby program.
5. Identify role of health information technology/health information exchange (HIT/HIE), as applicable	**Role of HIT/HIE** A key part of our Opi-End strategy relies on data to identify and appropriate intervene members currently abusing opioids or at risk for opioid abuse. Our SUD Segmentation Model features a proprietary algorithm that infuses best-in-class clinical and analytical expertise with evidence-based information and claims data. The algorithm blends financial and clinical risk, and considers behavior patterns and prior treatment to place individuals into unique SUD segments. Having access to real time or near real time data will further improve our ability to identify and intervene quickly.
6. Coordination and collaboration with existing Value Based Purchasing and Quality Initiatives	**Coordination with Existing Relevant VBP and Quality Initiatives** We are working directly with KDHE to enhance State policies and requirements in alignment with national best practices in opioid programs. We are also working with the four recipients of the SAMSHA Opioid grant, Four County, KU, RADAC and CKF. For example, the Heartland RADAC's Intensive Case Coordination (ICC) and Recovery Coaching program. RADAC is currently covering the following counties for us:

Proposed Integration Strategy #4: Addressing the Opioid Crisis	
	Wyandotte, Johnson, Shawnee, Douglas, Sedgwick, Ellis, Barton, and Saline Counties. The key to the success of this program is connecting ICC clients with needed services within the community and continued care coordination to address system barriers that present for this population. The key collaborative components of service include: continued access to state and federal benefits, securing safe sober housing, accessing mental health services including medication management and case management, accessing substance use services such as formalized treatment programs, as well as appropriate Recovery Oriented Systems of Care (ROSC) - including community support groups and/or recovery coaches; addressing physical health issues that are a result of chronic use, such as high blood pressure, diabetes and traumatic brain injury, etc.; seeking earned income and avoiding law enforcement as a result of their disability. The ultimate goal of the Heartland RADAC's ICC program is to reduce the use of inappropriate and costly services that are associated with this client population, while improving their quality of life.
7. Identify if the model would be implemented statewide or would be a pilot proposal and if the CONTRACTOR(S) has existing experience with the initiative in Kansas or in another state.	**Proposed Scope** Sunflower proposes that Opi-End be implemented as a statewide model and approach. **Existing Experience with Similar Models** Sunflower and many of our affiliates are in the process of implementing the Opi-End program, at varying levels of implementation. For Sunflower, we have contracted with RADAC for ICC and Recovery Coaching. We will add our Opi-End to the resources we will supply to RADAC. We will also expand this resource to CKF as part of our pilot through ACHESS and our VBP we are developing with them. In addition, several of our affiliate health plans have implemented stand-alone programs and innovations, the results of which have been used to help inform the Opi-End program and related innovations. We describe two examples with outcomes below. While many of our affiliates are in the pilot phase, most outcomes are projected, for example, prevention of 5% opioid use disorder patients can save $7-9 million annual. Though early, overall, Centene's opioid prescription rate has been decreasing in response to the multi-pronged interventions, as depicted below. 

Proposed Integration Strategy #4: Addressing the Opioid Crisis	
	Outside of the multi-faceted Opi-End program, examples of targeted programs our affiliates have successfully implemented include: • The Substance Use in Pregnancy Program involves targeted outreach to pregnant members who abuse opiates, alcohol, and other drugs. A trust-based case management approach encourages the member to participate in a personalized plan that helps her overcome addiction and improve the likelihood of a healthy pregnancy and an infant that does not suffer from withdrawal. The Substance Use in Pregnancy Program partners with state addiction programs and encourages counseling and medication in addition to intensive outpatient or inpatient addiction treatment if needed. Medication-assisted treatment with Subutex or methadone can replace the need for dangerous prescription or street drugs and prevents the pregnant member from going into withdrawal, which can be dangerous for the fetus. Subutex is particularly encouraged, as it has been shown to reduce the rates of infants with NAS and also NICU length-of-stay. This program was initially piloted by our Ohio affiliate health plan and received the 2014 Ohio Association of Health Plan's (OAHP) Pinnacle Award for Best Practice Health Care Programs and a 2015 Medicaid Health Plans of America Best Practices Compendium - Maternal Health Award. Our Ohio affiliate data shows that neonatal inpatient length-of-stay has reduced to an average of 13 days among infants delivered to mothers enrolled in the Substance Abuse in Pregnancy Program. Additionally, five out of nine members who were enrolled in the substance abuse program at the time of delivery had infants who were NAS free. • Our Arizona affiliate has implemented several programs over the past 24 months, including expansion of Medication Assisted Treatment providers in the network, a chronic pain management program, and substance abuse in pregnancy. As a result of these efforts, from Q1 2017 to Q4 2017, opioid-related utilization was reduced from 10.3% to 3.4%. **Stakeholder Engagement Strategy** As a widespread epidemic, we will use a community education approach to increase awareness. Chronic pain affects millions of Americans, and frequently is a co-occurring condition for individuals with BH diagnoses. Recognizing this clinical need, SAMHSA, the US Department of Health and Human Services, and the CDC have recently released standards to increase access to appropriate, high-quality and evidence-based care for pain. In alignment with our overarching goal to help providers ensure the safest and most effective treatment for our members, we will work with our provider communities to leverage existing regional best practice guidelines and train and educate on related policy changes, such as prescription limits. We will also take our opioid program to the next level by tackling the issue before it starts. For example, through education, awareness and promoting routine SUD screening in schools and providing age appropriate education to students and parents. We are providing education to our prescribers on alternative prescribing methods; enhancing collaboration with PCPs and Physician Assistants (PAs) to prevent opioid misuse and abuse; and providing Mental Health First Aid Training to First Responders.
8. Identify the proposed metrics, Outcomes or other measurements that the CONTRACTOR(S) will use to (i)	In addition to measures and strategies described in Strategy #1 above, we will look at costs associated with opioid abuse, which are most pronounced with BH, pharmacy, and ED cost categories, and ED visits associated with pain management. Centene estimates that the PMPM difference in costs due to opioid abuse is $250 to $325 PMPM.

Proposed Integration Strategy #4: Addressing the Opioid Crisis	
determine the payment methodology, if applicable; and (ii) evaluate the effectiveness of the arrangement.	
9. Identify the total number of Members expected to participate in the arrangement and when the arrangement is expected to start.	**Projected Member Participation** Based on Sunflower data, we have 22,559 members who fall into the moderate and high risk for opioid use (ORCA scores), representing 18% of our membership. **Proposed Implementation Date** Centene has outlined the following implementation plan for all affiliates, including Sunflower, with appropriate State approvals.  **Implementation Timeline** Sunflower's implementation of the Opi-End program will be complete by 2019.

TELEHEALTH PROJECTS (5.7.1.A.6)

Sunflower is committed to expanding the use and effectiveness of telehealth strategies and driving strategic innovation in the delivery of care while providing improved access through telehealth initiatives including telemedicine, telemonitoring, and telementoring. We recognize that successful telehealth projects require meaningful collaboration with provider and community partnerships and national and local telehealth experts to effectively address access issues, improve health outcomes, and decrease health care and other costs. We will collaborate with and build upon Kansas' existing telehealth initiatives supported by the Heartland Telehealth Resource Center to implement our proposed telehealth models described in the tables below.

Telehealth Experience

Today, Sunflower supports telehealth through multiple modalities including two-way, real time interactive communication, remote patient monitoring for members with certain diagnoses on the HCBS Frail and Elderly waiver and through our congestive health failure pilot, telephone,

online assessments, electronic consultations (e-consultations), and chronic care management. For more information on our telehealth experience, please see Section 5.5.Provider Network.

Proposed Telehealth Models

Aligned with the goals of KanCare 2.0, our telehealth initiatives are designed to enhance traditional service delivery and improve member health outcomes by improving access to care for rural, frontier, and underserved areas, improving access to behavioral health (BH) services, increasing independence of and access to services and housing for persons in LTSS, and supporting chronic pain management interventions.

As described in the tables below, our proposed telehealth strategies to be implemented during the upcoming Contract Period for KDHE's consideration include four new telehealth models:

- Proposed Telehealth Project #1: Telepsychiatry Psychotropic Medication Management (Telemedicine; 5.7.1.A.6.a) (***Table 5.7.1.A.6 _A: Telepsychiatry Psychotropic Medication Management***)
- Proposed Telehealth Project #2: Active Sensor Monitoring Program (Telemonitoring; 5.7.1.A.6.b) (***Table 5.7.1.A.6._B Active Sensor Monitoring Program***)
- Proposed Telehealth Project #3: Chronic Pain Management Project ECHO (Telementoring; 5.7.1.A.6.c) (***Table 5.7.1.A.6._C Chronic Pain Management Project ECHO***)
- Proposed Telehealth Project #4: Community Service Coordinator (CSC) Project ECHO (Telementoring; 5.7.1.A.6.c) (***Table 5.7.1.A.6_D CSC Project ECHO***)

Table 5.7.1.A.6 _A: Telepsychiatry Psychotropic Medication Management

Proposed Telehealth Project #1: Telepsychiatry Psychotropic Medication Management	
1. Topical area addressed	Telehealth Projects, LTSS, Physical and Behavioral Health Integration Strategies
2. Description of arrangement and objectives	**Description of Model** Sunflower recognizes that use of technology to deliver behavioral health services can help address barriers that can prevent our members from receiving care, including access issues in rural and frontier areas across Kansas. In early 2018, we will pilot our telepsychiatric program, supported by the Kansas Health Care Association and Leading Age Kansas to expand the availability of psychiatric medication management to members in Nursing Facilities (NFs) in rural, frontier, and underserved regions of the State. Recognizing the potential financial burden for these NFs due to reimbursement barriers from Medicare, Sunflower will support the telepsychiatry program including regular e-consultations for members on antipsychotics. Through this program, psychiatrists will ensure appropriate prescribing of psychotropic medications including the decrease or tapering off of members on antipsychotics. **Differentiating Component from Traditional Service Delivery and/or Payments** Working within the state's telemedicine framework, today, Sunflower allows all contracted providers to offer telemedicine services within their scope of practice as long as the provider provides a service covered by the current State telehealth codes and uses the correct telehealth equipment per State policy. Recognizing the State's telehealth policy, this strategy will enhance traditional service delivery by increasing access to telehealth technology necessary to support telepsychiatric services.

Proposed Telehealth Project #1: Telepsychiatry Psychotropic Medication Management	
	Strategy Goals The goals of our telepsychiatry program include: • Ensuring appropriate prescribing of psychotropic medications for members in NFs • Increasing member access to behavioral health services in rural and frontier areas • Increasing member oversight and treatment • Increasing appropriate metabolic screening for members on antipsychotics and lowering the rate of multiple concurrent antipsychotics use • Reducing the incidence of polypharmacy, adverse drug effects, and unnecessary pharmacy costs **Alignment with KanCare 2.0** This strategy directly aligns with KanCare 2.0 goals to increase independent living supports for members with BH needs which in turn improves member health outcomes.
3. Identify specific populations and services included in the arrangement	**Populations Impacted** The initial pilot program will be available to approximately 30 members in select NFs in geographically isolated rural, frontier, and underserved regions of the State. **Services Included** This program is limited to telepsychiatric services which will be offered in participating NFs. **Providers Included** Providers will include NFs, as well as support staff and member's family and/or caregiver.
4. Identify role of Service Coordination strategies, as applicable	**Role of Service Coordination Strategies** Critical to achieving the goals of our telepsychiatry pilot for psychotropic medication management is our member-centric high touch approach leveraging the Nursing Facility's Medical Director, Nursing Facility staff, the member and members' family, and Service Coordination staff. Service Coordinators will provide feedback and input into the program by identifying areas of need, including members needing additional supports and working collectively with the Integrated Care Team to bring that support.
5. Identify role of health information technology/health information exchange (HIT/HIE), as applicable	**Role of HIT/HIE** Access to information is critical to support the goals of the telepsychiatry program including helping in member oversight and treatment, reducing the incidence of polypharmacy and adverse drug effects. Key elements for data exchange include sharing of pharmacy utilization data and additional behavioral health data with medical and social data supporting a 360 degree view of the member. Support of this program also requires use of telehealth video equipment (e.g., desktops, tablets and standards based endpoints) which Sunflower will provide as part of this pilot program.
6. Coordination and collaboration with existing Value Based Purchasing and Quality Initiatives	**Coordination and Collaboration with Existing Relevant VBP and Quality Initiatives** Sunflower will work with existing programs and initiatives to promote and augment our telehealth strategies. Sunflower's VBP and quality initiatives extend beyond participation among traditional provider types to include NFs. Additionally, as part of our VBP program, we continue to evaluate our P4P measures and will consider inclusion of telehealth HEDIS BH measures to support telemedicine adoption, improved quality scores, and member health outcomes.
7. Identify if the model would be implemented statewide or would be a pilot proposal and if the CONTRACTOR(S)	**Implementation Strategy** The telepsychiatry program will be offered as a pilot to members who reside in NFs in rural, frontier, and/or underserved areas of the State. Sunflower has identified six NFs to include in the pilot program. **Existing Experience** To better understand current provider utilization of telehealth services, we analyzed claims data to identify telehealth services provided to members between 2015 and 2017.

Proposed Telehealth Project #1: Telepsychiatry Psychotropic Medication Management	
has existing experience with the initiative in Kansas or in another state.	From this analysis, we found that the majority of telemedicine live video services volume we experience is for a BH service. Recognizing this and that use of technology to deliver BH services can address the barriers that can prevent our members from receiving care, including access issues that occur in rural areas and the stigma that many individuals still feel exists surrounding mental health illness, Sunflower's BH Medical Director, Dr. Sosunmolu Shoyinka has conducted telepsychiatry virtual consults for Crisis Assessments, Psychiatrist Visits, and Therapy for almost two years. ***Sunflower Affiliate Health Plan Experience.*** Several of Sunflower's affiliate health plans support PCP access to psychiatric consultation by telemedicine and telepsychiatry through virtual video or provider to provider e-consultations. For example, Sunflower's Texas affiliate contracts with 38 of the 39 Texas Local Mental Health Authorities, which offer telepsychiatry. ***National Expertise.*** To help support Sunflower in the deployment of the telepsychiatry program, in 2018, Sunflower's parent company is creating a centralized Telehealth Resource Hub. Recognizing the need for an organization-wide center of expertise, the Telehealth Resource Hub is designed to help facilitate and coordinate telehealth and telemedicine activities for Sunflower and affiliate health plans. The Telehealth Resource Hub will serve as a resource library and disseminate best practices and lessons learned for implementing similar telemedicine programs. **Stakeholder Engagement Strategy** Sunflower has received support from the Kansas Health Care Association and Leading Age Kansas for our telepsychiatry program. Additionally, it will be implemented in collaboration with the participating NFs, the Nursing Facility Medical Director, the member, and the member's family. In addition, we will engage Service Coordinators in the member's Person Centered Service Plan (PCSP) and Plan of Care.
8. Identify the proposed metrics, Outcomes or other measurements that the CONTRACTOR(S) will use to (i) determine the payment methodology, if applicable; and (ii) evaluate the effectiveness of the arrangement.	**Proposed Metrics/Measurements** Based on the goals of the strategies described, the following measures will be used to evaluate effectiveness: • Member participation and attendance • Member satisfaction • Provider satisfaction • Drug utilization • Utilization (ED transfers from NFs) **Proposed Outcomes** Based on the proposed metrics/measurements described above, Sunflower anticipates to see the following outcomes: • Increase in member access to BH services • Increase in member satisfaction • Decrease in antipsychotic use • Decrease in rate of multiple concurrent antipsychotics use • Decrease in pharmacy costs • Decrease in medication related ED visits for program participants **Measurement Selection Methodology** Measures described were selected as a consistent method of evaluation as used across clinical and quality programs. **Monitoring Provider Performance** Sunflower continually monitors provider performance against predetermined performance objectives based on quality measures including quality of life measures. **Impact on Members** Additional Sunflower members will receive services not currently available today that will improve member care and quality outcomes by keeping members in lower levels of

Proposed Telehealth Project #1: Telepsychiatry Psychotropic Medication Management	
	care and strengthening the families/caregivers to support the member. **Providing Data to the State** Sunflower proposes a similar reporting structure and timeframes to those currently in place for reporting programmatic outcome data to KDHE. Sunflower will comply with all reporting requirements as described in Attachment H of the RFP. **Stakeholder Engagement Plan** Sunflower will work with our LTSS Advisory Committee, participating NFs, and Kansas Health Care Association to develop performance metrics.
9. Identify the total number of Members expected to participate in the arrangement and when the arrangement is expected to start.	**Anticipated Members in Arrangement** We anticipate approximately 30 members participating in the initial pilot program and pending successful pilot results will consider rolling out the program to additional members. **Start Date** January 2018 **Implementation Timeline** Our goal is to have the capacity and technology to provide the described telepsychiatry program to members starting in January 2018. We will work with each participating Nursing Facility on a timeline that meets them where they are and works within their capacities. **Roll-out** Sunflower has identified and begun discussions with six NFs across the State to pilot this program. We are conducting a vendor assessment to select a telepsychiatry vendor and once selected, will be able to roll out the pilot to all participating NFs.

Table 5.7.1.A.6._B Active Sensor Monitoring Program

Proposed Telehealth Project #2 Active Sensor Monitoring Program	
1. Topical area addressed	Telehealth Projects, LTSS
2. Description of arrangement and objectives	**Description of Strategy** In collaboration with Community Living Opportunities (CLO) and HomeLink Support Technologies, Sunflower will partner with CLO to help fund an active sensor monitoring pilot program which includes a model of housing, telehealth and supervision support, and networked onsite living supports for members with I/DD and others receiving HCBS services. The Neighborhood Network creates a support system for neighborhoods by using smart home technology, remote coaches and clinicians, and professional neighbors or roommates to deliver individualized care on demand or as scheduled to provide needed services to members in the most independent living arrangement possible. HomeLink delivers health-care and BH support, home security, in-home care, and emergency support to a members' home, when needed. HomeLink's active sensor monitoring technology combines wearable technology, beacons, and advances in home automation to create a smart system of real-time alerts, tracking, analysis, and reporting. HomeLink combines leading-edge active sensor monitoring technology with coaches and clinicians that are available to assist a member, when needed. **Differentiating Component from Traditional Service Delivery and/or Payments** Sunflower's proposed active sensor monitoring program will enhance traditional service delivery by delivering individualized care at the right time and in the right frequency that the member needs. Sunflower will fund the pilot program in partnership with CLO to support the administrative costs associated with offering the HomeLink technology necessary to deliver this telemonitoring model. Using remote monitoring and support

Proposed Telehealth Project #2 Active Sensor Monitoring Program	
	using smart home, security, and sensor technologies, this alternative model of care promotes independent living and quality of life. **Strategy Goals** The goals of the active sensor monitoring program are to: • Maximize and preserve member independence • Decrease ED and inpatient utilization • Reduction in costs due to improved access to services and early identification of member needs • Improve member satisfaction and individual member outcomes based on a member's Person Centered Service Plan (PCSP) goals **Alignment with KanCare 2.0** This model directly aligns with the KanCare 2.0 goals to address social determinants of health by increasing independent living supports for members who have intellectual, development or physical disabilities or traumatic brain injuries.
3. Identify specific populations and services included in the arrangement	**Populations Impacted** Individuals with I/DD and including those with chronic conditions, dual eligibles, and disabled adults and other members on an HCBS waiver. **Services Included in the Arrangement** Services include a combination of onsite and remote caregivers and HomeLink Support Technologies to provide needed services to members in the most independent living arrangement possible. **Providers Included in the Arrangement** The active sensor monitoring pilot program is in partnership with CLO, a provider of HCBS.
4. Identify role of Service Coordination strategies, as applicable	**Role of Service Coordination Strategies** The role of service coordination will be integral to the success of this model. Service Coordinators will provide care coordination services to members. Care coordination strategies include working as part of the Integrated Care Team including the PCP and caregiver to ensure members are connected to all needed services to ensure they remain in the least restrictive setting as it is appropriate. Additionally, through our Project ECHO model described below, we will facilitate trainings and offer resources to Community Service Coordinators (CSCs) to help them support members. **Potential Synergies** With the goal of maintaining and supporting the most independent member living arrangement, this model will incorporate Social Determinants of Health and Independence, in addition to identifying needed physical health, BH, and LTSS services.
5. Identify role of health information technology/health information exchange (HIT/HIE), as applicable	**Role of HIT/HIE** Timely access to information and the sharing of real-time alerts, notifications, and member level data is necessary to support this model. HomeLink's HIPAA compliant active sensor monitoring technology "connects" homes to allow remote caregivers or clinicians to: • Monitor, track, and respond to a member's needs • Control home automations to provide help and ensure safety • Track, trend, and report on member patterns to enable early intervention Additionally, the HomeLink system provides individually tailored safety options such as door and window alarms, a bedside floor mat that will automatically turn on a light when pressure is applied, a device that will allow the oven/stove to be turned on and off by remote support staff, a medication box with a small camera that allows a remote caregiver to watch the medications being taken, and to lock/unlock them remotely. The system also allows for individually tailored responses such as a phone call, tele-video connection, or deployment of caregivers. The HomeLink system also gathers information

Proposed Telehealth Project #2 Active Sensor Monitoring Program	
	to establish individual patterns and alerts the provider to disruptions in patterns to enable early intervention. Through this program, members would select a wearable device (badges, wristbands, and garment tags) and home proximity sensors called "beacons". The wearable devices examine movement and proximity to other beacons and sensors to more easily detect member needs and support through a home environment. For example, this type of system can detect and monitor how frequently a member accesses food from the refrigerator, or uses the bathroom. Information collected through the beacons is then securely transmitted for tracking, analytics, and reporting. Automated alerts let a member's caregivers know of any changes to behavioral patterns or needs – allowing the caregiver to follow up with the member in a timelier manner. This information can also be tracked and trended for review by the member's service coordinators.
6. Coordination and collaboration with existing Value Based Purchasing and Quality Initiatives	**Coordination and Collaboration with Existing VBP/Quality Initiatives** Sunflower will work with existing VBP programs and initiatives to promote and augment our telemonitoring program. For example, this strategy is in direct alignment with the objectives and goals outlined in our proposed LTSS Transition Coordination Incentive Program (see Proposed APM #6: LTSS Transition Coordination Incentive Program for full details).
7. Identify if the model would be implemented statewide or would be a pilot proposal and if the CONTRACTOR(S) has existing experience with the initiative in Kansas or in another state.	**Proposed Scope of Strategy** Sunflower will pilot this program in partnership with CLO. **Existing Experience with Strategy and Outcomes** ***Sunflower Experience: CLO and HomeLink.*** CLO and HomeLink's active sensor monitoring program currently supports Sunflower members with I/DD. Through CLO's Neighborhood Network approach, members are able to receive health and BH supports that maximize independence. Outcomes. Through this program, residents have experienced increased quality of life related to independence and ability to maintain relationships with friends and family. For example, one resident relies on the telemonitoring and technology supports in her home to provide consistent communication, behavioral guidance, and employment to make positive, independent decisions. ***Sunflower Experience: Congestive Heart Failure (CHF) Telemonitoring Program.*** Sunflower's data analytics teams utilizes analytic data to determine our most at risk and ill members with CHF. We then evaluate our ability to impact these members through Service Coordination and through telemonitoring services provided through our partnership with Windsor Place's in-home services. In July 2017, Sunflower partnered with Windsor Place's in-home telemonitoring program to offer services to our high-risk members with CHF. Part of the Kansas Heart and Stroke Collaborative, Windsor Home provides in-home telemonitoring to 35 Sunflower members. Upon consultation with the member's PCP, Windsor Place installs equipment in the member's home in order to remotely collect vitals such as blood pressure, weight, and oxygen saturation. This information is secure and only provided to the Sunflower's Service Coordinators and,

Proposed Telehealth Project #2 Active Sensor Monitoring Program	
	most importantly, the PCP involved in the care of the member. This program also provides local health coaches to improve care coordination. Outcomes. Preliminary results over the last five months show a reduction in hospital outpatient care primary and specialty care visits producing an overall member per month spend reduction and over 10% savings for the 35 member cohort. ***Sunflower Experience: HCBS Frail and Elderly Waiver Telemonitoring.*** Sunflower offers telemonitoring services to 54 members with certain diagnoses on the HCBS Frail & Elderly waiver. Outcomes. Members participating in the telemonitoring program resulted in a decrease in member spend and claims submitted (comparing 2016 to 2017). ***Sunflower Affiliate Health Plan Experience.*** Sunflower's affiliate health plan in Arizona successfully uses remote monitoring technology. Through this program passive sensors are installed in members' homes to remotely monitor patterns in activities of daily living Information on changes in activity is sent to the member's Care Manager, as appropriate, to provide timely and actionable information about the member's health needs. Through this process, when there is a significant change in activity, a member's Service Coordinator makes an outbound call to check-in on the member and follows up, as necessary. Outcomes. The Arizona affiliate's pilot project resulted in a statistically significant decrease in overall per member per month spend, driven by a significant decrease in hospitalizations in the pilot group compared to the control group. **Stakeholder Engagement Strategy** Through our partnership with CLO, Sunflower is working with CLO's providers and staff to deliver this model.
8. Identify the proposed metrics, Outcomes or other measurements that the CONTRACTOR(S) will use to (i) determine the payment methodology, if applicable; and (ii) evaluate the effectiveness of the arrangement.	**Proposed Metrics/Measurements** Based on the goals of the strategies described, the following measures will be used to evaluate effectiveness: • Wounds, falls, and rates of Urinary Tract Infections, and flu vaccination for seniors • Quality of life measures such as if the member feels safe in their home, are satisfied with where they live, decide their daily routine, etc. • Individual member outcomes based on PCSP goals • Member satisfaction • ED utilization **Proposed Outcomes** Sunflower's proposed outcomes include: • Improved member satisfaction • Improved member outcomes • Reduction in ED utilization • Improved quality of life metrics **Measurement Selection Methodology** Sunflower measurement were selected as a consistent method of evaluation as used across clinical and quality programs and to align with KDHE's objective to impact quality of care and increase independent living opportunities for LTSS members through innovative solutions. **Monitor Provider Performance** As part of our quality program and through our Centelligence® analytics and reporting capabilities including the LTSS Key Performance Indicator (KPI) Dashboard we will regularly monitor model progress toward goals. The LTSS KPI Dashboard provides actionable reports for our teams across service coordination, quality, operations, member satisfaction, enrollment, and financial metrics. This interactive dashboard allows Sunflower staff to review trends in provider performance, benchmark against Sunflower's affiliate LTSS health plans, and download data to drill down by provider. The

Proposed Telehealth Project #2 Active Sensor Monitoring Program	
	LTSS KPI Dashboard includes metrics on quality of life (e.g., ability to see friends and family, control over daily routine), member satisfaction, and integration risk factors that can lead to institutionalization (e.g., wounds, falls). **Impact on Members** The anticipated impact on members is all leading to greater member satisfaction and improved health outcomes. **Providing Data to the State** Through our Centelligence® analytics and reporting platform and LTSS Dashboard we are able to monitor, track, and report on Key Performance Indicators and monitor program performance and outcomes. We will provide scheduled and/or ad-hoc reports for this program, in the manner and frequency requested by the State. **Stakeholder Engagement Strategy** We will engage our LTSS Advisory Committee to receive direct input in the development of performance metrics. In addition, we will seek feedback from CLO.
9. Identify the total number of Members expected to participate in the arrangement and when the arrangement is expected to start.	**Anticipated Member Participation** During the initial pilot, we anticipate a smaller member cohort and based on pilot results, we will roll out the program to additional LTSS and I/DD members. **Implementation Timeframe and Start Date** We anticipate implementing the initial pilot in Fall 2018, with full deployment within 12 months of the implementation date of the Contract.

Table 5.7.1.A.6._C Chronic Pain Management Project ECHO

Proposed Telehealth Project #3: Chronic Pain Management Project ECHO	
1. Topical area addressed	Telehealth Projects, Physical and Behavioral Health Integration Strategies
2. Description of arrangement and objectives	**Description of Strategy** To increase PCP capacity to address services for members with chronic pain, Sunflower will develop a Chronic Pain Management Project ECHO (Extension for Community Healthcare Outcomes) for the KanCare 2.0 populations and to expand the capacity of providers to integrate physical and BH services and help address the opioid crisis in Kansas. The Chronic Pain Management ECHO will provide an opportunity for discussion, empowerment, and support through telementoring. This model supports PCPs to more effectively and confidently treat patients suffering from chronic pain and in all aspects of their experience. The Chronic Pain Management ECHO will integrate medical, pharmacological, and psychological considerations into the treatment of the chronic pain patients in rural, frontier, and underserved settings. Access to Project ECHO will supply PCPs and other providers with ongoing education, mentoring opportunities, and support and will address topics such as: • Accessing behavioral health resources • Compounded creams • Epidural steroid injections • Hyperalgesia • Post-Traumatic Stress Disorder • The dissatisfied patient • Long- vs. short-acting opioids Sunflower's Chronic Pain Management ECHO will include curriculum for case-based learning and discussion via an online video with courses such as, "Diagnosis of Chronic

Proposed Telehealth Project #3: Chronic Pain Management Project ECHO	
	Pain", "How to Effectively communicate with Chronic Pain Patient", and "Regulatory Oversight of Opioids". **Differentiating Component from Traditional Service Delivery and/or Payments** Project ECHO is a collaborative model of medical education and care management that empowers clinicians to provide better care to more people, right where they live. The ECHO model™ does not actually "provide" care to patients. Instead, it dramatically increases access to specialty treatment in rural, frontier, and underserved areas by providing front-line clinicians and service coordination teams with the knowledge and support they need to manage patients with complex conditions. Differentiating from traditional service delivery models, Project ECHO helps build capacity within communities and enhance the ability of primary care providers to manage basic specialty care services to coordinate care and support the needs of the members. **Strategy Goals** The goal of Chronic Pain Management ECHO includes: • Increasing providers' knowledge and self-efficacy to treat patients with chronic pain. • Increasing use of formal assessment tools and opioid agreements. • Increasing the Primary Care Providers (PCPs) referral to BH and physical therapy to decrease opioid prescribing. **Alignment with KanCare 2.0** In alignment with KanCare 2.0 goals, the Chronic Pain Management ECHO supports integration by recognizing that managing patients with chronic pain must be resolved through an integrated effort, leveraging the physical and BH system (including pharmacological, and psychological considerations).
3. Identify specific populations and services included in the arrangement	**Populations Impacted** Project ECHO creates ongoing learning communities where PCPs and other provider types can receive support and develop the skills they need to treat specific patients with chronic pain thus improving member care for members with chronic pain. **Providers Included in the Arrangement** The Chronic Pain Management ECHO will provide targeted education and training across the health care system with a particular focus on PCPs, prescribers, and alternative pain management providers.
4. Identify role of Service Coordination strategies, as applicable	**Role of Service Coordination Strategies** Critical to our success in achieving integrated care coordination is our member-centric high touch approach leveraging Community Health Workers, caregivers, and Service Coordinators in addition to the PCP and other members of the Integrated Care Team (IC Team). Service Coordinators will also be trained on Centene's national Opi-End program to ensure members are using opioids appropriately and/or otherwise receiving alternative pain management services. The Opi-End Program is designed to approach the opioid crisis in a more targeted fashion, developing and implementing specific policies and protocols to improve the way opioids are prescribed. *Please see section 5.7.2.A.5 Physical and Behavioral Health Integration Strategies for more information on our integration strategy to address the Opioid Crisis.* This is coupled with education on alternative pain management strategies will prepare Service Coordinators to engage providers and pharmacists in care planning to design appropriate interventions for members at risk. **Potential Synergies** With a goal of supporting whole person health, all related trainings, screenings, tools, and resources identified will incorporate SDOHI, in addition to physical, BH, LTSS, or social services. For example, ensuring access to our Community Resource Database for members, providers, Community Health Workers, and Service Coordinators.

Proposed Telehealth Project #3: Chronic Pain Management Project ECHO	
5. Identify role of health information technology/health information exchange (HIT/HIE), as applicable	**Role of HIT/HIE** Internet connectivity and video conferencing technology is key to the delivery of Project ECHO. Project ECHO relies on cloud based video and audio conferencing technology to deliver chat and webinars across mobile, desktop, and room systems. Through Project ECHO, no personal health information is shared.
6. Coordination and collaboration with existing Value Based Purchasing and Quality Initiatives	**Coordination with Existing Relevant VBP and Quality Initiatives** Sunflower is developing a variety of education and other supports to help providers navigate the often complex nuances of VBP structures while maximizing performance. For example, through Project ECHO, providers have access to curricula that will serve as an additional training resource intended to promote the right care, in the right place, at the right time. Through this additional resource and educational support, we are equipping providers with the educational tools needed to help improve provider VBP performance results. In addition, the Chronic Pain Management ECHO will offer providers the opportunity to receive Continuing Education Credits necessary to maintain their license.
7. Identify if the model would be implemented statewide or would be a pilot proposal and if the CONTRACTOR(S) has existing experience with the initiative in Kansas or in another state.	**Proposed Scope of Strategy** Providers across the health care system will be targeted for education with a particular focus on identification of providers who frequently prescribe opioids, have assigned members on high doses or opioid medication or have assigned members with high ED utilization as identified through claims data and our Centelligence® analytics and reporting platform. **Experience and Outcomes** ***Sunflower Experience.*** Dr. Karl Haake, Sunflower's Medical Director is the lead facilitator for Missouri's Chronic Pain ECHO Project. This Chronic Pain ECHO has resulted in positive outcomes including improved member satisfaction with the treatment they received, improved ability to monitor patients to ensure safe use of opioids, and improved care coordination between physical, BH, and pain management. Additionally, Sunflower's parent company recently executed a national contract with Project ECHO. Through this national contract, Sunflower has access to the database of trainings and programs currently offered through Project ECHOs worldwide. ***Sunflower Affiliate Experience.*** Sunflower's Missouri affiliate is in active conversations with the University of Missouri Health System's Missouri Telehealth Network (MTN) to expand use of Project ECHO. MTN's Show-Me-ECHO program uses technology to provide education, training, and engagement opportunities to PCPs concerning specific disease states or conditions that are chronic, costly, common and complex (including the Chronic Pain ECHO lead by Dr. Haake). Sunflower's Texas affiliate is actively working on launching a Chronic Pain ECHO in early 2018 in addition to a Substance Use Disorder ECHO. Through a three day launch summit, participants will include Federally Qualified Health Centers, Licensed Medical Health Associations, physical therapists, substance counsellors, yoga therapists, pain and addiction specialists, academic centers, the State Medicaid agency, and Project ECHO teams from Albuquerque, Connecticut, and University of California-Davis. **Stakeholder Engagement Strategy** Sunflower will create a Project ECHO in collaboration with the Heartland Telehealth Resource Center.

Proposed Telehealth Project #3: Chronic Pain Management Project ECHO	
8. Identify the proposed metrics, Outcomes or other measurements that the CONTRACTOR(S) will use to (i) determine the payment methodology, if applicable; and (ii) evaluate the effectiveness of the arrangement.	**Proposed Metrics/Measurements** Monitoring program outcomes is a core component of the Project ECHO model®. Based on the goals of the strategies described, we will monitor the following metrics: • Provider attendance in Project ECHO sessions • Provider knowledge based on Project ECHO session curriculum • Opioid prescriptions based on claims data **Proposed Outcomes** Proposed outcomes for this model include: • Increased use of formal assessment tools and opioid agreements among providers • Increased PCP referral to BH and physical therapy • Decrease in assigned membership exceeding 90 Morphine Milligram Equivalents (MMEs) dosages • Increased number of Chronic Pain Management ECHO participating providers accessing Sunflower Provider Portal reflecting improved care coordination between physical, BH, and pain management. **Measurement Selection** Measures described were selected as a consistent method of evaluation as used across clinical and quality programs. **Proposed Approach to Monitor Outcomes** We will regularly monitor through our Centelligence® data analytics and reporting tools including monitoring the utilization of opioid prescriptions for members. In addition, we will track provider participation and attendance through the Project ECHO registration process and track increase in knowledge based on increase in use of formal assessment tools. **Impact on Members** Through Project ECHO, we will provide clinicians with the trainings, tools, and resources needed to be able to better support member care while improving the member's health outcomes and quality of life. **Provider Data to the State** Through our Centelligence® reporting and analytics platform, Sunflower will track, monitor, and report program data to the State on a regular or ad-hoc basis in the format and frequency as requested by the State. **Stakeholder Engagement Plan** As a widespread epidemic, we will use a community education approach to increase awareness in addition to education through our parent company's national contract with Project ECHO. We will utilize resources and training courses used in similar Project ECHOs. In alignment with our overarching goal to help providers ensure the safest and most effective treatment for our members, we will work with our provider communities to leverage existing regional best practice guidelines and train and educate on related to Kansas Drug Utilization Review Board policy changes, such as prescription limits. We will also take our opioid program to the next level by tackling the issue before it starts. For example, through education, awareness and promoting routine SUD screening in schools and providing age appropriate education to students and parents. We are providing education to our prescribers on alternative prescribing methods; enhancing collaboration with PCPs and Physician Assistants (PAs) to prevent opioid misuse and abuse; and providing Mental Health First Aid Training to First Responders.
9. Identify the total number of Members expected to participate in the	**Anticipated Member Participation** Not Applicable **Implementation Timeline** Research and Development. Implementation of the Chronic Pain Management ECHO

Proposed Telehealth Project #3: Chronic Pain Management Project ECHO	
arrangement and when the arrangement is expected to start.	includes research and development activities that will take place over the next year. This includes researching courses offered, creating educational and communication materials, ensuring providers have the technical capacity to attend, and scheduling the virtual sessions. Provider Engagement. Successful ECHOs require provider engagement and participation. As part of the implementation, Sunflower will engage providers to participate and present cases for the scheduled virtual sessions as well as encourage provider participation through promotional flyers, electronic bulletins, and other communications. **Roll-out** The roll-out of the Chronic Pain Management ECHO will be in summer of 2019, will full deployment within 12 months of the implementation of the date of the Contract.

Table 5.7.1.A.6_D CSC Project ECHO

Proposed Telehealth Project #4: Community Service Coordinator (CSC) Project ECHO	
1. Topical area addressed	Telehealth Projects
2. Description of arrangement and objectives	**Description of Strategy** Sunflower will equip CSCs with trainings, tools, and resources through hosting a Project ECHO designed for CSCs. The CSC ECHO will support workforce development and skill training for CSC across the state and will include a comprehensive Service Coordination training curriculum program comprised of initial face-to-face training sessions for CSCs. These "train the trainer" sessions will support development of individual provider capacity and ongoing video conferences and video training modules to ensure the CSCs have the resources and information necessary to support member care and care coordination. Trainings will include topics such as: • HCBS waiver guidelines • HRA and HRS assessment guidelines • State-required needs assessment guidelines • State policy and processes, etc. As part of CSC skill development, Sunflower also intends to use the CSC ECHO to review de-identified member cases in order to share our integrated team member expertise and recommendations with the CSC team. **Differentiating Component from Traditional Service Delivery and/or Payments** Project ECHO is a collaborative model of medical education and care management that empowers clinicians to provide better care to more people, right where they live. The ECHO model™ does not actually "provide" care to patients. Instead, it dramatically increases access to specialty treatment in rural, frontier, and underserved areas by providing CSCs and front-line clinicians with the knowledge and support they need to manage patients with complex conditions. Differentiating from traditional service delivery models, Project ECHO helps build capacity within communities and enhance the ability of CSCs to coordinate care and support the needs of the members. **Strategy Goals** The goals of the CCS ECHO include increased knowledge of guidelines and State policies and processes, improved care coordination between Sunflower's Service Coordinator, the PCP, member, member's family or caregiver and other members of the IC Team, and shared best practices across CSCs. **Alignment with KanCare 2.0**

Proposed Telehealth Project #4: Community Service Coordinator (CSC) Project ECHO	
	In alignment with KanCare 2.0 goals, Project ECHO supports expansion of service coordination strategies providing services and supports to address SDOHI and provide coordinated care for members with physical, BH, LTSS, and social needs including youth in Foster Care.
3. Identify specific populations and services included in the arrangement	**Populations Impacted** Through our CSC ECHO, CSCs receive support and develop the skills they need to treat specific conditions thus improving member care and coordination for all Sunflower members. **Providers Included in the Arrangement** CSCs as part of the IC Team.
4. Identify role of Service Coordination strategies, as applicable	**Role of Service Coordination Strategies** Critical to our success in achieving integrated care coordination is our member-centric high touch approach leveraging Community Health Workers, caregivers, CSCs and Sunflower's SCs. Access to the CSC ECHO will equip CSCs and Sunflower's SCs with educational training resources, mentoring opportunities, and support in managing a members PH, BH, LTSS, and social needs through ongoing learning communities and "knowledge networks" that meet on a regular or as needed basis. **Potential Synergies** With a goal to support whole person health, all related trainings, screenings, tools, and resources identified will incorporate Social Determinants of Health and Independence, in addition to physical, BH, or LTSS services. For example, ensuring access to the PRAPARE tool and Community Resource Database. *Please see section 5.7.1.A.6 SDOH* for additional information on our proposed model to respond, assess, and act on members SDOHI needs.
5. Identify role of health information technology/health information exchange (HIT/HIE), as applicable	**Role of HIT/HIE** Internet connectivity and video conferencing technology is key to the delivery of Project ECHO. Project ECHO relies on cloud based video and audio conferencing technology to deliver chat and webinars across mobile, desktop, and room systems. Through Project ECHO, no personal health information is shared.
6. Coordination and collaboration with existing Value Based Purchasing and Quality Initiatives	**Coordination with Existing Relevant VBP and Quality Initiatives** Sunflower is developing a variety of education and other supports to help providers navigate the often complex nuances of VBP structures while maximizing performance. For example, through Project ECHO, providers have access to curricula that will serve as an additional training resource intended to promote the right care, in the right place, at the right time. Through this additional resource and educational support, we are equipping providers with the educational tool thereby improving provider VBP performance results.
7. Identify if the model would be implemented statewide or would be a pilot proposal and if the CONTRACTOR(S) has existing experience with the initiative in Kansas or in another state.	**Proposed Scope of Strategy** This strategy will be implemented statewide for CSCs. **Experience and Outcomes** Sunflower's Medical Director, Dr. Karl Haake is a lead facilitator for Missouri's Chronic Pain Project ECHO and has been an advocate for this model of education, training, and sharing of best practices. Additionally, Sunflower's parent company recently executed a national contract with Project ECHO. Through this national contract, Sunflower has access to the database of trainings and programs currently offered through Project ECHOs worldwide. ***Sunflower's Affiliate Experience.*** Sunflower's Arizona affiliate is actively working with the Arizona Telemedicine Program to develop Project ECHO program curriculum.

Proposed Telehealth Project #4: Community Service Coordinator (CSC) Project ECHO	
	Sunflower will be the first managed care organization in the county to create curriculum and host their own Project ECHO. We will apply Arizona's experience to develop similar Project ECHO programs. **Stakeholder Engagement Strategy** Sunflower will host a Project ECHO in collaboration with existing State resources including the Heartland Telehealth Resource Center. Additionally, Sunflower will engage our Medical Director, Dr. Karl Haake, an anesthesiologist and pain management consultant for the Missouri Primary Care Association and Lead facilitator for Missouri's Chronic Pain ECHO Project. We will work with Dr. Haake to develop our Project ECHO.
8. Identify the proposed metrics, Outcomes or other measurements that the CONTRACTOR(S) will use to (i) determine the payment methodology, if applicable; and (ii) evaluate the effectiveness of the arrangement.	**Proposed Metrics/Measurements** Monitoring program outcomes is a core component of the Project ECHO model®. Based on the goals of the strategies described, we will monitor short-term and long-term metrics to evaluate effectiveness such as: • Number of Project ECHO sessions conducted • CSC attendance and participation in Project ECHO sessions • CSC knowledge related to State policies and procedures, regulations, etc. **Proposed Outcomes** Proposed outcomes for this model include: • Increased CSC knowledge related to State policies and procedures, regulations and assessments • Increased member adherence to PCSP and Plan of Care Longer term outcomes include increased member and provider satisfaction and improved quality measures including quality of life measures as tracked through our LTSS KPI Dashboard. **Measurement Selection** Measures described were selected as a consistent method of evaluation as used across clinical and quality programs. **Proposed Approach to Monitor Outcomes** We will regularly monitor outcomes through the Project ECHO registration process, through our Quality Improvement Committee. **Impact on Members** Through Project ECHO, we will provide the trainings, tools, and resources needs to be able to better support member care while improving the member's quality of life and health outcomes. **Provider Data to the State** Sunflower will track, monitor, and report program data to the State on a regular or ad-hoc basis in the format and frequency as requested by the State. **Stakeholder Engagement Plan** We will work with our advisory committees on the development of the performance metrics. Additionally, through our parent company's national contract with Project ECHO, we will utilize additional resources and training courses used in similar Project ECHOs.
9. Identify the total number of Members expected to participate in the arrangement and when the arrangement is expected to start.	**Anticipated Member Participation** Not Applicable **Implementation Timeline** Research and Development. Implementation of the CSC ECHO includes developing course trainings, creating communication materials, ensuring contracted CSCs have the technical capacity to attend, and scheduling the virtual sessions. **Roll-out** The CSC ECHO will roll-out our prior to the start of the KanCare 2.0 program to support our train the trainer approach for contracted CSCs.

STATE-BASED DATA REGISTRIES, TOOLS, AND RESOURCES (5.7.1.B)

Sunflower acknowledges that KDHE will make available those registries, tools and resources set forth in Section 5.7.1.B of the RFP to support the implementation of Value Based Models and Purchasing Strategies.

REPORTING REQUIREMENTS (5.7.1.C)

Sunflower will comply with KDHE's requirement to provide reports which document and evaluate the effectiveness and Outcomes of Value Based Models and Purchasing Strategies implemented under the Contract.

Integrated Systems Drive Enhanced Reporting Capabilities. Our Management Information System (MIS) stores and processes data necessary to generate reports which document and evaluate the effectiveness and Outcomes of Value Based Models and Purchasing Strategies through Centelligence™, our award-winning proprietary and comprehensive family of integrated health care informatics and decision support solutions. Centelligence™ captures data from a wide variety of sources to process quality and other performance-related information. These include claims, lab data, eligibility, HRA, member touch points, and medical records inputs, HL7 data, authorizations, ADT and, HIE data. The Centelligence™ enterprise platform integrates these data to produce thousands of custom operational and KDHE-required reports, allowing Sunflower to measure provider and program performance against numerous outcomes and evidence-based measures, including:

- **Access to Care**: PCP visits/1000, patient engagement index
- **Quality of Care**: HEDIS, EPDST, State P4P measures, STARS, QRS
- **Risk Adjustment**: CDPS, HCC, HHS, ACG, ETG
- **Utilization Measures**: ED, IP, Diagnostics usage, Generic prescribing rates
- **Cost of Care Measures**: Total PMPM, ED/IP/Specialist/Ancillary PMPM
- **Potentially Preventable Events**: ED visits, IP stays, Readmissions
- **LTSS Focused Measures**: Rate of community transitions, fall rates, wounds, bed sores, members able to make decisions about their daily routine, members able to see family and friends, members satisfied with where they live
- **PH/PH Integration Focused Measures:** Delivery on shared outcome measures (e.g., depression screening, annual physicals, ED and IP reduction)

KDHE REVIEW OF PROPOSED METRICS

Sunflower acknowledges that KDHE may select some or all of the metrics proposed by Sunflower or other MCOs to measure the effectiveness of Value Based Models and Payment Strategies in addition to potentially including additional metrics as part of the final reporting process. Sunflower further acknowledges and agrees that the selected metrics and reports will constitute the reporting requirements for the Value Based Models and Purchasing Strategies approved for implementation. Sunflower looks forward to the opportunity to collaborate with KDHE in the development of its Value Based Models and Payment Strategies reporting process.

5.8 Utilization Management

5.8. UTILIZATION MANAGEMENT

SUNFLOWER DEMONSTRATED SUCCESS

Sunflower Health Plan (Sunflower) has direct experience administering an effective Utilization Management (UM) Program in Kansas since 2013. Our local program success is demonstrated through the following outcomes and process improvements:

2017 results of the CAHPS survey demonstrate excellent member experience related to getting needed care quickly:

- "Getting Needed Care" composite met or exceeded the NCQA Quality Compass 90th percentile for adults (87%) and above the 75th percentile for children (90%)
- "Getting Care Quickly" composites met or exceeded the NCQA Quality Compass 90th percentile for adults (88%) and the 50th percentile for children (92%)

Sunflower's Psychotropic Medication Utilization Review (PMUR) Program supports best practices in prescribing psychotropic medication for youth in Foster Care:

- Sunflower's efforts have resulted in an overall reduction in psychotropic medication utilized by members in foster care from 33.5% in 2013 to 28.9% in 2016
- 60+ day psychotropic medication utilization decreased from 13.4% in 2013 to 11.6% in 2016

Sunflower has expanded the PMUR program to all waiver members beyond just Foster Care:

- 2016 results of annual provider satisfaction survey showed a 5% improvement on overall composite for UM and Quality
- Exceeded Prior Authorization (PA) Turnaround Time goal of 98% timeliness on non-urgent requests and 99% on urgent requests in 2016
- 100% of all staff conducting medical necessity reviews passed Annual Inter Rater Reliability (IRR) testing with a score of 90% or higher
- Continuously review and reduce codes requiring Prior Authorization (PA) based on utilization trends, Physician Advisory Committee feedback and evidence-based guidelines

The overall strengths of our program include:

- Skilled and knowledgeable team members with high employee engagement and tenure
- Stable, experienced leadership
- Strong Kansas-licensed physician leadership through our Chief Medical Director, Behavioral Health Medical Director and Long Term Services and Supports Medical Directors
- Focus on member satisfaction and engagement
- Responsive to provider community through numerous avenues resulting in steady improvement in provider satisfaction
- Integrated Care Team with proven success managing high utilizing members
- Continual process innovation to improve efficiency and timeliness of PA decisions
- Comprehensive, fully integrated physical health (PH), behavioral health (BH), and Long term services and supports (LTSS) utilization management program

Compliance with Scope of Work (SOW)

Our Utilization Management program description meets or exceeds all contract, state, and federal requirements, and will continue to meet or exceed all KanCare 2.0 requirements described in Section 5.8 of the Scope of Work (SOW). Below we describe in detail our overall provider engagement and support process including accountability, oversight, and evaluation for complying with each element of the SOW. For ease of review we have included SOW references in headers and within the narrative.

5.8.1. UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

Our comprehensive, integrated UM program applies to all eligible members across all product types, age categories, and range of diagnoses, as well as all services and care settings across the continuum of care. Our UM program focuses on both individual and system processes to identify outliers to ensure individuals are meeting their health care goals and the system as a whole is meeting community based service delivery goals to improve member outcomes. Using established criteria and guidelines tailored to the community, Sunflower's UM program facilitates the right services, at the right time, in the right setting. The functions of the program include referrals, second opinions, prior authorization, concurrent review, discharge planning, and utilization oversight (e.g. PH, BH, LTSS, pharmacy, etc.) including monitoring over- and under-utilization. Our UM policies and procedures, will comply with all elements of the KanCare 2.0 scope of services, the most current NCQA Health Plan Standards and Guidelines, and other applicable State and Federal guidelines.

GOALS OF UM PROGRAM

The goals of the UM program are to optimize members' health status focusing on member choice and independence, recovery and a sense of well-being, preventative services and access to quality health care, while at the same time actively managing utilization trends. The program focuses on individualized treatment strategies that promote resiliency, wellness and the member's vision of a good life using evidence-based practices. UM program goals are based on utilization trends, member and provider feedback, contractual requirement, accreditation standards, quality outcomes, and internal innovation strategies. Interim goals are also developed with associated action plans when utilization trends emerge through our continuous real-time review processes.

Any and all adverse decisions are made by a Kansas-licensed practitioner.

UM WRITTEN PROGRAM DESCRIPTION (5.8.1.A-J)

Our Utilization Management Department maintains a comprehensive and integrated program that reviews services to determine medical necessity while continually monitoring and evaluating the appropriateness of care and services. The written UM program description outlines the program structure and includes a clear definition of authority and accountability for all activities between Sunflower and entities to which Sunflower delegates or subcontracts UM activities. It further identifies and describes the mechanisms to detect underutilization as well as over-utilization of services, and details the procedures used to evaluate medical

necessity, the criteria used, information sources, goals, timeframes, and the process used to review and approve the provision of medical services.

Program Authority (5.8.1.A)

The Sunflower Board of Directors (BOD) has ultimate authority and accountability for the oversight of the quality of care and services provided to members. It is the responsibility of Sunflower's Utilization Management Committee (UMC), chaired by the Chief Medical Director (CMD), to oversee and exercise operating authority over the UM Program. The UMC includes network physicians representing the range of providers within the Sunflower network (e.g. Family Medicine, Internal Medicine, Pediatrics, Behavioral Health, etc.) and across the regions in which we operate. The UMC also includes executive and senior leadership from numerous Sunflower departments; such as Service Coordination, Quality, Provider Relations and Pharmacy. The UMC reviews and approves clinical policies, medical necessity criteria, treatment protocols and UM policies and procedures. The UMC is responsible for reviewing UM activities, related information and making recommendations to our Quality Improvement Committee (QIC), which reports to the BOD. The UM program description, UM work plan and UM evaluation are reviewed and approved by the Sunflower BOD, QIC, and UMC, on an annual basis.

Chief Medical Director. Our Kansas-licensed CMD directly oversees Sunflower's UM program and has operational responsibility for all UM activities. The CEO, CMD, and Health Services Director are the senior executives responsible for implementing the UM program. Our BH Medical Director, a Kansas board certified psychiatrist and addictionologist, and Behavioral Health Supports Director are involved in the implementation, monitoring, and directing of BH aspects of the UM program, and a Kansas board certified dentist is involved in the implementation, monitoring, and directing of dental health aspects of the UM program. A Kansas-licensed pharmacist oversees the implementation, monitoring and directing of pharmacy services. The CMD's responsibilities include, but are not limited to coordination and oversight of the following activities:

- Direct oversight over the Health Services Director
- Assists in the development/revision of UM policies and procedures
- Provides clinical support to the UM staff in the performance of their UM responsibilities
- Assures that the Medical Necessity Criteria used in the UM process are appropriate and reviewed by physicians and other practitioners according to policy
- Assures that the Medical Necessity Criteria are applied in a consistent manner
- Assures that reviews of cases and appeals that do not meet Medical Necessity Criteria are conducted by the appropriate Kansas-licensed practitioners in a manner that meets all pertinent statutes, regulations and accreditation standards while taking into consideration the individual needs of the involved members
- Assures the Medical Necessity appeal process is carried out in a manner that meets all applicable contractual requirements, as well as all federal and state statutes and

regulations, is consistent with all applicable accreditation standards, and is done in a consistent and efficient manner

- Provides a point of contact for practitioners calling with questions about the UM process
- Communicates/consults with practitioners in the field as necessary to discuss UM issues
- Coordinates and oversees the delegation of UM activity as appropriate, including monitoring that delegated arrangement meets all applicable contractual requirements and accreditation standards
- Assures there is appropriate integration of physical and behavioral health services for all members
- Participates in and provides oversight to the UM committee and all other physician committees or subcommittees
- Recommends and helps to monitor corrective action as appropriate for practitioners with identified deficiencies related to UM
- Reports UM activities to the QIC as needed

Accountability for Delegated Entities

Sunflower delegates UM activities to entities that demonstrate the ability to meet our UM standards and standards for delegation, as outlined in the written UM program description, as well as all State and Sunflower regulations, policies and procedures. Sunflower conducts ongoing oversight and annual review of each delegate's UM program as outlined in our Oversight of Delegated Utilization Management policy. Delegation is dependent upon the following factors:

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

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

- Annual approval of the delegate's UM program (or portions of the program that are delegated), as well as any significant program changes that occur in between
- Routine reporting of key performance metrics that are required and/or developed or requested by the state, CMD, BOD, QIC, or UMC

- Annual or more frequent evaluation to determine whether the delegated activities are being carried out according to Sunflower policy and accreditation standards and state program requirements.

In the instance where the delegate is NCQA Accredited, Sunflower may assume that the delegate is carrying out responsibilities in accordance with NCQA standards and revise the annual audit or evaluation, per state or CMS contract requirements. At the time of pre-delegation Sunflower must evaluate the compatibility of the delegate's UM program with Sunflower's UM program. Once delegation is approved, Sunflower will require that the delegate provide the appropriate reports as determined by Sunflower to monitor the delegate's continued compliance with the needs of Sunflower. Sunflower will annually review ongoing accreditation status.

INTEGRATED APPROACH TO UTILIZATION MANAGEMENT (5.8.1.B)

Sunflower's UM Program incorporates all aspects of physical health, behavioral health and long term services and supports in a fully integrated approach connecting UM, Service Coordination, and Quality Improvement (QI) activities to promote a lifetime of healthy behaviors and outcomes. It ensures provision of quality services that are a covered benefit, medically necessary, appropriate to the patient's condition, incorporate the member's desired goals, rendered in the appropriate setting and meet professionally recognized standards of care.

Comprehensive Documentation Tool

Sunflower uses our integrated health management platform, TruCare, to house a single, comprehensive member record supporting Service Coordination and UM collaboration. This tool allows a member-centric view for all team members to review historical assessments, service utilization, and program participation while also assessing current and future needs, and connecting the member to the appropriate resources to meet those needs. In this model, there is *'no wrong door'* for a team member to access all the information needed to support a member as part of their care team with the member, their caregivers or supports if applicable, and their providers. For example, if a provider calls to request PA for a member, the UM team can easily see if the member has had the service, when, if other providers are following the member for similar concerns, or if they have a Service Coordinator (SC) and have discussed other options or participation in other synergistic programs. This information can be used to connect the provider with the SC or other plan resources as needed to coordinate care. Critical elements of the member record are also available securely to our network providers and authorized representatives via our secure, role-based Web Portals, allowing them similar access to a comprehensive, holistic view of the member's services, service or care plan, providers, and specialty program participation. All contacts with the member, provider, or the member's circle of support are documented in TruCare. All entries are electronically date and time stamped indicating user name to enhance care coordination and collaboration. Supporting medical records, letters, and associated communications are linked to the authorization. TruCare also includes a fully integrated appeals workflow for timely appeals process support, management,

and reports, allowing a full view of an authorization request cycle in one source that is transparent to all.

UTILIZATION MANAGEMENT SERVICES (5.8.1.C)

Prior Authorization (PA)

Sunflower will be fully integrated on all Physical and Behavioral Health UM Services.

The goal for setting PA requirements is to minimize burden on providers, practitioners and members while ensuring the medical necessity of certain services. PA is only required for those procedures and services for which the quality of care or financial impact can be favorably influenced by medical necessity or appropriateness of care review, such as non-emergent inpatient admissions, BH inpatient admissions, inpatient detoxification, Psychiatric Residential Treatment Facilities admissions, and Substance Use Disorder (SUD) Residential Treatment Facilities admissions, all out-of-network services, certain outpatient services, Durable Medical Equipment, LTSS services, ancillary services and specialty injectable medications, as described on the PA list. The UMC reviews the PA list regularly, in conjunction with the CMD and Health Services Director, to determine if any services should be added or removed from having a PA requirement. PA is never required for emergency services, urgent care or family planning services regardless of network participation status.

The written UM program description defines referrals, second opinions, extended specialist services, out-of-network providers, specialty injectable medications, decision timeframes and requirements for requests and approval. For example, members may self-refer (i.e. access services without PA) and access outpatient services without a referral up to a pre-specified initial authorization service limit for some services which are outlined in the Member Handbook and Provider Manual. If for any reason the providers in our network are unable to provide necessary services, which are covered under the contract, Sunflower will adequately and timely cover these services out of network as appropriate.

For services that Sunflower has determined requires PA and/or certification, only the minimally necessary information will be obtained. The intent is that information required not be overly burdensome for the member, the practitioner/staff, or the health care facility staff. Clinical information received, as well as rationale for the medical necessity determination, including any information supporting a specific setting or level of care (as appropriate) is documented and maintained in Sunflower's integrated health management platform TruCare.

Review and Approval of Medical Services (5.8.1.D)

As described below, our written UM program description includes the procedures used to evaluate medical necessity, including the criteria used, information sources, timeframes, and process for review and approval. The program description is supported by our comprehensive UM policies. We have included our Clinical Policies, procedures, and applicable practice guidelines in ***Attachment 5.8.3.E.4 UM Policies Procedures and Guidelines.***

Medical Necessity Review

Medical necessity determinations are made by appropriate Kansas-licensed professionals based on the requested services and as listed in the summary of benefits and care or services that could be considered either covered or non-covered, depending on the circumstances. Covered services, are those medically necessary health care services provided to members as outlined in our contract with the State. Medical necessity means that a health intervention is an otherwise covered category of service, is not specifically excluded from coverage, and is medically necessary, according to all of the following criteria:

- **"Authority":** The health intervention is recommended by the treating physician and is determined to be necessary by the Secretary of the Kansas Department of Health and Environment, or the Secretary's designee, as outlined in the Sunflower clinical policies.
- **"Purpose":** The health intervention has the purpose of treating a medical condition.
- **"Scope":** The health intervention provides the most appropriate supply or level of service, considering potential benefits and harms to the patient.
- **"Evidence":** The health intervention is known to be effective in improving health outcomes.
- **"Value":** The health intervention is cost-effective for this condition compared to alternative interventions, including no intervention. "Cost-effective" shall not necessarily be construed to mean lowest price. An intervention may be medically indicated and yet not be a covered benefit or meet this regulation's definition of medical necessity.

Other services, such as those provided to a member receiving LTSS, are not evaluated on a medical model but rather the service plan is based on the assessments completed with the member to determine the resources needed to support them to remain healthy and safe in the setting of their choice with supports provided under a HCBS program. This assessment will take into consideration the whole person needs of the member to safely remain in the community, including medical, BH, functional and SDOHI. Services authorized by the service coordination team follow state benefit and policies for the services provided in these programs, and are not subject to traditional Medical Necessity or InterQual review.

The written UM program description identifies covered services and notes that they may be subject to limitations. In accordance with State and federal policy and regulations, it provides definitions of the following terms to support criteria and procedures employed to determine medical necessity: effective; health intervention; health outcomes; medical condition; new intervention; scientific evidence; state designee; treat and treating physician. It additionally outlines coverage criteria for new interventions for which clinical trials have not been conducted because of epidemiological reasons, including rare or new diseases or orphan populations evaluation on the basis of professional standards of care or expert opinion.

Interventions that do not meet the definition of medical necessity may be covered at the choice of Sunflower as "in lieu of services." An intervention will be considered cost-effective if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the

characteristics of the individual patient will be determinative. Two levels of UM medical necessity review are available for all authorization requests:

Level I Review is conducted on covered benefits by a licensed UM nurse, BH professional or other appropriate professional depending on the service being requested. All reviewers are trained in the principles, procedures, and standards of utilization and medical necessity review. A Level I review is conducted utilizing McKesson's InterQual® criteria or applicable medical policy, 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. Other factors that must be considered when applying criteria to a given individual situation includes the member's age, comorbidities, complications, progress of treatment, psychosocial situation and home environment, when applicable. At no time shall a Level I review result in a reduction, denial, or termination of service. Adverse determinations can only be made by a Medical Director, or qualified designee, during a Level II review. Once the Level I review is completed, if an approval is not indicated by the review, it is forwarded to the Level II review process. Level I review is completed on LTSS services by a Program Specialist (social worker) or SC (e.g. registered nurse) following benefit guidelines, standardized assessment tools, and processes. LTSS services can be reduced, denied, or terminated at Level I by the qualified program staff reviewer.

Level II Review is conducted on a case-by-case basis by a Kansas licensed practitioner or other healthcare professional as appropriate. For instance, if the request is for behavioral health service, a qualified behavioral health practitioner will be consulted during the review. If the request is for dental services, a qualified dental practitioner will conduct the Level II review. Automatic referral for Level II review includes requests for services or procedures that require benefit determination, services that do not have existing medical necessity criteria, or are potentially experimental or new in practice. A Level II review is also indicated when the request does not meet the existing medical necessity criteria. All Level II reviews are conducted with consideration given to continuity of care, individual member needs at the time of the request, and the local delivery system available for care. A board-certified physician or specialist may be used in consultation for a medical necessity determination. All medical necessity adverse determinations are made by Kansas licensed practitioners.

Sunflower uses the Kansas Medical Assistance Program (KMAP) provider manuals to determine medical necessity when appropriate. Sunflower's Medical Necessity Criteria clinical policy describes how reviewers conducting a Level II review determine which medical necessity criteria should be applied when more than one set of criteria exists. Our clinical policies are available to providers on the Sunflower website and are applied when medical necessity criteria is not defined in a KMAP provider manual. Our Kansas licensed medical directors are responsible for ensuring the appropriate criteria are used while considering the unique and individual needs of the member.

Clinical Criteria

The goal in UM is to help guide best practice medicine in the most efficient and economical manner while addressing patient-specific needs. UM criteria employed by Sunflower are nationally recognized, evidence-based standards of care and include input from recognized medical experts. Utilization review criteria serve as an objective screening guide and are not intended to be a substitute for physician judgment. Utilization review decisions are made in accordance with scientific evidence and currently accepted standard of care practices, while taking into consideration the individual member needs, coexisting conditions and the local delivery system available for care.

As relayed in Section 5.8.1, the CMD, Sunflower Medical Director, delegated Kansas-licensed Medical Director, or other appropriate Kansas-licensed professional reviews all potential medical necessity denials for medical appropriateness and is the only one with authority to implement an adverse determination which results in reduction, suspension, denial, or termination of services. In general, Sunflower uses McKesson's InterQual® guidelines to determine medical necessity and appropriateness of care. InterQual® is a recognized leader in the development of clinical decision support tools and largest provider nationally. InterQual® is used by 3000 organizations and agencies to assist in managing health care for more than 100 million people. InterQual® is developed by generalist and specialist physicians representing a national panel from academic as well as community based practice, both within and outside the managed care industry. InterQual® provides a clear, consistent, evidence-based platform for care decisions that promote appropriate use of services, enhance quality, and improve health outcomes. Sunflower uses InterQual's Level of Care and Care Planning Criteria for Pediatric Acute, Adult Acute, Home Care, Durable Medical Equipment and Procedures to determine medical necessity and appropriateness of care. We 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. InterQual® guidelines are updated annually and reviewed and approved by the UMC prior to implementation. All staff who utilize InterQual® criteria in determining medical necessity undergo annual and ongoing training and must have successful Inter Rater Reliability (IRR) testing to do any reviews as noted in the IRR section within this response. For determination of medical necessity and appropriateness of substance use services, Sunflower uses American Society of Addiction Medicine (ASAM) criteria. Sunflower develops medical necessity criteria for behavioral health community based services based on the service description, network practitioner input and state guidance and approval.

New Technology Review

In instances of determining benefit coverage and medical necessity of new and emerging technologies, the new application of existing technologies, or application of technologies for which no KMAP, InterQual or Sunflower Clinical Policy Criteria exists, the CMD will review the scientific evidence related to the request to determine if medical necessity criteria can be met based on controlled clinical trials or the professional standard of care when applicable. The Sunflower Utilization Management Committee (UMC) is responsible for evaluating new

technologies or new applications of existing technologies for inclusion as Medical Necessity Criteria. The UMC develops, disseminates, and at least annually updates medical policies related to: medical procedures, BH procedures, pharmaceuticals and devices. Practitioners are notified in writing through the provider newsletters and the practitioner web portal of new technology determinations made by the Plan. 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 Utilization Management Department or may discuss the UM decision with the Sunflower CMD.

Preventive and Clinical Practice Guidelines

While clinical practice guidelines are not used as criteria for medical necessity determinations, the CMD, Medical Director(s) and UM staff will make UM decisions that are consistent with guidelines distributed to network practitioners. Such guidelines will include, but not be limited to, Adult and Child Preventive Health, Asthma, Major Depressive Disorder, Prenatal Care, Diabetes, Lead Screening, Treatment of Schizophrenia, Sickle Cell, Immunizations, treatment of Bipolar Disorder, Post Traumatic Stress Disorder, Substance Use and ADHD/ADD Guidelines for both adults and children. Clinical practice guidelines are also available to network providers via Sunflower's website.

CONCURRENT REVIEW/SERVICE COORDINATION

The concurrent review process assesses the clinical status of the member, verifies the need for continued hospitalization or for ongoing ambulatory care, facilitates the implementation of the practitioner's plan of care and promotes timely care. In addition, Concurrent review is used to determine the appropriateness of treatment rendered, the level of care, and monitors the quality of care to verify professional standards of care are met. Information assessed during the review includes:

- Clinical information to support the appropriateness and level of service requested
- Whether the diagnosis is the same or changed
- Clinical status assessment to determine if the member needs additional support or equipment to ensure a safe discharge to home or another level of care
- Additional days/service/procedures proposed
- Reasons for extension of the treatment or service

Concurrent review for inpatient hospitalization is conducted throughout the inpatient stay, with each hospital day approved based on review of the patient's condition and evaluation of medical necessity. Concurrent review can occur on-site or telephonically. The frequency of reviews are based on the severity/complexity of the member's condition and/or necessary treatment and discharge planning activity, and are not routinely conducted on a daily basis. If, at any time, services cease to meet inpatient or ambulatory criteria, discharge criteria are met and/or alternative care options exist, the nurse case manager contacts the attending physician and obtains additional information to justify the continuation of services. When the medical necessity for the case cannot be determined, the case is referred to the Medical Director for review. The need for service coordination or discharge planning services is assessed

during the admission review and each concurrent review, meeting the objective of planning for the most appropriate and cost-effective alternative to inpatient care. If at any time the UM staff become aware of potential quality of care issues, the Integrated Care Team will work to address any immediate risk to the member while a referral is placed to the QI Department to formally investigate and resolve the identified concern.

Retrospective Review

Retrospective review is an initial review of services that have already been rendered. This process encompasses services performed by a participating or non-participating practitioner without Sunflower notification and/or authorization and when there was no opportunity for concurrent review. A Sunflower UM staff member will review the request for retrospective authorization with information available either provided through eligibility or from the requestor. If supporting documentation shows the requestor was unaware of the member's eligibility with Sunflower and/or there were extenuating circumstances that prevented the provider from notifying Sunflower appropriately, the covered services that the provider rendered in good faith will be approved. If the supporting documentation reveals that the policies and procedures for timely notification were not followed by the provider, an administrative denial will be issued for the service. The decision, to authorize or deny, is made within 30 calendar days from receipt of the post-service request.

Behavioral Health (BH) Treatment Parity

Mental Health Parity and Addiction Equity Act of (MHPAEA) of 2008. Sunflower is committed to parity for mental health and substance use disorder services and treatment, and full compliance with MHPAEA and subsequent Federal and State guidance regarding parity. We ensure this compliance by requiring parity of both quantitative limits (QTLS) applied to Mental Health/Substance Use Disorder benefits and non-quantitative limits (NQTLS). Sunflower administers benefits for Substance Use Disorder (SUD) and/or services for mental health conditions as designated and approved by the state-specific contract and Plan benefits. Sunflower ensures non-quantitative treatment limitations (NQTL) are applied with a fair and equitable approach that takes into account recognized clinically appropriate standards of care. We validate that the processes used to determine how and when to apply limitations (e.g. prior authorizations) are comparable and applied no more stringently for behavioral health than for physical health. Our Utilization Management Committee (UMC) reviews processes for compliance with MHPAEA annually, or more frequently should benefits or guidelines change. The Physician Advisory Committee reviews the recommendations of the UMC to obtain feedback and participation from network providers and stakeholders in our process, thus providing an additional layer of oversight. The recommendations are then forwarded to the QIC for final review and approval.

Any and all adverse decisions are made by a Kansas-licensed practitioner.

Sunflower facilitates access to care for individuals seeking treatment for mental health conditions as well as substance use disorders and believe in a "no wrong door" approach. Our

strategies, evidentiary standards, and processes for reviewing treatment services are no more stringent than those in use for medical/surgical benefits in the same classification when determining to what extent a benefit is subject to NQTLs. Sunflower is dedicated to the principle that mental health and substance use services should be provided at the least restrictive level of care while ensuring safety, effectiveness, and a focus on recovery and resiliency.

Certification Process for Treatment Requests. In alignment with our integrated care model and MHPAEA, processes for evaluation of individual member behavioral health needs and authorization of those needs within benefit guidelines are handled as aforementioned under Medical Necessity above.

Pharmaceutical Management

The Pharmacy Management Program is overseen by the CMD, Health Services Director, and Sunflower Pharmacy Director. All policies and procedures utilized by Sunflower related to pharmaceutical management include the Kansas Drug Utilization Review Board criteria to determine medical necessity. The program is reviewed at least annually and updated as new pharmaceutical information becomes available. Policies and procedures are made available to practitioners via newsletter and/or Sunflower website. Pharmacy utilization data are viewed by the UMC quarterly to assess pharmaceutical utilization, opportunities, and trends. Sunflower follows all required KDHE policies related to pharmacy program management.

PROVIDER AND MEMBER REQUESTS FOR SERVICES (5.8.1.E)

Provider Requests for Services

The Sunflower Provider Manual details how providers may request services for members. Authorization requests may be submitted by fax, phone, or secure web portal. For LTSS members, providers may contact the member's Community Service Coordinator. Authorization determinations may be communicated to the provider by fax, phone, letter, or secure web portal. All adverse determinations are provided in writing. For all services on the Prior Authorization (PA) list, documentation supporting medical necessity is required.

Sunflower's public website includes a Prior Authorization Tool that allows providers to look up whether a service is a covered benefit and requires PA. Providers can use the Provider Portal to enter and view prior authorization requests and status via our PA request tool.
As a future IT enhancement to reduce the burden of the request process and reduce provider turn-around time for decisions, Sunflower is implementing IQConnect®. IQConnect® is a comprehensive, fully automated web based tool for providers where they enter or transmit necessary member and authorization request information, attach, or provide pertinent clinical detail and can receive a real-time immediate authorization response and authorization number. If immediate authorization cannot be granted, they are provided tracking information and notification when the review is complete and a determination has been rendered on their request.

Member Request for Services

Our member handbook details how members may request services. In addition members may contact their PCP who can tell the member if a service requires prior authorization. For LTSS, members may contact their Community Service Coordinator. The Member Handbook informs members that a list of services requiring prior authorization can be found on Sunflower's website at www.SunflowerHealthPlan.com and that members may also call Sunflower Customer Service at 1-877-644-4623 to see if a service require prior authorization.

Members and providers can access UM staff through a toll-free number at least 8 hours a day during normal business hours for inbound or outbound calls regarding UM issues or questions about the UM process. TDD/TTY services for deaf, hard of hearing or speech impaired members are available. The phone numbers for these are included in the member handbook, on the web and in all member letters. Additionally, language assistance for members to discuss UM issues is provided either by bilingual staff or through Language Line services. Inbound and outbound communications may include directly speaking with practitioners and members, or fax, electronic or telephone communications (e.g. sending email messages or leaving voicemail messages). After normal business hours and on holidays, calls to the UM department are automatically routed to our Nurse Advice Line (NAL). The NAL is not a delegated UM entity and therefore does not make authorization decisions. NAL staff take authorization information for next business day response by Sunflower or notify the Sunflower on-call nurse or physician in cases requiring immediate response.

UM TIMEFRAMES (5.8.1.F)

UM 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.
Timeframes used to review are from the point of a request to the decision, including both oral and written notification where indicated and in accordance with 42 CFR § 438 Subpart F, 1915(c) Waivers or State policy. Sunflower will make PA decisions as soon as possible, based on the member's medical condition. Sunflower monitors Turn-around-times (TAT) very closely and sets goals for timeliness as part of the UM Program Work Plan. In 2016, Sunflower exceeded the Standard (non-urgent) TAT Timeliness goal with 99% of non-urgent prior authorizations completed timely. **Standard decisions** are made within 14 days. An extension of this timeline may occur if the enrollee or provider requests an extension, or if Sunflower justifies (to the State agency upon request) a need for additional information to make an educated decision. Extensions will be in the member's interest. ***If the service is urgent, the decision is made within three days.*** Sunflower will make determinations for urgent concurrent, expedited continued stay and/or post stabilization review within 24 hours of receipt of the request for services. 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

Our IQConnect® technology will decrease TAT for requests submitted through the tool to allow for immediate determination and authorization number in most cases.

by Sunflower. If the request does not meet the definition of urgent care, the request may be handled as a new request and decided within the time frame appropriate for the type of decision (i.e., pre-service and post-service). If the member or PCP does not agree with Sunflower's decision, they can ask for a peer to peer or second review, an appeal.

Established timelines are also in place for practitioners to notify Sunflower of a service request. All timeframes are based on the requirements of the accreditation body (NCQA or URAC) where State or contract requirements are either silent or less stringent. For all pre-scheduled services requiring prior authorization, the provider must notify Sunflower within five days prior to the requested service date. PA is never required for emergent or urgent care services. Providers are required to notify Sunflower of all inpatient admissions and long-term care facility admissions within one business day following the admission. Post-stabilization services delivered in the ER 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.

Sunflower notifies the member and their PCP if a requested service is approved or denied in writing within the timeframes defined in Sunflower's Timeliness of UM Decisions and Notifications based on the type of request (e.g., standard, urgent, concurrent, retrospective). For urgent requests, Sunflower also makes a reasonable attempt to notify the member's provider verbally with the decision.

STAFFING, QUALIFICATIONS, AND TRAINING (5.8.1.G)

Sunflower utilizes the appropriate Kansas-licensed professional reviewers (e.g., RN, LSCSW, PharmD, MD) to make medical necessity determinations. Every UM program participant completes up to six months of training and may participate in our preceptor program. The preceptor signs off on the competency of the new hire to ensure the highest level of clinical comprehension and application. Annually reviewers must complete additional training in InterQual® to maintain their skill and knowledge of the medical necessity criteria. The purpose of inter-rater reliability (IRR) testing is to evaluate the consistency with which health plan staff involved in the UM and QI process apply InterQual® criteria in decision-making. Sunflower's goal is for 100% of Sunflower's UM staff to pass all applicable IRR tests with a score of 90% or higher. Sunflower has achieved this goal since 2013, ensuring consistence of reviews by our UM team. Additionally the UM team receives unlimited access to our professional education tool, CE Direct®, which includes a library of thousands of clinical and non-clinical health care related topics as well as weekly educational sessions developed to educate the Sunflower team on pertinent clinical topics, processes, regulations and policies, and finally topic specific training by our Medical Director team and Cornerstone application on trends in population health and specifically trends related to the Sunflower population gained through analysis.

The UM department monitors both the quality and timeliness of reviews through audits and routine daily monitoring of contract requirements, authorization volume, request type, and

TAT. If long term needs persist, staffing is evaluated and supplemented to meet the needs of our state, providers, and members.

NO INCENTIVES TO DENY OR LIMIT (5.8.1.H)

Compensation to individuals or entities that conduct UM activities is not structured as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member. All staff involved in making utilization or service authorization decisions are required to sign an Affirmative Statement regarding compensation annually. Compensation or incentives to staff or agents based on the amount or volume of adverse determinations; reductions or limitations on lengths of stay, benefits, services; or frequency of telephone calls or other contacts with health care practitioners or patients is prohibited. Sunflower will not permit or provide compensation or anything of value to its employees, agents, or contractors based on:

- The percentage of the amount by which a claim is reduced for payment, or the number of claims or the cost of services for which the person has denied authorization or payment; or
- Any other method that encourages the rendering of an adverse determination.

PEER REVIEWS (5.8.1.I)

Our Medical Directors, or other appropriately Kansas-licensed healthcare professionals (as indicated by case type), review all medical necessity denials of healthcare services offered under Sunflower's medical benefits. Personnel employed by or under contract to perform utilization review, including peer review, are appropriately qualified, trained and hold current Kansas professional licensure. Sunflower staff has access to an extensive array of Kansas licensed providers. Sunflower would follow required State processes if an emergency occured that would require using an appropriately credentialed professional who does not have Kansas license to render an adverse benefit determination, such as an unexpected loss of Sunflower resources.

USE OF SUBCONTRACTORS (5.8.1.J)

Sunflower requests approval from the State for any UM activities managed by a subcontractor. Delegation of UM activities allows for improved expertise around specific specialized services, such as high tech radiology or dental care. Sunflower holds all delegated subcontractors to the same standards as defined in our UM program description, including the requirement that adverse decisions be made by appropriately credentialed, Kansas-licensed providers. Additionally, Sunflower understands fully integrating some services, like behavioral health, without delegating key operational functions is critical to facilitate whole person care bringing value to both our members and providers. Sunflower has begun the process of fully integrating behavioral health management and this will be completed in 2018.

5.8.2. UTILIZATION MANAGEMENT PROGRAM EVALUATION

Sunflower monitors and evaluates the appropriateness of care and services on an ongoing basis. Our UM program evaluation is a fluid document updated regularly and submitted to the State for review at least annually.

The UM program is evaluated on a daily, weekly, monthly, quarterly, and annual basis through UM reports, making modifications and improvements as indicated. The CMD and Health Services Director evaluate the impact of the UM program by using:

- Member complaint, grievance and appeal data
- The results of member satisfaction surveys
- Provider complaints and provider satisfaction surveys
- Over- and under-utilization reports/trends
- Turn-around-Time (TAT) and authorization metrics
- HEDIS data
- Inpatient census and discharge information
- Drug Utilization Review (DUR) profiles (where applicable)
- Population health data

The evaluation covers all aspects of the UM program and includes Sunflower and all delegated services and subcontractors. This comprehensive evaluation describes mechanisms to detect services that are drivers of cost through both over and under-utilization. For example, high utilizer Emergency Room (ER) reports are used to identify members going to the ER frequently who may benefit from service coordination. While our readmission risk score helps us recognize members at increased risk for readmission based on their diagnoses and utilization patterns. Sunflower uses this score to prioritize post-hospitalization outreach and monitors outreach success to ensure predictive modeling results in real impact for Sunflower members. Sunflower uses underutilization reports like members without a PCP visit in the prior six and 12 months and diabetic members with inconsistent pharmacy claims to guide meaningful member outreach. The UM Program evaluation also provides detail related to prior authorizations, such as evidence to support applying or removing prior authorization requirements for specific services. Prior Authorization is only required for those procedures and services for which the quality of care or financial impact can be favorably influenced by medical necessity or appropriateness of care review. Home oxygen is an example of a service that no longer requires prior authorization due to an analysis showing the large majority of home oxygen PA requests were approved. Sunflower completed an analysis to determine the impact of removing the prior authorization from this service, and found the utilization did not increase after removing the prior authorization requirement. Sunflower's Integrated Care Team monitors utilization across the continuum of care, including members with high behavioral health (BH) service needs. Sunflower uses

Integrated Care Team Post-Hospital 10 Day Outreach increased from 23.4% in 2014 to 92.8% in 2017.

numerous metrics to evaluate BH service utilization; for example follow up after hospitalization, monitoring of medication side effects, and underutilization of recommended treatments. Sunflower recently completed, and submitted to the state, an analysis of compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) which will be part of the UM Program Evaluation.

The UM program evaluation and recommendations are submitted to the UMC for review, action, and follow-up. The final document is submitted to the Board of Directors/governing body through the QIC for approval. For example, in the area of cost containment, Sunflower did an analysis of members from each product type (total cohort of 450) with high utilization patterns from the prior 12 rolling months. The medical directors, nurses, and social workers reviewed raw data about their utilization, participation in care coordination, social determinants, and diagnoses to determine if the primary driver of their utilization patterns was likely modifiable (removing members impacted by catastrophic accidents, expensive medications, etc.). Based on this review, the multidisciplinary team decided what type of expertise would best meet the member's needs and outreach was initiated following protocol. This program resulted in a 30% reduction in all costs for a savings of over $5.1M in this high-utilizing cohort. Other pilots and programs are developed on an ongoing basis to meet the needs of specific populations identified through trend analysis showing an opportunity to improve member outcomes through appropriate utilization.

High Utilization Cohort management resulted in 30% all-cost reduction and associated savings of over $5.1M.

5.8.3. UTILIZATION MANAGEMENT ACTIVITIES

As described above, Sunflower's comprehensive UM program 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, BH care, community based services, short-term care, long term care, and ancillary care services.

COORDINATION AND INTEGRATION (5.8.3.A)

Sunflower facilitates coordination and integration both internally and externally, in accordance with our UM policies and procedures, contract requirements, NCQA standards and guidelines, and evidence based practices. Internally, the UM, Quality Improvement (QI), Service Coordination, Pharmacy and Therapeutics (P&T), Credentialing, Compliance, and Fraud and Abuse programs are closely linked in function and process. For example, the UM department monitors quality of care as a part of the prior authorization review process escalating all Quality of Care concerns to the QI Department for evaluation. The QI department works directly with members of the Service Coordination team to address the immediate needs of the member ensuring their safety while the QI team completes the QOC investigation and initiates corrective action when appropriate. This is one example of how utilization management, service

coordination and quality improvement activities are coordinated to respond to the immediate needs of the members while also systematically influencing the quality of care provided by Sunflower network providers. The UM Department also works closely with data analytics to prevent, detect, and respond to incidents of Fraud, Waste and Abuse among practitioners and members. The UM Department, Compliance Officer and Special Investigations Unit collaborate to resolve any potential issues that may be identified.

Sunflower Integration Activities

Sunflower encourages integration wherever possible through activities like our service coordination, innovative contracting and strategic funding. Sunflower's Integrated Care Team works with network providers to ensure members get the care they need and facilitates a 'no wrong door' approach to accessing care.

Sunflower Success Story. One such success story involved a Sunflower member who was unable to tolerate office visits, examination and lab tests in their provider's office due to extreme behavioral outbursts and aggression in these settings. The member's caregivers were concerned a medical problem with the member's ear was causing some of the member's symptoms. Furthermore, the member was due for recommended lab work that the primary care provider was unable to obtain. Fortunately, when the member was scheduled for a dental procedure under anesthesia the Sunflower service coordinator recognized the opportunity to coordinate care ensuring the member's needs were met. The member had a basic examination including ear exam and the lab recommended by the member's primary care physician during the dental visit under anesthesia.

Provider Incentives and Alternative Payment Models (APMs). Our provider incentives and APMs are another way Sunflower is encouraging integrated services. Examples provided below.

- Sunflower's Pay for Performance program with all CMHCs across the state of Kansas provides incentive rewards for behavioral health providers who ensure members receive recommended diabetes screenings.
- Our Prenatal Care Incentive Program requires providers to screen for mental health concerns and substance abuse while driving providers to use our Provider Portal that contains information critical to whole person care.
- Sunflower supports expansion of integrated clinic sites like GraceMed's Project Oasis that brings primary care, preventative services, and behavioral health services into one location.
- Sunflower involves network providers through participation in our BOD, QIC, UMC, and advisory committees; integrating participating providers as key partners in service coordination and care planning; and through peer to peer interactions with our CMD and Medical Directors.
- Sunflower coordinates UM education and service coordination activities with local providers, specifically but 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
- Supports that address social determinants of health and independence (SDOHI) such as employment, housing, nutrition, education and other SDOHI

IDENTIFYING AND ADDRESSING THE NEEDS OF THE KANCARE POPULATION (5.8.3.B)

Identifying and addressing member needs requires a multi-faceted approach at both the individual and system level. Specific activities include screening, intake, assessment, UM review, UM reporting and trends, discharge planning and aftercare, service coordination, crisis management, referrals, collaboration with providers/practitioners, disease management, preventative health activities, and psychiatric medication utilization review. Additional program components implemented to promote appropriate care include tracking utilization of services to guard against over and underutilization of services and interactive relationships with practitioners to promote appropriate practice standards and supporting our PCPs in assuring appropriate utilization of services along the continuum of care. Sunflower uses our expansive reporting platform for ongoing annual assessments of our population health management, service coordination, and utilization that direct us to identifying the needs of our member population. From those assessments, action plans and programs are developed to meet identified needs. For example, in 2016 Sunflower identified that we had a slight population shift which led us to an emerging opportunity for members with heart failure and programming to meet their needs. From this opportunity, Sunflower collaborated with a local provider of tele-monitoring services to develop an in home monitoring program while also developing a comprehensive member and provider outreach and education program. Sunflower's service coordination team has worked with the highest risk members for five months in the new program and has improved their outcomes resulting in a 10% reduction in unnecessary utilization and overall cost of service.

Assessing KanCare Population Needs

- ***Daily examples:*** *(inpatient census, assessment data, care gap and ED visit alerts (care coordinator, member, and provider), Nurse Advice Line call details)*
- ***Monthly and Quarterly examples:*** *(UM trends, UM/SC/LTSS Dashboards, high utilization and ED reports)*
- ***Annual examples:*** *Population Health Report, Care Management Assessment, UM and SC Program Evaluation, QAPI Program Evaluation*

ACCESS TO SERVICES (5.8.3.C)

All of our programs are designed to facilitate access to appropriate services for our members. This includes removal of unnecessary barriers, such as streamlined UM processes, limited PA requirements, and no PA requirement for emergency services. This also includes appropriate member and provider education, as described in Sections 5.10 and 5.6, respectively, of this response; service coordination, described in Section 5.4; and a comprehensive provider network to serve the holistic needs of our members, described in Section 5.5. The UM program seeks to advocate for the appropriate utilization of resources, using the following program components: 24-hour nurse triage for PH, BH, and LTSS services; prior authorization/precertification, second opinion, concurrent review, ambulatory review, service coordination, disease management, maternity management, preventive care management, discharge planning activities and out of network referrals when needed.

DISSEMINATION OF UM INFORMATION TO PROVIDERS AND MEMBERS (5.8.3.D)

Sunflower distributes the Kansas medical necessity definition, medical necessity criteria, authorization policies, procedures, and any applicable practice guidelines to all affected providers and, upon request, to members and potential members. Primary distribution is via our up to date website, with additional information and references in our Provider Manual, Member Handbook, Newsletters, and during initial orientation and ongoing provider and member education. Practice guidelines, clinical policies, and medical necessity criteria are present for providers through the Sunflower main web page and Provider Portal.

EDUCATION ON UM ACTIVITIES (5.8.3.E)

Sunflower provides educational materials and webinars to providers concerning obtaining PA for services, medical necessity criteria for services, and required timelines to ensure members receive the right care in the right setting and right time. Information is provided through initial orientation and ongoing provider education, made available through in person and web-based training, and materials including the Provider Manual, Newsletters and Bulletins, and Sunflower website. A description of the UM activities covered in our provider educational materials and trainings is include above under Subsections 5.8.1.C through 5.8.1.F.

As reflected in the Sunflower UM program description and described in 5.8.1 above, UM program policies, procedures, and practice guidelines:

- Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field
- Consider the needs of our members
- Are adopted in consultation with and reviewed and updated periodically with input from participating providers who are members of our UMC

Information, Education Materials, and Webinars

Each contracted practitioner receives a Provider Manual, a quick reference guide, and a comprehensive orientation that contains critical information about how and when to interact with the Utilization Management and Service Coordination Departments. The manual outlines

Sunflower's Utilization Management policies and procedures including those for prior authorization, associated timelines and medical necessity criteria for services to ensure efficient and seamless delivery of services. This information is also available on the Sunflower website. Sunflower also disseminates the Kansas medical necessity definition, ASAM criteria as contained in the Kansas Client Placement Criteria (KCPC system) (for SUD), authorization policies, procedures, and clinical practice guidelines to all providers through the Sunflower website and Provider Portal. All information regarding UM policies and procedures including medical necessity criteria for services, authorization policies, procedures, and any applicable practice guidelines are also available upon request to members and potential members.

Provider Input on Utilization Management Program Policies and Procedures

As noted in Section 5.8.1, Utilization Management Committee (UMC) membership includes participating network practitioners in utilization review activities as available and to the extent that there is not a conflict of interest.

The UMC meets at least four times per year providing a forum to receive provider suggestions for policies and procedures. The Health Services Director maintains detailed records of all meetings documenting changes made as a result of provider suggestions. Additionally, Sunflower has a robust provider relations team that provides training and a forum for providers to submit feedback on a regular basis. Sunflower actively meets with provider associations to provide an avenue for ongoing feedback and has numerous advisory committees (e.g. LTSS Advisory Committee and Physician Advisory Committee) where service providers are encouraged to provide feedback that guides Sunflower programs. Provider Grievances and provider satisfaction surveys provide an additional way to receive provider input.

INTER-RATER RELIABILITY

As described in 5.8.1G, the CMD and Health Services Director assess the consistency with which Medical Directors and other UM staff making clinical decisions apply UM criteria in decision making.

The assessment is performed as a periodic review by the Health Services Director or designee to compare how staff members manage the same case, forums in which the staff members and physicians evaluate determinations, and periodic audits against criteria. When an opportunity for improvement is identified through this process, Sunflower's leadership takes corrective action. New UM employees are required to successfully complete inter-rater reliability testing prior to being released from training oversight. In addition, monthly audits of UM activity provide regular assessment to ensure the UM team is consistently following Sunflower policies and NCQA standards while allowing for timely re-education when necessary.

CRITERIA USED FOR UTILIZATION MANAGEMENT

Sunflower uses the Kansas Medical Assistance Program Provider Manuals, InterQual and Centene Clinical Policies as criteria to determine medical necessity. For Centene Clinical

Policies, procedures, and applicable practice guidelines ***See Attachment 5.8.3.E.4 UM Policies Procedures and Guidelines.***

SOCIAL DETERMINANTS OF HEALTH AND INDEPENDENCE 5.8.3.1.

Sunflower's UM program is designed to achieve the ***Quadruple Aim*** (as stressed by Bodenheimer and Sinsky in 2014[1]) of improving the experience of care, improving the health of populations, reducing the per capita cost of health care and improving the work life of our network providers and their staff. We accomplish this by treating the whole-person and integrating all medical, behavioral health (BH), functional, social and other services the member receives to create a system of care around that individual. Creating this integrated, community-anchored system allows us to effectively address not only the clinical needs of the member, but also Social Determinants of Health and Independence (SDOHI) including but not limited to safe housing, food security, transportation, employment and career training, education and other non-clinical needs that have an impact on health outcomes and quality of life. Sunflower's UM staff identify SDOHI through review of PoS/PCPS, requests for authorization documentation, transition/discharge planning activities, and through interactions with members and connecting them to appropriate resources. We review services and refer members to service coordination after hospitalizations to ensure stability and safety in the community. Additionally, using Sunflower's Centelligence® Predictive Analytics engine our UM staff and clinical leadership can examine large data sets daily including utilization patterns and indicators of SDOHI, providing a comprehensive array of targeted clinical reports. This includes the regular re-computation and interpretation of a member's clinical data, delivering actionable insights for members that may be appropriate for additional follow up support to assist with SDOHI needs. Sunflower has also developed a collaboration with KAMU, the Primary Care Association of Kansas, on the use of Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE) at community-based health centers to better collect and respond to SDOHI data. As PRAPARE data can be collected in electronic health records (EHRs) Sunflower's goal is to securely extract PRAPARE data and further refine our predictive modeling capabilities through Centelligence creating regular reporting that enhances our understanding of SDOHI at the individual member and community level for effective interventions. In this way we can use aggregated reporting by geography to identify service shortages such as transportation, and the need for focused interventions.

Figure 5.8.3 Quadruple Aim

[1] Bodenheimer and Sinsky, From Triple to Quadruple Aim: Care of the Patient Requires Care of the provider, Annals of Family Medicine 12:6 Nov Dec 2014 pp 573-576

Member Stories

Working with members every day to address SDOHI is core to the work of our IC Team including UM staff. The stories we share below and on the next page are a small sample of successful Sunflower member stories that highlight our efforts providing assistance with addressing SDOHI through UM program activities.

MT

MT was admitted to the hospital due to severe bed bug bites that produced loss of skin and a subsequent infection. Through discharge planning Sunflower UM staff and the treatment team identified that her health conditions would not improve without home environment interventions. Sunflower, after consulting with Protective Services, local charities, the treating physician, and internal physicians coordinated a plan to provide the extermination with "in lieu of" funds. Our SC worked with local resources to find a willing exterminator to provide the extermination. The SC also coordinated with a newly established guardian for MT and the landlord to ensure future safety and making sure the clothes dryer was functioning properly after extermination to prevent future outbreaks. Prior to Sunflower intervention, admission to a long-term care facility was imminent because the member had no resources and local charities did not provide the necessary extermination. After the extermination, MT was able to return home and continued to heal in an environment that was safe to return to. MT is still in her home, and has expressed to her SC that she is grateful for her health and being in her own home rather than a nursing facility.

AB

AB is a member with very high service utilization who had to give up her apartment after several serious self-harm incidents led to repeated inpatient admissions. Her CMHC, which was supporting her with wrap-around services, felt unable to provide adequate support to help AB remain safely in the community. As she had then no stable, safe, permanent housing, Sunflower's team helped to locate a group housing option in the community, and an intensive treatment program to help stabilize her BH condition. AB is now residing in the community with the goal to continue with treatment services that makes it possible for her to remain in the community and return to a more independent living situation.

RB

Our UM team identified RB as a candidate for SC in 2014 due to inpatient admissions for BH complicated by co-occurring SUD and homelessness. RB's pattern was to live in recovery houses until he was kicked out for continued substance use, and then he would end up with an admission. Our SC worked with RB, the outpatient BH team and his primary care provider to develop a plan of action to stabilize RB. He was assessed and approved for admission to a nursing facility to help address previously untreated his physical health conditions, as well as his BH/SUD needs. This required RB to relocate to Independence, KS where he established BH outpatient services with a local CMHC. RB remained at the nursing facility for six months, at which time he was able to obtain his own apartment and live independently with outpatient support from the CMHC. He participated in outpatient services and residential substance abuse treatment to support his recovery over the next year and a half. Through SC support and RB's engagement in care, and stabilized living situation, RB's inpatient admissions reduced from 11 in 2014 to only three in 2015, to zero in 2016 and 2017 for SUD or BH reasons. RB continues to work with the local CMHC to support his recovery and goals and has maintained safe and stable housing since his discharge from the nursing facility.

5.8.3.2. MEDICATION-ASSISTED TREATMENT

Sunflower supports the expansion and availability of Medication-Assisted Treatment (MAT) and strategies to improve or expand the infrastructure for MAT providers for opioid use, alcohol dependence and other substance use disorder (SUD). Sunflower will use a multi-pronged approach to increase understanding of MAT, increase the number of MAT providers and increase access to MAT and other SUD treatments across Kansas including rural and frontier areas. We will continue to work with the State to develop policies and conduct trainings, and have developed webinars that are already widely available regarding MAT. In addition, Sunflower will launch a Project ECHO program that will make expert education and support to providers interested in learning more about MAT available in rural and frontier areas. Sunflower's efforts to expand the number of MAT providers and increase access include:

- Working with providers on alternate payment models (e.g. bundled payments for initiation of buprenorphine). This removes a critical barrier in the clinical process of starting MAT.
- Working with multiple stakeholders to facilitate innovative pilots to improve access to MAT in novel settings, such as:
  - MAT for incarcerated/decarcerated/re-entry populations, for example, our pilots in partnership with Alkermes to facilitate use of Vivitrol in incarcerated populations
- Using analytics that identifies MAT provider density in different parts of the State
- Disseminating materials to raise awareness of SAMHSA MAT provider application resources

- Participating in SUD Project ECHO aimed at educating emergency department physicians, PCPs, and mental health practitioners on prescribing MAT
- Developing materials used in training providers on SUD and MAT
- Leveraging analytics to identify "MAT deserts" within the state (done by Sunflower's affiliate in Texas) and distance to nearest MAT provider
- Educating providers on the need for MAT through Provider newsletter
- Leveraging data analytics to identify individual members who may have an opioid use disorder and thus may be appropriate for MAT
- Training all Sunflower clinical staff on MAT for SUD

5.8.3.3. EMERGENCY ROOM PROTOCOL

Sunflower supports integrated service delivery across all service types, including Emergency room (ER) services. Our UM staff work with hospital staff to ensure that all member health conditions requiring care are addressed, and that appropriate consultations are conducted when members are in ER or other acute settings prior to transfer or discharge. When opportunities are identified by the Sunflower team, we work directly with the provider to facilitate assessment and referrals as appropriate. Our ER protocols are evidence based and focused on addressing a member's whole person needs, while reducing unnecessary ER utilization. Sunflower will cover emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical and or behavioral condition in the judgment of a prudent layperson. Sunflower does not require prior authorization for emergency services, but works with providers and members through our ER Diversion program to prevent inappropriate use of the ER.

Emergency Room Notifications

Sunflower understands that for us to ensure that appropriate services, screening and support for medical and BH needs are addressed in the ER, we must be able to identify members that are in the ER faster. Through Sunflower's secure Provider Portal ER staff can alert Sunflower when our members are in ER. If the facility activates the ER notification, the data is automatically transmitted to our TruCare system for follow up by the Sunflower Integrated Care Team (IC Team) including UM staff allowing us to provide timely notification to PCPs and other relevant providers, as needed. This notification can help our staff to communicate with the treatment team, or if a hard to reach member presents in the ER, our IC Team can obtain updated contact information or assist in locating SDOHI supports. Our Washington affiliate has worked effectively with providers to expand the ER notification through secure access to ER data through a community sponsored secured environment/tool where payors and providers can transmit ER alerts and care gap notifications directly to other providers/care team members real-time. This notification can alert other providers within the ER's hospital when specific screenings or assessments are needed and (e.g. when a psychiatric consultation is needed) and intervention by all team members can proceed during the ER visit period. Sunflower supports this approach and would actively participate should a similar program be available in Kansas.

Emergency Room Diversion

Through hospital ER diversion efforts, Sunflower aims to increase the provision of preventative and non-emergent acute care services at the appropriate outpatient level of care, thereby reducing dependency on uncoordinated ER services. Sunflower's ER Diversion program includes early notification, data analysis and outreach and education. The ER notification indicator in our Provider Portal (discussed above) allows our UM or SC staff to identify members for additional outreach and education regarding treatment options and appropriate use of the ER.

Sunflower's Utilization Management department uses data from ER notifications and claims-based reporting data to identify members with high utilization of the ER. At the individual member level we evaluate the data based on the presenting primary diagnosis to determine if there are alternative services available to the member in a more appropriate care setting such as services from a primary care provider, BH provider, dentist or urgent care center. Our targeted member education allows us to encourage use of, or connect members to PCP, other outpatient, or urgent care services and decrease ER dependency. We assist members with establishing a care and treatment relationship with a primary care provider and provide education regarding alternative resources for care to eliminate ER utilization except in appropriate situations. Sunflower also identifies members as potential candidates for service coordination and identifies needs for additional resources. If the member's ER use meets the criteria for our Administrative Lock-in program, described in Section 5.8.3.5., our UM or SC staff can also make this recommendation.

Sunflower also analyzes ER utilization data to identify larger trends in ER use and opportunities for broader intervention and education programs. For example, if we identify that certain PCPs have patient rosters with higher ER use, our Provider Relations and clinical leadership can share this information with the provider and identify causes and interventions to reduce ER utilization. In counties with high ER utilization, Sunflower sends members a list of Urgent Care facilities, as well as educational information on the importance of accessing their PCP and preventative health services. Community level data can also indicate potential need for recruitment of providers, development of additional service types, or expanded hours of service for outpatient providers in our network. This information is shared with our network and provider relations staff for intervention.

5.8.3.4. EMERGENCY AND POST-STABILIZATION SERVICES

Emergency Services

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. Sunflower does not limit what constitutes an emergency medical condition on the basis of lists of diagnosis or symptoms.

Emergency services are covered when furnished by a qualified practitioner, including non-network practitioners, and will be covered until the member is stabilized. Sunflower will also cover any screening examination services conducted to determine whether an emergency medical condition exists. If a Sunflower network practitioner, or representative, instructs a member to seek emergency services, the medical screening examination and other medically necessary emergency services will be covered without regard to whether the condition meets the prudent layperson standard. Once the member's emergency medical condition is deemed stabilized by the attending emergency physician or treating provider, certification for hospital admission or prior authorization for follow-up care is required as previously described. Although Sunflower may establish guidelines and timelines for submittal of notification regarding the provision of emergency services, including emergent admissions, we will not limit or refute coverage of an emergency service based on the practitioner's or the facility's timely notification, except as related to any claim filing timeframes. Sunflower, and our network providers, will not require members who have an emergency medical condition to pay for subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.

Post-Stabilization Services

Sunflower policies regarding access to post-stabilization services ensure that requests for post-stabilization care subsequent to emergency treatment are handled in an urgent manner supporting the member and consistent with state and federal requirements (42 CFR § 422.113(c) and 42 CFR § 438.114(e)). Sunflower does not require prior authorization for post-stabilization services related to an emergency medical condition to maintain stabilization or to improve or resolve the member's condition. When reviewing requests for post-stabilization care subsequent to emergency treatment, a determination will be issued within one hour from notification during normal business hours, after hours and weekends. Post-stabilization services will not require prior authorization. Sunflower covers all authorized post-stabilization services provided by qualified providers, whether the provider is in Sunflower's network or out of network. Sunflower will ensure that members are not charged at a higher rate for obtaining post-stabilization services at an out of network provider.

Sunflower will cover non-authorized post-stabilization services in certain circumstances as outlined within the KanCare contract including situations where:

- Sunflower does not respond to the provider's request for pre-approval within one hour;
- Sunflower cannot be contacted, or
- A Sunflower peer reviewer is not available for consultation. Care will be continued until a Sunflower peer reviewer is available.

When this occurs with an out-of-network provider, Sunflower will give the treating provider the opportunity to consult with Sunflower's in-network provider and the treating provider may continue with care of the member until a Sunflower peer reviewer is reached or one of the criteria of 42 CFR § 422.113(c)(3) are met.

Sunflower understands that our financial responsibility for non-authorized post-stabilization services only ends when:

- A Sunflower in-network provider with privileges at the treating hospital assumes responsibility for the member's care;
- A Sunflower in-network provider assumes care for the member through transfer;
- A Sunflower representative and a treating provider reach an agreement regarding the member's care;
- The member is discharged; or
- The member loses eligibility.

Post Discharge Outreach

Sunflower provides post discharge outreach to members supporting coordination and continuity of care as members move from the acute care setting to ensure members have appropriate access to needed follow up care, home care services and medication with the goal of preventing secondary health conditions or complications, re-institutionalization, re-hospitalization or unnecessary ED use. Our post hospital outreach nurses outreach to identified members within 72 hours of discharge (irrespective of whether it includes a weekend and/or holiday). Utilizing the Inpatient Daily Census Report, their knowledge of discharging members with service coordination needs, and daily review process, the Concurrent Review Nurse will identify members that require post discharge outreach and send a notification to Sunflower designated staff for outreach. The Start Smart for Your Baby® team conducts post discharge outreach for NICU members. If notification of discharge is received greater than 72 hours from the member's time of discharge, the Sunflower service coordination team will make outreach as close to discharge as possible. Three attempts will be made within five days of discharge when possible. If a member in foster care needs continued service coordination or case management, the discharge outreach staff will send a referral to the regional foster care "designee" to complete the Star General Health Screen as outlined in the Sunflower Foster Care Management Work Process.

5.8.3.5. ADMINISTRATIVE LOCK-IN

The Sunflower Administrative Lock-In Program functions in accordance with the KanCare contract, and all applicable state and federal laws. Our program is a health and safety program designed to address member over utilization of health care services by providing coordinated health care. When members are enrolled in the Administrative Lock-In program, they are assigned to one primary care provider (PCP), one pharmacy for all prescriptions, and/or one hospital for non-emergent care. Sunflower's Integrated Care Team (IC Team) approach includes pharmacy and service coordinators to address Administrative Lock-In program placement and review providing the member with appeal rights should they disagree with their Lock-In placement. The Sunflower Compliance Department notifies KDHE/DHCF Program Integrity within the State required timeframe and via the required reporting format when a member has

been placed in Administrative Lock-In, and if a member in Lock-In transfers to fee-for-service or another Contractor.

Identification and Criteria for Medical, Pharmacy and Non-Emergency Services

Sunflower identifies members for the administrative lock-in process through Pharmacy, Quality, Compliance, Service Coordination or Utilization Management staff and data analytics processes that evaluate the inappropriate utilization of services (e.g. persistent non-compliance, abusive or threatening conduct, fraud/abuse, over-utilization). Sunflower's criteria for our Lock-in program include identification of one or more of the following conditions that occur in a period of approximately ninety consecutive calendar days in the previous twelve months:

- Concurrently obtaining services from two or more providers of the same specialty, not in the same group practice, with no referrals
- Utilizing two or more emergency facility visits for non-emergent diagnoses
- Concurrently using two or more prescribing physicians to obtain medications from the same or similar therapeutic class(es) of medication
- One or more occurrences of having prescriptions for the same therapeutic class of medication filled two or more times on the same or subsequent day by the same or different providers
- Concurrently using two or more pharmacies to obtain medications from the same or similar therapeutic class(es) of medication
- Report of member using the medical card to purchase medications on a fraudulent prescription
- Report of consumer using another member's card for obtaining their own services, or loaning a card to another individual to obtain Medicaid reimbursed services
- On request or recommendation of State Legal or KDHE/DHCF
- Consistently seeking/obtaining medical services which are not supported by diagnosis or medical records/documentation
- Dismissal by service coordinator/Healthcare Provider/Lock-in provider – for inappropriate behavior, medical non-compliance, etc.
- Consistently obtaining medication regimens which exceed the manufacturers maximum recommended dosage as approved by the FDA or obtaining a prescription medication regimen that creates a concern for the member's health
- Obtaining narcotic or teratogenic medications from one or more prescribers or at one or more pharmacies while the member is pregnant

Lock-In Process. UM staff conduct a comprehensive review of Sunflower's overall member utilization for all services including physical, behavioral, pharmacy and non-emergency ER utilization, at least a quarterly. This analysis identifies trends for members who utilize services at a frequency or amount which exceeds recommended criteria and indicates one or more criteria for our Lock-in program. When appropriate, members found to be over-utilizing their medical coverage through utilization review are educated as to appropriate service utilization

and how to obtain additional services or care coordination if necessary in order to maintain appropriate utilization. If education is unsuccessful and utilization pattern continues to meet one or more criteria, the member shall be restricted to receiving services from designated providers as indicated. Sunflower may place members in lock-in without an education and reassessment period based on the severity of the misuse or concern such as immediate health risk to the member or unborn child.

Whenever appropriate, Sunflower provides education to members regarding their behavior prior to placing a member in Administrative Lock-In. For example, if the member has a BH diagnosis or disability related to the persistent non-compliant behavior, Sunflower will work with the member and appropriate providers to identify alternatives that could reduce inappropriate utilization and better support the member's overall health and safety prior to placing the member in Administrative Lock-In. Sunflower documents any education or attempts to reach the member for education and support within TruCare, and we re-review member utilization approximately six months or less post-member education to assess for continued overutilization.

If the member continues to meet criteria for our Lock-in program they are restricted to a specific provider(s) for a period of at least 12 months. If abusive patterns continue during the initial 12 month period, or the member had previously been in Lock-in, or there are concerns about removing the Lock-in then Lock-in may be extended for an indefinite period of time.

Sunflower sends written notification of the Lock-in placement to the member and assigned providers that includes:

- The reason for enrolling a member in the lock-in program
- A description of the lock-in program
- The effective date of lock-in program enrollment
- Identification of the member's designated providers
- Information relating to the member's right to appeal and a State Fair hearing
- Contact information for the health plan

During the Lock-in period, the member will be required to use one pharmacy, primary care provider, and/or one hospital. We ensure that the member has reasonable access (taking into account geographic location and reasonable travel time) to Medicaid services of adequate quality. Restrictions do not apply to emergency services furnished to the member. Sunflower may conduct additional review for all ED, inpatient and outpatient claims of locked-in members.

5.8.4. KANCARE 2.0 HCBS WAIVER POPULATIONS

NEEDS ASSESSMENT PROCESS

A Community Service Coordinator (CSC), contracted with Sunflower, will complete the Health Risk and Needs Assessments for all members on HCBS waiver programs to propose the type of

HCBS services and number of units needed. A Sunflower Service Coordinator (SC) will review the assessments and proposed Person-Centered Service Plan, and will provide the approval for the services authorized.

- The CSC will utilize the State required needs assessment tools for each HCBS Program type
- The CSC will complete the assessments during scheduled reviews or when a member requests a new services or increased services units
- The Sunflower SC will utilize Sunflower's current processes for reviewing the HCBS functional needs assessment and HRA, and approving HCBS services. This includes guidelines for the amount of time to approve for each type of service need (ADL, IADL, supervision, etc.) based upon the level of support the member requires. It also includes situations for which a Manager level review is required (reduction related to the capable person requirements, or a reduction of more than five hours per week.)
- The Sunflower SC will upload the assessments and Person-Centered Service Plan into TruCare.
- If a member's needs change between scheduled assessments, the CSC will complete an interim assessment to determine if the approved amount or type of service needs to change, and for what period of time. This can be requested by the member/authorized representative, or by the provider. Assessments will be completed within seven calendar days of the member request, or within three business days if the request is urgent. The Sunflower SC will review the assessments, make the determination, and send the notices of action to the member and provider(s).

Sunflower in Action…

Karen is 50 years old and on an HCBS waiver. She was diagnosed with MS in 2001, but it was a misdiagnosis resulting in improper treatment, which contributed to her becoming paraplegic in 2012. Karen ended up in a nursing home. In 2012 Karen was diagnosed correctly with Devic's disease, and has been getting stronger and more independent ever since. Karen left the nursing home with help of the Money Follows the Person program and has been successful living in her own apartment. When Sunflower first met her, Karen had been taking bed baths and had not showered in the bathroom since leaving the nursing home. In 2016 we asked for a minor bathroom modification to cut out part of her tub so that she would again be able to take showers, instead of baths in bed. With the help of Independence Inc. and Sunflower, Karen's home modification was approved and completed. ***Karen is now able to take showers with the help of her worker. Karen has continued to re-gain her strength and independence, and as a result she has gradually reduced her HCBS hour. Recently, Karen's confidence and growing independence allowed her to change from agency directed services to self-directed services and hiring her own workers.***

Person Centered Service Plan

The CSC will complete the Person Centered Service Plan with the member, and persons whom the member chooses to have participate. The PCSP includes the following information:

96% of sunflower members are satisfied with the HCBS services they receive.

- Member's lifestyle preferences

- Member's strengths and needs
- Member's person-centered goals and outcome measures
- Type and amount of HCBS services approved
- Provider chosen for each service, and the NPI Number
- Effective Date of HCBS services
- To which service Client Obligation is assigned per Sunflower's Client Obligation work process
- Non-HCBS services the member receives, including informal, community supports
- Member's choice of providers, HCBS services vs. institutional care, and self-direction
- Any special exceptions
- Whether the member has a current Individual Education Plan
- Review (with member) of rights and responsibilities, grievances and appeals process, and how to report suspected abuse/neglect/exploitation

Timeline for Completion. New members are assessed within seven business days of eligibility (three business days, if urgent). The PCSP and authorizations will be completed within 14 business days of eligibility, (six business days, if urgent) for services to start. The annual assessment and PCSP is completed within 365 days of the previous assessment and PCSP. Sunflower has an established process to ensure continuity of care and seamless transition for members transferring from another MCO. When a new member comes to Sunflower from another MCO, Sunflower coordinates with the assigned contact at the previous MCO to securely obtain the member's existing PCSP, assessments and other information. Sunflower authorizes HCBS services at the current level approved until the assigned CSC completes a new assessment, PCSP, and new authorizations are in place.

Prior Authorizations

Enabling members that receive HCBS to remain in the community, in the least restrictive setting possible, is the role of HCBS services. Sunflower considers access to community based services that support the health, wellbeing and safety of our members as the priority for all prior authorizations (PA). Sunflower offers all network providers the ability to look up whether a PA is required through our PA tool on Sunflower's public website. If needed, providers can use the Provider Portal to submit PA requests and supporting information via our PA request tool. When making authorization determinations our UM staff assess the medical and functional needs of the member, taking into account supporting information and how access to, or denial of the service could impact the member's ability to safely remain in the community and their PCSP progression. In addition, Sunflower's process for approving equipment and supplies includes reviewing coverage by other primary insurance or by community informal supports. If the equipment and/or supplies are determined to meet our needs-based requirements, they are reviewed first using the member's medical benefit, and then using the HCBS Assistive Services benefit. If the item(s) are determined not to be covered by either, Sunflower will review for coverage as an in lieu of benefit if needed to help keep the member in a community

setting. We adjudicate claims for authorized HCBS services, and all services, in compliance the KanCare contract.

Initial Authorizations. As described previously in this response, Sunflower utilizes TruCare our fully integrated, electronic documentation system for entering and tracking authorizations for delivery and billing. Through this system Sunflower has full transparency for monitoring authorizations at all stages of the process to ensure HCBS initial authorizations are entered in compliance with all contract required timeframes *(5.8.4.D. 1-3)*. Sunflower issues initial authorizations for all HCBS services included on the member's PCSP prior to services beginning. Sunflower will work with members and HCBS providers to ensure continuity of care in circumstances when a retroactive initial authorization may be necessary. For example for members transitioning from another MCO, emergency placement, State agency or institutional care, members that may have experienced gaps in eligibility and those members that may have incurred a material change in condition to ensure continuity of care. Sunflower's secure Provider Portal is available to network providers for entering and viewing authorization requests and status for full transparency and to ensure timely communication of authorization requests and documentation. Sunflower's members have reported overall satisfaction with their ability to get needed care, and get needed care quickly, two good measures of our effectiveness in meeting authorization timelines. In 2017, the results of the CAHPS survey demonstrate excellent member experience in these areas:

In 2016, Sunflower Exceeded Prior Authorization (PA) Turnaround Time goal of 98% timeliness on non-urgent requests and 99% on urgent requests.

- **"Getting Needed Care"** composite met or exceeded the NCQA Quality Compass 90th percentile for adults (87%) and above the 75th percentile for children (90%)
- **"Getting Care Quickly"** composites met or exceeded the NCQA Quality Compass 90th percentile for adults (88%) and the 50th percentile for children (92%)

Reauthorizations. Continuity of care during transitions is critical for all members, but particularly for those utilizing HCBS to live in a community setting. Sunflower works with members and providers to ensure HCBS services are reauthorized prior to the expiration of current authorizations. Our service coordination staff communicate with the CSC, member and provider prior to expiration to request re-evaluation of services to ensure reauthorization at the appropriate scope, duration and frequency to meet the member's current level of need. Sunflower will honor expired authorizations for HCBS while the reauthorization is pending when the HCBS eligible member and their chosen service provider have fulfilled re-evaluation, impartial choice and documentation requirements in a timely manner. Claims for services provided between authorizations will be adjudicated consistent with program requirements. If an authorization is going to expire and the member is not able to be located, or is refusing to participate in the required assessments, Sunflower will follow the contract process for required number and type of attempts and contact the HCBS program manager.

5.8 Attachments

Adopted Clinical Practice and Preventive Health Guidelines

Condition/Disease	Guideline Title	Recognized Source	URL	Review/ Update
Medical				
Adult Preventive Care	American Cancer Society Guidelines for the Early Detection of Cancer (Revised July 2016)	American Cancer Society (ACS)	http://www.cancer.org/Healthy/FindCancerEarly/CancerScreeningGuidelines/american-cancer-society-guidelines-for-the-early-detection-of-cancer	Jun-15 Jun-16 Jun-17
	Morbidity and Mortality Weekly Report (MMWR)(Last updated June 15, 2017)	Centers for Disease Control and Prevention (CDC)	http://www.cdc.gov/mmwr/	Jul-15 Jun-16 Jun-17
	U.S. Preventive Services Task Force Recommendations. (Publication dates vary)	U.S. Preventive Services Task Force (USPSTF)	http://www.uspreventiveservicestaskforce.org/uspstopics.htm	Jun-15 Jun-16 Jun-17
Asthma	Asthma Care Quick Reference Diagnosing and managing asthma. Guidelines from the National Asthma Education and Prevention Program. Expert Panel Report 3. (Revised 2012.)	U.S. Department of Health and Human Services (HHS); National Institute of Health (NIH); National Heart, Lung, and Blood Institute (NHLBI)	http://www.nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf	Jun-15 Jun-16 Jun-17
	Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma (Full Report July 2007) and Changes to the Guidelines (August 2008)	U.S. Department of Health and Human Services (HHS); National Institute of Health (NIH); National Heart, Lung, and Blood Institute (NHLBI)	http://www.nhlbi.nih.gov/guidelines/asthma/index.htm	Jun-15 Jun-16 Jun-17
	2017 GINA Report, Global Strategy For Asthma Management and Prevention. Updated 2017	Global Initiative for Asthma (GINA)	http://ginasthma.org/2017-gina-report-global-strategy-for-asthma-management-and-prevention/	Jul-15 Jun-16 Jun-17

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Condition/Disease	Guideline Title	Recognized Source	URL	Review/ Update
Back Pain	Adult Acute Low Back Pain (Updated November 2012)	Institute for Clinical Systems Improvement (ICSI)	https://www.guideline.gov/summaries/summary/39319/adult-acute-and-subacute-low-back-pain and https://www.icsi.org/guidelines__more/catalog_guidelines_and_more/catalog_guidelines/catalog_musculoskeletal_guidelines/low_back_pain/	Jun-15 Jun-16 Jun-17
	Diagnosis and treatment of low back pain: a joint clinical practice guideline from the American College of Physicians and the American Pain Society (October 2, 2007)	American College of Physicians; American Pain Society	http://annals.org/article.aspx?articleid=736814	Jul-15 Jun-16 Jun-17
	Low back pain: clinical practice guidelines linked to the International Classification of Functioning, Disability, and Health from the Orthopedic Section of the American Physical Therapy Association (April 2012)	American Physical Therapy Association	http://www.guideline.gov/content.aspx?id=36828	Jul-15 Jun-16 Jun-17
Chlamydia Screening	Final Recommendation Statement Gonorrhea and Chlamydia: Screening, September 2014	U.S. Preventive Services Task Force (USPSTF)	http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/chlamydia-and-gonorrhea-screening	Jul-15 Jun-16 Jun-17
COPD	Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease (2017 Report)	The Global Initiative for Chronic Obstructive Lung Disease	http://goldcopd.org/gold-2017-global-strategy-diagnosis-management-prevention-copd/	Jun-15 Jun-16 Jun-17

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Condition/Disease	Guideline Title	Recognized Source	URL	Review/ Update
Coronary Artery Disease	Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents. The Report of the Expert Panel (October 2012)	U.S. Department of Health and Human Services (HHS); National Institute of Health (NIH); National Heart, Lung, and Blood Institute (NHLBI)	http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm	Jul-15 Jun-16 Jun-17
	ACC/AHA Prevention Guideline: 2013 ACC/AHA Guideline on the Assessment of Cardiovascular Risk. (Circulation. 2014; 129:S49-S73) (Published online November 12, 2013)	American College of Cardiology (ACC) and American Heart Association (AHA) Task Force	http://circ.ahajournals.org/lookup/doi/10.1161/01.cir.0000437741.48606.98	Jul-15 Jun-16 Jun-17
	AHA Scientific Statement: Exercise and Physical Activity in the Prevention and Treatment of Atherosclerotic Cardiovascular Disease (Circulation. 2003; 107:3109-3116)	The Council on Clinical Cardiology and the Council on Nutrition, Physical Activity, and Metabolism	http://circ.ahajournals.org/content/107/24/3109.long	Jun-15 Jun-16 Jun-17
	AHA Scientific Statement: Secondary Prevention of Atherosclerotic Cardiovascular Disease in Older Adults. (Circulation. 2013; 128:2422-2446)	American Heart Association (AHA)	http://circ.ahajournals.org/content/128/22/2422.full	Jul-15 Jun-16 Jun-17
	AHA/ACC/ASH Scientific Statement Treatment of Hypertension in Patients with Coronary Artery Disease. (Circulation 2015;131:e435-e470)	American Heart Association (AHA), American College of Cardiology (ACC), and American Society of Hypertension	http://circ.ahajournals.org/content/131/19/e435.full	Jul-15 Jun-16 Jun-17
	AHA/ACCF Guideline: AHA/ACCF Secondary Prevention and Risk Reduction Therapy for Patients with Coronary and	American Heart Association (AHA) and American College	http://circ.ahajournals.org/content/124/22/2458.full.pdf	Jun-15 Jun-16 Jun-17

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Condition/Disease	Guideline Title	Recognized Source	URL	Review/ Update
	Other Atherosclerotic Vascular Disease, 2011 Update (Circulation. 2011; 124: 2458-2473) and	of Cardiology Foundation (ACC)		
	The Primary and Secondary Prevention of Coronary Artery Disease: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines (8th Edition)(June 2008)	American College of Chest Physicians	http://journal.chestnet.org/article/S0012-3692(08)60130-0/fulltext	Jul-15 Jun-16 Jun-17 Sept-17
Diabetes	AACE/ACE Guidelines: American Association of Clinical Endocrinologists and American College of Endocrinology-Clinical Practice Guidelines for Developing a Diabetes Mellitus Comprehensive Care Plan (*Endocrine Practice 2015, Volume 21, S1-87*).	American Association of Clinical Endocrinologists and American College of Endocrinology	https://www.aace.com/files/dm-guidelines-ccp.pdf	Jun-15 Jun-16 Jun-17
	Clinical Practice Recommendations – 2017. Standards of Medical Care in Diabetes (Diabetes Care 2017, Volume 40, Supplement 1)	American Diabetes Association (ADA)	http://professional.diabetes.org/ResourcesForProfessionals.aspx?cid=84160	Jul-15 Jun-16 Jun-17
	Standards of Medical Care in Diabetes (Diabetes Care July 2017, 40: 811-987)	American Diabetes Association (ADA	http://care.diabetesjournals.org/content/current	Jun-15 Jun-16 Jun-17
Heart Failure	2017 ACC/AHA/HFSA Focused Update of the 2013 ACCF/AHA Guideline for the Management of Heart Failure: A Report of the ACC, AHA and HFSA (Circulation. 2017;	American College of Cardiology (ACC) Foundation, American Heart Association (AHA) Task Force on Practice Guidelines	http://circ.ahajournals.org/content/early/2017/04/26/CIR.0000000000000509	Jun-15 Jun-16 Jun-17

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Condition/Disease	Guideline Title	Recognized Source	URL	Review/ Update
	CIR.0000000000000509, originally published April 28, 2017)	and the Heart Failure Society of America (HFSA)		
	AHA Scientific Statement: Exercise and Heart Failure (Circulation. 2003; 107:1210-1225)	American Heart Association (AHA) Committee on Exercise, Rehabilitation, and Prevention	http://circ.ahajournals.org/content/107/8/1210	Jun-15 Jun-16 Jun-17
	HFSA 2010 Comprehensive Heart Failure Practice Guideline. (June 2010; 16: e1-e194)	Heart Failure Society of America (HFSA)	https://www.ncbi.nlm.nih.gov/pubmed/20610207 and http://www.hfsa.org/heart-failure-guidelines-2/	Jun-15 Jun-16 Jun-17
	Updated Clinical Practice Guidelines on Heart Failure: An International Alignment (May 2016)	American Heart Association (AHA), American College of Cardiology (ACC) Foundation, Heart Failure Society of American (HFSA), and the Heart Failure Association and the European Society of Cardiology	http://circ.ahajournals.org/content/early/2016/05/18/CIR.0000000000000436	Jun-16 Jun-17
Hyperlipidemia	ACC/AHA Prevention Guideline: 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults. (Circulation 2014; 129:S1-S45)	American College of Cardiology (ACC), American Heart Association (AHA) Task Force on Practice Guidelines	http://circ.ahajournals.org/content/129/25_suppl_2/S1	Jul-15 Jun-16 Aug-16 Jun-17
	Management of Blood Cholesterol in Adults: Systematic Evidence Review from the Cholesterol Expert Panel (2013)	U.S. Department of Health and Human Services, National Institute of Health, National	http://www.nhlbi.nih.gov/guidelines/cholesterol/ser/index.htm	Jul-15 Jun-16 Jun-17

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Condition/Disease	Guideline Title	Recognized Source	URL	Review/ Update
		Heart, Lung, and Blood Institute		
	Third Report of the National Cholesterol Education Program Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III) Final Report September 2002	National Institute of Health and National Heart, Lung, and Blood Institute	http://circ.ahajournals.org/content/106/25/3143.short?rss=1&ssource=mfc	Jun-15 Jun-16 Jun-17
Hypertension	2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults: Report From the Panel Members Appointed to the Eighth Joint National Committee (JNC 8) (JAMA. 2014;311(5):507-520. doi:10.1001/jama.2013.284427)	The Journal of the American Medical Association (JAMA)	http://jama.jamanetwork.com/article.aspx?articleid=1791497	Jun-15 Jun-16 Jun-17
	Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure (JNC7) (August 2004)	U.S. Department of Health and Human Services, National Institutes of Health, National Heart, Lung and Blood Institute	http://www.nhlbi.nih.gov/files/docs/guidelines/jnc7full.pdf	Jul-15 Jun-16 Jun-17
Immunizations	Adult Immunization Schedule , United States 2017	Advisory Committee on Immunization Practices (ACIP)	http://www.cdc.gov/vaccines/schedules/hcp/adult.html	Jun-15 Jun-16 Jun-17
	Birth-18 Years & "Catch-up" Immunization Schedules, United States, 2017	Advisory Committee on Immunization Practices (ACIP)	http://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html	Jun-15 Jun-16 Jun-17

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Condition/Disease	Guideline Title	Recognized Source	URL	Review/ Update
	Prevention and Control of Influenza with Vaccines: Recommendations of the ACIP — United States, 2016–17 Influenza Season	Advisory Committee on Immunization Practices (ACIP)	https://www.cdc.gov/mmwr/volumes/65/rr/rr6505a1.htm	Jun-15 Jun-16 Jun-17
Lead Screening	Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention Report of the Advisory Committee on Childhood Lead Poisoning Prevention of the Centers for Disease Control and Prevention (January 4, 2012)	Advisory Committee for Childhood Lead Poisoning Prevention	http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf	Jun-15 Jun-16 Jun-17
	Recommendations for Blood Lead Screening of Medicaid-Eligible Children Aged 1-5 Years: an Updated Approach to Targeting a Group at High Risk (Last Reviewed 07/28/2009)	Advisory Committee on Childhood Lead Poisoning, Division of Environmental and Emergency Health Services, and National Center for Environmental Health	http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5809a1.htm	Jul-15 Jun-16 Jun-17
Pediatric Preventive Care	Guidelines on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents (Revised 2013)	American Academy of Pediatric Dentistry	http://www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf	Jul-15 Jun-16 Jun-17
	Periodicity Schedule: Recommendations for Preventive Pediatric Health Care (2017)	American Academy of Pediatrics (AAP)	http://www.aap.org/en-us/professional-resources/practice-support/Pages/PeriodicitySchedule.aspx	Jun-15 Jun-16 Jun-17

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Condition/Disease	Guideline Title	Recognized Source	URL	Review/ Update
Perinatal Care	AFP by Topic: Prenatal (2017)	American Academy of Family Physicians (AAFP)	http://www.aafp.org/afp/topicModules/viewTopicModule.htm?topicModuleId=25	Jul-15 Jun-16 Jun-17
	Guidelines for Perinatal Care, Seventh Edition (October 2012)	The American College of Obstetricians and Gynecologists (ACOG)	Available online for ACOG members only. http://www.acog.org/About-ACOG/ACOG-Departments/Deliveries-Before-39-Weeks/ACOG-Clinical-Guidelines	Jun-15 Jun-16 Jun-17
Respiratory Illness	Adult and Pediatric treatment recommendations. (Last updated April 17, 2015)	Centers for Disease Control and Prevention (CDC)	http://www.cdc.gov/getsmart/community/for-hcp/outpatient-hcp/index.html	Jul-15 Jun-16 Jun-17
	Clinical Practice Guideline for the Diagnosis and Management of Group A Streptococcal Pharyngitis: 2012 Update by the Infectious Diseases Society of America. (Clin Infect Dis 2012; 55: e86-e102.) First published online Sept. 9, 2012.	Infectious Disease Society of America	http://cid.oxfordjournals.org/content/55/10/e86.full.pdf+html	Jul-15 Jun-16 Jun-17
	Upper Respiratory Tract Infections (Publication dates vary)	American Academy of Family Physicians (AAFP)	http://www.aafp.org/afp/topicModules/viewTopicModule.htm?topicModuleId=29	Jun-16 Jun-17
	Diagnosis and Treatment of Respiratory Illness in Children and Adults. (Updated January 2013)	Institute for Clinical Systems Improvement (ICSI)	https://www.icsi.org/guidelines__more/catalog_guidelines_and_more/catalog_guidelines/catalog_respiratory_guidelines/respiratory_illness/ and	Jul-15 Jun-16 Jun-17

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Condition/Disease	Guideline Title	Recognized Source	URL	Review/ Update
			https://www.guideline.gov/summaries/summary/43792/diagnosis-and-treatment-of-respiratory-illness-in-children-and-adults	
Sickle Cell	Evidence-Based Management of Sickle Cell Disease. Expert Panel Report, 2014.	U.S. Department of Health and Human Services; National Institutes of Health; National Heart, Lung, and Blood Institute	http://www.nhlbi.nih.gov/sites/www.nhlbi.nih.gov/files/sickle-cell-disease-report.pdf	Jul-15 Jun-16 Jun-17
	Sickle Cell Disease, Recommendations (Last updated September 14, 2015)	Centers for Disease Control and Prevention (CDC)	http://www.cdc.gov/ncbddd/sicklecell/recommendations.html	Jul-15 Jun-16 Jun-17
	The Management of Sickle Cell Disease, Fourth Edition (2004)	National Institutes of Health; National Heart, Lung, and Blood Institute	http://www.nhlbi.nih.gov/health/prof/blood/sickle/index.htm	Jun-15 Jun-16 Jun-17
Weight Management	Active Healthy Living: Prevention of Childhood Obesity Through Increased Physical Activity. (Pediatrics Vol. No.5 May 1, 2006 pp.1834-1842)	American Academy of Pediatrics (AAP)	http://pediatrics.aappublications.org/content/117/5/1834.full	Jul-15 Jun-16 Jun-17
	Adult Weight Management (AWM) Guideline (2014)	Academy of Nutrition and Dietetics	http://www.andeal.org/topic.cfm?menu=5276&cat=4688	Jun-15 Jun-16 Jun-17
	Managing Overweight and Obesity in Adults: Systematic Evidence Review from the Obesity Expert Panel (2013)	U.S. Department of Health and Human Services, National Institute of Health, National	http://www.nhlbi.nih.gov/health-pro/guidelines/in-develop/obesity-evidence-review	Jul-15 Jun-16 Jun-17

CENTENE Corporation

Adopted Clinical Practice and Preventive Health Guidelines

Condition/Disease	Guideline Title	Recognized Source	URL	Review/ Update
		Heart, Lung, and Blood Institute		
	Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report (December 2007)	American Academy of Pediatrics (AAP)	http://pediatrics.aappublications.org/content/suppl/2007/12/03/120.Supplement_4.S163.DC1/Obesity_Supplement_120-6.pdf	Jul-15 Jun-16 Jun-17
	Final Recommendation Statement Obesity in Children and Adolescents: Screening, June 2017	U.S. Preventive Services Task Force (USPSTF)	https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/obesity-in-children-and-adolescents-screening1	Jul-15 Jun-16 Jun-17
Behavioral Health				
ADHD	ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-deficit/Hyperactivity Disorder in Children and Adolescents. (Published online October 16, 2011; DOI: 10.1542/peds.2011-2654)	American Academy of Pediatrics (AAP)	http://pediatrics.aappublications.org/content/early/2011/10/14/peds.2011-2654.full.pdf+html	Jun-15 Jun-16 Jun-17
	Clinical Practice Guideline: Treatment of the School-Aged Child with Attention-Deficit/Hyperactivity Disorder (Pediatrics Vol. 108 No. 4 October 1, 2001 pp. 1033 - 1044)	American Academy of Pediatrics (AAP)	http://pediatrics.aappublications.org/content/108/4/1033.full?sid=6dac3588-095c-49c7-adc5-62643dc1641a	Jun-15 Jun-16 Jun-17

CENTENE Corporation

Adopted Clinical Practice and Preventive Health Guidelines

Condition/Disease	Guideline Title	Recognized Source	URL	Review/ Update
	Practice Parameter for the assessment and treatment of children and adolescents with attention-deficit/hyperactivity disorder (AACAP Revised: 7/2007)	American Academy of Child and Adolescent Psychiatry (AACAP)	http://www.jaacap.com/article/S0890-8567(09)62182-1/pdf	Jul-15 Jun-16 Jun-17
Anxiety Disorder	Practice parameter for the assessment and treatment of children and adolescents with anxiety disorders (Revised: 2/2007)	American Academy of Child and Adolescent Psychiatry (AACAP)	http://www.jaacap.com/article/S0890-8567(09)61838-4/pdf	Jul-15 Jun-16 Jun-17
Bipolar Disorder	Practice Guideline for the Treatment of Patients with Bipolar Disorder. Second Edition. (April 2002) and Guideline Watch (November 2005)	American Psychiatric Association (APA)	http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/bipolar.pdf and http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/bipolar-watch.pdf	Jul-15 Jun-16 Jun-17
	Practice parameter for the assessment and treatment of children and adolescents with bipolar disorder.(Revised: 1/2007)	American Academy of Child and Adolescent Psychiatry (AACAP)	http://www.jaacap.com/article/S0890-8567(09)61968-7/pdf	Jul-15 Jun-16 Jun-17
Major Depressive Disorder	Practice Guideline for the Treatment of Patients With Major Depressive Disorder. Third Edition. (2010)	American Psychiatric Association (APA)	http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/mdd.pdf	Jun-15 Jun-16 Jun-17
	Practice parameter for the assessment and treatment of children and adolescents with depressive disorders (Revised 11/2007)	American Academy of Child and Adolescent Psychiatry (AACAP)	http://www.jaacap.com/article/S0890-8567(09)62053-0/pdf	Jul-15 Jun-16 Jun-17
Oppositional Defiant Disorder	Practice parameter for the assessment and treatment of children and adolescents with oppositional defiant disorder. (1/2007)	American Academy of Child and Adolescent Psychiatry (AACAP)	http://www.jaacap.com/article/S0890-8567(09)61969-9/pdf	Jul-15 Jun-16 Jun-17

CENTENE Corporation

Adopted Clinical Practice and Preventive Health Guidelines

Condition/Disease	Guideline Title	Recognized Source	URL	Review/ Update
Panic Disorder	Practice Guideline for the Treatment of Patients with Panic Disorder. Second Edition. (January 2009)	American Psychiatric Association (APA)	http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/panicdisorder.pdf	Jul-15 Jun-16 Jun-17
Schizophrenia	The Practice Guideline for the Treatment of Patients With Schizophrenia. Second Edition.(April 2004) and Guideline Watch(September 2009)	American Psychiatric Association (APA)	http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/schizophrenia.pdf and http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/schizophrenia-watch.pdf	Jul-15 Jun-16 Jun-17
	The Practice Parameter for the Assessment and Treatment of Children and Adolescents with Schizophrenia (September 2013)	American Academy of Child and Adolescent Psychiatry (AACAP)	http://www.jaacap.com/article/S0890-8567(13)00112-3/pdf	Jun-17
Stress Disorder	The Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress Disorder. (November 2004) and Guideline Watch (March 2009)	American Psychiatric Association (APA)	http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/acutestressdisorderptsd.pdf and http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/acutestressdisorderptsd-watch.pdf	Jun-15 Jun-16 Jun-17

CENTENE Corporation

Adopted Clinical Practice and Preventive Health Guidelines

Condition/Disease	Guideline Title	Recognized Source	URL	Review/ Update
Substance Use Disorders	Practice Guideline for the Treatment of Patients With Substance Use Disorders(May 2006) and Guideline Watch (April 2007)	American Psychiatric Association (APA)	http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/substanceuse.pdf and http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/substanceuse-watch.pdf	Jul-15 Jun-16 Jun-17
Tobacco Cessation	Smoking Cessation During Pregnancy (Obstet Gynecol 2010; 116: 1241-4)	American College of Obstetricians and Gynecologists (ACOG)	http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Smoking-Cessation-During-Pregnancy	Jul-15 Jun-16 Jun-17
	Treating Tobacco Use and Dependence: 2008 update (May 2008)	U.S. Department of Health and Human Services (HHS); Public Health Service	http://www.ahrq.gov/sites/default/files/wysiwyg/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/update/treating_tobacco_use08.pdf	Jun-15 Jun-16 Jun-17
Use of Psychotropic Medication	Practice parameter for the use of psychotropic medication in children and adolescents (9/2009)	American Academy of Child and Adolescent Psychiatry (AACAP)	http://www.jaacap.com/article/S0890-8567(09)60156-8/pdf	Jul-15 Jun-16 Jun-17

REVISION LOG	DATE
Updated Adopted Clinical Practice and Preventive Health Guidelines attachment to most current versions of guidelines (Added Practice Guidelines for ADHD, Adult Preventive Care, Asthma, Back Pain, Bipolar Disorder, Coronary Artery Disease, Diabetes, Hyperlipidemia, Hypertension, Lead Screening, Major Depressive Disorder, Oppositional Defiant Disorder, Panic Disorder,	07/2015

Adopted Clinical Practice and Preventive Health Guidelines

Pediatric Preventive Care, Perinatal Care, Respiratory Illness, Schizophrenia, Sickle Cell, Stress Disorder, Substance Use Disorders, Tobacco Cessation, Use of Psychotropic Medication. Removed Practice Guidelines for Back Pain, Coronary Artery Disease, Heart Failure, and Hyperlipidemia.)	
Updated Adopted Clinical Practice and Preventive Health Guidelines attachment to most current versions of guidelines (Added Practice Guidelines for Heart Failure, Respiratory Illness, and Pediatric Medical and Psychiatric Management).	06/2016
Updated Adopted Clinical Practice and Preventive Health Guidelines attachment to most current version of guidelines. Added footer to notate Clinical Policy Committee approval dates. Revised column header to read, "Review/Update Date". Deleted the following as they are out of date: The Practical Guide to the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults; Lead Toxicity How should patients exposed to lead be evaluated?; Practice parameter for the psychiatric assessment and management of physically ill children and adolescents. Updated heart failure guidelines to include, "2017 ACC/AHA/HFSA Focused Update of the 2013 ACCF/AHA Guideline for the Management of Heart Failure: A Report of the ACC, AHA and HFSA (Circulation. 2017; CIR.0000000000000509, originally published April 28, 2017)". Updated schizophrenia guidelines to include, "The Practice Parameter for the Assessment and Treatment of Children and Adolescents with Schizophrenia (September 2013)".	07/2017
Updated link to, "The Primary and Secondary Prevention of Coronary Artery Disease: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines".	09/2017

Adopted Clinical Practice and Preventive Health Guidelines

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Compliance 360, Centene's P&P management software, is considered equivalent to a physical signature.

Corporate Vice President of Quality Improvement: _____Electronic Signature_____

Approved by Centene Clinical Policy Committee on 07/2017, 06/2016, 07/2015.

POLICY ADDENDUM

DEPARTMENT: Quality Improvement	**DOCUMENT NAME:** Preventive Health and Clinical Practice Guidelines Addendum
PAGE: 1 of 2	**REPLACES DOCUMENT:**
APPROVED DATE:	**RETIRED:**
EFFECTIVE DATE: 4/1/2016	**REVIEWED/REVISED:**
PRODUCT TYPE: All	**RELATED POLICY NUMBER:** CC.QI.08

SCOPE: Health Services Group of New York (HSGNY)

PURPOSE: To define the additional requirements of HSGNY as they relate to Preventive Health and Clinical Practice Guidelines. These are exceptions to the primary policy. Only the exceptions are present in the addendum, please refer to the primary policy for the complete policy and procedure statement.

ADDENDUM: The following portions of the policy are to be **excluded**:

1) **Plan Distribution to Practitioners and Members**
   a) Guidelines are distributed to all practitioners who are likely to use them and upon request to members, potential members and providers. Revised guidelines are distributed on a timely basis. Guidelines are also distributed to new practitioners if the original distribution has already occurred.
   b) New or updated guidelines are disseminated to providers via the Plan website as soon as possible (or per state contract timeframe, if applicable).
   c) A listing of adopted clinical practice and preventive health guidelines is maintained in the Provider Manual, with the links to the full guidelines or with a notation that the links and/or full guidelines are available on the Plan website or hard copy upon request.
   f) Mechanisms to notify and distribute guidelines include, but are not limited to:
      - New practitioner orientation materials
      - Provider newsletters
      - Special mailings

REFERENCES
EHP-Centene MSA Contract ID 4848-2491-5497

POLICY ADDENDUM

DEPARTMENT: Quality Improvement	**DOCUMENT NAME:** Preventive Health and Clinical Practice Guidelines Addendum
PAGE: 2 of 2	**REPLACES DOCUMENT:**
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EFFECTIVE DATE: 4/1/2016	**REVIEWED/REVISED:**
PRODUCT TYPE: All	**RELATED POLICY NUMBER:** CC.QI.08

ATTACHMENTS

DEFINITIONS:

REVISION LOG	**DATE**

POLICY AND PROCEDURE

DEPARTMENT: Quality Improvement	**DOCUMENT NAME:** Preventive Health and Clinical Practice Guidelines
PAGE: 1 of 7	**REPLACES DOCUMENT:** CC.MEDM.QI.06
APPROVED DATE: 8/16/02	**RETIRED:**
EFFECTIVE DATE: 8/16/02	**REVIEWED/REVISED:** 5/05; 4/06; 10/06; 11/07; 3/08; 4/08; 3/09; 5/09; 7/09, 7/10, 8/11, 03/12, 07/12, 12/13, 06/14, 08/15, 3/16, 08/16, 11/2016, 07/2017, 09/2017
PRODUCT TYPE: All	**REFERENCE NUMBER:** CC.QI.08

SCOPE:
Centene Corporate and Plan Medical Management, Quality Improvement/Quality Management (QI/QM) and Provider Relations departments.

PURPOSE:
To establish a process by which the Plan adopts/develops and distributes preventive health and clinical practice guidelines to assist practitioners and members make decisions about appropriate health care for specific clinical circumstances.

POLICY:
The Plan, whenever possible, adopts preventive and clinical practice guidelines (CPG) from recognized sources for the provision of acute, chronic and behavioral health services relevant to the populations served. The Plan also presents guidelines to the Quality Committee for appropriate physician review and adoption. Guidelines are updated at least every two years or upon significant new scientific evidence or changes in national standards.

The Plan adopts clinical practice guidelines for at least two non-preventive acute or chronic medical conditions. The Plan also adopts at least two behavioral health guidelines (preventive or non-preventive) relevant to their population, including one guideline addressing children and adolescents, as applicable. One of the guidelines may be a behavioral health component of a medical guideline. At least two of the adopted clinical practice guidelines directly correspond with two disease management programs offered by the Plan. Guidelines are based on the population's health needs and/or opportunities for improvement as identified through the Quality Assessment and Performance Improvement (QAPI) Program. (Note: If the Plan benefit does not include behavioral health services, the Plan must adopt at least four non-preventive clinical practice guidelines related to medical conditions).

Clinical practice guidelines (CPG) may include, but are not limited to:

- ADHD Treatment Guidelines
- Asthma Guidelines
- Diabetes Care Guidelines
- Sickle Cell Guidelines
- Chronic Obstructive Pulmonary Disease

The Plan also adopts applicable preventive health guidelines for perinatal care, care for children up to 24 months old, care for children 2–19 years old, care for adults 20–64 years old, and care for adults 65 years and older. Preventive health guidelines may include, but are not limted to:

- Adult Preventive Health Guidelines
- Child Preventive Health Guidelines

POLICY AND PROCEDURE

DEPARTMENT: Quality Improvement	**DOCUMENT NAME:** Preventive Health and Clinical Practice Guidelines
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PRODUCT TYPE: All	**REFERENCE NUMBER:** CC.QI.08

- Immunization Guidelines
- Lead Toxicity Screening Guidelines
- Guidelines for Perinatal Care

PROCEDURE:

1) Development, Adoption and Revision

a) The QI/QM designee, in coordination with the Corporate Clinical Policy Committee (CPC), is responsible for researching evidence-based guidelines. Whenever possible, guidelines from recognized sources are adopted. Source data is documented in the guidelines to include the scientific basis or the authority upon which it is based.

b) Board-certified practitioners who will utilize the guidelines have the opportunity to review and give advice on the guidelines through the Corporate CPC and the Plan's Quality Committee. Specialist review is documented in the meeting minutes, as applicable.

c) If guidelines from a recognized source cannot be found, Centene's CPC is consulted for assistance in guideline sourcing or development.

d) The Plan QI/QM designee updates guidelines upon significant new scientific evidence or change in national standards and guidelines are reviewed by the Corporate CPC and Plan Quality Committee at least every two years.

2) Internal Use of Practice Guidelines

a) The Plan utilizes evidence-based clinical practice guidelines, preventive health guidelines, and/or other scientific evidence, as applicable, in developing, implementing and maintaining clinical decision support tools used to support utilization and care management.

b) When appropriate, the Plan may choose to use a vendor's clinical decision support tools. The Plan will ensure through due diligence and regular updates that evidence-based practice is utilized in development of the clinical decision support tools.

c) When the Plan deems necessary, customized assessments or utilization management tools are developed as follows:

   i) Utilize clinical sources with documented evidence-based practice.

   ii) A team consisting of Plan and Corporate staff, which includes licensed clinical staff, develops the necessary tools.

   iii) The Vice President of Medical Management and the Chief Medical Officer review and approve the modifications.

d) The clinical documentation system provides a link to the clinical practice or preventive health guideline as applicable for access by clinical staff during utilzation management and care management.

POLICY AND PROCEDURE

DEPARTMENT: Quality Improvement	**DOCUMENT NAME:** Preventive Health and Clinical Practice Guidelines
PAGE: 3 of 7	**REPLACES DOCUMENT:** CC.MEDM.QI.06
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EFFECTIVE DATE: 8/16/02	**REVIEWED/REVISED:** 5/05; 4/06; 10/06; 11/07; 3/08; 4/08; 3/09; 5/09; 7/09, 7/10, 8/11, 03/12, 07/12, 12/13, 06/14, 08/15, 3/16, 08/16, 11/2016, 07/2017, 09/2017
PRODUCT TYPE: All	**REFERENCE NUMBER:** CC.QI.08

3) Plan Distribution to Practitioners and Members

a) The Plan distributes guidelines to all practitioners who are likely to use them and upon request to members, potential members and providers. Revised guidelines are distributed on a timely basis. The Plan also distributes guidelines to new practitioners if the original distribution has already occurred.

b) New or updated guidelines will be disseminated to providers via the Plan website as soon as possible (or per state contract timeframe, if applicable).

c) A listing of adopted clinical practice and preventive health guidelines is maintained in the provider manual, with the links to the full guidelines or with a notation that the links and/or full guidelines are available on the Plan website or hard copy upon request.

d) Members may be notified of their right to request guidelines in the member handbook, member newsletter, or other member materials.

e) If a member or potential member requests a copy of guidelines, it is noted in the member services call tracking system, and the member is referred to the Plan website, or a hard copy is mailed to the member if requested.

f) Mechanisms to notify and distribute guidelines include, but are not limited to:
   - New practitioner orientation materials
   - Provider and member newsletters
   - Member handbook
   - Special mailings

g) Distribution of practice guidelines is tracked in the QI/QM Work Plan and summarized in the QI/QM Annual Program Evaluation.

4) Performance Measurement

a) If applicable, based on state contract and accreditation (e.g. NCQA, URAC, etc.) requirements, the Plan measures practitioner compliance with at least two important aspects of each of the four clinical guidelines (two of which must be behavioral health) and two preventive health guidelines at least annually. This may be done in conjunction with delegated vendors as applicable.

b) The analysis can be either population or practice-based.
   i) If population based, the services/treatments received by members are assessed, via claims data or HEDIS rates, to measure compliance with the guidelines.
   ii) If practice-based, a sample of practitioners' or practices' records may be evaluated for adherence to specific guidelines.

c) Whenever possible, the Plan uses applicable HEDIS measures to monitor practitioner compliance with adopted guidelines.

d) If the performance measurement rates fall below the Plan, State, and/or CMS goals, the Plan implements interventions for improvement, as applicable.

POLICY AND PROCEDURE

DEPARTMENT: Quality Improvement	**DOCUMENT NAME:** Preventive Health and Clinical Practice Guidelines
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PRODUCT TYPE: All	**REFERENCE NUMBER:** CC.QI.08

5) Delegation

a) The Plan's delegated managed behavioral health vendor (if applicable) performs the adoption, updating and distribution (i.e. to the delegated behavioral health vendor's practitioner network) for the behavioral health guidelines required by this policy.
b) The Plan may also delegate adoption, updating, and performance monitoring of specific disease state clinical practice guidelines to a disease management vendor.
c) The Plan and delegate(s) collaborate to monitor practitioner compliance with the adopted standards and to implement interventions for improvement, as applicable
d) Oversight of delegated processes is conducted as outlined in the Oversight of Delegated Quality Improvement policy and procedure.

REFERENCES

CC.QI.14 – Oversight of Delegated QI
NCQA current QI Health Plan Standards and Guidelines
Centers for Medicare & Medicaid Services (CMS) Medicare Managed Care Manual Chapter 5 (Quality Assessment)

ATTACHMENTS

Attachment 1 – Adopted Clinical Practice and Preventive Health Guidelines

CC_QI_08_Preventiv
e_Health_and_CPG 2

Attachment 2 – Health Services Group New York Addendum

CC_QI_08 Addendum
HSGNY_2016.docx

REVISION LOG:	**DATE**
Reviewed. Revised Attachment 1 with most recent version of Recognized Source Guidelines.	3/09
Removed Schizophrenia and replaced with Bipolar Disorder CPG.	5/21/09
Added section 2 – Internal Use of CPGs. Under section 5, clarified that compliance monitoring and interventions are a combined effort between delegate and Plan. Updated NCQA reference to 2009.	7/23/09
Updated NCQA reference to 2010	7/31/2010
Reviewed per NCQA 2011 standards.	08/11

POLICY AND PROCEDURE

DEPARTMENT: Quality Improvement	**DOCUMENT NAME:** Preventive Health and Clinical Practice Guidelines
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PRODUCT TYPE: All	**REFERENCE NUMBER:** CC.QI.08

Updated Adopted Clinical Practice and Preventive Health Guidelines Attachment to most current versions of guidelines.	08/11
Added bullet points 3.b New or updated guidelines….; 3.d Members will be notified; 3.e If a member or potential member requests; and 3.f Distribution of Practice Guidelines will be tracked	03/12
Updated Adopted Clinical Practice and Preventive Health Guidelines attachment to most current versions of guidelines	07/12
Updated Adopted Clinical Practice and Preventive Health Guidelines attachment to most current versions of guidelines (added Practice Guidelines for Back Pain, COPD, Coronary Artery Disease, Heart failure, Hyperlipidemia, Hypertension, Stress Disorder, Tobacco Cessation, and Weight Management).	12/13
Updated Adopted Clinical Practice and Preventive Health Guidelines attachment to most current versions of guidelines and updated links for (Adult Preventive Care, Hypertension, Immunizations Schedules, Pediatric Preventive Care, Sickle Cell and Stress Disorder).	06/14
Updated Policy Description, Updated bullet points 3.b. New or updated guidelines…, 3.e. If a member or potential member requests…, 4.a. If applicable based on state contract and accreditation…, 4.b. The analysis can be either…, 5.a. Cenpatico Behavioral Health is…, and 5.b.ii. Plan distributes the… Removed CC.UM.10 – New Technology Review from references.	07/15
Added Health Services Group New York (HSGNY) Addendum	3/16
Updated References. Updated Attachment 1 – Adopted Clinical Practice and Preventive Health Guidelines. Updated References. Updated Clinical Practice Guidelines and Preventive Guidelines. Minor grammar changes. Updated "Procedure: Development, Adoption, and Revision"; A), B), C), and D). Updated "Internal Use of Practice Guidelines"; 2.a., 2.b., and 2.e. to include "clinical decision support tools". Updated "Delegation" 5.a. The Plan's delegated managed…, and 5.b.i Plan has delegated the adoption...	08/16
Updated policy to include Medicare specific language throughout. Minor grammar changes. Updated References. Added Chronic Obstructive Pulmonary disease to clinical practice guidelines inclusion list. Update 4. Performance Measurement to include CMS.	11/16
Referenced the department as QI/QM to encompass all Plans' Quality department name. Removed statement under Policy description, "age groups under 65 years and older are not applicable to Medicare" and "Antepartum Fetal Surveillance Testing Guidelines". Updated 2. C. ii. To include "which includes licensed clinical staff". Removed 2.e. "When a change occurs in a clinical practice or preventive health guideline, the clinical documentation system, including clinical decision support tools, is updated promptly to reflect the	07/2017

POLICY AND PROCEDURE

DEPARTMENT: Quality Improvement	**DOCUMENT NAME:** Preventive Health and Clinical Practice Guidelines
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PRODUCT TYPE: All	**REFERENCE NUMBER:** CC.QI.08

change" and f. "The customized assessments and utilization management tools are reviewed on a biannual basis to ensure they reflect the latest scientific and evidence-based practice". Updated 4.a. to include, "at least annually". Updated 5.b. removing, i. "The Plan has delegated the adoption and updating of the asthma and diabetes clinical practice guidelines to the disease management vendor" and ii. "The Plan distributes the guidelines to Plan practitioners as applicable".	
Updated Attachment 1 to include the most recent guidelines.	09/2017

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Compliance 360, Centene's P&P management software, is considered equivalent to a physical signature.

Corporate Vice President of Quality Improvement: _____Signature on file_____

CENTENE Corporation

Clinical Policy: Attention Deficit Hyperactivity Disorder Assessment and Treatment

Reference Number: CP.MP.124
Effective Date: 08/16
Last Review Date: 08/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Attention deficit hyperactivity disorder (ADHD) is one of the most common neurobehavioral disorders in children and also occurs with an increasing prevalence of diagnosis in adults. ADHD affects the cognitive, academic, emotional, and social well-being of individuals and can persist throughout life. While there is no single test to diagnose ADHD, a clinical assessment based on defined clinical parameters establishes criteria for diagnosis in children and adults.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that the following services for the assessment and treatment of ADHD are **medically necessary**:

A. Assessment

1. Complete medical evaluation with history and physical examination;
2. Parent/child interview or patient interview, if adult, to obtain information listed in Diagnostic and Statistical Manual of Mental Health Disorders, Fifth Edition (DSM-5);
3. Complete psychiatric evaluation or other services provided by a psychiatrist, psychologist, or other behavioral health professional;
4. Laboratory evaluation prior to stimulant medication therapy, including any of the following:
   a. Complete blood count;
   b. Liver function tests;
   c. Cardiac evaluation and screening incorporating an electrocardiogram (ECG);
5. Measurement of thyroid hormone levels if patient exhibits clinical manifestations of hyperthyroidism;
6. Assessment of comorbid behavioral health and/or medical diagnoses and associated symptoms;
7. When not otherwise excluded, other services for the assessment of ADHD to meet the DSM-5 criteria.

B. Treatment:

1. Pharmacotherapy;
2. Behavioral modification;
3. Treatment of comorbid behavioral health and/or medical diagnoses and associated symptoms;
4. When not otherwise excluded, other services for the treatment of ADHD.

II. It is the policy of health plans affiliated with Centene Corporation that the following services for the assessment and treatment of ADHD are **investigational or unproven** (may not be all-inclusive):

CLINICAL POLICY
Attention Deficit Hyperactivity Disorder

A. Assessment:
1. Actimeter
2. Computerized electroencephalogram (EEG)
3. Computerized Tests of Attention and Vigilance
4. Education and achievement testing
5. Electronystagmography in the absence of symptoms of vertigo or balance dysfunction
6. Event-related potentials
7. Functional near-infrared spectroscopy
8. Hair analysis
9. IgG blood tests
10. Measurement of zinc
11. Neuroimaging (e.g., CT [computed tomography], CAT [computerized axial tomography], MRI [magnetic resonance imaging], including diffusion tensor imaging), MRS (magnetic resonance spectroscopy), PET (positron emission tomography), and SPECT (single-photon emission computerized tomography)
12. Neuropsychiatric EEG-based assessment aid system
13. Neuropsychologic testing for suspected uncomplicated cases of ADHD (without history of head trauma, seizures)
14. Otoacoustic emissions in the absence of signs of hearing loss
15. Quotient ADHD system / test
16. Synaptosomal-associated protein (SNAP) 25 gene polymorphisms testing
17. Transcranial magnetic stimulation – evoked measures (e.g., short-interval cortical inhibition in motor cortex) as a marker of ADHD symptoms
18. Tympanometry in the absence of hearing loss

B. Treatment:
1. Acupuncture/acupressure
2. Anti-*candida albicans* medication
3. Anti-fungal medication
4. Anti-motion sickness medication
5. Auditory Integration Therapy
6. Applied kinesiology
7. Brain integration
8. Chelation
9. Chiropractic manipulation
10. Cognitive behavior modification
11. Cognitive rehabilitation
12. Computerized training on working memory
13. Deep pressure sensory vest
14. Dietary counseling and treatments, i.e., Feingold diet
15. Dore program / dyslexia – dyspraxia attention treatment (DDAT)
16. Educational intervention (e.g., classroom environmental manipulation, academic skills training, and parental training)
17. EEG biofeedback
18. Herbal remedies
19. Homeopathy

20. Intensive behavioral intervention programs
21. Megavitamin therapy
22. Metronome training
23. Mineral supplementation
24. Music therapy
25. Optometric vision training
26. Psychopharmaceuticals (lithium, benzodiazepines, and selective serotonin reuptake inhibitors, unless the patient also exhibits anxiety and depression)
27. Reboxetine
28. Sensory integration therapy
29. The Good Vibrations Device
30. The Neuro Emotional Technique
31. Therapeutic eurythmy (movement therapy)
32. Transcranial magnetic stimulation / cranial electric stimulation
33. Yayarin
34. Vision therapy
35. Yoga

Background

ADHD is among the most commonly diagnosed neurodevelopmental disorders in children and adolescents and is increasingly being diagnosed in adults. The main characteristics of ADHD are symptoms of inattention, hyperactivity, and impulsivity that have continued for at least six months and are maladaptive and inconsistent with development level.[1] There is no single genetic or behavioral test to diagnose ADHD. Instead a clinical diagnosis based on the *Diagnostic and Statistical Manual of Mental Disorders-5* (DSM-V) criteria is applicable for both children and adults.[2] The prevalence of adult ADHD has been estimated to be around 4.4% in the United States and 3.4% internationally, whereas the prevalence in children and adolescents ranges from 2 –18%.[2,3]

In 2011, the American Academy of Pediatrics (AAP) published a clinical practice guideline to clarify the diagnosis, evaluation, and treatment parameters of ADHD.[4] This guideline expanded the age range of children to include preschool aged children and adolescents and suggests an expanded scope for behavioral interventions.[4] The evaluation of comorbid conditions that might coexist with ADHD must also be considered.[4] Similar clinical recommendations have been made by various organizations for adults, including the Canadian ADHD Resource Alliance, the American Academy of the Child and Adolescent Psychiatry, the National Institutes of Health, and the British Association for Psychopharmacology.[5] Pharmacotherapy can provide a way to manage ADHD symptoms and improve quality of life.

Stimulants and non-stimulants are common examples of medications prescribed to treat ADHD. Chan, *et al*, performed a systemic review of sixteen randomized clinical trials and one meta-analysis that involved 2668 participants and evaluated pharmacological and psychosocial treatments of ADHD in adolescents aged 12 years to 18 years. They found that extended-release methylphenidate and amphetamine formulations, atomoxetine, and extended-release guanfacine led to clinically significant symptom reduction.[6]

While the pathogenesis of ADHD is unknown, the clinical impairments in neurobehavioral and neurodevelopmental functioning pathways elicit deficiencies in vigilance, perceptual-motor speed, working memory, verbal learning, and response inhibition.[2] Consequently ADHD affects the cognitive, academic, emotional, and social wellbeing of individuals and can persist throughout life.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2017, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT codes considered not medically necessary when billed with a sole diagnosis of ADHD

CPT® Codes	Description
70450	Computed tomography, head or brain; without contrast material
70551	Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material
70553	Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences
76390	Magnetic resonance spectroscopy
78607	Brain imaging tomographic (SPECT)
78608	Brain imaging, positron emission tomography (PET); metabolic evaluation.
78609	Brain imaging, positron emission tomography (PET); perfusion evaluation
81229	Cytogenetic constitutional (genome-wide) microarray analysis; interrogation of genomic regions for copy number and single nucleotide polymorphism (SNP) variants for chromosomal abnormalities
82365	Infrared spectroscopy
82784	Gammaglobulin (immunoglobulin); IgA, IgD, IgG, IgM, each
82787	Gammaglobulin (immunoglobulin); immunoglobulin subclasses (eg, IgG1, 2, 3, or 4), each
84630	Zinc
86001	Allergen specific IgG quantitative or semiquantitative, each allergen
92065	Orthoptic and/or pleoptic training, with continuing medical direction and evaluation
90867	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management
90868	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session

CLINICAL POLICY
Attention Deficit Hyperactivity Disorder

CPT® Codes	Description
90869	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management
90901	Biofeedback training by any modality
92541	Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording
92542	Positional nystagmus test, minimum of 4 positions, with recording
92544	Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recordings
92550	Tympanometry and reflex threshold measurements
92558	Evoked otoacoustic emissions, screening (qualitative measurement of distortion product or transient evoked otoacoustic emissions), automated analysis
92567	Tympanometry (impedance testing)
92585	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive
92586	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited
92587	Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report
92588	Distortion product evoked otoacoustic emissions; comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report
95803	Actigraphy testing recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)
95812	Electroencephalogram (EEG) extended monitoring; 41-60 minutes
95813	Electroencephalogram (EEG) extended monitoring; greater than 1 hour
95816	Electroencephalogram (EEG); including recording awake and drowsy
95819	Electroencephalogram (EEG); including recording awake and asleep
95925	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs
95926	Short latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in lower limbs
95927	Short latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in the trunk or head
95928	Central motor evoked potential study (transcranial motor stimulation); upper limbs
95929	Central motor evoked potential study (transcranial motor stimulation); lower limbs
95930	Visual evoked potential (VEP) testing central nervous system, checkerboard or flash

CLINICAL POLICY
Attention Deficit Hyperactivity Disorder

CPT® Codes	Description
95933	Orbicularis oculi (blink) reflex, by electrodiagnostic testing
95937	Neuromuscular junction testing (repetitive stimulation paired stimuli), each nerve, any 1 method
95938	Short latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs
95939	Central motor evoked potential study (transcranial motor stimulation);in upper and lower limbs
96101	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report
96102	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face
96103	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI), administered by a computer, with qualified health care professional interpretation and report
96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report
96118	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report
96119	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face
96120	Neuropsychological testing (eg, Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour
96366	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour
96367	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion, up to 1 hour
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes

CPT® Codes	Description
97532	Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact, each 15 minutes
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes
97810	Acupuncture, one or more needles, w/o electric stimulation; initial 15 minutes of personal one-one contact with the patient.
97811	Acupuncture, one or more needles, w/o electric stimulation; each additional 15 minutes of personal one-one contact with the patient with re-insertion of needles.
97813	Acupuncture, one or more needles, with electric stimulation; initial 15 minutes of personal one-one contact with the patient.
97814	Acupuncture, one or more needles, with electric stimulation; each additional 15 minutes of personal one-one contact with the patient, with re-insertion of the needle(s).
98940	Chiropractic manipulative treatment (CMT); spinal, 1-2 regions
98941	Chiropractic manipulative treatment (CMT); spinal, 3-4 regions
98942	Chiropractic manipulative treatment (CMT); spinal, 5 regions
98943	Chiropractic manipulative treatment (CMT); extraspinal, 1 or more Regions

HCPCS codes considered not medically necessary when billed with a sole diagnosis of ADHD

HCPCS Codes	Description
P2031	Hair analysis (excluding arsenic)
S8040	Topographic brain mapping

ICD-10-CM Diagnosis Codes that Support Medical Necessity

ICD-10-CM Code	Description
F90.0 – F90.9	Attention-deficit hyperactivity disorders

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed	08/16	08/16
References reviewed and updated	07/17	08/17

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2. Bukstein O. "Attention deficit hyperactivity disorder: Epidemiology, pathogenesis, clinical features, course assessment, and diagnosis. In: UpToDate Hermann R. (Ed), UpToDate, Waltham, MA. Accessed on July 26, 2017.
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5. ATTENTION-DEFICIT, SUBCOMMITTEE ON. "ADHD: clinical practice guideline for the diagnosis, evaluation, and treatment of attention-deficit/hyperactivity disorder in children and adolescents." *Pediatrics* (2011): peds-2011.
6. Gibbins, Christopher, and Margaret Weiss. "Clinical recommendations in current practice guidelines for diagnosis and treatment of ADHD in adults." *Current psychiatry reports* 9.5 (2007): 420-426.
7. Chan, Eugenia, Jason M. Fogler, and Paul G. Hammerness. "Treatment of Attention-Deficit/Hyperactivity Disorder in Adolescents: A Systematic Review." *JAMA* 315.18 (2016): 1997-2008.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan

retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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CENTENE Corporation

CLINICAL POLICY

Department: Medical Management	**Document Name:** Clinical Policy Committee
Page: 1 of 6	**Reference Number:** CP.CPC.01
Effective Date: 09/08	**Replaces Document:**
Reviewed: 05/10, 05/11, 06/12, 09/17	**Revised:** 05/09, 07/09, 05/11, 05/13, 09/13, 09/14, 09/16, 09/17
Specialist Review: N/A	**Committee Approval:** 09/08, 05/09, 07/09, 05/10, 06/11, 06/12, 06/13, 09/13, 09/14, 09/15, 09/16, 09/17

Subject

Clinical Policy Committee process

Description

The Clinical Policy Committee ensures that clinical policies provide a guide to medical necessity, are reviewed and approved by appropriately qualified physicians, and are available to all Centene Health Plans.

Policy

The Centene Corporate Chief Medical Officer (CMO) or his/her designee is responsible for establishing and maintaining a Clinical Policy Committee (CPC) composed of physicians and other medical and operational representatives as appropriate from Corporate Medical Management and each Plan to assist in the identification of need, development, revision, and/or review of clinical policy. All clinical policies require approval by the CPC. Physicians participating in the CPC shall be board-certified and shall be licensed in good standing in at least one state.

Clinical policies include medical, behavioral health, medical pharmacy benefits, and durable medical equipment and devices. These policies include but are not limited to:

- New and emerging technologies
- New uses for existing technologies
- Coverage issues relating to new and existing technologies
- Clinical guidelines for the evaluation and treatment of specific conditions
- Criteria used in the authorization of drugs included on a Plan prior authorization list
- Clinical/medical criteria or information used in pre- or post-service review

The CMO or designee performs an annual review of all existing clinical policies to determine continued applicability and appropriateness. In connection with this annual review, the CMO or designee is responsible for identifying which policies require revisions. The CMO or designee shall send any such policies to the CPC to oversee the revision process and for subsequent re-approval.

Purpose

The purpose of clinical policies is to provide a guide to medical necessity. Benefit determinations should be based in all cases on the applicable contract provisions governing plan benefits ("Benefit Plan Contract") and applicable state and federal requirements, as well as applicable plan-level administrative policies and procedures. To the extent there are any conflicts between these policies and the Benefit Plan Contract provisions, the Benefit Plan Contract provisions will control.

Clinical policies are intended to be reflective of current scientific research and evidence-based clinical standards. Clinical policies are not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment given to members.

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All clinical policies are available to providers in compliance with all federal, statutory and regulatory requirements and upon request.

I. Membership

The CMO or designee recruits and replaces, as needed, CPC members to maintain a committee that includes:

A. Voting members:
   1. One Medical Director from each Plan (at minimum), including the Behavioral Health subsidiary
   2. Corporate Medical Directors
   3. One Pharmacist from each Plan for pharmacy related policies

B. Non-voting members:
   1. One representative from each Plan's medical operations department
   2. Corporate Director of Clinical Policy
   3. Corporate Medical Management Staff

C. Ad hoc advisors
   1. Representatives from the pharmacy subsidiary
   2. Internal legal counsel
   3. Plan Compliance Directors
   4. Outside experts and/or relevant interested parties depending upon the specialty area or special needs of the clinical policy.

II. Committee Maintenance and Oversight

A. The CMO or designee acts as the chairperson for meetings and activities performed by the CPC (Committee Chair). The Corporate Director of Clinical Policy reports to the Committee Chair.

B. The Corporate Director of Clinical Policy oversees the Clinical Policy Department which is tasked with the following responsibilities in connection with the development and approval of clinical policies:
   1. Coordinating research and development of clinical policies, which includes:
      a. Prioritizing all inquiries for new policies and maintaining an electronic log of all requests for research and new policies with the requestor and subject of review;
         i. Highest priority is given to inquires based on open medical management cases such as pending authorizaitons or appeals cases. Response to these requests typically occur within 24 hours. Priority then continues based on requests originating from providers or members, needs identified through financial analysis, followed by inquires by vendors and technologies identified through trade publications.
      b. Conducting prelimary review of topics as follows:
         i. A critical appraisal of the current published medical literature from peer-reviewed publications including systematic reviews, randomized controlled trials, cohort

studies, case control studies, and diagnostic test studies with statistically significant results that demonstrate safety and effectiveness.

ii. Evidence based guidelines developed by national organizations and recognized authorities.

iii. Opinions and assessments by nationally recognized medical associations including physician specialty societies, consensus panels, or other nationally recognized research or technology assessment organizations such as Hayes, UpToDate, or ECRI.

iv. Reports and publications of government agencies such as the Food and Drug, Administration (FDA), Centers for Disease Control (CDC), or National Institutes of Health (NIH).

v. External review organization recommendations.

c. Conveying the findings of the preliminary review to the requestor within the priority-based time frame. In cases of open medical management decisions, the requestor will use the information provided by the clinical policy staff and the specifics of the particular case to render a decision. Preliminary review findings are saved in an electronic file for future policy development.

d. For topics identified through medical management needs, if two requests for the same topic are submitted, a formal medical policy is developed. Requests identified through financial analysis will follow this policy development process.

i. The clinical policy staff utilizes the preliminary research to draft a policy. Relevant CPT, HCPCS and ICD-10 codes are identified and included in the policy. A review of historical handling and/or payment of the policy topic is also conducted to share with the CPC as appropriate.

ii. Opinions from external physicians are solicited as appropriate, including behavioral health physicians. The policy is sent for CPC review and approval.

iii. Subsequent to each new policy approval, the clinical policy staff sends a notice to all medical directors and Medical Management leadership to inform them of new policies that have been approved by the CPC.

iv. The completed policies are reviewed annually or updated more frequently as dictated by current medical literature, medical director or other relevant staff requests and appeals analysis.

v. Completed policies are posted on CNet for access by internal staff and for Plans to link to Plan websites for members and providers.

e. Communication of these policies to Provider networks is arranged by the Plan marketing or Provider Network Department.

2. Coordinating activities of the CPC including, but not limited to, the review, revision, approval, and maintenance processes of all clinical policies. This includes scheduling meetings, sending necessary agendas and attachments, documenting meeting minutes, clinical policy reference number assignment, and the maintenance of such documents in electronic files and within the organizational internal database.

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3. Generating reports reflecting CPC activity on a quarterly basis, or more frequently as needed, for the Committee Chair.
4. Notifying all relevant persons/departments regarding approved policies and related materials through email, including:
   a. Claim Support Service Manager for dissemination to IS and claims. Corporate Medical Affairs (MA) offers direction/coordination for any system needs to support the clinical policy.
   b. Corporate Medical Management VP, Corporate Medical Management New Business Implementation VP and Corporate Medical Management Auditing and Training Teams for dissemination and auditing.
   c. Committee members for dissemination to their specific Plan personnel, including marketing and/or provider relations for appropriate provider notification of policy changes.
5. Facilitating training, as needed, with the corporate Medical Management Training Department.

III. Meeting Frequency

A. CPC meetings are held, at minimum, on a quarterly basis. Frequency is dependent upon clinical policy revision cycles and/or clinical policy need (as determined by the CMO or designee).
B. Meetings are held in a physical location as well as through the use of alternative media as determined by the participation of members from remote locations or by the urgency of the clinical policy. Such media include video, telephonic conference call, or email.

IV. Committee Member Activities and Responsibilities:

A. Identification of new subjects to consider for clinical policy development can occur in the following ways:
   1. Through UM authorization requests;
   2. New technologies identified through trade publications;
   3. Inquiries from providers and vendors;
   4. Review of appeals cases;
B. Review of clinical policies which includes:
   1. New clinical policy drafts;
   2. Policies due for scheduled review;
   3. Updates or revisions to existing policies outside of the scheduled review due to advances or changes in standards of care, new information, missing information or content error;
   4. Updates regarding the status of any policies under review;
   5. Policy and prioritization requests for new clinical policies;
C. Electronic approval of clinical policies
   Policies will be reviewed and approved through an electronic web poll process.
   1. All draft clinical policies are loaded into the Qualtrics Survey tool.

2. An email notification is sent to each of the CPC members with a link for the current survey with policies due for review as well as the required completion date for review. A minimum of 1 week is given for review of clinical policies.
3. The survey directs CPC members to indicate if the policy meets their approval with a vote stating either (a) "yes," (b) "yes, with comments," (c) "no," or (d) "abstain." "Yes, with comments" and "no" votes require feedback to be supplied before the reviewer can complete the survey.
4. The Committee Chair determines, based on voting feedback, whether an issue identified during the voting process will be included on the agenda for discussion at the following CPC meeting. If so, the feedback will be distributed with the agenda for consideration prior to the meeting.
5. In the context of the electronic approval process, CPC actions are determined by a majority vote of the voting members responding. A majority of the voting committee members must respond to the review request to be considered a quorum. If a quorum does not respond, a follow-up email is sent to request additional members to respond.
6. Survey results are maintained electronically in the folder dated with the survey fielded date, along with all of the policies that were submitted for approval at that time.

D. Attendance and Participation
1. Committee members are expected to attend all scheduled meetings and participate in the review of documents forwarded electronically for review and consensus.
2. The Committee Chair has the right to replace a committee member who does not participate in 2 or more consecutive committee meetings.
3. In the context of CPC meetings, CPC actions are determined by a majority vote of the voting members present. A majority of the voting committee members must be present to constitute a quorum.
4. A Corporate designee (or an assigned Administrative Assistant) will document meeting minutes. Meeting minutes include the agenda topic, pertinent discussion, proposed changes submitted/discussed, and any action taken or consensus reached with respect to the proposed changes.

E. Approvals
The CMO or designee approves all clinical policies. The Committee Chair is authorized to act as the CMO designee for the purpose of approving clinical policies.
1. Within 10 business days of the survey poll close date or CPC meeting date, the Corporate Director of Clinical Policy incorporates any agreed changes and loads the approved policy into Compliance 360.
2. The CMO designee locks the policy in an approved status in Compliance 360 for immediate use by the Health Plans.

Revision Log	Date
Changed CPC meeting frequency from quarterly to bi-monthly	05/11
No changes	06/12

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Updated section 4c to reflect internet voting surveys for CPC policy review and approval process	05/13
Clarified that the CPC gives the final approval for all clinical policies Removed the requirement that each policy is sent to the CMO via Compliance 360 for final administrative approval.	09/13
Added written clarification in A.1 that the voting members includes the Medical Director from the behavioral health subsidiary	02/14
Removed Corporate Quality staff from Membership Changed meeting frequency bullet point to include email (not just when deemed necessary)	08/14
Minor wording changes for clarity	09/15
Under II.B, added language consistent with Health Net MAC Charter that will be incorporated into CPC process Under IV.A clarified areas where topics can be identified to be consistent with HN MAC charter language	09/16
Changed IV.E. to 10 days, from 5 days, based on processing time due to volume of policies being reviewed.	09/17

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Clinical Policy Web Posting

Reference Number: CP.CPC.02
Effective Date: 12/16
Last Review Date: 12/17 Revision Log

Description
This policy details corporate and health plan responsibilities for initial posting and maintenance of clinical, payment, and specialty drug policies (herein referred to as "clinical policies") on the public health plan websites.

Work Process

I. Initial set up
- A. Corporate responsibilities for initial set up of clinical policy folders include:
  1. Communicating with Compliance360 (C360) staff to have the appropriate folders built and access granted to the appropriate parties.
  2. Communicating with corporate and health plan marketing departments to ensure proper set up of web pages.
  3. Communicating with plan level designee regarding status of project.
- B. Health plan responsibilities for initial set up of clinical policy folders includes:
  1. Identifying a designee who will be the main point of contact and perform all work related to posting and maintaining clinical policies.
  2. Determining which policies are appropriate to post.
  3. Communicating with the health plan marketing or compliance department to determine applicable state regulations, such as web page or specific policy approval requirements.
  4. Identifying plan-level approvers (if needed).
  5. Linking appropriate policies from corporate and health plan folders in C360 to the specified web posting folder (refer to CC.COMP.22.01 Creating and Maintaining P&Ps).
  6. Notifying providers that clinical policies are available and providing training on how to find them, as needed.

II. Ongoing maintenance
- A. Maintenance of clinical policies
  1. The corporate clinical policy team and Clinical Policy Committee will review and approve all corporate clinical policies on an annual basis and upon significant change in evidence-based guidelines. The corporate clinical policy team will post the updated policies in the clinical policy folder.
  2. Email updates will be sent to the health plan designees on the following basis:
     - a. Notification when a policy is being retired, including a list of any policies that will replace the retired policy.
     - b. Monthly updates including policy revisions and new policies.
     - c. A quarterly summary of all policies created or revised in the past quarter.
  3. The health plan Medical Director and local Utilization Management Committee will review and approve all health plan-specific clinical policies on an annual basis and upon significant change in evidence-based guidelines. The applicable corporate clinical policy should be reviewed as a basis for conducting policy reviews. The

health plan is responsible for notifying the clinical policy designee in a timely manner of any changes, new policies, and retired policies.

4. Based on policy updates, the health plan designee will make updates to the clinical policy web posting folder as necessary.

B. Quarterly review of posted clinical policies
   1. The health plan designee should review the clinical policy web posting folder on at least a quarterly basis to ensure:
      a. All policies are current
      b. All policies are still appropriate to be posted on the public web site
      c. Any appropriate new policies are added
      d. Any retired policies are made non-searchable

C. Ensuring compliance
   1. The corporate clinical policy team will ensure corporate clinical policies follow evidence-based guidelines and compliance with NCQA (National Committee for Quality Assurance) regulations.
   2. The health plan will ensure compliance with local regulations related to clinical policies, posting of policies on the public website, and communicating with providers; as well as ensuring health plan-specific policies follow evidence-based guidelines and meet NCQA regulations.

D. Notifying providers
   1. It is the responsibility of the health plan to communicate with providers when clinical policies are made available on the public website.
   2. The health plan will provide ongoing support and communication to providers regarding clinical policies changes via the public website.

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed	11/16	12/16
I.A.1 updated to include granting access to appropriate parties. I.A.2 updated to include health plan marketing department. All policy references updated.	11/17	12/17

References

1. CC.COMP.22 Policy and Procedure Documentation
2. CC.COMP.22.01 Creating and Maintaining P&Ps
3. CC.MRKT.02 Health Plan Websites

CENTENE Corporation

Clinical Policy: Ventricular Assist Devices

Reference Number: CP.MP.46
Effective Date: 12/09
Last Review Date: 04/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

A ventricular assist device (VAD) is a mechanical pump that helps a person's heart that is too weak to pump blood through the body. The VAD is designed to provide sufficient blood flow to the damaged or diseased heart. It is sometimes referred to as a "bridge to transplant" since it can help a patient survive until a heart transplant can be performed.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that all FDA approved VADs, when used according to their FDA labeled indications (including body size recommendations), are considered **medically necessary** when meeting the following:

A. For implantable VADs, none of the following contraindications:
   1. Life expectancy in the absence of heart disease ≤ 2 years;
   2. Malignancy within 5 years that is expected to significantly limit survival;
   3. Irreversible renal or hepatic dysfunction, severe obstructive pulmonary disease, or other systemic disease with multi-organ involvement;
   4. A pattern of demonstrated noncompliance or lack of sufficient care-giver support which would place a VAD at serious risk of failure;
   5. Active substance abuse, including alcohol.

B. Has one of the following indications:
   1. Member is post-cardiotomy for support of blood circulation; *or*
   2. As a bridge to transplant for members who are awaiting heart transplantation and not expected to survive until a donor heart can be attained; *or*
   3. As destination therapy for members with end-stage heart failure (NYHA Class IV end-stage left ventricular failure for at least 90 days with a life expectancy of < 2 years) who are ineligible for heart transplantation due to age or co-morbidities and all of the following:
      a. Failure to respond to one of the following:
         i. Optimal medical management (including beta-blockers and ACE inhibitors if tolerated) for at least 45 of the last 60 days, or
         ii. Has been balloon pump-dependent for 7 days, or
         iii. IV inotrope-dependent for 14 days *and*
      b. Left ventricular ejection fraction (LVEF) < 25%, and
      c. Functionally limited with a peak oxygen consumption of < 14 ml/kg/min unless balloon pump- or inotrope-dependent or physically unable to perform the test.

II. Pediatric VADs are considered **medically necessary** under the FDA Humanitarian Device Exemption (HDE) guidelines for the following devices:

A. Berlin Heart EXCOR® Pediatric VAD as a bridge to cardiac transplantation when meeting the following criteria:

1. Members ≤ 16 years, and
2. Severe isolated left ventricular or biventricular dysfunction, and
3. Is a candidate for cardiac transplant and requires circulatory support.

B. HeartAssist® Pediatric VAD as a bridge to cardiac transplantation when meeting the following criteria: [16]
1. Members 5 to 16 years old;
2. Body surface area > 0.7 m^2 and < 1.5 m^2;
3. In NYHA Class IV end-stage heart failure refractory to medical therapy;
4. Listed as a candidate for cardiac transplantation;
5. None of the following contraindications:
   a. Unable to tolerate anticoagulation therapy;
   b. Anatomical features which prevent the implantable components of the device from fitting properly.

III. Any requests for VADs not meeting the above criteria will be considered **not medically necessary**.

Note: HDE is granted by FDA. A Humanitarian Use Device (HUD) is a device that is intended to benefit patients in the treatment or diagnosis of a disease or condition that affects fewer than 4,000 individuals in the United States annually. An HUD may only be used in facilities that have established a local institutional review board to supervise clinical testing of devices and after an IRB has approved the use of the device to treat or diagnose the specific disease.

Background

VADs have shown beneficial effects on myocardial function through improvement in myocardial contractile performance; reversal of down regulation of betareceptors seen in heart failure (HF), with restoration in the ability of the heart to respond to the inotropic effects of sympathetic stimulation; and normalization of chamber geometry, and reduction of myocardial fibrosis, hypertrophy, and disruption in cytoskeletal proteins.

This suggests that failing human myocytes have the capability of undergoing beneficial functional and electrophysiologic changes and an increase in contractile strength in the presence of hemodynamic unloading and improved neurohumoral and circulatory derangements. This remodeling generally is complete by about 40 days, with evidence of clinical benefit and an improvement in quality of life.

Since 2000, there have been improved outcomes in VAD implantation in the pediatric population. Early experience involved the most critically ill children who often were near death at the time of VAD implantation. More recently, centers' increasing experience with the surgical techniques, timing, and postoperative care; the use of more long-term devices over time; and refinements in patient selection, have resulted in improved outcomes despite the increasing use of VADs in smaller and more complex patients. Further study is warranted to optimize criteria for pediatric patient and device selection.

In one study reported by Blume, et al, 86% of pediatric patients who received a VAD were successfully bridged to transplantation from 2000 to 2003. Prior to 2000, only 63% of pediatric

patients were successfully bridged to transplantation. The subgroups of patients with congenital heart disease and in smaller, younger patients, who rarely are large enough for most long-term assist devices, did not have as successful applications as the rest of the population.

A prospective multi-institutional investigational device exemption trial compared patients with the Berlin Heart EXCOR with a control group supported on extracorporeal membrane oxygenation (ECMO). Between May 2009 and December 2010, a total of 48 patients ≤16 years of age met the inclusion criteria and were separated into 2 cohorts according to body surface area (cohort 1, <0.7 m2; cohort 2, ≥0.7 m2) with 24 patients in each group. The median survival time for cohorts 1 and 2 (>174 and 144 days, respectively) far exceeded that of ECMO (cohort 1, 13 days; cohort 2, 10 days; $P<0.001$ by log-rank test). Based on the results of this trial, the Berlin Heart EXCOR was granted HDE approval as a device to provide long-term mechanical circulatory support as a bridge to cardiac transplantation in children with severe left or biventricular dysfunction. [19]

American College of Cardiology Foundation/American Heart Association
Nondurable mechanical circulatory support including the use of a percutaneous and extracorporeal ventricular assist device is reasonable as a 'bridge to recovery'. [17]

National Health Service
This organization currently funds the use of long-term VADs as bridge-to-transplant to support heart transplant candidates who are too unwell to undergo the procedure or are unlikely to survive in a good clinical state until a suitable donor heart becomes available. [18]

Coding Implications
This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2016, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
33975	Insertion of ventricular assist device; extracorporeal, single ventricle
33976	Insertion of ventricular assist device; extracorporeal, biventricular
33977	Removal of ventricular assist device; extracorporeal, single ventricle
33978	Removal of ventricular assist device; extracorporeal, biventricular
33979	Insertion of ventricular assist device, implantable intracorporeal, single ventricle
33980	Removal of ventricular assist device, implantable intracorporeal, single ventricle
33981	Replacement of extracorporeal ventricular assist device, single or biventricular, pump(s), single or each pump

CLINICAL POLICY
Ventricular Assist Devices

CPT® Codes	Description
33982	Replacement of ventricular assist devices pump(s); implantable intracorporeal, single ventricle, without cardiopulmonary bypass
33983	Replacement of ventricular assist devices pump(s); implantable intracorporeal, single ventricle, with cardiopulmonary bypass
33990	Insertion of ventricular assist device, percutaneous including radiological supervision and interpretation; arterial access only
33991	Insertion of ventricular assist device, percutaneous including radiological supervision and interpretation; both arterial and venous access, with transseptal puncture
33992	Removal of percutaneous ventricular assist device at separate and distinct session from insertion

HCPCS Codes	Description
Q0478	Power adapter for use with electric or electric/pneumatic ventricular assist device, vehicle type
Q0479	Power module for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0480	Driver for use with pneumatic ventricular assist device, replacement only
Q0481	Microprocessor control unit for use with electric ventricular assist device, replacement only
Q0482	Microprocessor control unit for use with electric/pneumatic combination ventricular assist device, replacement only
Q0483	Monitor/display module for use with electric ventricular assist device, replacement only
Q0484	Monitor/display module for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0485	Monitor control cable for use with electric ventricular assist device, replacement only
Q0486	Monitor control cable for use with electric/pneumatic ventricular assist device, replacement only
Q0487	Leads (pneumatic/electrical) for use with any type electric/pneumatic ventricular assist device, replacement only
Q0488	Power pack base for use with electric ventricular assist device, replacement only
Q0489	Power pack base for use with electric/pneumatic ventricular assist device, replacement only

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
I50.1	Left ventricular failure
I50.9	Heart failure, unspecified (biventricular) heart failure NOS
I97.0	Post-cardiotomy syndrome

ICD-10-CM Code	Description
Z94.1	Heart transplant status
Z95.811	Presence of heart assist device

Reviews, Revisions, and Approvals	Date	Approval Date
Updated VAD criteria to current CMS NCD guidelines for artificial hearts and related devices Coding implications and references reviewed and updated Added criteria for Pediatric VADs based on HDE approvals Specialist review: Internal medicine, cardiology	05/13	05/13
References reviewed and updated	05/14	05/14
Updated formatting, no criteria review or changes	01/15	
References reviewed and updated	04/15	04/15
Template updated; References reviewed and updated; added contraindications per ISHLT guidelines and Heart Assist 5 instructions for use. Specialist reviewed.	04/16	04/16
Reviewed references and updated. Added a position statement from the American Cardiology Foundation /American Heart Association, as well as National Health Service on VADs. Restructured criteria in section I for clarity. Changed I.A.1. to specify that the contraindication of illness causing life expectancy less than 2 years is different than heart failure.	04/17	04/17

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members

and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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CENTENE Corporation

Clinical Policy: Intensity-Modulated Radiotherapy

Reference Number: CP.MP.69
Effective Date: 03/14
Last Review Date: 03/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Medical necessitycriteria for intensity-modulated radiotherapy (IMRT). IMRT is an advanced form of 3-dimensional (3-D) conformal radiation therapy. It delivers a more precise radiation dose to the tumor while sparing healthy surrounding tissue. While IMRT empirically offers advances over other radiation therapies, an understanding of accepted practices and the risks and benefits over conventional or 3-D conformal radiation must be taken into consideration.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that IMRT is **medically necessary** for any of the following indications:
- A. Age ≤ 18 years;
- B. Target volume is in close proximity to critical structures that must be protected;
- C. The volume of interest must be covered with narrow margins to adequately protect immediately adjacent structures;
- D. An immediately adjacent area has been previously irradiated and abutting portals must be established with high precision;
- E. The target volume is concave or convex, and critical normal tissues are within or around that convexity or concavity;
- F. Dose escalation is planned to deliver radiation doses in excess of those commonly utilized for similar tumors with conventional treatment. Or

II. Indications considered **medically necessary** by cancer site include any of the following:
- A. Primary, metastatic, or benign tumors of the central nervous system, including brain, brain stem, and spinal cord;
- B. Primary, metastatic tumors of the spine where spinal cord tolerance may be exceeded by conventional treatment;
- C. Primary, metastatic, or benign lesions of the head and neck area including orbits, sinuses, skull base, aerodigestive tract (lips, mouth, tongue, nose, throat, vocal cords and part of the trachea and esophagus), and salivary glands;
- D. Anal cancer, for curative treatment;
- E. Prostate cancer, nonmetastatic;
- F. Cases of thoracic and abdominal malignancies when target volume is in proximity to critical structures;
- G. Select breast cancer cases for:
  1. Left breast cancer due to risk to immediately adjacent cardiac and pericardial structures; or
  2. When homogeneity of dose is essential and the patient has at least one of the following conditions:
     - a. Left or right breast cancer in macromastia as defined by cup size of D or larger,

b. Separation of ≥ 25.5 cm in the intra-thoracic distance from the midpoint of the posterior light field border of the medial tangential field to the midpoint of the posterior; [23] or

H. Other pelvic and retroperitoneal tumors that meet the requirements for medical necessity.

Background

A major goal of radiation therapy is the delivery of an appropriate dose of radiation to the targeted tissue while minimizing radiation exposure to the surrounding healthy tissue. The introduction of IMRT allowed for significant improvement of dose distributions by irradiating sub-regions of the target to different levels**.** It uses a computer-based planning method called inverse planning that allows the delivery of generally narrow, patient specific spatially and often temporally modulated beams of radiation to solid tumors within a patient.

IMRT changes the intensity of radiation in different parts of a single radiation beam while treatment is delivered. The dose of radiation given by each beam can also vary, enabling IMRT to simultaneously treat multiple areas within the target to different dose levels. Theoretical concerns about IMRT include dose inhomogeneity, additional time required for planning computation and QA verification, and exposure of larger volumes of normal tissues to a lower dose of radiation.

There were a number of studies done, including a multicenter, randomized, double-blind trial that have noted IMRT improved the homogeneity of the radiation dose distribution and decreased acute toxicity, when used for breast cancer. [23,24,25,26,27]

NCCN

A revision in the guideline notes: Either IMRT or 3-D conformal radiation therapy is recommended for cancers of the oropharynx in order to minimize dose to critical structures. [22]

For greater homogeneity of target dose and to spare normal tissues using compensators such as tissue wedges, forward planning using segments and IMRT may be used. [11]

Coding Implications

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CPT® Codes	Description
77301	Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications

CPT® Codes	Description
77338	Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan
77386	Intensity modulated treatment delivery (IMRT) includes guidance and tracking, when performed; complex
77418	Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session
0073T	Compensator-based beam modulation treatment delivery of inverse planned treatment using 3 or more high resolution (milled or cast) compensator convergent beam modulated fields, per treatment session

HCPCS Codes	Description
G6015	Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
C00.0	Malignant neoplasm of external upper lip
C00.1	Malignant neoplasm of external lower lip
C00.3	Malignant neoplasm of upper lip, inner aspect
C00.4	Malignant neoplasm of lower lip, inner aspect
C00.8	Malignant neoplasm of overlapping sites of lip
C14.8	Malignant neoplasm of overlapping sites of lip, oral cavity and pharynx
C21.1	Malignant neoplasm of anal canal
C26.9	Malignant neoplasm of ill-defined sites within the digestive system
C30.0	Malignant neoplasm of overlapping sites of larynx
C31.0	Malignant neoplasm of maxillary sinus
C31.1	Malignant neoplasm of ethmoidal sinus
C31.2	Malignant neoplasm of frontal sinus
C31.3	Malignant neoplasm of sphenoid sinus
C31.8	Malignant neoplasm of overlapping sites of accessory sinuses
C32.3	Malignant neoplasm of laryngeal cartilage
C32.8	Malignant neoplasm of overlapping sites of larynx
C33	Malignant neoplasm of trachea
C41.2	Malignant neoplasm of vertebral column
C48.0	Malignant neoplasm of retroperitoneum
C48.1	Malignant neoplasm of specified parts of peritoneum

ICD-10-CM Code	Description
C48.8	Malignant neoplasm of overlapping sites of retroperitoneum and peritoneum
C50.012	Malignant neoplasm of nipple and areola, left female breast
C50.022	Malignant neoplasm of nipple and areola, left male breast
C50.112	Malignant neoplasm of central portion of left female breast
C50.122	Malignant neoplasm of central portion of left male breast
C50.212	Malignant neoplasm of upper-inner quadrant of left female breast
C50.222	Malignant neoplasm of upper-inner quadrant of left male breast
C50.312	Malignant neoplasm of lower-inner quadrant of left female breast
C50.322	Malignant neoplasm of lower-inner quadrant of left male breast
C50.412	Malignant neoplasm of upper-outer quadrant of left female breast
C50.422	Malignant neoplasm of upper-outer quadrant of left male breast
C50.512	Malignant neoplasm of lower-outer quadrant of left female breast
C50.522	Malignant neoplasm of lower-outer quadrant of left male breast
C50.612	Malignant neoplasm of axillary tail of left female breast
C50.622	Malignant neoplasm of axillary tail of left male breast
C50.812	Malignant neoplasm of overlapping sites of left female breast
C50.822	Malignant neoplasm of overlapping sites of left male breast
C61	Malignant neoplasm of prostate
C69.61	Malignant neoplasm of right orbit
C69.62	Malignant neoplasm of left orbit
C76.1	Malignant neoplasm of thorax
C76.2	Malignant neoplasm of abdomen
C71.0	Malignant neoplasm of cerebrum, except lobes and ventricles
C71.1	Malignant neoplasm of frontal lobe
C71.2	Malignant neoplasm of temporal lobe
C71.3	Malignant neoplasm of parietal lobe
C71.4	Malignant neoplasm of occipital lobe
C71.5	Malignant neoplasm of cerebral ventricle
C71.6	Malignant neoplasm of cerebellum
C71.8	Malignant neoplasm of overlapping sites of brain
C72.0	Malignant neoplasm of spinal cord
C76.3	Malignant neoplasm of pelvis
D10.0	Benign neoplasm of lip
D10.1	Benign neoplasm of tongue
D10.2	Benign neoplasm of floor of mouth
D10.39	Benign neoplasm of other parts of mouth
D11.0	Benign neoplasm of parotid gland
D11.7	Benign neoplasm of other major salivary gland
D13.0	Benign neoplasm of esophagus
D33.0	Benign neoplasm of brain, supratentorial
D33.1	Benign neoplasm of brain, infratentorial
D33.3	Benign neoplasm of cranial nerves

ICD-10-CM Code	Description
D33.4	Benign neoplasm of spinal cord
D33.7	Benign neoplasm of other specified parts of central nervous system
N62	Hypertrophy of breast
Z85.01	Personal history of malignant neoplasm of esophagus
Z85.02X	Personal history of malignant neoplasm of stomach
Z85.07	Personal history of malignant neoplasm of pancreas
Z85.12	Personal history of malignant neoplasm of trachea
Z85.21	Personal history of malignant neoplasm of larynx
Z85.22	Personal history of malignant neoplasm of nasal cavities, middle ear, and accessory sinuses
Z85.3	Personal history of malignant neoplasm of breast
Z85.46	Personal history of malignant neoplasm of prostate
Z85.81X	Personal history of malignant neoplasm of lip, oral cavity, and pharynx
Z85.840	Personal history of malignant neoplasm of eye
Z85.841	Personal history of malignant neoplasm of brain
Z86.011	Personal history of benign neoplasm of brain

Reviews, Revisions, and Approvals	Date	Approval Date
Policy Developed and reviewed by Radiation Oncologist	02/14	03/14
References reviewed and updated	02/15	03/15
Template updated References reviewed and updated	02/16	03/16
Policy updated. References reviewed. In the policy statement, added under 'Select breast cancer cases: When homogeneity of dose is essential and the patient has at least one of the following conditions'. The two conditions were previously listed. Coding tables updated	02/17	03/17

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CLINICAL POLICY
IMRT

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Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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CENTENE Corporation

Clinical Policy: Vagus Nerve Stimulation

Reference Number: CP.MP.12
Effective Date: 09/08
Last Review Date: 10/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Vagus nerve stimulation (VNS) has been used in the treatment of epilepsy and has been studied for the treatment of refractory depression and other indications. Electrical pulses are delivered to the cervical portion of the vagus nerve by an implantable device called a neurocybernetic prosthesis. Chronic intermittent electrical stimulation of the left vagus nerve is designed to treat medically refractory epilepsy. It has recently been introduced and approved by the FDA as an adjunctive therapy for treatment-resistant major depression.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that VNS is **medically necessary** in patients with medically refractory seizures who meet all of the following:
- **A.** Diagnosis of partial-onset seizures or generalized seizures;
- **B.** Intractable epilepsy (both):
  1. Failure of at least 1 year of adherent therapy of at least two anti-seizure drugs, *and*
  2. Continued seizures which have a major impact on activities of daily living; *and*
- **C.** Not a suitable candidate for or has failed resective epilepsy surgery;
- **D.** Request is for an FDA-approved device.

II. It is the policy of health Plans affiliated with Centene Corporation that VNS therapy is considered **investigational** for any other conditions, including but not limited to the following, because the evidence is limited supporting its safety and efficacy:
- **A.** Refractory (treatment resistant) major depression or bipolar disorder;
- **B.** Obesity;
- **C.** Headaches;
- **D.** Cognitive impairment associated with Alzheimer's disease.

III. It is the policy of health plans affiliated with Centene Corporation that the following types of VNS therapy are considered **investigational** due to the lack of large, high-quality studies supporting their use:
- **A.** Aspire SR Model 106 (Cyberonics) for vagus nerve stimulation;
- **B.** Transcutaneous VNS or active auricular transcutaneous electrical nerve stimulation.

Removal of Implant

Less than 0.5 percent of all patients have had the device removed. It can be turned off in the physician's office if the patient feels it is not helping or if the patient cannot tolerate the stimulation. If the device needs to be removed, only the pulse generator is removed, as attempting to remove the electrodes from around the nerve can cause damage and is not recommended.

Background

The vagus nerve stimulator is a pacemaker-like device implanted under the skin in the left side of the chest through a small incision, with a second small incision made at the base of the neck. The surgery is performed under local, regional, or general anesthesia and lasts 45 minutes to two hours. Most often it is performed as an outpatient surgery but some patients need to stay in the hospital overnight following surgery.

Partial (focal) seizures

Several studies have been done evaluating the safety and effectiveness of vagus nerve stimulation for treatment of epilepsy. A randomized active-control trial known as the E05 study found that 94 patients (of the total 254 patients in the study) receiving high stimulation showed an average reduction in seizure frequency, compared to baseline, of 28% versus 15% reduction in the 102 patients receiving low stimulation. A total of 310 patients completed the E03 and E05 double-blinded trials. Mean decline of seizure frequency overall was about 25-30% compared to baseline. Clinical experience has shown that improvement in seizures is maintained, or may even increase over time, but these data are based on uncontrolled observations. Side effects in both studies were similar and included hoarseness and occasional shortness of breath.

Although questions regarding patient selection criteria, optimal stimulation parameters, and cost-effectiveness in the United States remain under investigation, there is sufficient evidence regarding the benefit and safety of VNS to conclude that VNS may improve health outcomes in patients with medically refractory partial-onset seizures who are not suitable candidates for surgery or in whom surgical treatment has failed.

Generalized seizures

Study results suggest VNS may be effective for generalized epilepsy (Karceski & Schachter, 2015). However, case series and observational studies constitute the majority of available evidence. Although VNS is not currently FDA approved for the treatment of generalized seizures, it is often used in children and other patients, and in Europe is approved as adjunct therapy for epileptic disorders predominantly characterized by generalized or focal seizures that are refractory to antiseizure medications. In addition, the National Institute for Health and Care Excellence (NICE) recommends VNS for focal and generalized seizures, and the Scottish Intercollegiate Guidelines Network (SIGN) guidelines recommend VNS for epilepsy in patients unsuitable for respective surgery without stipulating seizure type.

Depression

VNS was FDA-approved for treatment resistant depression in 2005. However, VNS has no rigorous research data proving it is efficacious for treatment-resistant, unipolar major depression. Open-label studies suggest VNS may be effective; however, these are at risk for bias due to placebo effects. The one randomized trial of VNS for depression found no benefit, with outcomes comparable for active and sham treatment (response rates of 15 vs. 10 percent). In addition, there is a lack of thorough safety data for the use of VNS in depression.

Other Investigational Indications

Ongoing research efforts continue to investigate the role of vagus nerve stimulation (VNS) for a the treatment of a variety of indications, including but not limited to cognitive deficits in

Alzheimer's disease, resistant obesity, and headaches. Data supporting the long-term safety and efficacy from large clinical trials of VNS for the treatment of these indications, however, continue to be lacking.

AspireSR Model 106 (Cyberonics) for Vagus Nerve Stimulation
The AspireSR Model 106 (Cyberonics Inc.) received FDA Premarket Approval (PMA) in February 2014. The newest modification to the vagus nerve stimulation (VNS) implant detects tachycardia heart rates, which may be associated with an impending seizure, and automatically delivers stimulation to the vagus nerve. Like its predecessors, the AspireSR can also deliver stimulation in the normal and magnet modes. However, when programmed for AutoStim mode, the AspireSR requires no patient interaction to trigger the delivery of electrical stimulation. The AutoStim mode should not be used in patients with significant arrhythmias being treated with pacemakers and/or an implantable defibrillator, beta-blockers, or any other treatment that may impact the intrinsic heart rate.

A few small, preliminary studies and case reports have evaluated the AspireSR Model 106, and have shown positive results (Boon et al., 2015; Fisher et al., 2015; Schneider et al., 2015; Hampel et al, 2015). However, there is insufficient evidence to establish the safety and efficacy of the AspireSR Model 106 in reducing seizures until further, high quality trials establish its clinical value.

Transcutaneous Vagus Nerve Stimulation
Active auricular transcutaneous electrical nerve stimulation is also referred to as transcutaneous vagus nerve stimulation (tVNS). Noninvasive, tVNS stimulates the afferent auricular branch of the vagus nerve located medial of the tragus at the entry of the acoustic meatus. Given that the right vagal nerve has efferent fibers to the heart, tVNS is safe to be performed only in the left ear. tVNS has been proposed to study cognitive functioning in patients with epilepsy and major depression. The rationale is that direct stimulation of the afferent nerve fibers on the ear area with afferent vagus nerve distribution should produce a similar effect as classic VNS in reducing depressive symptoms without the burden of surgical intervention.

A noninvasive, transcutaneous vagal nerve stimulator has been in use in Europe. The device stimulates the auricular branch of the vagus nerve. It does this via a small earphone-like stimulator. Although no randomized studies have been done in patients with epilepsy, it appears promising in one pilot study (Bauer et al, 2016). Small studies have shown positive results with tVNS for the treatment of depression (Hein et al, 2013; Fang et al, 2016). Additional, larger, peer-reviewed studies, with longer follow-up are necessary to determine the long-term safety and efficacy of transcutaneous VNS for depression.

Coding Implications
This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2017, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage.

CLINICAL POLICY
Vagus Nerve Stimulation

Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT®* Codes	Description
61885	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array
61886	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to two or more electrode arrays
64553	Percutaneous implantation of neurostimulator electrodes; cranial nerve
64568	Incision for implantation of cranial nerve (eg, vagus nerve) neurostimluator electrode array and pulse generator
64569	Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator
64570	Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator

HCPCS Codes	Description
C1767	Generator, neurostimulator (implantable), nonrechargeable
C1778	Lead, neurostimulator (implantable)
C1816	Receiver and/or transmitter, neurostimulator (implantable)
C1883	Adaptor/extension, pacing lead or neurostimulator lead (implantable)
L8680	Implantable neurostimulator electrode, each
L8681	Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only
L8682	Implantable neurostimulator radiofrequency receiver
L8683	Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver
L8685	Implantable neurostimulator pulse generator, single array , rechargeable, includes extension
L8686	Implantable neurostimulator pulse generator, single array, nonrechargeable, includes extension
L8687	Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension
L8688	Implantable neurostimulator pulse generator, dual array, nonrechargeable, includes extension
L8689	External recharging system for battery (internal) for use with implanted neurostimulator, replacement only

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
G40.001	Localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset, not intractable, with status epilepticus

CLINICAL POLICY
Vagus Nerve Stimulation

ICD-10-CM Code	Description
G40.009	Localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset, not intractable, without status epilepticus
G40.011	Localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset, intractable, with status epilepticus
G40.019	Localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset, intractable, without status epilepticus
G40.111	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, intractable, with status epilepticus
G40.119	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, intractable, without status epilepticus
G40.201	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, not intractable, with status epilepticus
G40.209	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, not intractable, without status epilepticus
G40.211	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, intractable, with status epilepticus
G40.219	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, intractable, without status epilepticus
G40.309	Generalized idiopathic epilepsy and epileptic syndromes, not intractable, without status epilepticus
G40.319	Generalized idiopathic epilepsy and epileptic syndromes, intractable, without status epilepticus
G40.A09	Absence epileptic syndrome, not intractable, without status epilepticus
G40.A11	Absence epileptic syndrome, intractable, with status epilepticus
G40.A19	Absence epileptic syndrome, intractable, without status epilepticus
G40.409	Other generalized epilepsy and epileptic syndromes, not intractable, without status epilepticus
G40.411	Other generalized epilepsy and epileptic syndromes, intractable, with status epilepticus
G40.419	Other generalized epilepsy and epileptic syndromes, intractable, without status epilepticus
G40.509	Epileptic seizures related to external causes, not intractable, without status epilepticus
G40.802	Other epilepsy, not intractable, without status epilepticus
G40.803	Other epilepsy, intractable, with status epilepticus
G40.804	Other epilepsy, intractable, without status epilepticus
G40.909	Epilepsy, unspecified, not intractable, without status epilepticus
G40.911	Epilepsy, unspecified, intractable, with status epilepticus

CLINICAL POLICY
Vagus Nerve Stimulation

ICD-10-CM Code	Description
G40.919	Epilepsy, unspecified, intractable, without status epilepticus

Reviews, Revisions, and Approvals	Date	Approval Date
Deleted age criteria; background updated	09/13	10/13
Reviewed and references and coding updated	09/14	10/14
Combined with VNS for depression policy Added bipolar disorder to not medically necessary list Converted into new template, added ICD-10 codes	10/15	10/15
Added generalized seizures as medically necessary. Removed requirement for 4-6 seizures per month. Added requirement that VNS be performed with a FDA approved device. Changed depression and bipolar disorder to investigational, and also added obesity, headaches, cognitive impairment due to Alzheimers, transcutaneous VNS/auricular transcutaneous electrical nerve stimulation, and AspireSR Model 106 as investigational. Added supporting background information.	09/16	10/16
Changed II. to apply to the listed conditions as well as others that were not mentioned. Coding updates. References reviewed and updated.	10/17	10/17

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and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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CENTENE Corporation

Clinical Policy: Cochlear Implant Replacements

Reference Number: CP.MP.14
Effective Date: 02/09
Last Review Date: 09/17

Revision Log
Coding Implications

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

This policy outlines medical necessity criteria for the replacement of cochlear implants and/or cochlear implant components. The cochlear implant has 4 basic components: a microphone, worn externally behind the ear, which picks up sounds; an external speech processor which converts sounds to electrical signals; a transmitter and receiver/stimulator which forward the signals; and implanted electrodes, which stimulate the fibers of the auditory nerve.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that ***replacement*** of a cochlear implant(s) and/or its external components (external speech processor, controller, etc.) is considered **medically necessary** when any one of the following is present:
- **A.** The existing device(s) is no longer functional and cannot be repaired; or
- **B.** A change in the member's condition makes the existing unit(s) inadequate for the hearing-related activities of daily living and improvement is expected with a replacement unit(s).

II. It is the policy of Health Plans affiliated with Centene Corporation that ***replacement or upgrade*** of an existing, properly functioning cochlear implant and/or its external components (external speech processor, controller, etc.) is considered **not medically necessary** when requested only for convenience or to simply upgrade to a newer technology.

Background

Sensorineural hearing loss, or nerve deafness, is a type of hearing loss that results from problems with the inner ear, related to the cochlea, eighth nerve, internal auditory canal, or brain. A common cause of hearing loss in adults is presbycusis, a progressive condition caused by the loss of function of hair cells in the inner ear. Severe to profound hearing loss in children most often is caused by genetics, prenatal, perinatal, or postnatal causes. A cochlear implant, an electronic device surgically placed under the skin, bypasses the hair cells and directly transmits sounds through multiple electrodes, which stimulate the auditory nerve. Once the auditory nerve is activated, signals are sent to the brain. The brain learns to recognize these signals and the person experiences this as hearing.

Cochlear implants have been studied since the 1950s and were approved by the FDA in adults in the mid-1980s. National Institute of Health (NIH) scientists determined cochlear implants to be cost beneficial. The cost of cochlear implantation, adjustments and training averages $60,000 whereas the services, special education and adaptation related to a child that is deaf before age three costs more than $1 million.

Recent studies have been conducted evaluating the use of bilateral cochlear implants compared to unilateral implants. Many of these studies have shown that children obtained significantly higher hearing thresholds in the bilateral implants. Speech recognition scores in quiet and noisy conditions were also improved in bilateral users. Studies also have shown better scores on sentence and word recognition tests for bilateral users.

Very little data has been published comparing differences between bilateral cochlear implants and cochlear implant with a hearing aid on the opposite ear. One small study showed improved localization abilities and speech perception scores for two former users of cochlear implant/hearing aid within the first 6 months after the second implant was activated. However, performance showed a slight decline after 6 months of use. Further studies are needed in this area to determine efficacy for bilateral cochlear implants in adults.

While evidence is increasing regarding the use of bilateral implants, bilateral implantation is not without problems. Limited nerve survival that remains may be asymmetrical, resulting in an unnatural pattern of neural activity in stimulation with electrical pulses. This asynchronous stimulation across devises might result in individual neural impulses which are unlikely to result in useful cues related to interaural differences. Also, bilateral implantation doubles the risks associated with surgical intervention and is very costly.

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Coding Implications

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CLINICAL POLICY
Cochlear Implant Replacements

CPT®* Codes	Description
69717	Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy
69718	Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy

HCPCS Codes	Description
L8615	Headset/headpiece for use with cochlear implant device, replacement
L8616	Microphone for use with cochlear implant device, replacement
L8617	Transmitting coil for use with cochlear implant device, replacement
L8618	Transmitter cable for use with cochlear implant device, replacement
L6819	Cochlear implant, external speech processor and controller, integrated system, replacement
L8623	Lithium ion battery for use with cochlear implant device speech processor, other than ear level replacement
L8624	Lithium ion battery for use with cochlear implant device speech-processor, ear level replacement, each
L8627	Cochlear implant, external speech processor, component, replacement
L8628	Cochlear implant, external controller component, replacement
L8629	Transmitting coil and cable, integrated, for use with cochlear implant device, replacement

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
H90.3	Sensorineural hearing loss, bilateral
H90.41	Sensorineural hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side
H90.42	Sensorineural hearing loss, unilateral, left ear, with unrestricted hearing on the contralateral side
H90.5	Unspecified sensorineural hearing loss
Q85.00	Neurofibromatosis, unspecified
Q85.02	Neurofibromatosis, type 2
Z96.21	Cochlear implant status

Reviews, Revisions, and Approvals	Date	Approval Date
References reviewed and updated	03/12	04/12
References reviewed and updated	04/13	05/13
Added criteria for replacement of implants and components	06/13	06/13

Reviews, Revisions, and Approvals	Date	Approval Date
Clarified policy language to discuss replacement of implants or components only	09/14	09/14
Background updated Converted into new template	09/15	09/15
Converted to new template. References reviewed. ICD 10 codes added.	09/16	09/16
Clarified in II that replacements are not medically necessary when requested *only* for convenience/ to upgrade to newer technology. References reviewed and updated.	09/17	09/17

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

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CENTENE Corporation

Clinical Policy: Stereotactic Body Radiation Therapy

Reference Number: CP.MP.22
Effective Date: 12/08
Last Review Date: 03/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Stereotactic body radiation therapy (SBRT) and stereotactic radiosurgery (SRS) are radiation therapies delivered via stereotactic guidance to a small, precise target. It largely spares the surrounding tissue by multiple non-parallel radiation beams converging into one sharply defined target. It greatly reduces the amount of radiation to which the surrounding tissue is exposed. SBRT is used to treat extra-cranial sites and can be performed in one to five sessions (fractions). SRS is used to treat intra-cranial and spinal targets. SRS is typically performed in a single session but can be performed in a limited number of sessions, up to a maximum of five. Gamma-ray photons, X-ray photons, protons, helium ions, and neutrons have all been used for SBRT and SRS.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that up to 5 sessions of SBRT is **medically necessary** for any of the following indications:
- A. Early stage non-small cell lung cancer (i.e., stage I-II, NO) in patients who are not surgical candidates;
- B. Acoustic neuroma;
- C. Localized malignant conditions in the body where highly precise application of high-dose radiotherapy is required, including tumors of any type arising in or near previously irradiated regions;
- D. Recurrences of metastatic spine cancer after previous radiation.[23]

II. It is the policy of health plans affiliated with Centene Corporation® that up to 5 sessions of SRS are **medically necessary** for any one of the following indications:
- A. Cranial indications when unresectable due to its deep intracranial location or member is unable to tolerate conventional operative intervention:
  1. Inoperable, small (< 3 cm) arteriovenous (AV) malformations, or
  2. Benign tumors including meningiomas, pituitary adenomas, craniopharyngiomas, hemangiomas, and neoplasms of the pineal gland; or
- B. Small acoustic neuromas (< 3 cm) or enlarging neuromas in patients who are not candidates for surgery; or
- C. Brain malignancies, primary and/or metastatic lesions; or
- D. Intracranial lesions where the patient refuses surgery; or
- E. Severe, sustained trigeminal neuralgia not responsive to other treatments, or
- F. A booster treatment for larger cranial or spinal lesions that have been treated initially with external beam radiation therapy or surgery. Avoid SBRT when in close proximity to cranial nerves II and VIII if the maximal dose delivered exceeds 10 Gy; or
- G. Relapse in previously irradiated cranial or spinal field where additional stereotactic precision is required to avoid unacceptable vital tissue radiation; or

H. Inoperable spinal tumors causing compression or intractable pain.

III. It is the policy of health plans affiliated with Centene Corporate that more than 5 sessions of SBRT or SRS or for indications other than listed above, is considered **not medically necessary**.

Background

Stereotactic ablative radiotherapy is also known as SBRT. SRS and SBRT both pair a high degree of anatomic targeting accuracy and reproducibility with very high doses of extremely precise, externally generated, ionizing radiation to inactivate or eradicate a defined target(s). The target is defined by high resolution stereotactic imaging. The procedure involves a multidisciplinary team often consisting of a surgeon, radiation oncologist, radiologist, medical radiation physicist, dosimetrist, radiation therapist, radiation therapy nurse and a specialist of the disease site such as a neurologist.

Stereotactic describes a procedure during which a target lesion is localized relative to a fixed 3-D reference system, such as a rigid head frame affixed to a patient, fixed bony landmarks, a system of implanted fiducial markers, or other similar system. This localization procedure allows physicians to perform image-guided procedures with a high degree of accuracy and precision.

The risk of developing permanent damage following SRS varies by the location of the lesion in the brain. Lesions located deep in the gray matter (thalamus, basal ganglia) or brainstem (pons, midbrain) carry the maximum risk of neurologic complications. Complications are less likely with lesions in the frontal and temporal lobes. Fractionated radiation therapy is often preferred to SRS for the treatment of lesions in the deep gray matter or the brainstem.

Technologies that are used to perform SBRT and SRS include Gamma Knife, LINAC, CyberKnife and proton beam or heavy-charged-particle radiosurgery. In order to enhance precision, various devices may incorporate robotics and real time imaging.[4]

Gamma Knife

Standard gamma knife uses 192 or 201 beams of highly focused gamma rays all aiming at the target region. The Gamma Knife is ideal for treating small to medium size lesions.

Linear accelerator- (LINAC)

LINAC machines deliver high-energy x-rays, also known as photons. It can provide treatment on larger tumors in a single session or during multiple sessions (fractionated SRT). The principles of LINAC are identical to GammaKnife.[4]

CyberKnife

This device combines a mobile LINAC machine with an image guided robotic system that delivers either a single large dose or fractionated radiation therapy. The overall length of time of treatment on a CyberKnife is typically longer than with other radiation therapy modalities. [4 11]

Proton Beam

There is limited use of this in North America; however the number of centers has dramatically increased in the last several years. Protons are atoms that carry a positive charge. Compared to the use of photons (x-rays), the energy from protons conforms to the tumor better and causes less damage to the surrounding tissue. This allows a greater dose of radiation to be used due to minimizing the effects to normal tissue.

National Comprehensive Cancer Network
SBRT should have longer follow-up and prospective multi-institutional data to evaluate longer-term results for prostate cancer, especially since late toxicity theoretically could be worse in hypofractionated regimens compared to conventional fractionation. [13]

The World Health Organization notes the following information regarding Grade I meningiomas: stereotactic or image guided therapy is recommended when using tight margins or when close to critical structures.[23]

A revision to the metastatic spine guideline notes that in selected cases or recurrences after previous radiation, SBRT is appropriate.[23]

Definitive radiation therapy, particularly SBRT, is recommended for individuals with early stage non-small cell lung cancer (i.e., stage I-II, NO) who are medically inoperable or those who refuse surgery.[22]

Coding Implications
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CPT® Codes	Description
61796	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 simple cranial lesion
61797	Each additional cranial lesion, simple
61798	1 complex cranial lesion
61799	Each additional cranial lesion, complex
63620	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 spinal lesion
63621	Each additional spinal lesion
63621	Each additionalspinal lesion
77371	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source cobalt 60 based

CPT® Codes	Description
77372	Linear accelerator based
77373	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions
77432	Stereotactic radiation treatment management of cranial lesion(s) (complete course of treatment consisting of one session)
77435	Stereotactic body radiation therapy, treatment management, per treatment course, to one or more lesions, including image guidance, entire course not to exceed 5 fractions

HCPS	Description
G0339	Image-guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session or first session of fractionated treatment
G0340	Image-guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum five sessions per course of treatment

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
C34.11	Malignant neoplasm of upper lobe, right bronchus or lung
C34.12	Malignant neoplasm of upper lobe, left bronchus or lung
C34.2	Malignant neoplasm of middle lobe, bronchus or lung
C34.31	Malignant neoplasm of lower lobe, right bronchus or lung
C34.32	Malignant neoplasm of lower lobe, left bronchus or lung
C34.81	Malignant neoplasm of overlapping sites of right bronchus and lung
C34.82	Malignant neoplasm of overlapping sites of left bronchus and lung
C71.0	Malignant neoplasm of cerebrum, except lobes and ventricles
C71.1	Malignant neoplasm of frontal lobe
C71.2	Malignant neoplasm of temporal lobe
C71.3	Malignant neoplasm of parietal lobe
C71.4	Malignant neoplasm of occipital lobe
C71.5	Malignant neoplasm of cerebral ventricle
C71.6	Malignant neoplasm of cerebellum
C71.7	Malignant neoplasm of brain stem
C17.8	Malignant neoplasm of overlapping sites of brain
C72.0	Malignant neoplasm of spinal cord
C72.1	Malignant neoplasm of cauda equine
C72.21	Malignant neoplasm of right olfactory nerve
C72.22	Malignant neoplasm of left olfactory nerve
C72.31	Malignant neoplasm of right optic nerve
C72.32	Malignant neoplasm of left optic nerve

CLINICAL POLICY
Stereotactic Body Radiation Therapy

ICD-10-CM Code	Description
C72.41	Malignant neoplasm of left acoustic nerve
C72.42	Malignant neoplasm of right acoustic nerve
C72.59	Malignant neoplasm of other cranial nerve
D18.02	Hemangioma of intracranial structures
D32.0	Benign neoplasm of cerebral meninges
D33.0	Benign neoplasm of brain, supratentorial
D33.1	Benign neoplasm of brain, infratentorial
D33.3	Benign neoplasm of cranial nerves
D35.2	Benign neoplasm of pituitary gland
D35.4	Benign neoplasm of pineal gland
D43.0	Neoplasm of uncertain behavior of brain, supratentorial
D43.1	Neoplasm of uncertain behavior of brain, infratentorial
D43.3	Neoplasm of uncertain behavior of cranial nerves
D43.4	Neoplasm of uncertain behavior of spinal cord
D43.8	Neoplasm of uncertain behavior of other specified parts of central nervous system
D44.4	Neoplasm of uncertain behavior of craniopharyngeal duct
G50.0	Trigeminal neuralgia
Q28.2	Arteriovenous malformations of cerebral vessels
Z51.0	Encounter for antineoplastic radiation therapy

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed Specialist review (radiation oncology)	10/08	12/08
Specialist review (radiation oncology)	08/10	
Policy reviewed	09/10	09/10
Policy reviewed References reviewed and updated	10/11	12/11
References reviewed and updated Removed CPT 77421 as this is not appropriate for Stereotactic Radiosurgery	11/12	12/12
Updated codes and disclaimers for HIX products	05/13	
Clarified language in Policy/Criteria section	12/13	12/13
Removed Authorization Criteria section Added indication for patients who refuse surgery and with more tumors arising in or near previous irradiated regions Clarified differences in SBRT and SRS and split Policy/Criteria appropriately Specialist review (radiation oncology)	03/14	03/14
Bibliography reviewed and updated Procedure codes updated per 2015 code updates for deleted codes	02/15	03/15

Reviews, Revisions, and Approvals	Date	Approval Date
References reviewed and updated; added acoustic neuroma as an indication for SBRT; for SRS, removed acoustic neuroma from cranial indications and added a requirement that it be small or enlarging if not a candidate for surgery.	03/16	03/16
References reviewed and updated; added (i.e., stage I-II, NO) as indication to define non-small cell lung cancer per NCCN; added SBRT as indication for recurrences of metastatic spine cancer after previous radiation, per NCCN; added CyberKnife to the background information as a technology used to perform SBRT and SRS; added information to background section from NCCN that SBRT needs longer follow-up before used on prostate cancer; added additional information from NCCN to support SBRT to background section.	02/17	03/17

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CLINICAL POLICY
Stereotactic Body Radiation Therapy

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CENTENE Corporation

Clinical Policy: Multiple Sleep Latency Testing

Reference Number: CP.MP.24
Effective Date: 10/08
Last Review Date: 05/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Multiple Sleep Latency Testing (MSLT) is part of the routine evaluation of patients suspected of having narcolepsy or idiopathic hypersomnia. It objectively measures an individual's tendency to fall asleep. It is considered the standard measurement of sleepiness and has proven to be a sensitive and reproducible test for quantifying sleepiness. It is not a part of the routine evaluation for other sleep disorders. A polysomnogram (PSG) should be conducted prior to the MSLT, and should not demonstrate significant sleep pathology (e.g., obstructive sleep apnea, central sleep apnea, etc.) in order to justify and validate a MSLT**.**

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that MSLT is **medically necessary** for ages 2 and above, when the all of the following criteria are met:

A. Excessive daytime sleepiness (EDS) for ≥ 8 weeks, as measured by a score of 10 or more on the Epworth Sleepiness Scale;
B. If age is 2 to 11 years, all of the following:
   1. Has had a consultation with a pediatric neurologist, pediatric pulmonologist, or pediatric sleep medicine specialist, and the MSLT has been ordered by the consulting physician;
   2. The MSLT will be conducted in a facility specializing in pediatric sleep disturbances with consultant pediatrics available;
C. A standard PSG is planned for the night before the MSLT;
D. Suspected narcolepsy and any of the following, or suspected idiopathic hypersomnia;
   1. Cataplexy (brief, sudden loss of muscle tone);
   2. Hypnagogic and/or hypnopompic hallucinations;
   3. Sleep paralysis;
E. Medical conditions considered and treated if indicated;
F. Medications deemed noncontributory;
G. No psychiatric disorder by history, or psychiatric disorder under the care of a psychiatrist or psychologist;
H. Drug and alcohol misuse excluded.

Background

Narcolepsy has been reported in children as young as 2 years; however, the peak onset is 15 years, with a less pronounced peak at 36 years. The classic pentad of narcolepsy consists of EDS, cataplexy, hypnagogic and/or hypnopompic hallucinations, disrupted nocturnal sleep, and sleep paralysis. Children rarely manifest all 5 classic symptoms. They often deny EDS, and restlessness and over-activity sometimes predominate. Academic deterioration, inattentiveness, and emotional lability are common. Serial MSLTs may be required for diagnosis, and usually multiple confounding factors are involved.

Diagnosing narcolepsy in children presents a number of difficulties. Even within age groups of children, clinical manifestations of sleep problems can vary by age and developmental level. There are consistent data showing the diagnostic utility of MSLT in school-aged children as young as 5 years with suspected narcolepsy. Studies show MSLT is a highly sensitive test in this population, with sensitivity for diagnosing narcolepsy ranging from 79% to 100%. (Aurora et al, 2012).

The same standard criteria used for adults are used for MSLT in children and studies are scored similarly, using the same normative data. However, special issues exist regarding performance, interpretation, and operating characteristics of MSLT in children. Children with suspected narcolepsy must be evaluated by a pediatric neurologist, pulmonologist, or sleep medicine specialist.

Coding Implications

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CPT® Codes	Description
95805	Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness.
95810	Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist
95811	Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist

HCPCS Codes	Description
N/A	

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
G47.11	Idiopathic hypersomnia with long sleep time
G47.12	Idiopathic hypersomnia without long sleep time
G47.31	Primary central sleep apnea
G47.33	Obstructive sleep apnea (adult) (pediatric)

ICD-10-CM Code	Description
G47.37	Central sleep apnea in conditions classified elsewhere
G47.411	Narcolepsy with cataplexy
G47.419	Narcolepsy without cataplexy
G47.421	Narcolepsy in conditions classified elsewhere with cataplexy
G47.429	Narcolepsy in conditions classified elsewhere without cataplexy
G47.53	Recurrent isolated sleep paralysis
R43.3	Overactivity

Reviews, Revisions, and Approvals	Date	Approval Date
Removed specific InterQual and MCG guideline references References reviewed and updated Specialist review- pediatric neurology	05/14	05/14
Bulleted out Policy/Criteria section, added specific criteria to B rather than reference to external criteria	05/15	05/15
Removed revision history prior to 2014. Added requirement that requests for children < 5 years be evaluated by a medical director; allowed MSLT to be ordered by pediatric neurologist, pulmonologist, or sleep medicine specialist; updated background description of narcolepsy to include hypnopompic hallucinations and disrupted nocturnal sleep.	05/16	05/16
Changed policy to apply to ages 2 + (previously applied to ages 5-18). Removed portion of description noting that requests under age 5 need to be reviewed by the medical director. Added requirements for: excessive daytime sleepiness, as measured by 10 on ESS; that suspected narcolepsy should be in conjunction with any of the following: cataplexy, hypnagogic/ hypnopompic hallucinations, or sleep paralysis; that medical conditions should be treated if indicated, psychiatric disorders treated if present, medications deemed noncontributory, and drug or alcohol misuse excluded. CPT, HCPCS, and ICD-10 codes added.	04/17	05/17
Clarified language in criteria with the following: added Pediatric pulmonologist under I.B.1; added with consultant pediatrics available under I.B.2; added under the care of a psychiatrist or psychologist instead of 'managed' under I.G.	10/17	

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

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CENTENE Corporation

Clinical Policy: Articular Cartilage Defect Repairs

Reference Number: CP.MP.26
Effective Date: 10/08
Last Review Date: 05/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Cartilage transfer procedures include autologous chondrocyte implantation, osteochondral allograft transplantation (OAG or OCA) [i.e., including repair of anterior cruciate ligament and meniscus], and osteochondral autograft transplantation [mosaicplasty, Osteochondral Autograft Transplantation System (OATS)]. They are techniques for repairing articular cartilage that has been damaged by trauma or degenerative processes. This policy outlines the medical necessity criteria for each of these procedures.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that autologous chondrocyte implantation (ACI) is **medically necessary** when *all* of the following criteria are met:

A. Age 15 – 55 years, or documented skeletal maturity if < 18;
B. BMI < 35 cm/M^2;
C. Focal, full-thickness (grade III or IV) articular cartilage defect involving the femoral condyle (medial, lateral, or trochlear);
D. Femoral condyle defect size 1–10 cm^2;
E. Disabling symptoms such as locking, swelling, or knee pain that is unresponsive to conservative treatment for a minimum of 2 months (e.g., medication, physical therapy) AND arthroscopic or other surgical repair;
F. Knee is stable with intact menisci and ligaments, has normal joint space by X-ray, and is in good alignment (a corrective procedure to stabilize the knee may be performed in combination with or prior to autologous chondrocyte implantation [ACI]);
G. Surgery is not intended to treat osteoarthritis of the knee;
H. Patient is willing and able to comply with prescribed postoperative rehabilitative program.

II. It is the policy of health plans affiliated with Centene Corporation that osteochondral allograft transplant OR osteochondral autograft transplant of the knee is considered **medically necessary** when *all* of the following criteria are met:

A. Focal, full-thickness (grade III or IV) articular cartilage defect of the lateral or medial femoral condyle, or trochlear region of the knee;
B. For osteochondral autograft transplant (e.g., OATS/Mosaicplasty), lesion is ≤ 2 cm^2; or for osteochondral allograft transplant (e.g., OCA), lesion is > 2cm^2;
C. Disabling symptoms such as locking, swelling, or knee pain that is unresponsive to conservative treatment for a minimum of two months (medication, physical therapy);
D. No evidence of arthritis on the corresponding tibial surface;
E. Normal appearing hyaline cartilage surrounding the border of the defect;
F. Normal knee alignment;

G. Not currently a candidate for total or partial knee replacement.

III. It is the policy of health plans affiliated with Centene Corporation that meniscal allograft transplant is considered **medically necessary** when all of the following criteria are met:
A. Physically active and physiologically young, under age 55;
B. Documented mild to moderate articular damage (Outerbridge grade II or less);
C. Missing > 50% of a meniscus as a result of previous surgery or injury, or a meniscus tear that cannot be repaired;
D. Disabling knee pain refractory to conservative treatment;
E. Normal alignment without varus or valgus deformities;
F. None of the following contraindications to meniscal allograft transplant:
1. Systemic metabolic degenerative disease; (i.e., gout);
2. Arthritis of the knees or rheumatoid arthritis;
3. Flattening of the femoral condyles or severe degenerative changes (greater than 50% joint space narrowing, bone on bone, or erosion to subchondral bone);
4. Patients who have undergone partial or total meniscectomy and do not presently have symptoms or problems with their knee.

IV. It is the policy of health plans affiliated with Centene Corporation that minced articular cartilage repair (allograft or autograft) is considered investigational because effectiveness has not been established.

V. It is the policy of health plans affiliated with Centene Corporation that ACI, osteochondral allograft transplant, or osteochondral autograft transplant for any other indication or any other joint surface not listed above is considered **experimental/investigational** because effectiveness has not been established.

Background
Articular cartilage is a highly resilient, viscoelastic material that plays an essential role in reducing stress on subchondral bone and minimizing friction within the joint. Articular cartilage is hyaline cartilage, which consists primarily of matrix, water and only a small number of chondrocytes (cartilage cells). Hyaline cartilage has a low capacity for regeneration because of its avascular and relatively acellular composition.

Osteochondral (OC) surfaces that are damaged by trauma or degenerative process usually fill in with fibrocartilage which is less suitable for absorbing stress than is hyaline cartilage. In younger adults, trauma is the most frequent cause of articular cartilage damage. Indications for OC repair include tears, chondral flaps, and loose bodies. All of these defects can result in joint pain, swelling, locking, and giving way.

Other causes of articular defects include degenerative conditions such as osteonecrosis, osteochondritis dissecans, and osteoarthritis. Osteonecrosis is the death of bone en masse and may arise spontaneously or can result from chronic steroid use. The etiology of this condition is uncertain, although it is thought to result from loss of the blood supply to an area of the subchondral bone. Osteoarthritis, or degenerative arthritis, is the most common form of arthritis

in the United States and is characterized by the erosion of articular cartilage (NIAMS, 2001; Hangody et al., 2004; Koulalis et al., 2004).

ACI is a two-stage process in which, first, the healthy cartilage cells are harvested and cultured and then, reimplanted into the defect under a membranous patch at a later date. Allograft transplant involves the transplant of a cadaveric graft consisting of viable articular cartilage and underlying subchondral bone to cover large (> 2 cm^2), full-thickness cartilage defects of the knee. Autograft procedures consist of removing small osteochondral cylinders from low weight-bearing surfaces of the affected joint or another joint in the same patient and inserting them into the affected area to create a mosaic of islands of hyaline cartilage in an area that would otherwise remain without cartilage or fill with only fibrocartilage.

Meniscal allograft transplantation is a surgical procedure that involves grafting a donor meniscus into the knee of a recipient. The goal of meniscal transplant surgery is to replace the meniscus cushion before the articular cartilage is damaged. The donor cartilage supports and stabilizes the knee joint, and therefore relieves knee pain.

Nonsurgical treatment options for damage to articular cartilage include weight reduction, physical therapy, braces and orthotics, intra-articular injection of hyaluronic acid derivatives, and non-steroidal anti-inflammatory agents. A realignment osteotomy (i.e., proximal tibial, distal femoral) is a surgical option to reduce the compressive stress on the damaged articular cartilage in the medial or lateral compartments of the knee. This can be performed instead of, or in addition to, a cartilage replacement procedure listed above. Total joint replacement provides a surgical option but is not advised for younger patients because implants might not withstand the higher levels of physical activity for an extended period of time. A 2003 National Institutes of Health (NIH) Consensus Conference advised that other options should be considered for patients under the age of 55 (Hand et al).[8]

The American Academy of Orthopaedic Surgeons (AAOS) believes that for appropriate patients musculoskeletal allografts represent a therapeutic alternative. These tissues should be acquired from facilities that demonstrate compliance, use well-accepted banking methodology, and follow Food and Drug Administration Good Tissue Practices. The AAOS urges all tissue banks to follow rigorous national guidelines and standards and recommends the use of tissue from banks that are accredited by the American Association of Tissue Banks.[3]

The AAOS has information on meniscal transplant surgery and notes that patient eligibility for this procedure includes missing more than half of a meniscus as a result of previous surgery or injury, or a meniscus tear that cannot be repaired.[3]

In summary, there have been a number of randomized controlled studies as well as non-comparative studies that have noted improvement in repairing articular cartilage that has been damaged by trauma or degenerative processes, through the procedures noted within this policy.

Coding Implications

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CLINICAL POLICY
Articular Cartilage Defect Repairs

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CPT® Codes	Description
27407	Repair, primary, torn ligament and or capsule of knee; cruciate
27412	Autologous chondrocyte implantation, knee
27415	Osteochondral allograft, knee, open
27416	Osteochondral autograft(s), knee, open (e.g., mosaicplasty) (includes harvesting of autograft[s])
28446	Open osteochondral autograft, talus (includes obtaining graft[s])
29866	Arthroscopy, knee, surgical; osteochondral autograft(s) (e.g. mosaicplasty) (includes harvesting of the autograft)
29867	Arthroscopy, knee, surgical; osteochondral allograft (eg, mosaicplasty)
29868	Arthroscopy, knee, surgical; meniscal transplantation (includes arthrotomy for meniscal), medial or lateral

HCPCS Codes	Description
J7330	Autologous cultured chondrocytes, implant
S2112	Arthroscopy, knee, surgical, for harvesting of cartilage (chondrocyte cells

ICD-10-CM Diagnosis Codes that Support Medical Necessity

ICD-10-CM Code	Description
M17.0-M17.9	Osteoarthritis of knee
M25.561-M25.569	Pain in knee
M25.861-M25.869	Other specified joint disorders, knee
M93.261-M93.269	Osteochondritis dissecans of knee
M94.9	Disorder of cartilage, unspecified
S83.30X (A,D,S)-S83.31X(A,D,S)	Tear of articular cartilage of knee, current
S89.80X (A,D,S)-S89.82X (A,D,S)	Other specified injuries of lower leg

Reviews, Revisions, and Approvals	Date	Approval Date
Clarified description language Added autologous chondrocyte implantation Renamed policy from Mosaicplasty to Articular Cartilage Defect Repairs Specialist review - orthopedic	05/14	05/14
Added criteria in which procedures would be considered medically necessary and clarified when and what procedures would not be medically necessary Specialist review - orthopedic	05/15	05/15
Policy converted to new template Revision history prior to 2014 removed References reviewed and updated Added BMI criteria for ACI and age criteria for OAT	05/16	05/16
Added criteria for meniscal allograft transplant from the American Academy of Orthopedic Surgeons (2014)	08/16	09/16
Added locking and swelling to list of disabling symptoms that could qualify member for procedures in sections I and II. Edited II.B. to correctly label mosaicplasty and OATS as autografts, and OCA as an allograft.	05/17	05/17

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Important Reminder

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

CLINICAL POLICY
Articular Cartilage Defect Repairs

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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CENTENE Corporation

Clinical Policy: Hyperbaric Oxygen Therapy

Reference Number: CP.MP.27
Effective Date: 06/09
Last Review Date: 03/17

Coding Implications
Revision Log

See Important Reminder **at the end of this policy for important regulatory and legal information.**

Description

Hyperbaric oxygen therapy (HBOT) is a medical treatment with pure oxygen at 2-3 times greater than normal atmospheric pressure. The elevated pressure and oxygen concentration allows higher levels of oxygen in the systemic circulation, creating hyperoxygenation of tissues. It is useful for conditions related to decreased tissue oxygenation. This policy addresses medical necessity criteria for the use of hyperbaric oxygen therapy.

Treatment may be carried out in either a monoplace pressurized chamber or in a larger multiplace pressurized chamber. The monoplace chamber is most common and accommodates one patient lying supine during therapy. The multiplace chamber accommodates several patients and medical personnel. Topical or limb specific therapy is a technique where therapy is applied to a specific wound or limb that requires treatment. The entire body is not exposed during this treatment.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that hyperbaric oxygen therapy is **medically necessary** for the following indications:

A. As a primary therapy for any of the following medical conditions:

1. Decompression illness, or air or gas embolism for up to 10 treatments depending on severity and length of time between occurrence and first treatment;
2. Acute carbon monoxide poisoning for up to 3 treatments in 24 hours when any of the following criteria are present:
   a. Unconscious at scene or hospital;
   b. CO level >25%;
   c. CO level >20% or evidence of fetal distress in pregnant women;
   d. End-organ ischemia (eg, ECG changes, chest pain, altered mental status);
   e. Severe metabolic acidosis (pH <7.1);
3. Severe anemia from class IV hemorrhage when unable to transfuse for medical or religious reasons when any of the following symptoms are present:
   a. Shock, systolic blood pressure below 90 mmHg, or pressure maintained by vasopressors;
   b. Changes in mental status from disorientation to coma;
   c. Ischemic changes of the myocardium as demonstrated on the EKG;
   d. Ischemic gut.

   Treatments are considered medically necessary until red blood cells have been adequately replaced to alleviate the above signs and symptoms (Hgb of 6-8 g/dl).

B. As adjunctive treatment to accepted standard medical or surgical treatment for the following medical conditions:

1. Clostridial myostitis and myonecrosis (gas gangrene) for *up to 10 treatments when member is on dual IV antibiotic therapy and receiving surgical debridement*;
2. Crush injuries, suturing of severed limbs, and other acute traumatic ischemia when loss of function, limb, or life is threatened, including compartment syndrome. *Up to 20 treatments are considered medically necessary*;
3. Enhancement of healing of problematic wounds, such as one of the following:
   a. Hypoxic wounds such as arterial insufficiency ulcers or diabetic ischemic ulcers: Members with non-reconstructable anatomy or whose ulcer is not healing despite revascularization, and both of the following:
      i. Wound is hypoxic (due to ischemia);
      ii. The hypoxia is reversible by hyperbaric oxygenation;
   b. Diabetic foot ulcers meeting all of the following criteria:
      i. Wagner grade III or greater;
      ii. Failure of at least 30 days of standard wound care
      iii. Assessment of vascular status and correction of any vascular problems in the affected limb, if possible
      iv. Transcutaneous oximetry (PtcO2/ TCOM) measurement < 40 mmHg indicating wound is hypoxic

   Approve initial treatment course of 30 sessions. If wound shows measureable signs of improvement after initial treatments, an additional 10 sessions are considered medically necessary when repeat room air TCOM, as compared to initial TCOM, has improved but continues to be abnormal. If the repeat room air TCOM is normal, additional session of HBOT are considered not medically necessary. Further treatment after failure to show measureable improvement after each authorization period is considered not medically necessary.
4. Actinomycotic brain abscess after surgical drainage and currently on IV antibiotics based on gram stain results. *Up to 20 treatments is considered medically necessary*;
5. Necrotizing soft tissue infections when receiving surgical debridement and on appropriate IV antibiotic therapy.

   Approve initial treatment course of 30 sessions. If wound shows measureable signs of improvement after initial 30 treatments, additional follow-up treatment is considered medically necessary in increments of 10 sessions each. Further treatment after failure to show measureable improvement after each authorization period is considered not medically necessary;
6. Refractory osteomyelitis
   a. Unresponsive to 4 weeks of culture-directed IV antibiotics, and
   b. Has undergone drainage and complete debridement of necrotic bone, and
   c. Antibiotics will continue during HBOT. OR
   d. In rare cases where surgical debridement may be debilitating or adversely affect the central nervous system, a trial of HBOT and antibiotic therapy may be approved prior to surgery.

   Approve initial treatment course of 30 sessions. If wound shows measureable signs of improvement after initial treatments, an additional 10 sessions are considered medically necessary. Further treatment after failure to show measureable improvement after each authorization period is considered not medically necessary.
7. Delayed soft tissue radiation injuries

Approve initial treatment course of 30 sessions. If wound shows measureable signs of improvement after initial treatment, approve additional treatments in increments of 10, up to a total of 60 treatments. Further treatment after failure to show measurable improvement after each authorization period is considered not medically necessary.

8. Osteoradionecrosis of the jaw *prior to surgical debridement for 30 sessions and postoperatively for 10 sessions*;
9. Prevention of osteoradionecrosis in asymptomatic patients when surgery is required in a field which was previously irradiated with at least 6,800 cGy. *Twenty preoperative and 10 postoperative sessions are considered medically necessary*;
10. Compromised skin grafts and flaps, most common in members with compromised circulation, diabetes or vasculopathy, or irradiated tissue. Also appropriate for wound bed preparation prior to a flap in situation where surgical prognosis is poor (i.e. previous failed flap, radiation, etc.). Documentation should support that potential mechanical/surgical causes of flap compromise have been addressed or none are present

    Approve initial treatment course of 20 sessions. If wound shows measureable signs of improvement after initial treatments, an additional 10 sessions are is considered medically necessary. Further treatment after failure to show measureable improvement after each authorization period is considered not medically necessary.

II. Topical and/or limb specific hyperbaric oxygen therapy is considered **not medically necessary** because it is considered experimental/investigational.

III. HOBT for sudden sensorineural hearing loss is considered **not medically necessary** because clinical studies do not prove clear benefit.

Contraindications

A. Untreated pneumothorax;
B. Any current or prior treatment with bleomycin;
C. Treatment with doxorubicin (Adriamycin®) within 2-3 days of HBOT
D. Patients undergoing current disulfuram (Antabuse) therapy should generally not receive multiple HBOT treatments. Emergent need for HBOT should consider risks and benefits;
E. Current cisplatin treatment, unless emergent HBOT is needed;
F. If mafenide acetate (Sulfamylon®) is being used, such as with burn treatment, the mafenide acetate should first be cleaned off the patient prior to HBOT. Silver sulfadiazene (Silvadene®) is not a problem;

Relative contraindications include obstructive lung disease, upper respiratory or sinus infections, recent ear surgery or injury, fever, and claustrophobia.

Background

HBOT serves four primary functions. It increases the concentration of dissolved oxygen in the blood, enhancing perfusion. New blood vessels may develop from the formation of a collagen matrix. Oxygen replaces inert gas in the bloodstream, which is then metabolized by the body; and it works as a bactericide.

Decompression illness and gas embolism
Decompression illness occurs when excess nitrogen forms bubbles in the tissues due to a reduction in ambient pressure, such as occurs with ascent from scuba diving. These bubbles are what cause the symptoms that are referred to as decompression illness or "the bends". Trapping of gas within the lungs during ascent can cause bubbles to be forced into the bloodstream (arterial gas embolism) where they can block the flow of blood or damage the lining of blood vessels supplying critical organs such as the brain. This can also occur in non-divers due to air entering the body during medical diagnostic or therapeutic procedures. Symptoms can include joint pain, numbness, tingling, skin rash, extreme fatigue, weakness of arms or legs, dizziness, loss of hearing, and in severe cases, complete paralysis or unconsciousness.

HBOT reduces the size of the air bubbles, drives the remaining gas into physical solution, and washes out inert gas from the bubble. The bubble either dissolves or shrinks enough to allow blood flow to return. The resumption of blood flow allows local swelling to subside with resultant improvement in circulation and oxygen supply. Concomitantly, the high levels of oxygen in the hyperbaric chamber have the potential to immediately restore cellular oxygen levels.

HBOT is the definitive treatment for decompression illness and gas embolism. The success of the treatment depends on the severity of the case and the delay of administration. If treatment is started within a few hours after onset of symptoms, most cases will successfully respond to a single treatment. In a small number of cases, repetitive treatments are recommended until no further improvement can be observed (<20 treatments).

Carbon monoxide poisoning
Carbon monoxide (CO) poisoning occurs by either accidental or intentional inhalation. Approximately 5-6% of patients evaluated in the emergency departments for CO poisoning are treated with HBOT. CO binds to hemoglobin in red blood cells at the sites usually utilized to carry oxygen. Oxygen, especially hyperbaric oxygen, accelerates the clearance of CO from the body, restoring oxygen delivery to tissues of the body. Hyperbaric oxygen has been shown to block a number of other mechanisms of toxicity from CO.

The benefit of HBOT for patients treated more than 12 hours after CO exposure is unproven. Rapidly providing treatment will result in the best outcomes for the individual. All patients meeting the criteria should receive at least one treatment as soon after exposure as possible, with possible additional therapy to limit or prevent further complications.

Clostridial myostitis and myonecrosis (gas gangrene)
Gas gangrene is an acute, rapidly progressing infection of soft tissues caused by one of several bacteria known as clostridium. The organisms causing gas gangrene produce poisons, known as exotoxins, which are capable of liquefying adjacent tissue and inhibiting local defense mechanisms. The infection can destroy healthy tissue and spread over the course of hours.

Exposure to high amounts of oxygen inhibits replication, migration, and exotoxins production of clostridium. Clostridium bacteria are anaerobic, meaning only a low level of oxygen is needed

for it to grow. Repeated HBOT has the potential to slow progress of the infection while allowing antibiotics and surgical resection of infected tissue to control it. HBOT can decrease the intensity of surgery needed and can possibly prevent limb amputation that might otherwise be necessary.

HBOT should be implemented early in the treatment of these infections and can involve 2 to 3 daily sessions.*Crush injuries and other acute traumatic ischemias*
Crush injuries and other acute ischemias, most often compartment syndromes, can occur from severe trauma such as motor vehicle accidents, falls, and gunshot wounds. With severe injuries, complication rates can be as high as 50%. Infection, non-healing fractures, and amputations are complications that can be decreased with the use of HBOT.

Treatments should be started as soon as possible after an injury and continued for 7 – 10 days. The oxygen delivered to the injured tissue reduces swelling and provides an environment more conducive to healing and fighting infections.

Enhancement of healing of problematic wounds
Problematic wounds are those that fail to respond to established medical and surgical treatments. Generally, HBOT is reserved for hypoxic wounds where hypoxia can be measured and reversed with a trial of supplemental oxygen or while in a hyperbaric chamber. Most of these are associated with diabetes or non-diabetic vascular insufficiency that occurs due to multiple local and systemic factors contributing to inhibition of tissue repair. The HBOT increases the oxygen level in the blood and tissues, inducing significant changes in the wound repair process that promotes healing. Treatment of diabetic foot wounds has shown a potential to decrease the incidence of limb amputations. Treatment protocols may include treatment twice daily initially, then once daily after symptoms have reversed.

Severe anemia when unable to transfuse for medical or religious reasons
For the case of HBOT for severe anemia, there must be a loss of enough red blood cell mass to compromise sufficient oxygen delivery to tissue in patients who cannot be transfused. Reasons for inability to transfuse include the threat of blood product incompatibility, concern for transmissible disease, or prohibition of transfusion due to religious beliefs. Intermittent use of HBOT is essential due to the toxicity of prolonged oxygen administration.

Intracranial abscess
Brain abscess formation can be a severe complication of sinus or bone infections of the skull. There are frequently multiple abscesses which can be very difficult to treat. Surgical drainage may cause unavoidable damage to surrounding tissues. Fine needle aspiration is becoming more common and generally avoids the problem of extensive damage. White blood cells may not have enough oxygen to effectively eliminate the infection deep in the abscess, away from their normal blood supply. Antibiotics also may not penetrate well into the brain abscess.

Most of these abscesses are caused by anaerobic bacteria. In the same manner as the treatment of gas gangrene, HBOT increases the oxygen level, exposing bacteria to levels that may inhibit or kill them. It also provides oxygen to white blood cells that improves their killing power. HBOT should be implemented early in the treatment regime, with 2 to 3 daily 90 minute sessions.

Necrotizing soft tissue infections
Clinical syndromes included in necrotizing soft tissue infections include crepitant anaerobic cellulitis, progressive bacterial gangrene, necrotizing fasciitis, and nonclostridial myonecrosis. These may result from either a single strain or a mixed population of bacteria, typically occurring after trauma, surgery, and/or around foreign bodies. Generally these infections occur in compromised hosts and induce conditions that further compromise normal host defense mechanisms by decreasing tissue oxygen levels and impairing white blood cells.

When surgical and antibiotic treatment fails, HBOT should be considered as adjunct treatment in specific cases where risk of morbidity and mortality are high. Treatment should be individualized but may start with 2 sessions per day until extension of necrosis has been halted, then once daily.

Refractory osteomyelitis
HBOT can be used as adjunct therapy for the treatment of refractory osteomyelitis. Osteomyelitis cause by anaerobic bacteria can be successfully treated by directly killing or inhibiting the growth of these organisms. Osteomyelitis can be associated with reduced segmental blood flow and consequent reduced oxygen tension that may limit neutrophil and macrophage activity. HBOT may increase the oxygen tension in infected bone and lead to successful healing.

HBOT should be reserved for treatment of advanced stages or types of osteomyelitis (III or IV) which have been unresponsive to 4 weeks of culture-directed antibiotic therapy and surgical debridement. Daily treatments are likely for four to six weeks.

Delayed radiation injury (soft tissue and bony necrosis)
Chronic complications from radiation therapy result from scarring and narrowing of the blood vessels within the area which received treatment. This process can progress to the point of tissue or bone necrosis. The high dose oxygen from HBOT is carried in the blood to the site of injury to be available for repair of the damage done by the narrowed blood vessels. Treatments are generally daily for 1-2 hours, up to 60 days.

HOBT is also appropriate for prophylaxis for osteoradionecrosis in patients who are asymptomatic but require surgery in a field which was previously irradiated with at least 6,800 cGy. This generally occurs with dental abstraction following head and neck radiation.

Compromised skin grafts and flaps
Common causes for failure of skin grafts include previous radiation to the wound area, diabetes, and certain infections due to inadequate oxygenation of the wound bed. In these cases, HBOT can increase the oxygen to the wound bed both before and after skin grafting. Lack of oxygen supplied to a graft due to factors such as age, nutritional status, smoking, and previous radiation can result in inadequate blood flow to a new graft. HBOT can help minimize the amount of tissue which does not survive and also reduces the chance for repeat flap procedures.

Treatment regimens of 90 to 120 minutes daily for 6 to 30 days have been advocated. Initiation of therapy within 24 hours of grafting appears the most beneficial in these high risk cases.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2015, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
99183	Physician attendance and supervision of hyperbaric oxygen therapy, per session

HCPCS Codes	Description
G0277	Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
A42.81-A42.89	Other forms of actinomycosis
A48.0	Gas gangrene
D50.0	Iron deficiency anemia secondary to blood loss (chronic
D62	Acute posthemorrhagic anemia
E10.621	Type 1 diabetes mellitus with foot ulcer
E10.622	Type 1 diabetes mellitus with other skin ulcer
E11.621	Type 2 diabetes mellitus with foot ulcer
E11.622	Type 2 diabetes mellitus with other skin ulcer
I74.2	Embolism and thrombosis of arteries of the upper extremities
I72.3	Embolism and thrombosis of arteries of the lower extremities
I72.5	Embolism and thrombosis of iliac artery
L59.8	
L97.10-L97.929	Non-pressure chronic ulcer of lower limb, not elsewhere classified
M27.2	Inflammatory conditions of jaws
M27.8	Other specified diseases of jaws
M72.6	Necrotizing fasciitis
M86.30-M86.39	Chronic multifocal osteomyelitis
M86.40-M86.49	Chronic osteomyelitis with draining sinus

ICD-10-CM Code	Description
M86.50-M86.59	Other chronic hematogenous osteomyelitis
M86.60-M86.9	Other chronic osteomyelitis
M86.8X0-M86.8X9	Other osteomyelitis
O88.011-O88.03	Obstetric air embolism
S07.0XX+-S07.9XX+	Crushing injury of head
S17.0XX+-S07.9XX+	Crushing injury of neck
S28.0XX+-S28,229+	Crushing injury of thorax, and traumatic amputation of part of thorax
S35.511+-S35.513+	Injury of iliac artery
S38.001+-S38.03X+	Crushing injury and traumjatic amputation of abdomen, lower back, pelvis and external genitalia
S45.001+-S45.009+	Injury of axillary artery
S47.1XX+-S47.9XX+	Crushing injury of shoulder and upper arm
S48.011+-S48.929+	Traumatic amputation of shoulder and upper arm
S57.00X+-S57.82X+	Crushing injury of elbow and forearm
S67.00X+-S67.92X+	Crushing injury of wrist, hand and fingers
S68.011+-S68.729+	Traumatic amputation of wrist, hands and fingers
S75.001+-S75.099+	Injury of femoral artery
S77.00X+-S77.22X+	Crushing injury of hip and thigh
S85.001+-S85.009+	Unspecified injury of popliteal artery
S85.801+-S85.899	Injury of other blood vessels at lower leg level
S87.00X+-S87.82X+	Crushing injury of lower leg
S97.00X+-S97.82X+	Crushing injury of ankle and foot
T57.3X1+-757.3X4+	Toxic effect of hydrogen cyanide

ICD-10-CM Code	Description
T58.01X+-T58.94X+	Toxic effect of carbon monoxide
T66.XXX+	Radiation sickness, unspecified
T70.0XX+-T70.9XX+	Effects of air pressure and water pressure
T79.0	Air embolism (traumatic)
T79.A11+-T79.9XX+	Traumatic compartment syndrome
T80.0XX+	Air embolism following infusion, transfusion and therapeutic injection
T81.4XX+	Infection following a procedure
T85.693+	Other mechanical complication of artificial skin graft and decellularized allodermis
T85.81-T85.89	Other specified complications of internal prosthetic devices, implants and grafts, not elsewhere classified
T86.820-T86.829	Complications of skin graft (allograft) (autograft)

Reviews, Revisions, and Approvals	Date	Approval Date
Policy Developed		06/09
References reviewed and updated Added language regarding absolute contraindication to treatment.	08/10	08/10
References reviewed and updated	08/11	10/11
References reviewed and updated	10/12	10/12
State Specific Coverage table removed	05/13	
Removed coverage criteria for thermal burns and central retinal artery occlusion as evidence fails to demonstrate effectiveness for this indication Updated section for Contraindications to include additional items	10/13	10/13
Rephrased criteria sections to be more consistent with algorithm style questioning Updated criteria in II.C.1 to more clearly state guidance for treatment	10/14	10/14
Clarified timeframe language for medically necessary treatment sessions	01/15	01/15
Updated template References reviewed and updated	02/16	03/16
Corrected HCPCS code as C code retired and G is correct	09/16	09/16
Updated criteria under IB 3b to more clearly state guidance for treatment. In addition, clarified when additional treatments would be considered medically necessary. Removed IB 3c from policy Revised IB 6d to limit follow up treatments to an additional 10 sessions as guidelines state 20-40 postoperative HBOT sessions generally achieve sustained therapeutic benefit	03/17	03/17

Reviews, Revisions, and Approvals	Date	Approval Date
Revised IB 7a to state 30 sessions approved initially, up to a total of 60 sessions, in increments of 10 sessions. Revised IB 8 adding requirement for documentation supporting potential mechanical/surgical causes of flap compromise have been addressed or none are present. Revised number of sessions considered medically necessary. Added sudden sensory neural hearing loss as not medically necessary References reviewed and updated. ICD-10 codes added. Reviewed by specialist.		

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence

of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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CENTENE Corporation

Clinical Policy: Cosmetic and Reconstructive Surgery

Reference Number: CP.MP.31
Effective Date: 03/09 Revision Log
Last Review Date: 04/17

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Medical necessity criteria for cosmetic or reconstructive surgery.

Not all cosmetic procedures are listed in this policy. The Medical Director has the final decision to deny coverage for services deemed cosmetic in nature and not medically necessary.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that *reconstructive surgery* is considered **medically necessary** when performed to improve the function of a body part after conservative therapy when the abnormality results from an illness, trauma or a congenital defect. Certain reconstructive procedures may be covered if improving appearance is the only benefit, e.g. post-mastectomy breast reconstruction.* These procedures may include, but are not limited to:

A. Reconstruction due to trauma;
B. Skin tag removal when located in an area of friction with documentation of repeated irritation and bleeding (refer to Benefit Plan Contract);
C. Post-mastectomy or post significant lumpectomy resulting in asymmetry: breast reconstruction, including nipple reconstruction, tattooing and surgery on contralateral breast to restore symmetry;
D. Scar/keloid revisions/removal for members < 18 years old when accompanied by pain unresponsive to standard therapy and are recurrently infected, unstable, friable, or with functional impairment.

Refer to the most current version of the Health Plan adopted nationally recognized decision support tools for other procedures that may be considered cosmetic in certain cases.

*Note: This includes reconstruction after prophylactic mastectomy with BRCA mutation if the mastectomy is a covered benefit in the State.

II. It is the policy of Health Plans affiliated with Centene Corporation that *cosmetic surgery* is **not medically necessary** and generally not a covered benefit when performed to improve a patient's normal appearance and self-esteem. These procedures include, but are not limited to:

A. Excision of excessive skin
B. Body contouring
C. Body lift
D. Breast augmentation
E. Liposuction, excluding lipoma as directed by InterQual® criteria
F. Surgery to correct unsatisfactory results from previous cosmetic and/or non-covered service

G. Revision, removal, or replacement of breast implants previously placed for cosmetic reasons
H. Removal of excess skin or body contouring procedures following weight loss or bariatric surgery when removal is solely cosmetic
I. Facial augmentation
J. Abdominoplasty
K. Dermabrasion
L. Skin rejuvenation and resurfacing
M. Electrolysis, laser hair removal
N. Hair replacement
O. Tattooing (except when covered for breast reconstruction post-mastectomy)
P. Injectable filler
Q. Circumcision revisions done only to improve appearance

Medical records must accompany all requests for plastic and reconstructive surgery, photographs are also commonly needed. Proof of conservative therapies attempted must be documented when applicable.

Background

Reconstructive surgery is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, previous or concurrent surgeries, trauma, infection, tumors or disease. It is generally performed to improve the functioning of a body part and may or may not restore a normal appearance. Functional impairment is a health condition in which the normal function of a part of the body or organ system is less than age appropriate at full capacity, such as decreased range of motion, diminished eyesight or hearing, etc. that variably impacts activities of daily living.

Cosmetic surgery is performed to reshape normal structures of the body in order to improve the appearance and self-esteem of a patient. It is generally not considered medically necessary. This policy will provide general guidelines as to when cosmetic and reconstructive surgery is or is not medically necessary.

Reviews, Revisions, and Approvals	Date	Approval Date
References reviewed and updated	04/13	05/13
Added additional examples of procedures commonly considered medically necessary and not medically necessary	04/14	05/14
Added criteria for panniculectomy Added definition for functional impairment in Description Clarified language under scar/keloid revisions for members < 18 years Added “medical-record documented” therapy in II.B	03/15	04/15
Template updated References reviewed Criteria for panniculectomy removed and placed into CP.MP.109	04/16	04/16
References reviewed and updated	4/17	04/17

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Important Reminder

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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CENTENE Corporation

Clinical Policy: Hyperemesis Gravidarum Treatment

Reference Number: CP.MP.34
Effective Date: 03/09
Last Review Date: 06/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Hyperemesis gravidarum is a term reserved to describe the most severe cases of nausea and vomiting in pregnancy (NVP). It results from severe nausea and vomiting, and the resultant inability to rehydrate and replenish nutritional reserves. A diagnosis of hyperemesis gravidarum is best made when it is based on objective findings such as moderate to large ketonuria and weight loss. Weight loss of 5% or greater is often described as diagnostic of hyperemesis gravidarum but this is not to suggest that measures to improve nausea and vomiting should not be undertaken prior to this. Hyperemesis gravidarum tends to begin earlier in pregnancy and last longer than those patients with less severe NVP.

When the step-approach algorithm does not allow for continued adequate hydration of the patient, intravenous (IV) infusion or subcutaneous (SQ) micropump infusion of metoclopramide or ondansetron can allow for treatment until the patient can reliably take oral medications. The ability to perform activities of daily living, tolerate most food intake, and take oral medications are measures that objectively and subjectively instruct the practitioner as to the value of these therapies. When these therapies have allowed the patient to return to the above states of function, they can be discontinued. Oral therapies can be used in conjunction with IV and SQ infusion if tolerated. There is not a place for continuous, long-term IV or SQ infusion of medications to manage hyperemesis if the patient is functioning as described above.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that Hyperemesis Gravidarum Treatment is **medically necessary** when meeting the following criteria:

A. *IV infusion or SQ micropump infusion of metoclopramide or ondansetron* for the treatment of intractable hyperemesis gravidarum (must meet all):

1. Failed at least one drug in each step of the step therapy approach listed in Table 1 below;
2. Other potential causes of nausea and vomiting have been ruled out;
3. Information about symptoms, food intake, urinary ketones, urine specific gravity, and daily weights is supplied;
4. Clinical signs of hyperemesis gravidarum, including nausea and vomiting, have been persistent for ≥3 weeks;
5. Within this time there has been documented weight loss and dehydration or electrolyte abnormalities.

Infusion may be approved at 2-week intervals based on the patient's response to therapy.

1. Non-responder - If injectable/intravenous antiemetics have offered no improvement, they should be discontinued.

2. Responder - If the patient is symptom-free with minimal vomiting and nausea and no dehydration for five days, the therapy can be discontinued.
3. Partial responder - If the patient does not meet non-responder or responder criteria, the therapy should continue. An additional 10-14 days are recommended before further reauthorization is required.

B. *Home enteral therapy* for maternal weight loss secondary to hyperemesis (must meet all):
1. Attempted and failed the step therapy approach listed in Table 1 below;
2. Other potential causes of nausea and vomiting have been ruled out;
3. Information about symptoms, food intake, urinary ketones, urine specific gravity, and daily weights is supplied;
4. Clinical signs of hyperemesis gravidarum, including nausea and vomiting, have been persistent for ≥3 weeks;
5. Within this time, there has been documented weight loss and dehydration or electrolyte abnormalities;
6. Enteral therapy is started in the hospital.

Therapy may be approved at intervals of 5 to 21 days, based on the individual member's needs.

C. *Parenteral therapy with home total parenteral nutrition (TPN)* for the management of intractable hyperemesis gravidarum (must meet all):
1. Attempted and failed the step therapy approach listed in Table 1 below;
2. Other potential causes of nausea and vomiting have been ruled out;
3. Information about symptoms, food intake, urinary ketones, urine specific gravity, and daily weights is supplied;
4. Clinical signs of hyperemesis gravidarum, including nausea and vomiting, have been persistent for ≥3 weeks;
5. Within this time, there has been documented weight loss and dehydration or electrolyte abnormalities;
6. There has been over 5% weight loss since the beginning of pregnancy and the member is over 14 weeks pregnant;
7. The patient has failed IV or SQ Zofran or Reglan therapy;
8. The patient has failed, or is not a candidate for, enteral therapy (nausea is unrelated to olfactory or gustatory cues);
9. The member has been fully consented as to the risks of line infection, bacteremia, sepsis, thrombosis, and fetal loss;
10. A peripherally inserted central catheter (PICC) line is started in the hospital.

Therapy may be approved at intervals of 5 to 14 days based on the individual member's needs.

Background

Hyperemesis gravidarum and NVP are self-limiting problems given appropriate time, dietary adjustments, intensive support, and counseling. The presentation is often a symptomatic issue and not an issue of dehydration. Intense nausea with small amounts of emesis needs to be

differentiated from true hyperemesis and associated dehydration. Therapeutic decisions should be based on the clinical presentation and objective findings.

Step-therapy approaches that begin with monotherapy and add medicines with different mechanisms of anti-emetic action are the most effective treatment regimes. A step-therapy algorithm should result in satisfactory treatment for the majority of patients with "hypernausea" or hyperemesis gravidarum. Time, oral intake, psychotherapy, education, and intensive support should allow for the patient to eventually return to a state where she can again function and eat properly.

Table 1: Nausea and vomiting in pregnancy step-therapy
If there is not improvement after the first step, proceed to the next. Dosages and frequency may be adjusted based on tolerability and improvement in symptoms.

- Initial therapy, one of the following:
  - Pyridoxine (vitamin B_6) 10-25 mg by mouth (PO) every 6-8 hours;
  - Ginger 250 mg capsules four times daily;
  - Pyridoxine (vitamin B_6) 10-25 mg and doxylamine (Unisom) 12.5 mg PO every 6-8 hours (equivalent to Diclegis);
  - Dimenhydrinate (Dramamine) 50-100 mg PO every 4-6 hours;
  - Promethazine 12.5 – 25 mg PO, rectal suppository or IM every 4 hours;
  - Prochlorperazine 5 to 10 mg PO or IV every 6 -8 hours, or 25 mg rectally twice daily;
  - Diphenydramine 25 to 50 mg PO or 10 to 50 mg IV every 4 to 6 hours as needed;
  - Meclizine 25 mg PO every 4 to 6 hours as needed.
- Step 2, one of the following:
  - Metoclopramide (Reglan) 5 - 10 mg PO, intramuscularly, or IV, three times daily or four times daily;
  - Ondansetron (Zofran) 4 or 8 mg PO twice daily or three times daily. Zofran oral disintegrating tablets may be more useful.

Failed outpatient management, multiple hospitalizations, electrolyte disturbances, and/or persistent weight loss might necessitate long term venous access for fluid and electrolyte replacement and possible supplemental nutrition. The overall percentage of patients with nausea and vomiting in pregnancy requiring parenteral nutrition or IV anti-emetic therapy is very small.

Complications
Hyperemesis gravidarum and its effects are rarely the cause of fetal morbidity or mortality or of maternal mortality. Maternal death, however, has been reported to have occurred in 10% of cases before modern medicine. It is the most common cause of hospitalization in the first half of pregnancy.

Other reported maternal complications of hyperemesis gravidarum are:

- Wernicke's encephalopathy
- Beriberi
- Central pontine myelinolysis
- Hepatic insufficiency
- Acute tubular necrosis
- Peripheral neuropathy

- Traumatic damage to the esophagus, retina, or spleen secondary to vomiting

Management
There is no single accepted method of management of NVP and hyperemesis gravidarum. Commonalities are the treatment of the nausea itself, hydration, and alteration in diet. Frequent, small meals, higher protein, lower carbohydrate meals, and meals that are higher in liquid content all have some scientific validity as a means to lessen the problem.

Fear of medication is one of the most common reasons for under-treatment of NVP. This may come from the patient, her family, or the medical office. The common oral therapies have been shown to be safe. There is more potential for harm when there is untreated hyperemesis gravidarum that leads to hospitalization and risk for iatrogenic problems such as IV site infection, versus treatments for hyperemesis gravidarum. Untreated hyperemesis gravidarum also increases the chance that an underlying undiagnosed problem other than NVP could worsen.

There is one FDA-approved prescription drug for the treatment of NVP, Diclegis, which was approved on April 9, 2013. Diclegis is a combination of doxylamine succinate 10mg and pyridoxine hydrochloride (Vit B6) 10mg. Doxylamine and pyridoxine are both available in over-the-counter formulations. Off-label uses of many other drugs have been supported by the literature and ACOG in regards to safety.

It should also be kept in mind that gastroesophageal reflux can affect up to 50% of pregnancies. Associated symptoms are heartburn, belching, nausea, and early satiety. A therapeutic trial of ranitidine is safe and often effective. There is the possibility of mild underlying chronic gastric problems such as gastritis. These would be undetected and the patient would not be a candidate for endoscopy.

Step-therapy approaches that add medicines with different mechanisms of anti-emetic action are the most effective treatment regimes. Decisions as to the need for home IV hydration should be made alongside decisions of treatment of nausea and vomiting. IV hydration alone, with SQ/IV medication, or following SQ/IV medication regimes often play a necessary role. Clinicians should include measures of hydration (specific gravity, rapid weight loss, ketonuria) in their assessment of the patient's status and not rely only on the verbal reports of nausea and vomiting when considering ongoing care.

When considering long term IV or SQ access for severe hyperemesis treatment, the risks must be weighed against the benefits carefully. Risks of PICC line complications in the gravid patient have been documented.

A 2007 study[4] looked at three treatment methods for ninety-four patients that were stratified into:
1) management with intravenous medication alone,
2) management with nasogastric or nasoduodenal tube, and
3) management with placement of a PICC line.

The enteral and parenteral nutrition patients also had medical therapy. All of the patients in the IV therapy arm had at least two medications. Five of the thirty-three patients with a PICC line

also had TPN. Each patient was admitted for the treatment of nausea and vomiting, ketonuria, and electrolyte disturbances. The authors described the differences as "striking." The study showed that serious complications, i.e., bacteremia, sepsis, and thrombosis, were observed in the *majority* of the PICC line group. There were three fetal losses in the PICC line group, including an intrauterine demise at 20 weeks that resulted from infection of a PICC line placed at 12 weeks. There were no significant differences in neonatal outcomes in regards to fetal weight at delivery, gestational age at delivery, and Apgar scores. There were more admissions to the NICU in the PICC line group. The authors concluded that due to severe, life-threatening complications, the use of "PICC lines for the management of hyperemesis is rarely indicated and, except in specific circumstances, should be avoided."

A nutritional strategy that is often underutilized is enteral feeding using pediatric nasogastric tubes. This has been used with success in patients with intractable nausea, vomiting, weight loss, and hospitalization. One study[5] looked at seven patients who had strong gustatory and olfactory cues who used enteral feedings. In each case there was improvement within 24 hours. Six patients were discharged with continued out-patient enteral feeds. Oral liquids were tolerated by all patients within 2-5 days.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2016, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour
96361	Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)

HCPCS Codes	Description
S9364	Home infusion therapy, total parenteral nutrition (TPN); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem (do not use with home infusion codes S9365-S9368 using daily volume scales)
S9365	Home infusion therapy, total parenteral nutrition (TPN); 1 liter per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula

	(lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem
S9366	Home infusion therapy, total parenteral nutrition (TPN); more than 1 liter but no more than 2 liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem
S9367	Home infusion therapy, total parenteral nutrition (TPN); more than 2 liters but no more than 3 liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem
S9368	Home infusion therapy, total parenteral nutrition (TPN); more than 3 liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
E51.11-E51.12	Beriberi (Dry and/or wet)
E51.2	Wernicke's encephalopathy
E86.0	Dehydration
E87.8	Other disorders of electrolyte and fluid balance, not elsewhere classified
G37.2	Central pontine myelinolysis
K72.00	Acute and subacute hepatic failure without coma
N17.0	Acute kidney failure with tubular necrosis
O21.0	Mild hyperemesis gravidarum
O21.1	Hyperemesis gravidarum with metabolic disturbance
O21.2	Late vomiting of pregnancy
O26.821-O26.823	Pregnancy related peripheral neuritis (First, second &/or third trimester)
R63.4	Abnormal weight loss
R82.4	Acetonuria (Ketonuria)

Reviews, Revisions, and Approvals	Date	Approval Date
References reviewed and updated; Updated Authorization Protocols with reauthorization criteria and description.	4/12	4/12
Added Diclegis as new FDA approved drug for hyperemesis and clarified that Doxylamine and pyridoxine are both available as OTC meds	5/13	6/13
References reviewed and updated	6/14	6/14

Reviews, Revisions, and Approvals	Date	Approval Date
Moved majority of description information to background section Converted Algorithm for treatment into Table 1 Reorganized policy/criteria section into appropriate numbering bullets and reworded section. Clarified approval intervals language Removed prognosis and differential diagnosis sections Clarified step therapy requirements into 2 steps	6/15	6/15
Converted to new template Added promethazine, prochlorperazine, diphenhydramine and meclizine to initial step therapy per UpToDate treatment algorithm. Reviewed by specialist.	5/16	06/16
Minor wording changes to background for clarity. References reviewed and updated.	06/17	06/17

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Important Reminder

CLINICAL POLICY
Hyperemesis Gravidarum Treatment

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CLINICAL POLICY
Hyperemesis Gravidarum Treatment

Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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CENTENE Corporation

Clinical Policy: Experimental Technologies

Reference Number: CP.MP.36
Effective Date: 06/09
Last Review Date: 09/17 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
This policy outlines general guidelines to use in determining coverage of experimental or investigational or potentially experimental or investigational medical and behavioral health technologies. These guidelines are to be used only when there is no other policy, criteria, or coverage statement available.

Policy
It is the policy of health plans affiliated with Centene Corporation® ("Health Plans") that all coverage determinations regarding technologies (i.e., drugs, procedures, devices, services, or supplies) that are or may be considered experimental or investigational must be considered on a case-by-case basis by a physician or ad hoc committee and must be made in accordance with the Benefit Plan Contract provisions and applicable state and federal requirements.

A technology is considered experimental or investigational if it meets any of the following criteria:

A. It is currently the subject of active and credible evaluation (e.g., clinical trials or research) to determine:
   1. Clinical efficacy, *or*
   2. Therapeutic value or beneficial effects on health outcomes, *or*
   3. Benefits beyond any established medical based alternatives.

B. It does not have final clearance from applicable governmental regulatory bodies (such as the US Food and Drug Administration "FDA") and unrestricted market approval for use in the treatment of a specified medical condition or the condition for which authorization of the service is requested and is the subject of an active and credible evaluation.

C. The most recent peer-reviewed scientific studies published or accepted for publication by nationally recognized medical journals do not conclude, or are inconclusive in finding, that the service is safe and effective for the treatment of the condition for which authorization of the service is requested.

Under no circumstances is this policy to be construed as an acknowledgement or acceptance by the Health Plans of any obligation to cover experimental or investigational technologies where such technologies are not included in the benefits set forth in the Benefit Plan Contract or by applicable state and federal requirements. The Plan reserves the right to refuse coverage of an experimental or investigational technology on the grounds that such coverage is not required under the member's benefit plan. Approval of an experimental technology with respect to a particular case does not guarantee coverage of the same technology with respect to any other cases.

Criteria

The criteria listed below should be weighed when evaluating the medical necessity of a technology that is or may be experimental or investigational. Where medical necessity of a technology is confirmed under this policy, steps should be taken to ensure that the technology is furnished by a participating or in-state provider to the extent possible.

A. The technology should have final approval from appropriate governmental regulatory bodies. Regulatory bodies include the U.S. Food and Drug Administration (FDA) or any other governmental body with authority to regulate the technology. The indication for the technology under review does not need to be the same indication for which the technology has been approved.

If a request is for coverage of routine costs as part of a clinical trial, see CP.MP.94 Clinical Trials.

B. At least two studies published in peer-reviewed medical literature should be available that would support conclusions regarding the effect of the technology and its likely net health impact. Such studies must, by the standards of accepted medical research, be well-designed and well-conducted investigations yielding quality and consistent results, and the results of such studies should demonstrate the effect the technology will have on the disease, injury, illness, or condition in question.

The opinions and evaluations of national medical associations, consensus panels, and other technology evaluation bodies, or other specialists or professionals who are subject matter experts with respect to the technology, may be taken into consideration according to the scientific quality of the supporting evidence and rationale for such opinions and evaluations.

C. The technology should be used to improve net health outcome of a severely disabling or life-threatening condition. The health benefits of the technology must outweigh any harmful effects or risks to the member.

D. Other established treatment alternatives to the technology should have been exhausted and failed or no established treatment exists.

E. The improvement to be gained by employing the technology should be attainable outside the control setting (i.e., in practice).

F. In the case of diagnostic procedures, it is anticipated that the results of the procedure will help determine the best plan of care. There must be some potential intervention or alteration to the current plan of care based on the diagnostic results.

G. The member fully understands the risks and benefits regarding the requested technology or treatment and has given informed consent.

Reviews, Revisions, and Approvals	Date	Approval Date
Moved information from Authorization Protocols to Policy section. Added reference to CP.MP.94 Clinical Trials	10/14	10/14
Removed "To the extent coverage….administrative reasons" sentence from 1st paragraph under criteria Converted into new template	10/15	10/15
Redefined experimental/investigational per Health Net definition.	09/16	09/16
References reviewed and updated.	09/17	09/17

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or

regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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CENTENE Corporation

Clinical Policy: Bariatric Surgery

Reference Number: CP.MP.37
Effective Date: 06/09
Last Review Date: 08/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

There are two categories of bariatric surgery: restrictive procedures and malabsorptive procedures. Gastric restrictive procedures include procedures where a small pouch is created in the stomach to restrict the amount of food that can be eaten, resulting in weight loss. The laparoscopic adjustable gastric banding (LAGB) and laparoscopic sleeve gastrectomy (LSG) are examples of restrictive procedures. Malabsorptive procedures bypass portions of the stomach and intestines causing incomplete digestion and absorption of food. Duodenal switch is an example of a malabsorptive procedure. Roux-en-y gastric bypass (RYGB), biliopancreatic diversion with duodenal switch (BPD-DS), and biliopancreatic diversion with gastric reduction duodenal switch (BPD-GRDS) are examples of restrictive and malabsorptive procedures.

LAGB devices are currently not FDA approved for adolescents less than 18 years, but an industry-sponsored prospective study is in progress, and numerous retrospective studies of adolescents have been published with favorable results.

Policy/Criteria

It is the policy of health plans affiliated with Centene Corporation® that the bariatric surgery procedures LAGB, LSG, and laparoscopic RYGB for adolescents and adults and laparoscopic BPD-DS/BPD-GRDS for adults are **medically necessary** when meeting the following criteria under **section I *and* II:**

I. Medical history, meets all of the following:

A. Age and BMI (meet criteria in 1 *or* 2)

1. Age ≥ 18 years and (a or b):
   a. BMI ≥ 40 kg/m², or;
   b. BMI ≥ 35 and < 40 kg/m² with at least *one* of the following comorbidities:
      i. Type 2 diabetes mellitus (DM)
      ii. Poorly controlled hypertension
      iii. Dyslipidemia
      iv. Obstructive sleep apnea
      v. Obesity-hypoventilation syndrome/Pickwickian syndrome
      vi. Nonalcoholic fatty liver disease or nonalcoholic steatohepatitis
      vii. Gastroesophageal reflux disease (GERD)
      viii. Asthma
      ix. Venous stasis disease
      x. Severe urinary incontinence
      xi. Osteoarthritis (hip, knees and/or ankles)
      xii. Pseudotumor cerebri
2. Age < 18 years and (a or b):
   a. BMI ≥ 40 kg/m² with at least *one* comorbidity listed below that is uncontrolled with lifestyle or pharmacotherapy management:
      i. Hypertension
      ii. Dyslipidemias
      iii. Nonalcoholic steatohepatitis
      iv. Venous stasis disease

v. Significant impairment of activities of daily living
vi. Intertriginous soft-tissue infections
vii. Stress urinary incontinence
viii. GERD
ix. Weight related arthropathies that impair physical activity
x. Obesity related psychosocial distress

b. BMI ≥ 35 kg/m² with at least *one* severe comorbidity listed below that has significant short-term effects on health that is uncontrolled with lifestyle or pharmacotherapy management:
   i. Type 2 DM
   ii. Obstructive sleep apnea
   iii. Pseudotumor cerebri
   iv. Severe and progressive steatohepatitis

B. Continued obesity despite previous weight loss attempts unless waiting for attempted weight loss could result in worsening of a health condition.

II. P**reoperative evaluation and medical clearance** requirements within 6 months of the scheduled surgery include *all* of the following:

A. Cardiac evaluation includes an electrocardiogram and *one* of the following categories (1 *or* 2):
   1. LOW CARDIAC RISK candidates need cardiac clearance by a PCP or cardiologist. If additional testing is needed, it should be conducted by a cardiologist. Low risk candidates include those with all of the following:
      a. 1 or fewer comorbidities;
      b. No known ischemic heart disease;
      c. Age < 40 years with < 2 comorbidities;
      d. No known structural heart disease or murmurs;
   2. HIGH CARDIAC RISK candidates need consultation/evaluation and cardiac clearance from a cardiologist. High risk candidates include those with any of the following:
      a. Diabetes type I for any duration or type II for > 5 years;
      b. Uncontrolled hypertension;
      c. Structural heart disease;
      d. Ischemic heart disease or have had a cardiac event;
      e. Congestive heart failure;
      f. Arrhythmia or history of arrhythmia;
      g. Age > 40 years with ≥ 2 comorbidities.

B. Glycemic control should be optimized as evidenced by *one* of the following:
   1. HbA1c 6.5 - 7.0%;
   2. Fasting blood glucose level of ≤ 110 mg/dL;
   3. 2-hour postprandial blood glucose concentration of ≤ 140 mg/dL;
   4. HbA1c of 7 - 8% in candidates with advanced microvascular or macrovascular complications, extensive co-morbid conditions, or long-standing diabetes in which the general goal has been difficult to attain despite intensive efforts.

C. Pulmonary Evaluation:
   1. Chest x-ray;

2. Screening for obstructive sleep apnea;
3. Pulmonary function testing and arterial blood gas analysis for candidates with intrinsic lung disease or disordered sleep patterns;
4. Polysomnography (PSG) for evaluation of obstructive sleep apnea in members who meet at least *one* of the following criteria for PSG:
   a. Recurrent witnessed apnea during sleep > 10 seconds in duration;
   b. Excessive or inappropriate daytime sleepiness such as falling asleep while driving or eating;
   c. Sleepiness that interferes with daily activities not explained by other conditions, such as poor sleep hygiene, medication, drugs, alcohol, psychiatric or psychological disorders;
   d. Having an Epworth Sleepiness Scale score > 10;
   e. Persistent or frequent disruptive snoring, choking or gasping episodes associated with awakenings;
5. Specialist should be consulted for interpretation of any abnormal findings.

D. Physical maturity (age < 18 years) - completed 95% of predicted adult stature based on bone age or reaching Tanner stage IV.

   Bone age is determined by an x-ray of the wrist and hand that gives an estimate of how mature a child's bones are in years. Using this bone age and other factors, the child's predicted adult height may be calculated. The percent of adult height achieved is simply the child's current height divided by the predicted adult height times 100.

E. Nutritional evaluation, including micronutrient measurements and treatment of insufficiencies/deficiencies prior to surgery.

F. Nutritional therapy/counseling
   1. Initial comprehensive diet history to include assessment of current pattern of nutrition and exercise and steps to modify problem eating behaviors;
   2. Monthly nutritional counseling until the date of the surgery;
   3. Prescribed exercise program;
   4. Must provide documentation that counseling has been conducted regarding the potential for success of weight loss surgery dependent on post-op diet modification (if patient < 18 years of age, consultation must be with adolescent AND parent/guardian).

G. Age appropriate psychiatry/psychology consultation including all of the following:
   1. An in-person psychological evaluation to assess for major mental health disorders which would contradict surgery and determine ability to comply with post-operative care and guidelines;
   2. If history is positive for alcohol or drug abuse, meets both of the following:
      a. Must provide documentation of alcohol and drug abstinence for ≥ 1 year prior to surgery;
      b. Negative urine drug screen within 3 months of request;

3. If age < 18 years: evaluation must also include assessment of emotional maturity, decisional capacity, family support and family willingness to participate in lifestyle changes.

H. Members at risk for primary hypothyroidism are screened with a TSH level and treated if found to be hypothyroid.

I. A fasting lipid panel must be obtained and treatment initiated for dyslipidemia.

J. Screening for Helicobacter pylori in high-prevalence areas.

K. Prophylactic treatment for gouty attacks in patients with a history of gout.

L. If tobacco user, must stop use > 6 weeks prior to surgery.

III. Repeat Surgeries

A. Repeat bariatric surgery is considered medically necessary for one of the following:
   1. To correct complications from a previous bariatric surgery, such as obstruction or strictures;
   2. Conversion from LAGB to a RYGB or BPD-DS; or revision of a primary procedure that has failed due to dilation of the gastric pouch when all of the following criteria are met:
      a. All criteria listed above for the initial bariatric procedure must be met again;
      b. Previous surgery for morbid obesity was at least 3 years prior to repeat procedure;
      c. Weight loss from the initial procedure was less than 50% of the member's excess body weight at the time of the initial procedure;
      d. Documented compliance with previously prescribed postoperative nutrition and exercise program. If non-compliant with postoperative regimen, member will be required to take part in an established multidisciplinary bariatric program to meet all of the initial surgery criteria listed above;
      e. Supporting documentation from the provider should also include a clinical explanation of the circumstances as to why the procedure failed and if initial procedure failure was related to non-compliance with diet then why the requesting provider feels member will be compliant with diet after repeat surgery.

IV. Contraindications for surgical weight loss procedures include:

A. Medically correctable causes of obesity;
B. An ongoing substance abuse problem within the preceding year;
C. Untreated major depression or psychosis;
D. Uncontrolled and untreated eating disorders (eg, bulimia);
E. A medical, psychiatric, psychosocial, or cognitive condition that prevents adherence to post-operative dietary and medication regimens or impairs decisional capacity;
F. Current or planned pregnancy within 12 to 18 months of the procedure;
G. Severe cardiac disease with prohibitive anesthetic risks;
H. Severe coagulopathy;

I. Inability on the part of the patient or parent (if adolescent) to comprehend the risks and benefits of the surgical procedure.

V. It is the policy of health plans affiliated with Centene Corporation® that the following bariatric surgery procedures are considered **investigational,** because the medical literature indicates that studies have been inadequate to determine their efficacy and long-term outcomes:
A. Distal gastric bypass (very long limb gastric bypass);
B. Loop Gastric Bypass ("Mini-Gastric Bypass");
C. Laparoscopic re-sleeve gastrectomy (LRSG) performed after the resulting gastric pouch is primarily too large or dilates after the original LSG;
D. Fobi pouch;
E. Laparoscopic greater curvature plication (Gastric Imbrication);
F. LAP-BAND when BMI is 30 to 35 with or without comorbid conditions;
G. AspireAssist;
H. Endoscopic Suture Revisions post bariatric surgery.

VI. It is the policy of health plans affiliated with Centene Corporation® that the following bariatric surgery procedures are considered **not medically necessary,** due to potential complications and a lack of positive outcomes:
A. Biliopancreatic diversion (BPD) procedure (also known as the Scopinaro procedure);
B. Jejunoileal bypass (jejuno-colic bypass);
C. Vertical Banded Gastroplasty (VBG);
D. Gastric balloon;
E. Gastric pacing;
F. Gastric wrapping.

Background
There is sufficient evidence in peer-reviewed medical literature to support the use of the above mentioned bariatric surgeries for the clinically obese individual. Persons with clinically severe obesity are at risk for increased mortality and multiple co-morbidities. These co-morbidities include hypertension, hypertrophic cardiomyopathy, hyperlipidemia, diabetes, cholelithiasis, obstructive sleep apnea, hypoventilation, degenerative arthritis and psychosocial impairments.

The majority of severely obese patients losing weight through non-operative methods alone regain all the weight lost over the next five years. Surgical treatment is the only proven method of achieving long term weight control for the morbidly obese. Eating behaviors after surgery improve dramatically due to the restricted size of the stomach allowing only small amounts of food to be taken in at a time.

The success of the bariatric surgery does rely on the motivation and dedication to the program of the patient. The patient must be able to participate in the treatment and long-term follow up required after surgery. Studies have shown that about 10% of patients may have unsatisfactory weight loss or regain much of the weight they have lost. This may occur due to frequent snacking on high-calorie foods or lack of exercise. Technical problems that may occur include a

stretched pouch due to overeating following surgery. Ensuring patients are motivated to lose weight can help prevent some of these issues.

Maximum weight loss usually occurs between 18 and 24 months postoperatively. The average weight loss at five years ranges from 48 to 74% after gastric bypass and 50 to 60% following gastric banding. Several studies have follow-up from 5-15 years with these patients maintaining weight loss of 50-60% of excess weight.

The Lap Band is a small bracelet-like band placed around the top of the stomach to produce a small pouch about the size of a thumb. The size of the outlet is controlled by a circular balloon inside the band that can be inflated and deflated with saline solution through an access port placed under the skin. The more inflated the balloon, the narrower the opening and slower passage of food to the rest of the stomach.

Roux-en-Y gastric bypass (RYGB) creates a small stomach pouch, bypassing most of the stomach, duodenum, and upper intestine. Weight loss occurs through restriction of food intake and by decreasing the absorption of food by re-routing food directly from the pouch into the small intestine.

Biliopancreatic diversion with duodenal switch (BPD-DS) is a complex operation that includes 1) removing a large portion of the stomach to promote smaller meal sizes, 2) re-routing of food away from much of the small intestine to partially prevent absorption of food, and 3) re-routing of bile and other digestive juices which impair digestion. The operation bypasses most of the duodenum, but leaves a small portion for food and the absorption of some vitamins and minerals. BPD-DS produces significant weight loss, but has a greater risk of long-term complications due to decreased absorption of food, vitamins, and minerals.

There are both early and later complications associated with these operations. Early complications can include bleeding, infections, leaks from suture sites and blood clots. Strictures, hernias, and malnutrition, especially when not taking prescribed vitamins and minerals, are all late complications that can occur in addition to the above mentioned stretched pouch or separated stitches. A repeat surgery is at times required to repair some of these complications.

Bariatric Surgery in Adolescents
Weight loss surgery has been performed in small groups of adolescents since the 1970s. Recent data has shown a significant increase in the rate since 2000. It is likely that we will continue to see a rise in the rate of adolescents undergoing weight loss surgery with the current pediatric obesity epidemic. Children and adolescents who are severely obese are at risk for the same mortality and co-morbidities as adults. These co-morbidities include hypertension, hypertrophic cardiomyopathy, hyperlipidemia, diabetes, cholelithiasis, obstructive sleep apnea, depression and impaired quality of life. In addition, children in the BMI category ≥ 35 kg/m^2 will almost always remain obese and 65% will have a BMI ≥ 40 as an adult.

Changes in diet and physical activity must be attempted prior to weight loss surgery in adolescents. A multi-disciplinary, family-based approach should be undertaken to support a

staged weight loss plan. However, studies suggest that dietary and behavioral interventions rarely result in significant and sustained weight loss in adolescents. This same multi-disciplinary and family approach must be taken when evaluating and planning for bariatric surgery in an adolescent.

The multi-disciplinary team should include an experienced bariatric surgeon, pediatric obesity specialist, nurse, dietician, and pediatric psychologist or psychiatrist. Additional sub-specialists must be readily available for evaluation of co-morbidities. The success of the bariatric surgery does rely on the motivation and dedication to the program of the patient and their family. The patient and family must be willing and able to participate in the treatment and long-term follow up required after surgery. The adolescent must show evidence of mature decision-making with appropriate understanding of the risks and benefits of surgery.

Current existing retrospective data on adolescent weight loss surgery demonstrate that both bypass and banding lead to clinically significant and durable decrease in weight loss and BMI. Obesity-related diseases also improve or resolve after surgically induced weight loss in adolescents. There have not been enough studies to indicate what the long-term weight loss sustainability is in adolescents. Specific predictors of weight regain after bariatric surgery are still unknown.

Investigational Procedures
Long-limb or Distal Gastric Bypass for Superobesity: An RCT has recently been completed by Svanevik et al., but only perioperative outcomes have been reported thus far. Svanevik et al. found that in superobese patients with BMI between 50 and 60 kg/m(2), distal gastric bypass was associated with longer operating time and more severe complications resulting in reoperation than proximal gastric bypass. There is increased risk of adverse nutritional outcomes with longer limb gastric bypass. At this time the long-limb or distal gastric bypass for superobesity is considered investigational, until more long-term studies can be done which reflect better outcomes than existing procedures.

Loop Gastric Bypass (Mini Gastric Bypass): The mini gastric bypass has not been universally accepted due to higher rates of alkaline bile reflux and limited long-term research. More long-term research is needed to solidify mini gastric bypass surgery's position as a viable bariatric surgery option.

Re-Sleeve Gastrectomy for Failed Laparoscopic Sleeve Gastrectomy: Iannelli et al. (2012) noted that laparoscopic sleeve gastrectomy (LSG) was rapidly accepted as a valuable bariatric procedure before its effectiveness on weight loss in the long-term is clearly demonstrated. The authors report a feasibility study including 13 patients undergoing a redo LSG for either progressive weight regain after initial weight loss of insufficient weight loss. AlSabah et al. describe 24 patients who underwent re-sleeve laparoscopic gastrectomy after an initial LSG. Compared to 12 patients that initially had LSG, which was converted to LRYGB, results were similar, with no significant differences in percent of excess weight loss at one year. They conclude that larger and longer follow-up studies are needed to verify results.

Fobi Pouch or Silastic® Ring: The Fobi Pouch bariatric operation for obesity is a combination of stomach reduction and gastric bypass. The Silastic ring is placed around the vertically constructed gastric pouch above the anastomosis between the pouch and the intestinal Roux limb. Possible long term nutritional deficiencies involve fat soluble vitamin deficiencies of Calcium, Iron, B12, and Folic Acid. Patients are placed on nutritional supplements for the rest of their lives, and yearly monitoring is needed. The Fobi Pouch gastric bypass takes about double the time that a vertical banded gastroplasty operation takes. There is limited research on the outcomes of the fobi pouch versus other bariatric surgery procedures.

Gastric Imbrication: Fried et al. (2011) completed a 3-year RCT on the safety and efficacy of laparoscopic adjustable gastric banding with and without imbrication sutures. The results of the RCT have demonstrated that SAGB combined with a conservative approach to band adjustments and limited retrogastric dissection is effective and safe with and without imbrication sutures. Not using imbrication sutures results in significant benefits in operative speed with comparable clinical weight loss and intermediate term safety. Sharma et al. conducted a randomized, double blinded trial comparing LSG and laparoscopic gastric imbrication (LGI). They found no differences in weight, age, or BMI preoperatively at 6 months or 3 years between the two groups.

The AspireAssist System (AspireAssist) was FDA approved in 2016. It is a weight loss device comprised of an endoscopically-placed percutaneous gastrostomy tube and an external device to facilitate drainage of about 30% of each meal consumed. It is meant to be used in conjunction with diet and exercise. Thompson et al. (2017) performed a 1-year RCT comparing results of 207 patients treated with AspireAssist. The treatment group (n=137) received AspireAssist and lifestyle counseling and the control group (n=70) received lifestyle counseling alone. Compared to the control group, those who received the AspireAssist and counseling lost more weight: 58.6% of participants in the AspireAssist group and 15.3% of participants in the Lifestyle Counseling group lost at least 25% of their excess body weight ($P<0.001$). Additionally, Noren et al. (2016) conducted a prospective observational study on 25 patients. By the end of the 2-year observation period only 15 patients were still in the study. They concluded that AspireAssist is an efficient and safe treatment for obesity. There is no research on AspireAssist versus other bariatric surgery procedures.

Endoscopic Suture Revisions Post Bariatric Surgery: To enhance weight loss, endoscopic procedures to promote restriction of the pouch or stoma include sclerotherapy of the site using 6 to 30 mL of sodium morrhuate injected circumferentially; tissue plication systems to reduce the size of the gastrojejunostomy and the gastric pouch; revisional surgery using a tissue plication device known as StomaPhyX to reduce the pouch size; and application of the endoclip to reduce the size of the gastrojejunal anastomosis. There is a lack of long-term outcomes for endoscopic suture revisions post RYGB.

Not Medically Necessary Procedures

Biliopancreatic Diversion (BPD) Procedure (Scopinaro procedure): The biliopancreatic diversion (BPD) is a malabsorptive procedure that was introduced as a solution to the high rates of liver failure resulting from bowel exclusion in the jejunoileal bypass. The procedure consists of a partial gastrectomy and gastroileostomy with a long segment of Roux limb and a short common channel, resulting in fat and starch malabsorption. BPD also has a restrictive component. The

BPD/DS procedure differs from the BPD in the portion of the stomach that is removed, as well as preservation of the pylorus. This allows more forward flow of the contents of the biliopancreatic limb and avoids the complications of stasis that plagued the jejunoileal bypass (JIB). It is associated with fewer complications than BPD alone. BPD/DS is a complex procedure that is only performed at a few centers in the U.S.

Jejunoileal Bypass or Jejunoileal Intestinal Bypass (JIB): The jejunoileal bypass (also called the intestinal bypass) is performed by dividing the jejunum close to the ligament of Treitz and connecting it a short distance proximal to the ileocecal valve, thereby diverting a long segment of small bowel, resulting in malabsorption. This procedure is no longer performed due to the high complication rate and frequent need for revisional surgery. Per the American Society for Metabolic & Bariatric Surgery, the JIB is no longer a recommended bariatric surgical procedure. The lessons learned from the JIB include the crucial importance of long-term follow-up and the dangers of a permanent, severe and global malabsorption.

Vertical Banded Gastroplasty (VBG): VBG has fallen out of favor as a restrictive procedure for severe obesity, due largely to the advantages of adjustable gastric banding. VBG requires division of the stomach or intestinal resection, while LAGB does not. In addition, the staples used in VBG may break down and cause weight regain, and VBG requires the use of prosthetic mesh that may increase the incidence of stomach stenosis. Thus, CMS says in their National Coverage Determination for Bariatric Treatment for Morbid Obesity that “VBG procedures are essentially no longer performed.”

Gastric Balloon: Previous endoscopic technologies used to treat obesity endoscopically, such as the gastric balloon, had limited exposure in the U.S. and were removed from the market because of associated complications, such as balloon deflation with migration and resultant small intestinal obstruction.

Gastric Pacing: A number of procedures have been investigated for weight loss surgery but have not been totally accepted by the surgical community. Gastric pacing has been performed in several trials but has not been shown to have any long-term effect and has been abandoned.

Gastric Wrapping: A gastric wrap is minimally invasive surgery and involves folding the stomach in on itself and then the edges are stitched to turn the stomach into a narrow tube therefore restricting the amount of food that can be consumed. As this surgery is very new and not widely offered. There is a paucity of peer-reviewed scientific literature on this procedure.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2017, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CLINICAL POLICY
Bariatric Surgery

CPT®* Codes	Description
43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)
43645	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption
43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components)
43771	Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only
43772	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only
43773	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only
43774	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)
43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty
43843	Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty
43845	Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)
43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy
43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption
43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)
43860	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; without vagotomy
43865	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; with vagotomy
43886	Gastric restrictive procedure, open; revision of subcutaneous port component only
43887	Gastric restrictive procedure, open; removal of subcutaneous port component only
43888	Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only

CLINICAL POLICY
Bariatric Surgery

CPT®* Codes	Description
HCPCS Codes	**Description**
S2083	Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline

ICD-10 Codes	Description
E10-E13.9	Diabetes Mellitus
E66-E66.9	Overweight and obesity
E74-E74.9	Other disorders of carbohydrate metabolism
E78-E78.9	Disorders of lipoprotein metabolism
G47-G47.9	Sleep disorder
G93.2	Benign intracranial hypertension
I10-I15	Hypertensive diseases
I20-I20.9	Angina pectoris
I25-I25.9	Chronic ischemic heart disease
I27-I27.9	Other pulmonary heart disease
I42-I42.9	Cardiomyopathy
I50-I50.9	Heart failure
I67-I67.9	Other cerebrovascular diseases
I83-I83.93	Varicose veins of lower extremities
K21-K21.9	Gastro-esophageal reflux disease
K31.1	Adult hypertrophic pyloric stenosis
K31.6	Fistula of stomach and duodenum
K56.5	Intestinal adhesions [bands] with obstruction (postprocedural) (postinfection)
K68- K68.9	Disorders of retroperitoneum
K91-K91.89	Intraoperative and postprocedural complications and disorders, not elsewhere classified
M16-M16.9	Osteoarthritis of hip
M24-M24.9	Other specific joint derangements
M25.879 - M25.8-	Other specified joint disorders
M50-M50.93	Cervical disc disorders
M51-MM51.9	Thoracic, thoracolumbar, and lumbosacral intervertebral disc disorders
M53-M53.9	Other and unspecified dorsopathies, not elsewhere classified
M54- M54.9	Dorsalgia
R06-R06.9	Dyspnea
R09-R09.89	Other symptoms and signs involving the circulatory and respiratory systems
R26-R26.9	Abnormalities of gait and mobility
T85.59- T85.598	Other mechanical complication of gastrointestinal prosthetic devices, implants and grafts

ICD-10 Codes	Description
T81-T81.9	Complications of procedures, not elsewhere classified

Reviews, Revisions, and Approvals	Date	Approval Date
Added gastric reduction duodenal switch Removed bariatric surgery center requirement	08/14	08/14
Reformatted into new template Bariatric surgeon specialist reviewed	08/15	08/15
Changed criteria for low cardiac risk patients to include clearance by a PCP in addition to cardiologist. Pulmonary evaluation criteria changed to include screening for OSA, limiting PFT to at-risk patients.	03/16	
Added Investigational and Not Medically Necessary procedures, as well as supporting background information. Added that the psychological evaluation must be done in-person. Clarified requirement for documentation of at least 1 year free of drugs and alcohol if history of abuse; added requirement for negative UDS within 3 months of request if history of abuse.	08/16	08/16
Added uncontrolled and untreated eating disorders (eg, bulimia) under contraindications. Added AspireAssist to investigational procedures and added related background information.	08/17	08/17
Modified Sections I.B. and I.C. requiring a 6 month trial of an exercise/weight loss program, or a medical condition that would supercede the need for such a program, and instead required "previous attempts at weight loss" per the American Society for Metabolic and Bariatric Surgery updated position statement on insurance mandated preoperative weight loss requirements (2016). Removed requirement in II.F. for 6 months of nutritional counseling, while still requiring monthly nutritional counseling until date of surgery. Removed requirement for *documented compliance* with exercise program in section II.G. Modified II.A.2 removing requirement for specific cardiac testing (stress test, echocardiogram) for high cardiac risk candidates and revised to state they require consultation/evaluation and cardiac clearance from a cardiologist.	11/17	11/17

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

CLINICAL POLICY
Bariatric Surgery

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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CENTENE Corporation

Clinical Policy: Ultrasound in Pregnancy

Reference Number: CP.MP.38
Effective Date: 02/11
Last Review Date: 08/17

Revision Log
Coding Implications

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
This policy outlines the medical necessity criteria for ultrasound use in pregnancy. Ultrasound is the most common fetal imaging tool used today. Ultrasound is accurate at determining gestational age, fetal number, viability, and placental location; and is necessary for many diagnostic purposes in obstetrics. The determination of the time and type of ultrasound should allow for a specific clinical question(s) to be answered. Ultrasound exams should be conducted only when indicated and must be appropriately documented.

Policy/Criteria
It is the policy of health plans affiliated with Centene Corporation® that the following ultrasounds during pregnancy are considered **medically necessary** when the following conditions are met:

I. Standard first trimester ultrasound (76801)
II. Standard second or third trimester ultrasound (76805)
III. Detailed anatomic ultrasound (76811)
IV. Transvaginal ultrasound (76817)
V. Not medically necessary conditions

I. One standard *first trimester ultrasound (76801)* is allowed per pregnancy.

Subsequent standard first trimester ultrasounds are considered **not medically necessary** as a limited or follow-up ultrasound assessment (76815 or 76816) should be sufficient to provide a re-examination of suspected concerns.

II. One standard *second or third trimester ultrasound (76805)* is allowed per pregnancy.

Subsequent standard second or third trimester ultrasounds are considered **not medically necessary** as a limited or follow-up ultrasound assessment (76815 or 76816) should be sufficient to provide a re-examination of suspected concerns.

III. One *detailed anatomic ultrasound (76811)* is allowed per pregnancy when performed to evaluate for suspected anomaly based on history, laboratory abnormalities, or clinical evaluation; or when there are suspicious results from a limited or standard ultrasound. Further indications include the possibility of fetal growth restriction and multifetal gestation. This ultrasound must be billed with an appropriate high risk diagnosis code from Table 4 below.

A second detailed anatomic ultrasound is considered **medically necessary** if a new maternal fetal medicine specialist group is taking over care, a second opinion is required, or the patient has been transferred to a tertiary care center in anticipation of delivery of an anomalous fetus requiring specialized neonatal care.

Further anatomic ultrasounds are considered **not medically necessary** as there is inadequate evidence of the clinical utility of multiple detailed fetal anatomic examinations.

IV. *Transvaginal ultrasounds (TVU)* are considered **medically necessary** when conducted in the first trimester for the same indications as a standard first trimester ultrasound, and later in pregnancy to assess cervical length, location of the placenta in women with placenta previa, or after an inconclusive transabdominal ultrasound. Cervical length screening is conducted for women with a history of preterm labor or to monitor a shortened cervix based on Table 1 below. Up to 12 transvaginal ultrasounds are allowed per pregnancy.

Table 1: Berghella approach to TVU measurement of cervical length for screening singleton gestations

Past pregnancy history	TVU cervical length screening	Frequency	Maximum # of TVU
Prior preterm birth 14 to 27 weeks	Start at 14 weeks and end at 24 weeks	Every 2 weeks as long as cervix is at least 30 mm*	6
Prior preterm birth 28 to 36 weeks	Start at 16 weeks and end at 24 weeks	Every 2 weeks as long as cervix is at least 30 mm*	5
No prior preterm birth	One exam between 18 and 24 weeks	Once	1

* Increase frequency to weekly in women with TVU cervical length of 25 to 29 mm. If <25 mm before 24 weeks, consider cerclage.

V. 3D and 4D ultrasounds are considered investigational and are therefore **not medically necessary**. Studies lack sufficient evidence that they alter management over two-dimensional ultrasound in a fashion that improves outcomes.

The following additional procedures are considered **not medically necessary**:

- Ultrasounds performed solely to determine the sex of the fetus or to provide parents with photographs of the fetus;
- Scans for growth evaluation performed less than 2 weeks apart;
- Ultrasound to confirm pregnancy in the absence of other indications;
- A follow-up ultrasound in the first trimester in the absence of pain or bleeding.

Classifications of fetal ultrasounds include:

I. Standard First Trimester Ultrasound - 76801

A standard first trimester ultrasound is performed before 14 weeks and 0 days of gestation. It can be performed transabdominally, transvaginally, or transperineally. When performed

transvaginally, CPT 76817 should be used. It includes an evaluation of the presence, size, location, and number of gestational sac(s); and an evaluation of the gestational sac(s).

Indications for a first trimester ultrasound include the following:

- To confirm an intrauterine pregnancy
- To evaluate a suspected ectopic pregnancy
- To evaluate vaginal bleeding
- To evaluate pelvic pain
- To estimate gestational age
- To diagnose and evaluate multiple gestations
- To confirm cardiac activity
- As adjunct to chorionic villus sampling, embryo transfer, or localization and removal of an intrauterine device
- To assess for certain fetal anomalies, such as anencephaly, in high risk patients
- To evaluate maternal pelvic or adnexal masses or uterine abnormalities
- To screen for fetal aneuploidy (nuchal translucency) when a part of aneuploidy screening
- To evaluate suspected hydatidiform mole

II. Standard Second or Third Trimester Ultrasound - 76805

A standard ultrasound in the second or third trimester involves an evaluation of fetal presentation and number, amniotic fluid volume, cardiac activity, placental position, fetal biometry, and an anatomic survey.

Indications for a standard second or third trimester ultrasound include the following**:**

- Screening for fetal anomalies
- Evaluation of fetal anatomy
- Estimation of gestational age
- Evaluation of fetal growth
- Evaluation of vaginal bleeding
- Evaluation of cervical insufficiency
- Evaluation of abdominal and pelvic pain
- Determination of fetal presentation
- Evaluation of suspected multiple gestation
- Adjunct to amniocentesis or other procedure
- Evaluation of discrepancy between uterine size and clinical dates
- Evaluation of pelvic mass
- Examination of suspected hydatidiform mole
- Adjunct to cervical cerclage placement
- Evaluation of suspected ectopic pregnancy
- Evaluation of suspected fetal death
- Evaluation of suspected uterine abnormality
- Evaluation of fetal well-being
- Evaluation of suspected amniotic fluid abnormalities
- Evaluation of suspected placental abruption

- Adjunct to external cephalic version
- Evaluation of prelabor rupture of membranes or premature labor
- Evaluation for abnormal biochemical markers
- Follow-up evaluation of a fetal anomaly
- Follow-up evaluation of placental location for suspected placenta previa
- Evaluation with a history of previous congenital anomaly
- Evaluation of fetal condition in late registrants for prenatal care
- Assessment for findings that may increase the risk of aneuploidy

III. Detailed Anatomic Ultrasound - 76811

A detailed anatomic ultrasound is performed when there is an increased risk of an anomaly based on the history, laboratory abnormalities, or the results of the limited or standard ultrasound.

IV. Other Ultrasounds – 76817

A transvaginal ultrasound of a pregnant uterus can be performed in the first trimester of pregnancy and later in a pregnancy to evaluate cervical length and the position of the placenta relative to the internal cervical os. When this exam is done in the first trimester, the same indications for a standard first trimester ultrasound, 76801, apply.

Background

The Routine Antenatal Diagnostic Imaging with Ultrasound (RADIUS) trial showed that routine U/S screening of a low risk population did not lead to improved perinatal outcomes. This was a practice based, multi-center randomized trial. There were no significant differences in birth weight or preterm delivery rates.

Ultrasound is used most often in pregnancy for the estimation of gestational age. It has been shown that the use of multiple biometric parameters can allow for accuracy to within 3-4 days in a mid-trimester study (14-22 weeks). Accurate dating of a pregnancy is crucial as many important decisions might be made based on this date—whether or not to resuscitate an infant delivered prematurely, when to give antenatal steroids, when to electively deliver a term infant, and when to induce for post-dates.

Pregnancy dating with a first trimester or mid-trimester ultrasound will reduce the number of misdated pregnancies and subsequent unnecessary inductions for post-dates pregnancies. Third trimester ultrasounds for pregnancy dating are much less dependable.

Ultrasound is a helpful tool for the evaluation of fetal growth in at-risk pregnancies and the diagnosis of a small-for-gestational age baby (SGA). Those SGA babies with actual chronic hypoxemia and/or malnutrition can be termed growth restricted (FGR) if it is suspected that their growth has been less than optimal.

ACOG does not yet recommend the use of three- or four-dimensional ultrasound as a replacement for any necessary two-dimensional study. ACOG states “the technical advantages of three-dimensional ultrasonography include its ability to acquire and manipulate an infinite number of planes and to display ultrasound planes traditionally inaccessible by two-dimensional

ultrasonography. Despite these technical advantages, proof of a clinical advantage of three-dimensional ultrasonography in prenatal diagnosis in general still is lacking."

The Society of Maternal Fetal Medicine specifically addresses what is often considered a level II screening U/S or routine U/S, stating:

> "CPT 76811 is not intended to be the routine scan performed for all pregnancies. Rather, it is intended for a known or suspected fetal anatomic or genetic abnormality (i.e., previous anomalous fetus, abnormal scan this pregnancy, etc.). Thus, the performance of CPT 76811 is expected to be rare outside of referral practices with special expertise in the identification of, and counseling about, fetal anomalies.
>
> It is felt by all organizations involved in the codes development and description that only one medically indicated CPT 76811 per pregnancy, per practice is appropriate. Once this detailed fetal anatomical exam (76811) is done, a second one should not be performed unless there are extenuating circumstances with a new diagnosis. It is appropriate to use CPT 76811 when a patient is seen by another maternal-fetal medicine specialist practice, for example, for a second opinion on a fetal anomaly, or if the patient is referred to a tertiary center in anticipation of delivering an anomalous fetus at a hospital with specialized neonatal capabilities.
>
> Follow-up ultrasound for CPT 76811 should be CPT 76816 when doing a focused assessment of fetal size by measuring the BPD [biparietal diameter], abdominal circumference, femur length, or other appropriate measurements, OR a detailed re-examination of a specific organ or system known or suspected to be abnormal. CPT 76805 would be used for a fetal maternal evaluation of the number of fetuses, amniotic/chorionic sacs, survey of intracranial, spinal, and abdominal anatomy, evaluation of a 4-chamber heart view, assessment of the umbilical cord insertion site, assessment of amniotic fluid volume, and evaluation of maternal adnexa when visible when appropriate."

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2016, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Table 2: CPT® Codes Covered When Supported by Appropriate Diagnosis

CPT Codes	Description
76801	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (<14 weeks 0 day), transabdominal approach; single or first gestation

CPT Codes	Description
76805	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (≥14 weeks 0 day), transabdominal approach; single or first gestation
76811	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation
76817	Ultrasound, pregnant uterus, real time with image documentation, transvaginal

Table 3: CPT Codes considered Not Medically Necessary:

CPT Codes	Description
76376	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image post-processing under concurrent supervision; not requiring image post-processing on an independent workstation
76377	requiring image post-processing on an independent workstation

Table 4: ICD-10 Diagnosis Codes that Support Medical Necessity for First Detailed Fetal Ultrasound

ICD-10-CM Code	Description
B06.00 – B06.9	Rubella [German measles]
B50.0 – B54	Malaria
B97.6	Parvovirus as the cause of diseases classified elsewhere
E66.01	Morbid (severe) obesity due to excess calories [severe obesity with a BMI of 35 or >]
O09.511 – O09.519	Supervision of elderly primigravida
O09.521 – O09.529	Supervision of elderly multigravida
O09.811 – O09.819	Supervision of pregnancy resulting from assisted reproductive technology
O24.011 – O24.019, O24.111 – O24.119, O24.311 – O24.319, O24.811 – O24.819, O24.911 – O24.919	Diabetes mellitus in pregnancy
O30.001 – O30.099	Twin pregnancy
O30.101 – O30.199	Triplet pregnancy
O30.201 – O30.299	Quadruplet pregnancy
O31.10x+ - O31.23x+	Continuing pregnancy after spontaneous abortion / intrauterine death of one fetus or more
O33.6xx+	Maternal care for disproportion due to hydrocephalic fetus
O33.7xx+	Maternal care for disproportion due to other fetal deformities

ICD-10-CM Code	Description
O35.0xx+	Maternal care for (suspected) central nervous system malformation in fetus
O35.1xx+	Maternal care for (suspected) chromosomal abnormality in fetus
O35.2xx+	Maternal care for (suspected) hereditary disease in fetus
O35.3xx+	Maternal care for (suspected) damage to fetus from viral disease in mother
O35.4xx+	Maternal care for (suspected) damage to fetus from alcohol
O35.5xx+	Maternal care for (suspected) damage to fetus by drugs
O35.6xx+	Maternal care for (suspected) damage to fetus by radiation
O35.8xx+	Maternal care for other (suspected) fetal abnormality and damage
O35.9xx+	Maternal care for (suspected) fetal abnormality and damage, unspecified
O36.011+ - O36.099+	Maternal care for rhesus isoimmunization
O36.111+ - O36.199+	Maternal care for other isoimmunization
O36.511+ - O36.599+	Maternal care for other known or suspected poor fetal growth
O40.1xx+ - O40.9xx+	Polyhydramnios
O41.00x+ - O41.03x+	Oligohydramnios
O69.81x+ - O69.89x+	Labor and delivery complicated by other cord complications
O71.9	Obstetric trauma, unspecified
O76	Abnormality in fetal heart rate and rhythm complicating labor and delivery
O98.311 – O98.319, O98.411 – O98.419, O98.511 – O98.519, O98.611 – O98.619, O98.711 – O98.719, O98.811 – O98.819	Other maternal infectious and parasitic diseases complicating pregnancy
O99.320 – O99.323	Drug use complicating pregnancy
O99.411 – O99.419	Diseases of the circulatory system complicating pregnancy
Q04.8	Other specified congenital malformations of brain [choroid plexus cyst]
Q30.1	Agenesis and underdevelopment of nose [absent or 7ypoplastic nasal bone]
Q62.0	Congenital hydronephrosis [fetal pyelectasis]
Q71.811 – Q71.819	Congenital shortening of upper limb [humerus]
Q72.811 – Q72.819	Congenital shortening of lower limb [femur]
Q92.0 – Q92.9	Other trisomies and partial trisomies of the autosomes, not elsewhere classified [fetuses with soft sonographic markers of aneuploidy]
R93.5	Abnormal findings on diagnostic imaging of other abdominal regions, including retroperitoneum

ICD-10-CM Code	Description
R93.8	Abnormal findings on diagnostic imaging of other specified body structures
Z68.35 – Z68.45	Body mass index (BMI) 35.0 – 70 or greater, adult

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Reviews, Revisions, and Approvals	Date	Approval Date
Policy created & reviewed by Obstetrical specialist	01/11	01/11
Reviewed with no changes Obstetrical specialist reviewed	02/12	03/12
Reviewed with no changes	04/13	05/13
Nuchal translucency removed Divided criteria into first and second trimester Added indications for transvaginal ultrasound Obstetrical specialist reviewed	05/14	08/14
Reformatted policy Added ICD-9 and ICD-10 codes for when a standard ultrasound would be appropriate Obstetrical specialist reviewed Removed prior authorization language	08/15	08/15
Removed ICD-9 codes	11/15	
Added follow-up ultrasound as an alternative in Policy/Criteria sections I and II	02/16	
Reviewed with no criteria changes.	08/16	08/16
Allowed up to 6 TVU per pregnancy and added ICD-10 codes indicating when > 6 TVUs are appropriate	11/16	
Added to ICD-10 code list for standard ultrasounds: O02.0 – O02.9, O03.9, O28.0 – O28.9, Z32.01	01/17	
Removed ICD-10 code tables for 76801 and 76805, and 76817 No diagnosis code limitations in place for these codes. 76817 frequency over time changed to 12 from 6	05/17	
Added that transperineal u/s can be appropriate for a standard first trimester ultrasound scan per updated ACOG guidelines. Added	08/17	08/17

Reviews, Revisions, and Approvals	Date	Approval Date
"possibility of fetal growth restriction and multifetal gestation" to indications for detailed ultrasound in section III. Added "as an adjunct to embryo transfer" as an indication for standard first trimester ultrasound in "classifications of fetal ultrasound" section I. Added "The maternal cervix and adnexa are examined as clinically appropriate and when feasible" to description of standard second or third trimester ultrasound in "classifications of fetal ultrasound" section II. Minor wording clarifications made to criteria throughout policy to ensure consistency with latest ACOG practice bulletin for Ultrasound in Pregnancy, No. 175.		
Removed – in the primary diagnosis position from section III as this is not a requirement for the edit.	12/17	

Important Reminder

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CLINICAL POLICY
Ultrasound in Pregnancy

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Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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CENTENE Corporation

Clinical Policy: Gastric Electrical Stimulation

Reference Number: CP.MP.40
Effective Date: 09/09
Last Review Date: 10/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Gastric electrical stimulation (GES) has been used in patients who are proven refractory to conventional treatment for gastroparesis. It can be used as an alternative to surgery to reduce some symptoms of gastroparesis. Electrodes that are surgically or endoscopically attached to the stomach wall deliver timed electrical impulses to trigger stomach contractions. This stimulation has not shown a significant improvement in gastric emptying, but has been shown to benefit those with nausea and vomiting as their main symptoms.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation that GES is **medically necessary** for diabetic and idiopathic gastroparesis when all of the following criteria are met:
- A. Diagnosis of gastroparesis confirmed by scintigraphy;
- B. Severe nausea and vomiting occurring at least once daily on most days of the week for the duration of ≥1 year;
- C. Documented intolerance or failure to a trial of antiemetic and prokinetic drug therapy;
- D. Does not have any of the following contraindications:
  1. Pregnancy;
  2. Chemical dependency;
  3. Undergoing peritoneal dialysis;
  4. Diagnosis of cancer with a limited estimated life span.

Note: Current recommended combination prokinetic therapy includes metoclopramide and erythromycin.

II. It is the policy of health plans affiliated with Centene Corporation that GES is **not medically necessary** for reduction in pain, fullness, bloating, or acid reflux symptoms as there is no evidence to support efficacy of such therapy.

III. It is the policy of health plans affiliated with Centene Corporation that GES is **investigational** for the treatment of obesity due to a lack of evidence in the peer review literature demonstrating the long term safety and efficacy of this device.

Background

Gastric Electrical Stimulation for Gastroparesis

Gastroparesis is a disorder in which there is delayed gastric emptying following ingestion of food, in the absence of mechanical obstruction, due to abnormal or absent motility of the

stomach. The stomach is unable to contract normally, and therefore cannot crush food nor propel food into the small intestine properly.

Approximately two-thirds of gastroparesis cases are idiopathic or associated with diabetes mellitus, but gastroparesis may also develop after gastric surgery and in other less common conditions. The main symptoms include nausea, vomiting, early satiety, bloating, and discomfort. Nausea and vomiting may be so severe that they cause weight loss, dehydration, electrolyte disturbances, and malnutrition.

It is theorized that GES works in the following ways:

1. Activation of the central mechanisms for nausea and vomiting control related to afferent nerves being stimulated by the constant high frequency current in the stomach wall.
2. Enhanced relaxation of the fundus of the stomach by the electrical current, thus providing better accommodation and decreased sensitivity to distention.
3. Augmentation of the amplitude of gastric slow wave after eating.
4. Increase in cholinergic function and decreased sympathetic functions.
5. Small and unpredictable improvements in gastric emptying.

The results of a number of studies have shown an improvement in quality of life score, even though on average, gastric emptying did not change. Quality of life scores improved along with a decrease in hospital admission days, reduction in hemoglobin A1C, and weight gain. Nausea and vomiting have also showed improvements for at least one year after surgery.

Gastric Electrical Stimulation for Obesity

GES is currently under investigation as a treatment for obesity. Cha et al. (2014) reviewed current approaches to evaluate the effect of GES on obesity. 31 studies were included in their systematic review. Although most of the studies showed weight loss in the treatment group, most had a follow-up duration of 12 months or less. Some of the evaluated GES treatments also showed positive effects in lowering HbA1c and blood pressure.[9] Cha et al. stated that GES holds great promise for the treatment of obesity, but stronger studies with longer follow-up are needed to determine long-term effects.[9] Lebovitz (2016) reviewed the evidence on three different methods of GES, including the Transcend® Implantable Gastric Stimulator, the Maestro™ vagal blockade device, and the DIAMOND™ gastric electrical stimulatory device.[10] Two randomized controlled trials failed to show a significant benefit in excess weight loss with the Transcend device.[10] The other evaluated GES device, the DIAMOND, has been assessed in clinical trials with obese patients with type 2 diabetes. Findings were positive but varied among the patients included in treatment. Effects included reduced HbA1c and weight loss, and seemed to be influenced by baseline HbA1c levels and triglyceride levels.[10] Further research is needed to determine long-term effects and appropriate patient selection criteria to ensure the best outcomes.

Coding Implications

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for informational purposes only. They are current at time of review of this policy. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT®* Codes	Description
43647	Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum
43648	Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum
43881	Implantation or replacement of gastric neurostimulator electrodes, antrum, open
43882	Revision or removal of gastric neurostimulator electrodes, antrum, open
64590	Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling
64595	Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver

HCPCS Codes	Description
C1767	Generator, neurostimulator (implantable), nonrechargeable
C1778	Lead, neurostimulator (implantable)
L8689	Implantable neurostimulator, pulse generator, any type
L8680	Implantable neurostimulator electrode, each
L8688	Implantable neurostimulator pulse generator, dual array, nonrechargeable, includes extension

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
E08.43	Diabetes mellitus due to underlying condition with diabetic autonomic (poly) neuropathy
E09.43	Drug or chemical induced diabetes mellitus with neurological complications with diabetic autonomic (poly) neuropathy
E10.43	Type I diabetes mellitus with diabetic autonomic (poly) neuropathy
E11.43	Other specified diabetes mellitus with diabetic autonomic (poly) neuropathy
E13.43	Other specified diabetes mellitus with diabetic autonomic (poly) neuropathy
K31.84	Gastroparesis

Reviews, Revisions, and Approvals	Date	Approval Date
References reviewed and updated. Modified language regarding trial of antiemetic and prokinetic drug therapy.	09/11	11/11
References reviewed and updated.	12/12	12/12
Clarified langue in bullet points under Policy/Criteria	10/13	10/13
References and coding reviewed and updated	10/14	10/14
Converted into new template References & coding reviewed and updated	10/15	10/15
Added obesity as an investigational indication; added supporting background information. Changed exclusions to contraindications in criteria.	10/16	10/16
Added criteria that gastroparesis should be confirmed by scintigraphy. Modified criteria in I.B requiring daily vomiting to say that vomiting should happen at least once daily on *most days of the week*. References reviewed and updated. Codes updated.	10/17	10/17

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Important Reminder

CLINICAL POLICY
Gastric Electrical Stimulation

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CLINICAL POLICY
Gastric Electrical Stimulation

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CENTENE Corporation

Clinical Policy: Functional MRI

Reference Number: CP.MP.43
Effective Date: 09/09
Last Review Date: 10/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Functional magnetic resonance imaging (fMRI) is an imaging procedure in which an MRI is used to localize regions of activity in the brain by measuring blood flow and/or metabolism following task activation. It localizes areas for critical functions such as thought, speech, movement and sensation. It is most appropriately used in preoperative planning when the lesion is located near eloquent areas of the brain.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that fMRI is **medically necessary** when performed for either A, B, C, or D:

A. Assessment of intracranial neoplasm and other targeted lesions for one of the following:
   1. Pre-surgical planning and operative risk assessment, or
   2. Assessment of eloquent cortex (e.g. language, sensory motor, visual centers) in relation to tumor or other focal lesions, or
   3. Surgical planning (biopsy or resection), or
   4. Therapeutic follow-up.

B. Evaluation of preserved eloquent cortex.

C. Assessment of eloquent cortex for epilepsy surgery.

D. Assessment of radiation treatment planning and post-treatment evaluation of eloquent cortex.

II. It is the policy of health plans affiliated with Centene Corporation that fMRI for any indication not listed above is considered **not medically necessary**.

Background

FMRI using blood oxygenation level dependent imaging (BOLD) technique is a proven and useful tool for the evaluation of eloquent cortex in relation to a focal brain lesion, such as a neoplasm or vascular malformation.

There are several methods that are used to identify eloquent areas of the brain, including the Wada test and electrocortical stimulation mapping (ESM). The Wada test consists of a cerebral angiogram followed by the injection of a drug to evaluate which side of the brain is responsible for speech and memory. ESM involves the surgical placement of electrodes on the brain to identify and mark specific areas of importance. Both tests are invasive, time consuming and involve multiple resources.

fMRI has been proposed as an alternative to these methods. During fMRI, the patient is asked to conduct specific language, memory or motor activities while sequential MRI images are

collected. The activities cause an increase in blood flow to the areas of the brain being used, allowing for their identification and location.

Evidence in published, peer-reviewed scientific literature indicates a good correlation between fMRI pre-surgical brain mapping and invasive pre-surgical brain mapping. Current literature supports fMRI as a valuable adjunct tool when used in conjunction with other brain mapping techniques because the fMRI provides information that aids the surgical team in pre-surgical planning.

Woermann et al (2003) compared the determination of language dominance using fMRI with results of the Wada test in 100 patients with different localization-related epilepsies. The concordance between both tests was 91% with an overall rate of false categorization by fMRI of 9%. It was concluded that language fMRI might reduce the necessity of the Wada test for language lateralization, especially in temporal lobe epilepsy.

Another study by Medina and colleagues (2005) looked at the effect of fMRI on diagnostic work-up and treatment planning in 60 patients with seizure disorders who were candidates for surgical treatment. The study revealed change in anatomic location or lateralization of language-receptive and language-expressive areas (28% and 21% of patients respectively). Statistically significant increases were found in confidence levels after fMRI in regard to motor and visual cortical function evaluation. In 63% of patients, fMRI results helped to avoid further studies, including Wada test. In 52% and 42% of patients, intraoperative mapping and surgical plans, respectively, were altered because of fMRI results. They concluded fMRI results influenced diagnostic and therapeutic decision making of the seizure team; results indicated language dominance change, confidence level in identification of critical brain function areas increased, patient and family counseling were altered, and intraoperative mapping and surgical approach were altered.

Patrella et al (2006) evaluated the effect of preoperative fMRI localization of language and motor areas on therapeutic decision making in 39 patients with potentially resectable brain tumors. Results showed treatment plans before and after fMRI differed in 19 patients ($P < .05$), with a more aggressive approach recommended after imaging in 18 patients. fMRI resulted in reduced surgical time (estimated 15-60 minutes) in 22 patients who underwent surgery, a more aggressive resection in six, and a smaller craniotomy in two. They concluded fMRI enables the selection of a more aggressive therapeutic approach than might otherwise be considered because of functional risk. In certain patients, surgical time may be shortened, the extent of resection increased, and craniotomy size decreased.

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CLINICAL POLICY
Functional MRI

Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT®* Codes	Description
70554	MRI, brain, functional MRI; including test selection and administration of repetitive body part movement and/or visual stimulation; not requiring physician or psychologist administration
70555	requiring physician or psychologist administration of entire neurofunctional testing

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Reviews, Revisions, and Approvals	Date	Approval Date
Clarified policy/criteria language into bullet points	10/13	10/13
Added criteria A.4 and B per ACR-ASNR-SPR Practice parameters	10/14	10/14
Converted into new template References reviewed and updated	10/15	10/15
Template updated References reviewed and updated	10/16	10/16
In I.A changed "brain tumor" to "intracranial neoplasm and other targeted lesions" based on ACR guidelines updated in 2017. Added I.D "Assessment of radiation treatment planning and post-treatment evaluation of eloquent cortex" based on ACR guidelines updated in 2017.	10/17	10/17

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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CENTENE Corporation

Clinical Policy: Physical, Occupational, and Speech Therapy Services

Reference Number: CP.MP.49
Effective Date: 04/11
Last Review Date: 08/17 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

To provide guidelines for the authorization of outpatient speech therapy, occupational therapy, and/or physical therapy evaluation and treatment services.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that *outpatient speech therapy, occupational therapy, and/or physical therapy evaluation and treatment services* are considered **medically necessary** when all the following criteria are met:

A. Signs and symptoms of physical deterioration or impairment in ≥ 1 of the following areas, or for prevention of disability in ≥ 1 of the following areas:
   1. Sensory/motor ability
   2. Functional status as evidenced by inability to perform basic activities of daily living (ADLs) and/or mobility
   3. Cognitive/psychological ability
   4. Cardiopulmonary status
   5. Speech/language/swallowing ability/cognitive-communication disorders that result in disability

B. Treatment is ordered by an examining physician and a formal evaluation is conducted by a licensed/registered speech, occupational, or physical therapist. The evaluation must include the following:
   1. History of illness or disability
   2. Relevant review of systems
   3. Pertinent physical assessment
   4. Current and previous level of functioning
   5. Tests or measurements of physical function
   6. Potential for improvement in the patient's physical function
   7. Recommendations for treatment and patient and/or caregiver education

C. Treatment requires the judgment, knowledge, and skills of a licensed/registered therapist or therapy assistant and cannot be reasonably learned and implemented by non-professional or lay caregivers. Repetitive therapy drills which do not require a licensed/certified professional's feedback are not covered services.

D. Treatment meets accepted standards of discipline-specific clinical practice, and is targeted and effective in the treatment of the member's diagnosed impairment or condition.

E. Treatment does not duplicate services provided by other types of therapy, or services provided in multiple settings (see section regarding school-based therapy).

F. Treatment conforms to a plan of care (POC) specific to the member's diagnosed impairment or condition. The written POC signed by the therapist must include all of the following:

1. Diagnosis with date of onset or exacerbation
2. Short- and long- term functional treatment goals that are specific to the member's diagnosed condition or impairment, and measurable relative to the member's anticipated treatment progress. Treatment techniques and interventions to be used – amount, frequency, and duration required to achieve measurable goals.
3. Education of the member and primary caregiver, if applicable. This should include a plan for exercises/interventions to be completed at home between sessions with the therapist.
4. A brief history of treatment provided to the member by the current or most recent provider, if applicable.
5. A description of the member's current level of functioning or impairment, and identification of any health conditions which could impede the member's ability to benefit from treatment.
6. Member's most recent standardized evaluation scores, with documentation of age equivalency, percent of functional delay, or standard deviation (SD) score, when appropriate, for the member's diagnosis/disability.
7. Providers should also include any meaningful clinical observations, summary of a member's response to the evaluation process, and a brief prognosis statement.

G. Treatment is expected to either:
   1. Produce clinically significant and measurable improvement in the member's level of functioning within a reasonable, and medically predictable, period of time; OR
   2. Prevent significant functional regression as part of a medically necessary program and:
      a. If member is under 21 years and achieves a clinical and functional plateau, the provider adjusts the POC, and provides monthly (or as appropriate) reassessments to update and modify the home care program. If the member's functional level is in jeopardy or declining, the POC can be adjusted accordingly by the therapy provider.
      b. EPSDT (early and periodic screening, diagnosis and treatment) members: members who are receiving EPSDT services may continue to receive medically necessary therapies where loss or regression of present level of function is likely within a reasonable and medically predictable period of time.

H. Where appropriate, nationally recognized clinical decision support criteria will be used as a guideline in the medical necessity decision making process.

II. *Children with Developmental Delays*

The Individuals with Disabilities Education Act (IDEA) is a federal mandate ensuring services to children with disabilities throughout the nation. IDEA Part B is for children 3-21 years to be evaluated and/or treated in a school-based setting when a developmental delay or impairment impacts the child's ability to access the general education environment. In these cases, children are entitled to the protections and services identified as part of the Individual Education Plan (IEP), and the child's home school/district shall be the primary provider and payer of the required treatment services. IDEA Part C is for infants and toddlers (0-2) and their families to receive early intervention services. Infants and toddlers who are identified with developmental delays may be eligible for an Individual Family Service Plan (IFSP) in which treatment and/or family support services are provided for free or at a minimal cost.

A. A member's established IFSP or IEP shall be submitted for review relative to any request for treatment. An attestation that no IFSP or IEP exists, or that treatments are not being duplicated across multiple providers or settings, may also be accepted. Coordination of care between school and provider will be established to prevent duplication of services. Services shall not be considered duplicative if child's course of treatment occurs during school breaks, after school hours, or during summer months. In the absence of an attestation, a denial of requested treatments may occur when an IFSP or IEP is available but not provided. Denial of duplicative treatment may occur when documented.
B. The provision of a formal and complete evaluation by a licensed/registered therapist is permissible once every 6 months; however, it is not a requirement for assessing the need for continued treatment.
C. Standardized scores greater than or equal to 1.5 SD below the mean (except where state requirements are more stringent) may qualify as medically necessary as defined by age equivalent/chronological age; however, such a score may not be used as the sole criteria for determining a member's eligibility for initial or continuing treatment services.
D. A denial of treatment due to a member's "failure to benefit or progress" may be made in those cases when a condition or developmental deficit being treated has failed to be ameliorated or effectively treated despite the application of therapeutic interventions in accordance with the member's POC or if maximum medical benefit has been achieved.
E. Treatment(s) may be re-instituted in accordance with this policy should a documented regression occur.
F. An examining physician's order for treatment or physician's signature on the POC must accompany all treatment requests, regardless of history.

III. Not all treatment modalities are covered benefits. Coverage of specific modalities depends upon their proven efficacy, safety, and medical appropriateness as established by accepted and discipline-specific clinical practice guidelines.

IV. Treatment of the member in the home may be medically necessary if the treatment can be safely and adequately performed in the member's home environment, and the diagnosed impairment or condition makes transportation to an outpatient rehab facility impractical or medically inappropriate.

<u>Outpatient or Home Health Therapy Utilization Guidelines</u>

I. Initial Request

A. Initial Evaluation requirements are based on the individual member benefit contract.
B. Initial request for treatment, following evaluation, meets all of the following:
   1. Therapy is considered medically necessary for members with clearly diagnosed impairments or conditions.
   2. The POC, as outlined above under section I.F., is complete and signed by the therapist.
   3. If applicable, IFSP/IEP or attestation is submitted and verifies no duplication of services for children with developmental delays.
C. If services are approved, up to 6 months of treatment may be authorized when the medical prognosis clinically supports the need for up to 6 months of treatment.

II. Continued Authorization

A. Treatment progress must be clearly documented in an updated POC/current progress summary signed by the therapist, as submitted by the requesting provider at the end of each authorization period and/or when additional visits are being requested. Documentation must include the following:
   1. The member's updated standardized evaluation scores, with documentation of age equivalency, percent of functional delay, or SD score, if applicable.
   2. Objective measures of the member's functional progress relative to each treatment goal and a comparison to the previous progress report.
   3. Summary of member's response to therapy, with documentation of any issues which have limited progress.
   4. Documentation of member's participation in treatment as well as member/caregiver participation in or adherence with a home exercise program (HEP), if applicable.
   5. Brief prognosis statement with clearly established discharge criteria.
   6. An explanation of any significant changes to the member's POC and the clinical rationale for revising the POC.
   7. Prescribed treatment modalities, their anticipated frequency and duration.
   8. Physician signature must be on the POC or on a prescription noting the service type.
   9. If applicable, IFSP/IEP or attestation is submitted and verifies no duplication of services for children with developmental delays.

B. If services are approved, up to 6 months of treatment may be authorized when the medical prognosis clinically supports the need for up to 6 months of treatment.

III. Discontinuation of Therapy

A. Reasons for discontinuing treatment may include, but are not limited to, the following:
   1. Member has achieved treatment goals as evidenced by one or more of the following:
      a. No longer demonstrates functional impairment or has achieved goals set forth in the plan of care
      b. Has returned to baseline function
      c. Will continue therapy with a HEP
      d. Has adapted to impairment with assistive equipment or devices
      e. Member is able to perform ADLs with minimal to no assistance from caregiver
   2. Member has reached a functional plateau in progress, or will no longer benefit from additional therapy.
   3. Member is unable to participate in the POC due to medical, psychological, or social complications.
   4. Non-compliance with a HEP and/or lack of participation in scheduled therapy appointments.

Background

Physical and occupational therapy are defined as therapeutic interventions and services that are designed to improve, develop, correct or ameliorate, rehabilitate or prevent the worsening of physical functions and functions that affect ADLs that have been lost, impaired or reduced as a result of an acute or chronic medical condition, congenital anomaly or injury. Various types of interventions and techniques are used to focus on the treatment of dysfunctions involving

neuromuscular, musculoskeletal, or integumentary systems to optimize functioning levels and improve quality of life.

Speech therapy is defined as services that are necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities and for the diagnosis and treatment of swallowing disorders (dysphagia), regardless of the presence of a communication disability. Speech therapy is designed to correct or ameliorate, restore or rehabilitate speech/language communication and swallowing disorders that have been lost or damaged as a result of chronic medical conditions, congenital anomalies or injuries.

"Medically Necessary Services" refers to services or treatments which are ordered by an examining physician and which (pursuant to the EPSDT Program) diagnose or correct or significantly ameliorate defects, physical and mental illnesses, and health conditions. "Correct" or "ameliorate" means to optimize a member's health condition, to compensate for a health problem, to prevent a serious medical deterioration, or to prevent the development of additional health problems.

Reviews, Revisions, and Approvals	Date	Approval Date
Initial authorization and continued authorization treatment frequency clarified and added references to developmental delay Language simplified throughout the policy	06/13	06/13
References reviewed and updated	07/14	07/14
Removed instructions for UM and reworded to state only specific UM guidelines References reviewed and updated	07/15	08/15
Added 'or prevention of disability' in I.A	08/16	08/16
Clarified in I.A. that prevention of disability should also apply to one or more of criteria I.A.1 - I.A.5. Added "cognitive-communication disorders that result in disability" as an indication in I.A.5 per updated ST guidelines. Added to I.F.3. the requirement for a home exercise plan to be taught to member and/or caregiver. Edited I.G. and I.H. to state that treatment should either produce improvement or prevent regression (per updated ST guidelines citing Medicare changes). Outpatient/Home Health Utilization Guidelines section I: specified that evaluation should meet all of the criteria in I.B.	08/17	08/17
Removed section C. in "Initial request" and "Continued Authorization" that specified approved frequency of visits based on severity criteria.	12/17	

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2. The American Physical Therapy Association (APTA), Criteria for Standards of Practice for Physical Therapy (2014).

http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/Practice/CriteriaStandardsPractice.pdf#search=%22standards of practice%22
3. American Speech Language hearing Association, Medical Review Guidelines for Speech-Language Pathology Services (2015). http://www.asha.org/practice/reimbursement/SLP-medical-review-guidelines/
4. Clark GF, Youngstrom MJ. Guidelines for documentation of occupational therapy (2013). Am J Occupational Therapy. 2013 Nov-Dec;67 S32-S38. doi:10.5014/ajot.2013.67S32
5. McKesson Corporation InterQual® criteria.
6. MCG (formerly Milliman Care Guidelines®) guidelines.
7. Standards of Practice, the American Occupational Therapy Association. American Journal of Occupational Therapy, December 2015, Vol. 69, 6913410057p1-6913410057p6. doi:10.5014/ajot.2015.696S06. http://ajot.aota.org/article.aspx?articleid=2477354
8. World Confederation for Physical Therapy, Position Statement: Standards of Physical Therapy Practice (Revised 2011). http://www.wcpt.org/sites/wcpt.org/files/files/WCPT-PoS-Standards_of_Physical_Therapy_Practice-Aug07.pdf

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

CLINICAL POLICY
Physical Therapy, Occupational Therapy, Speech Therapy

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CENTENE Corporation

Clinical Policy: Outpatient Testing for Drugs of Abuse

Reference Number: CP.MP.50
Effective Date: 09/12
Last Review Date: 09/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Urine drug testing is a key diagnostic and therapeutic tool that is useful for patient care and monitoring of adherence to a controlled substance treatment regimen (e.g., for chronic non-cancer pain) and to identify drug misuse or addiction prior to starting or during treatment with controlled substances.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that outpatient drug testing for drugs of abuse (DOA) is **medically necessary** for confirmatory/definitive (quantitative) testing for a specific drug(s) when members meet the criteria in A or B:

- **A.** Member has a documented history or suspicion of illicit or prescription drug use or noncompliance or a high probability of non-adherence to a prescribed drug regimen documented in the medical record; *and all of the following:*
  1. A preliminary/presumptive drug test has been previously performed; *and*
  2. The findings from that preliminary/presumptive (qualitative) test (either positive or negative) are either:
     - a. Inconsistent with the expected results as suggested by the member's medical history, clinical presentation, and/or member's own statement after a detailed discussion about their recent medication and drug use, or
     - b. The test yielded results consistent with the clinical scenario but drug class-specific assays are needed to identify the precise drug(s) that resulted in the positive test result. *and*
  3. Resolving the inconsistency is essential to the ongoing care of the member, *and*
  4. The requested confirmatory/definitive test is only for the specific drug(s) or number of drug classes for which preliminary analysis has yielded unexpected results. OR
- **B.** The request is for a serum therapeutic drug level in relation to the medical treatment of a disease or condition (e.g. phenobarbital level in the treatment of seizures).

II. Urine drug testing is considered **not medically necessary** if provided for reasons that include, but are not limited to, the following:

- **A.** As a condition of:
  1. Employment or pre-employment purposes (pre-requisite for employment or as a requirement for continuation of employment).
  2. Participation in school or community athletic or extracurricular activities or programs
- **B.** Screening for medico-legal purposes such as court-ordered drug screening (unless required by state regulations).
- **C.** Screening in asymptomatic patients.
- **D.** As a component of a routine physical/medical examination; e.g. (enrollment in school, enrollment in the military, etc.).

E. As a component of a medical examination for any other administrative purposes not listed above (e.g., for purposes of marriage licensure, insurance eligibility, etc.).
F. Same-day screening of drug metabolites in both a blood and urine specimen by either preliminary or confirmatory/definitive analyses.
G. Specimen validity/adulteration testing, as this is considered part of the laboratory quality control practices.

Authorization Protocols
Outpatient confirmatory/definitive testing for DOA requires prior authorization **except** when performed for children < 6 years of age.

Requests for prior authorization will be accepted up to 5 business days after specimen collection and reviewed for medical necessity based on the above stated criteria.

Request Requirements
A clinical laboratory may not bill for a service unless it has received a written request to perform that specific service from an authorized prescriber who is treating the member and will use the test for the purpose of diagnosis, treatment, or an otherwise medically necessary reason as defined in this policy. Any claim for a service for which a prior-authorization has not been provided may be subject to denial. Any clinical laboratory billing for a service must maintain such request in its records, and make such records available upon request.

Background
A drug of abuse is defined as a drug, chemical, or plant product known to be misused for recreational purposes. In the United States, the basic screening test for DOA includes five drugs: amphetamine, cocaine, marijuana, opioids, and phencyclidine. Other common drugs tested for include benzodiazepines, a wider range of opioids, barbiturates, and methamphetamine. These tests can vary by region based on epidemiologic trends. There currently is no uniformity for what is included in extended DOA assay testing, or what cutoff values should be used for detection of drugs that are not covered by workplace testing laws.

The three methods of drug assays include immunoassay, chromatography, and mass spectrometry. Immunoassay is the most widely used method for initial testing for DOA and offers results within minutes. They are able to detect low concentrations of a drug with a high degree of specificity. This can be most easily performed using point-of-care test kits such as a urine drug cup. Unfortunately, in the clinical setting point-of-care testing does not perform to manufacturers' claims and untrained staff can improperly interpret test results.

Gas chromatography/mass spectrometry (GCMS) or liquid chromatography (LC/MS) are typically used as confirmatory tests. Chromatography is used to separate a specimen into its component parts and mass spectrometry to identify those parts. Chromatography, LC/MS and GC/MS require highly trained lab staff and instruments to provide a highly sensitive and specific technique for detecting drugs or metabolites. It often takes many hours to obtain results, thus these methods are generally not used for initial screening in the clinical setting. The mass spectrometer is capable of detecting even minute amounts of a given substance and is considered to have the highest specificity of all lab detection methods. It is most commonly used for

confirmatory test results that are primarily of forensic importance. GC/MS rarely provides results that are clinically necessary or useful beyond those obtained by standard immunoassays or chromatography.

The ordering clinician must be knowledgeable regarding the type of testing being requested, level of suspicion for drug use or exposure, the purpose for obtaining the test, and the likelihood of false-positive or false-negative results. Knowledge of potential drug exposure allows a clinician working in an addiction or chronic pain management program to include testing for a metabolite of a parent drug instead of simply testing for the parent drug for a patient with a tendency for opioid abuse. If initial screening does not correlate with expected findings, then confirmatory testing improves the accuracy of initial results especially with concern of false-positive or false-negative results.

Immunoassays can yield false-positive results when cross-reacting medications or drugs are present. Cross-reacting substances can be found in common prescription medications, over-the-counter cold medications, and even in some food substances. The highest false-positive results occur with amphetamine testing due to the chemical structure of amphetamine being present in many over-the counter medications and herbal supplements. False-negative results can occur from improper specimen collection, transport, or testing procedures or from patient attempts to subvert the testing. The most common cause of false-negative results is a test failure to detect a specific drug within a given class of drugs.

Coding Implications

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CPT®* Codes	Description
80184	Phenobarbital
80324	Amphetamines; 1 or 2
80325	Amphetamine; 3 or 4
80326	Amphetamines; 5 or more
80345	Barbiturates
80346	Benzodiazepines; 1-12
80347	Benzodiazepines; 13 or more
80348	Buprenorphine
80349	Cannabinoids, natural
80350	Cannabinoids, synthetic; 1-3
80351	Cannabinoids, synthetic; 4-6
80352	Cannabinoids; synthetic; 7 or more
80353	Cocaine
80354	Fentanyl

CLINICAL POLICY
Outpatient Testing for Drugs of Abuse

CPT®* Codes	Description
80356	Heroin metabolite
80357	Ketamine and norketamine
80358	Methadone
80359	Methylenedioxyamphetamines (MDA, MDEA, MDMA)
80360	Methylphenidate
80361	Opiates, 1 or more
80362	Opioids and opiate analogs; 1 or 2
80363	Opioids and opiate analogs; 3 or 4
80364	Opioids and opiate analogs; 5 or more
80365	Oxycodone
80371	Stimulants, synthetic
83992	Phencyclidine (PCP)

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HCPCS Codes	Description
G0480	Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 1-7 drug class(es), including metabolite(s) if performed
G0481	Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); definitive, qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 8-14 drug class(es), including metabolite(s) if performed
G0482	Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); definitive, qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 15-21 drug class(es), including metabolite(s) if performed
G0483	Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers),

HCPCS Codes	Description
	including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); definitive, qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 22 or more drug class(es), including metabolite(s) if performed

Reviews, Revisions, and Approvals	Date	Approval Date
Added language to allow for 5 days post specimen collection to request PA	07/14	
Added background information	10/14	10/14
CPT codes updated per 2015 code changes	01/15	
Added temporary HCPCS codes to code list	07/15	
Added under Criteria: A.2.b option for concordant test results but specific quantitative analysis needed to identify specific drug	10/15	10/15
Added new 2016 G codes for definitive drug testing, clarified in criteria the addition of definitive testing	02/16	
Added same day urine/blood screening and sample validity testing limitations to the not medically necessary section. Replaced “qualitative” language with “preliminary,” and “quantitiative” with “confirmatory/definitive.”	09/16	10/16
Added term “presumptive” and “qualitative” to preliminary drug testing. Codes reviewed and updated. Reviewed by neurology/pain management specialist. References reviewed and updated.	09/17	09/17

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Important Reminder

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decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

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Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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CENTENE Corporation

Clinical Policy: Reduction Mammoplasty and Gynecomastia Surgery

Reference Number: CP.MP.51
Effective Date: 08/12
Last Review Date: 09/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Reduction mammoplasty, also known as breast reduction surgery, is a surgical procedure in women to reduce the weight, mass, and size of the breast. Gynecomastia surgery is the surgical correction of over-developed or enlarged breasts in men.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation that reduction mammoplasty in females for non-cosmetic indications is **medically necessary** when the criteria in A or B below are met:

A. Macromastia:

1. Member is ≥ 16 years of age and/or Tanner stage V of Tanner staging of sexual maturity (See Appendix A for Tanner Staging); *and*
2. The estimated amount of breast tissue to be removed meets the minimum weight requirement based on the member's body surface area (BSA) per Appendix B, adapted from the Schnur Sliding Scale. The DuBois and DuBois body surface calculator (found here: http://www-users.med.cornell.edu/~spon/picu/calc/bsacalc.htm) may be used to calculate BSA if only height and weight are given; *and*
3. Member has at least two (2) of the following persistent symptoms, affecting activities of daily living for at least one year:
   a. Headaches associated with neck and upper back pain;
   b. Pain in neck, shoulders, or upper back not related to other causes (e.g., poor posture, acute strains, poor lifting techniques);
   c. Breast pain;
   d. Painful kyphosis documented by X-rays;
   e. Pain/discomfort/ulceration/grooving from bra straps cutting into shoulders;
   f. Paresthesia of upper extremities due to brachial plexus compression syndrome
   g. Intertrigo;
   h. Significant discomfort resulting in severe restriction of physical activities; *and*
4. Member has undergone an evaluation by a physician who has determined that all of the following criteria are met:
   a. Pain is unresponsive to conservative treatment as evidenced by physician documentation of therapeutic measures including at least two of the following:
      i. Analgesic/non-steroidal anti-inflammatory drugs (NSAIDs);
      ii. Physical therapy/exercise when skeletal pathology is present;
      iii. Supportive devices (e.g., proper bra support, wide bra straps);
      iv. Medically supervised weight loss program;
      v. Orthopedic or spine surgeon evaluation of spinal pain; *and*
   b. The pain is not associated with another diagnosis, e.g. arthritis; *and*

c. There is a reasonable likelihood that the member's symptoms are primarily due to macromastia; *and*
d. Reduction mammoplasty is likely to result in improvement of the chronic pain; *and*
e. Women ≥ 40 years of age are required to have a mammogram that was negative for cancer performed within the year prior to the date of the planned reduction mammoplasty procedure.

B. *Gigantomastia of Pregnancy*
The member has gigantomastia of pregnancy, accompanied by *any* of the following complications, and delivery is not imminent:
1. Massive infection; *or*
2. Significant hemorrhage; *or*
3. Tissue necrosis with slough; *or*
4. Ulceration of breast tissue.

II. It is the policy of health plans affiliated with Centene Corporation that male gynecomastia surgery is considered **medically necessary** when the criteria in A or B are met:

A. *Adolescents <18 years*
Adolescent members with unilateral or bilateral grade II, III, or IV gynecomastia (per Appendix C), and meets all of the following:
1. Persists for at least two years after pathological causes are ruled out; *and*
2. Persists without improvement after appropriate treatment for at least six months for any underlying cause, including discontinuation of gynecomastia-inducing drugs and/or substances; *and*
3. Experiences pain and discomfort due to the distention and tightness from the hypertrophied breast(s) that has not responded to medical management.

B. Adults ≥18 years
1. Unilateral or bilateral grade III or IV gynecomastia (per Appendix B); *and*
2. Glandular breast tissue is the primary cause of the gynecomastia; *and*
3. Persists for at least one year after pathological causes are ruled out; *and*
4. Persists without improvement after appropriate treatment for at least six months for any underlying cause, including appropriate discontinuation of gynecomastia-inducing drugs and/or substances; *and*
5. Experiences pain and discomfort due to the distention and tightness from the hypertrophied breast(s) that has not responded to medical management; *and*
6. Malignancy has been ruled out.

Medical Record Documentation Requirements
Medical records must accompany all requests for reduction mammoplasty procedures. Photographic documentation must be provided, along with detailed documentation supporting the medical necessity of breast reduction, which will include height and weight information. When applicable, there must be documented evidence of conservative therapies attempted in order to substantiate the condition being refractory to treatment.

Background
Reduction mammoplasty is the surgical reduction of breast size. It was originally adopted in medical practice in the 1920s. The surgery was proposed as a means of alleviating physical problems associated with excessive breast size and breast ptosis. Among these problems are pain in the neck, upper and lower back, shoulder, arm, and breast; headaches; paresthesia of the upper extremities; intertrigo (inflammation of skin folds); itching; striae; difficulty exercising; postural changes; inability to find appropriate clothing; bra strap grooving; difficulty sleeping; and psychological illnesses including anxiety and depression. Radiographic evidence of chronic postural changes has also been demonstrated. Reduction mammoplasty is also performed for many patients who request surgery to address breast deformities or asymmetry.

Several procedures are available to accomplish breast reduction. Each procedure has its own unique approach to breast reshaping through various methods of skin incisions and resection patterns. Currently, the two surgical approaches to reduction mammoplasty that are most widely used are the Wise pattern reduction mammoplasty and vertical pattern breast reduction. The Wise pattern reduction mammoplasty is most commonly used in the United States, and the vertical pattern breast reduction is more popular in Europe. Both are pedicle-based procedures, with the Wise pattern scars entirely below the nipple and the vertical pedicle scars above the nipple. A crescent-shaped mass of tissue is removed from the inferior portion of each breast, and the skin is resected and sutured. Both grafting and pedicle- based techniques are used in cases where it is necessary to reposition the nipple-areola complex. These procedures seek to preserve the blood and nerve supply to the nipple-areola complex and create a symmetrical and natural appearance, while reducing breast volume and weight. Care is also taken to avoid scars that may be visible when the patient is clothed.

Gynecomastia is the benign proliferation of glandular breast tissue in men. Physiologic gynecomastia is common in newborns, adolescents, and men older than 50 years of age. In newborns and adolescents, it generally resolves spontaneously without intervention. In older men, decreasing free-testosterone levels can contribute to physiologic gynecomastia. However, they are less likely to present for evaluation and treatment than adolescents.

Non-physiologic gynecomastia can occur at any age and can be a result of a medical condition, medication use, or substance abuse. Persistent pubertal gynecomastia is the most common cause of non-physiologic gynecomastia. It generally resolves six months to two years after onset. However, if symptoms persist after two years, or after 17 years of age, further evaluation is needed to determine cause and appropriate treatment. Medications such as antipsychotics, antiretrovirals, and prostate cancer therapies are common triggers, as well as non-prescription drugs such as performance-enhancing supplements and anabolic steroids. Common medical conditions that can cause gynecomastia include Klinefelter's syndrome, adrenal tumors, brain tumors, chronic liver disease, androgen deficiency, endocrine disorders, and testicular tumors.

Appendices
Appendix A
Criteria for distinguishing Tanner stages 1 to 5

Tanner Stage	Breast	Pubic Hair
1 (Prepubertal)	No palpable glandular tissue or pigmentation of areola; elevation of areola only	No pubic hair; short, fine vellous hair only
2	Glandular tissue palpable with elevation of breast and areola together as a small mound; areola diameter increased	Sparse, long pigmented terminal hair chiefly along the labia majora
3	Further enlargement without separation of breast and areola; although more darkly pigmented, areola still pale and immature; nipple generally at or above mid-plane of breast tissue when individual is seated upright	Dark, coarse, curly hair, extending sparsely over mons
4	Secondary mound of areola and papilla above breast	Adult-type hair, abundant but limited to mons and labia
5 (Adult)	Recession of areola to contour of breast; development of Montgomery's glands and ducts on the areola; further pigmentation of areola; nipple generally below mid-plane of breast tissue when individual is seated upright; maturation independent of breast size	Adult-type hair in quantity and distribution; spread to inner aspects of the thighs in most racial groups

Appendix B

Adapted from Schnur Sliding Scale – body surface area and estimated minimum cutoff weight for breast tissue per breast to be removed.

Body Surface Area (m^2)	Weight of tissue to be removed per breast (grams)
1.35	199
1.40	218
1.45	238
1.50	260
1.55	284
1.60	310
1.65	338
1.70	370
1.75	404
1.80	441

Body Surface Area (m^2)	Weight of tissue to be removed per breast (grams)
1.85	482
1.90	527
1.95	575
2.00	628
2.05	687
2.15	819
2.20	895
2.25	978
$\geq$ 2.30	1000

Appendix C

Gynecomastia Scale adapted from the McKinney and Simon, Hoffman and Kohn scales:

I. Grade I: Small breast enlargement with localized button of tissue that is concentrated around the areola
II. Grade II: Moderate breast enlargement exceeding areola boundaries with edges that are indistinct from the chest
III. Grade III: Moderate breast enlargement exceeding areola boundaries with edges that are distinct from the chest with skin redundancy present
IV. Grade IV: Marked breast enlargement with skin redundancy and feminization of the breast

CLINICAL POLICY
Reduction Mammoplasty and Gynecomastia Surgery

Coding Implications

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CPT®* Codes	Description
19300	Mastectomy for gynecomastia
19318	Reduction mammoplasty

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ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
G44.89	Other headache syndrome
G54.0	Brachial plexus disorders
L30.4	Erythema intertrigo
M25.511 - M25.519	Pain in shoulder
M40.00 - M40.05	Postural kyphosis
M40.10 - M40.15	Other secondary kyphosis
M40.202 - M40.205	Unspecified kyphosis
M40.292 - M24.295	Other kyphosis
M54.2	Cervicalgia
M54.9	Dorsalgia, unspecified
N62	Hypertrophy of breast
N64.4	Mastodynia
Q98.4	Klinefelter's syndrome, unspecified

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed. Specialist reviewed	06/12	08/12
Restructured order of criteria	07/13	08/13
Combined pain in neck, shoulders or upper back into one bullet point and added breast pain, paresthesia, and intertrigo to criteria point A.2 Changed A.3.a to two of the following Changed gynecomastia surgery from not medically necessary to medically necessary when meeting criteria Specialist reviewed	08/14	09/14
Changed "Authorization Protocols" to "Medical Record Documentation Requirements"	09/15	09/15

Reviews, Revisions, and Approvals	Date	Approval Date
Converted to new template		
Table formatting updated I.A.3.a added that headaches are associated with neck and upper back pain; I.A.3.b added that pain is not related to other causes; I.A.4.a added medically supervised weight loss and orthopedic evaluation as options. Added ICD-10 codes.	08/16	09/16
Reworded I.A.2. for clarity. Added "Significant discomfort resulting in severe restriction of physical activities" to I.A.3 based on UpToDate patient selection criteria.	09/17	09/17

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CLINICAL POLICY
Reduction Mammoplasty and Gynecomastia Surgery

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CENTENE Corporation

Clinical Policy: Ferriscan R2-MRI

Reference Number: CP.MP.53
Effective Date: 11/12
Last Review Date: 11/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

FerriScan R2-MRI is a magnetic resonance imaging (MRI) -based solution for measuring liver iron concentration (LIC) in patients with iron overload.

Policy/Criteria

I. It is the policy of Health Plans affiliated with Centene Corporation® that the Ferriscan® R2-MRI is **medically necessary** for the measurement of liver iron concentration in suspected cases of iron overload due to the following conditions:
- **A.** Hereditary hemochromatosis;
- **B.** Iron-loading anemias with or without multiple transfusions:
  1. Thalassemia major and thalassemia intermedia;
  2. Sideroblastic anemia;
  3. Chronic hemolytic anemias (e.g., sickle cell disease);
  4. Inherited or acquired aplastic anemia;
  5. Myelodysplastic syndromes;
- **C.** Dietary iron overload;
- **D.** Iron overload in liver diseases:
  1. Hepatitis C and B;
  2. Alcohol-induced liver disease;
  3. Porphyria cutanea tarda;
  4. Fatty liver disease;
  5. Gestational alloimmune liver disease
- **E.** Neonatal iron overload;
- **F.** Aceruloplasminemia;
- **G.** Repeated hemin infusions for acute porphyrias.

Background

FerriScan® is a non-invasive technology based on MRI. It has a high sensitivity and specificity for the measurement of LIC over the entire range encountered in clinical practice. It can be set up on most 1.5 Tesla MRI scanners (the most common type of clinical scanner). FerriScan makes a map of the liver iron concentration and calculates the mean LIC. The results are unaffected by the presence of fibrosis or cirrhosis. Image data is acquired on an MRI scanner and is electronically transmitted to a data analysis center. All data is analyzed to ensure correct acquisition and the LIC results are transmitted back to the originating MRI center.

The operational principle of the R2-MRI Analysis System is based on fitting signal decay curves to the image signal intensities (e.g. of the liver) at the different echo times for the MR data set on a voxel-by-voxel (3-D pixel) basis to determine transverse relaxation rate (R2) images, that may

be further transformed by a defined calibration to provide a quantitative measure of liver iron concentrations.

Measurements have been shown to have a high degree of sensitivity and specificity for liver iron concentration measured by biopsy. FerriScan images give information on liver iron distribution. The mean LIC value given in the FerriScan report is then used to guide chelation therapy.

Magnetic resonance evaluation for hepatic iron concentration is improved compared with programs that were used several years ago. However, this type of imaging will not detect cellular liver damage due to iron overload.

The American College of Radiology's 2015 Practice Parameter for the performance of MRI of the liver states that indications for MRI of the liver include hemochromatosis, hemosiderosis, or steatosis. Additionally, multiple studies have confirmed the clinical utility of R2 MRI in the measurement of LIC for iron-overloading conditions such as thalassemia[7] and sickle cell anemia[8]. A study of R2 MRI results vs. simulated liver biopsy results found R2 MRI to be superior to liver biopsy for serial LIC observations[9]. Furthermore, a review of the current state of liver iron quantification by MRI states that R2 MRI provides validated measurement of LIC, and has advantages over liver biopsy, in that is in non-invasive.[10]

The R2-MRI Analysis System (Inner Vision Biometrics PTY LTD) received FDA 510(k) clearance (K043271) on January 21, 2005. In January 2013, the FDA authorized the FerriScan R2-MRI to be marketed as an imaging companion diagnostic device for the safe and effective use of Exjade in patients with non-transfusion-dependent thalassemia.

Coding Implications

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CPT®* Codes	Description
76498	Unlisted MRI procedure

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
B16.0-B1.9	Acute hepatitis B
B17.10-B17.11	Acute hepatitis C
B18.0	Chronic viral hepatitis B, with delta -agent

ICD-10-CM Code	Description
B18.1	Chronic viral hepatitis B without delta-agent
B18.2	Chronic viral hepatitis C
B19.10-B19.11	Unspecified viral hepatitis B
B19.20-B19.21	Unspecified viral hepatitis C
D46.0	Refractory anemia without ring sideroblasts, so stated
D46.1	Refractory anemia with ring sideroblasts
D46.20-D46.22	Refractory anemia with excess of blasts
D56.1	Beta Thalasemia
D61.01-D61.8	Constititional aplastic anemia
D61.89	Other specified aplastic anemias and other bone marrow failure syndromes
D61.9	Aplastic anemia, unspecified
D64.0	Hereditary sideroblastic anemia
D64.1	Secondary sideroblastic anemia due to disease
D64.2	Secondary sideroblastic anemia due to drugs and toxins
D64.3	Other sideroblastic anemia
E80.1	Porphyria cutanea tarda
E83.10	Disorders of iron metabolism, unspecified
E83.110	Hereditary hemochromatosis
E83.118	Other hemochromatosis
K70.0-K70.9	Alcoholic liver disease
K76.0	Fatty (change of) liver, not elsewhere classified

Reviews, Revisions, and Approvals	Date	Approval Date
References reviewed and updated	11/14	11/14
References reviewed and updated Converted into new template	11/15	11/15
Changed Ferriscan from not medically necessary to medically necessary in cases of suspected iron overload. Added supporting background information. Added ICD-10 codes. Specialist reviewed.	10/16	11/16
Added "inherited or acquired" to B.4 Aplastic anemia. Added D.5 Gestational alloimmune liver disease, removed "chronic" from D. Iron overload in liver diseases. Removed E. African iron overload because this would be included under C. Dietary iron overload. Added G. Repeated hemin infusions for acute porphyrias.	11/17	11/17

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering

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This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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CENTENE Corporation

Clinical Policy: Hospice Services

Reference Number: CP.MP.54
Effective Date: 05/13
Last Review Date: 07/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Medical necessity criteria for hospice services.

Policy
It is the policy of health plans associated with Centene Corporation® that hospice is considered **medically necessary** when the *requirements in Criteria sections I, II, and III are met:*

I. The Required Documentation has been submitted, and
II. The member meets one of the severity of illness criterion
- **A.** Cancer, or
- **B.** ALS, or
- **C.** Heart Disease, or
- **D.** Pulmonary Disease, or
- **E.** Dementia, or
- **F.** HIV, or
- **G.** Liver Failure, or
- **H.** Acute or Chronic Renal Failure, or
- **I.** Stroke, or
- **J.** Coma, or
- **K.** Non-Disease Specific Decline in Clinical Status; and

III. The requested intensity of service is appropriate
- **A.** Routine Hospice Home Care, or
- **B.** Continuous Hospice Home Care, or
- **C.** Inpatient Respite Hospice Care, or
- **D.** General Inpatient, Short Term (non-respite) Hospice Care.

Note: Hospice room and board (long term care/nursing home) coverage is based on the Benefit Plan Contract.

It is the policy of health plans affiliated with Centene Corporation that hospice is considered **not medically necessary** when requested for the circumstances listed in Criteria section IV.

Criteria
I. Required Documentation
- **A.** Documentation of hospice medical director certification of hospice appropriateness for the initial 90 day certification period.
  1. The written certification must identify the terminal illness diagnosis that prompted the member to seek hospice care, includes a statement that the member's life expectancy

is six months or less if the terminal diagnosis runs its normal course; details specific clinical findings supporting a life expectancy of 6 months or less; and

2. The documentation also includes a hospice election statement signed by the member or the member's healthcare proxy stating they understand the nature of hospice care; and

B. Documentation that the member is no longer seeking curative treatment for their terminal diagnosis. Per the Affordable Care Act, the only exception for this may be for children under 21 who are covered by Medicaid or the Children's Health Insurance Program (CHIP), where concurrent hospice and curative therapy is an option.

II. Severity of Illness

The presence of significant comorbidities should be considered when using these criteria to determine hospice appropriateness.

A. *Cancer* – meets 1, 2, and 3:

1. Palliative performance scale (PPS) (Appendix A) or Karnofsky performance status scale (KPS) (Appendix B) score decreased to < 70%; and
2. Dependence for at least 2 ADLs (i.e. ambulation, continence, transfers, dressing, feeding, bathing); and
3. Disease status is one of the following:
   a. Metastatic cancer at presentation, deferring therapy, or
   b. Progression to metastatic disease with decline despite therapy or deferring therapy, or
   c. Brain, pancreatic, or small cell lung cancer.

B. *ALS* – meets 1, 2, and 3:

1. PPS (Appendix A) or KPS (Appendix B) score decreased to < 70%; and
2. Dependence for at least 2 ADLs (i.e. ambulation, continence, transfers, dressing, feeding, bathing); and
3. Disease status is one of the following:
   a. Signs or symptoms of impaired respiratory function, not electing tracheostomy or invasive ventilation, and FVC < 40% (if results available), or
   b. Rapid progression with critical nutritional impairment indicated by at least 5% loss of body weight (with or without tube feeding), or
   c. Rapid progression with other life-threatening complications (sepsis, recurrent aspiration, pyelonephritis, stage 3-4 decubiti).

C. *Heart Disease* – meets 1, 2, and either 3 or 4:

1. PPS (Appendix A) or KPS (Appendix B) score decreased to < 70%; and
2. Dependence for at least 2 ADLs (i.e. ambulation, continence, transfers, dressing, feeding, bathing); and
3. Disease status is one of the following:
   a. Congestive Heart Failure (CHF), both of the following:
      i. Symptomatic at rest (NYHA Class IV), with ejection fraction (EF) < 20% (if results available), and
      ii. Presently optimally treated with diuretics and vasodilators or has failed therapy with IV inotropes; or

b. Coronary Artery Disease (CAD), all of the following:
   i. Elderly member with intractable angina who is not a candidate for coronary revascularization, and
   ii. No longer responding well to nitrates, beta- and calcium-channel blockers and other appropriate medications, and
   iii. Not a candidate for cardiac transplant.

D. *Pulmonary Disease* – has fixed obstructive disease OR restrictive disease and meets ALL of the following:
1. PPS (Appendix A) or KPS (Appendix B) score decreased to < 70%; and
2. Dependence for at least 2 ADLs (i.e. ambulation, continence, transfers, dressing, feeding, bathing); and
3. Severity, all
   a. Disabling symptoms at rest or with minimal exertion, and
   b. Diminished functional capacity, i.e., bed-to-chair existence, and
   c. FEV1 <30% predicted; and
4. Progressiveness, both
   a. Two ED visits in prior six months or one hospitalization in last year for pulmonary infection for respiratory failure with intubation or BiPAP, and
   b. Member states they do not want to be intubated; and
5. PaO2 ≤ 55 mmHg or SaO2 ≤ 88% at rest on room air; or PaCO2 ≥ 50 mmHg.

E. *Dementia* – meets ALL of the following:
1. Increasing severity indicated by FAST (Appendix C) stage 7 or beyond; and
2. Inability to ambulate; and
3. Increasing medical complications indicated by one of the following in the past 12 months:
   a. Aspiration pneumonia, or
   b. Pyelonephritis, or
   c. Multiple stage 3-4 decubiti, or
   d. Fever recurrent after a course of antibiotics, or
   e. Weight loss > 10% over six months or albumin <2.5 gms/dl.

F. *HIV* **–** meets ALL of the following:
1. CD4+ (T-cell) count < 25 or viral load > 100,000 copies/ml; and
2. PPS or KPS score < 50%; and
3. At least one of the following AIDS-related conditions:
   a. Central nervous system or poorly responsive systemic lymphoma, or
   b. Wasting: loss of > 33% of lean body mass, or
   c. Mycobacterium avium complex (MAC) bacteremia, or
   d. Progressive multifocal leukoencephalopathy (PML), or
   e. Refractory visceral Kaposi's sarcoma (KS), or
   f. Renal failure in the absence of dialysis, or
   g. Refractory cryptosporidium infection, or
   h. Refractory toxoplasmosis.

G. *Liver Failure* – meets ALL of the following:
1. PPS (Appendix A) or KPS (Appendix B) score decreased to < 70%; and
2. Dependence for at least 2 ADLs (i.e. ambulation, continence, transfers, dressing, feeding, bathing); and
3. Member has end-stage liver disease and is not on the transplant list; and
4. PT > 5 seconds or INR > 1.5; and
5. Albumin < 2.5 gm/l; and
6. And at least one of the following:
   a. Recurrent bleeding esophageal varices despite therapy, or
   b. Refractory ascites, or
   c. Episode of spontaneous bacterial peritonitis, or
   d. Hepatorenal syndrome, or
   e. Hepatic encephalopathy.

H. *Acute or Chronic Renal Failure* – meets ALL of the following:
1. PPS (Appendix A) or KPS (Appendix B) score decreased to < 70%; and
2. Dependence for at least 2 ADLs (i.e. ambulation, continence, transfers, dressing, feeding, bathing); and
3. Member is in renal failure, not receiving dialysis and one of the following:
   a. Serum Creatinine > 8 mg/dl (> 6 diabetes), or
   b. GFR < 10 (or < 15 with diabetes), or
   c. GFR <15 with CHF (or < 20 with diabetes and CHF).

I. *Stroke* **–** meets ALL of the following:
1. PPS or KPS < 40%; and
2. Inadequate oral intake with one of the following:
   a. Weight loss of > 10% body weight in up to 6 months, or > 7.5% in up to three months, or
   b. Serum albumin < 2.5, or
   c. Recurrent aspiration, or
   d. Dysphagia and declining tube feeding and hydration.

J. *Coma* – member is comatose with at least three of the following on day 3 of coma:
1. Abnormal brain stem response,
2. Absent verbal response,
3. Absent withdrawal to painful stimuli,
4. Creatinine > 1.5.

K. *Non-Disease Specific Decline in Clinical Status* (the presence of significant comorbidities should be considered when using these criteria), ALL of the following:
1. Irreversible decline, based on both baseline and follow-up determinations; and
2. Clinical deterioration based on:
   a. Progressive dependence for ADLs, or
   b. Decreasing KPS or PPS from < 70%, or
   c. Increasing frequency of ER visits or hospitalizations, or
   d. Worsening of :

i. clinical status - such as recurrent infections, inanition with progressive weight loss, dysphagia, or decreasing albumin, or
ii. signs - such as hypotension, ascites, edema, pleural or pericardial disease, or decreased consciousness, or
iii. symptoms - such as intractable dyspnea, cough, nausea, diarrhea, or pain, or
iv. laboratory results - arterial blood gases, tumor markers, electrolytes, creatinine, or liver function tests; or

e. Progressive or stage 3-4 decubiti.

III. Intensity Of Service

Authorization is required prior to the initiation of hospice services, *for each benefit period*, and for *each change* in the level of intensity of service. Changes in level of care must be reviewed to determine medical necessity. The level of care and the dates of service requested must be specified. Only one level of care may be authorized for each day of hospice care provided to an eligible member. *The appropriate HCPCS or revenue (rev) code must be billed according to applicable contract provisions*.

A. *Routine Hospice Home Care* (HCPCS T2042 or rev code 0651)
1. Routine hospice home care is medically necessary when < 8 hours of nursing care, which may be intermittent, is required in a 24-hour period.

B. *Continuous Hospice Home Care* (HCPCS T2043 or rev code 0652)
1. Continuous hospice home care is medically necessary to maintain the member at home, when the member requires ≥ 8 hours of nursing care in a 24 hour period (begins and ends at midnight).

C. *Inpatient Respite Hospice Care* (HCPCS T2044 or rev code 0655)
1. Respite hospice care is medical necessary to relieve family members or other primary caregivers of care duties for no more than 5 consecutive days per episode.
   a. Respite care is short term inpatient care, and not residential or custodial care.

D. *General Inpatient, Short Term (non-respite) Hospice Care* (HCPCS T2045 or rev code 0656)
1. General inpatient, short term (non-respite) care services are medically necessary when the intensity or scope of care needed during an acute crisis is not feasible in the home setting and requires frequent adjustment by the member's care team; and
2. The individual treatment plan is specifically directed at acute symptom management and/or pain control.

IV. Hospice services are considered **NOT medically necessary** under the following circumstances:

A. Members with any of the following as the primary diagnosis:
1. Debility or unspecified debility, or
2. Failure to thrive; or

B. The member is no longer considered terminally ill as evidenced by a review of the medical documentation; or

C. Services, supplies or procedures that are directed towards curing the terminal condition, with the possible exception of children covered under Medicaid or CHIP, or

D. Member chooses to revoke the hospice election by submitting a signed, written statement with the effective date of the revocation; or

E. Member is discharged from hospice services; i.e. member is no longer considered terminally ill, member refuses services or is uncooperative, moves out of the area, or transfers to a non-covered hospice program. In the event a member is discharged from hospice, benefit coverage would be available as long as the member remained eligible for coverage of medical services.

Definitions

Levels of Care - four distinct levels of care are available

A. *Routine Hospice Home Care*
Routine hospice home care is care provided in the member's home and is related to the terminal diagnosis and plan of care written for the member. Routine hospice home care may include up to 8 hours of skilled nursing care in a 24-hour period. This care may be provided in a private residence, hospice residential care facility, nursing facility, or an adult care home.

B. *Continuous Hospice Home Care*
Continuous hospice home care consists primarily of skilled nursing care at home during brief periods of crisis in order to achieve palliation or management of acute medical symptoms and only as necessary to maintain the member at home. Continuous care must provide a minimum of 8 hours of nursing care in a 24 hour period, which begins and ends at midnight; the nursing care need not be continuous.

Continuous care may be supplemented by home health aide or homemaker services, but at least 50% of the total care must be provided by a nurse, and the care required must be predominantly nursing, rather than personal care or assistance with activities of daily living. Continuous hospice home care is not intended to be respite care or an alternative to paid caregivers or placement in another setting. Continuous hospice home care may include any of the services outlined in the covered services definition below.

C. *Inpatient Respite Hospice Care*
Short-term inpatient respite hospice care is provided in an approved inpatient hospice facility, hospital or nursing home for no more than 5 consecutive days per episode. It is allowed to relieve family members or other primary caregivers of the primary caregiving duties. A primary caregiver is an individual, designated by the member, who is responsible for the 24 hour care and support of the member in his or her home. A primary caregiver is not required to elect hospice if it has been determined by the hospice team that the member is safe at home alone at the time of the election.

D. *General Inpatient, Short Term (non-respite) Hospice Care*
General inpatient care, under the hospice benefit, is short-term, non-respite hospice care and is appropriate when provided in an approved hospice facility, hospital or nursing home. It is specifically used for pain control and symptom relief which is related to the

terminal diagnosis and cannot be managed in the home hospice setting. The goal is to stabilize the member and return him/her to the home environment. General inpatient, short term hospice care may include any of the services outlined in the covered services definition below.

Certification Periods
Certification (benefit) periods include an initial 90-day benefit period, followed by a second-90 day benefit period, followed by an unlimited number of 60-day benefit periods. Hospice care is continuous from one period to another, unless the member revokes, or the hospice provider discharges or does not recertify.

Discontinuation of Hospice
If a member revokes or is discharged from hospice care, the remaining days in the benefit period are lost. If/when the member meets the hospice coverage requirements, they can re-elect the hospice benefit, and will begin with the next benefit period.

Covered Services
When the above coverage criteria are met, the following hospice care services may be covered as part of the hospice treatment plan:

- **A.** Physician services
- **B.** Appropriate skilled nursing services
- **C.** Home health aide services
- **D.** Physical and/or occupational therapy
- **E.** Speech therapy services for dysphagia/feeding therapy
- **F.** Medical social services
- **G.** Counseling services (e.g., dietary, bereavement)
- **H.** Short-term inpatient care
- **I.** Prescription drugs (all drugs and biologicals that are necessary for the palliation and management of the terminal illness and related conditions)
- **J.** Consumable medical supplies (e.g., bandages, catheters) used by the hospice team.

Non-covered Services
The following services are considered not covered as part of the hospice treatment plan:

- **A.** Services during an acute inpatient stay *for a diagnosis that is unrelated to the terminal illness* for which the member is receiving hospice care
- **B.** Services for individuals no longer considered terminally ill
- **C.** Services, supplies or procedures, or medication that are directed towards curing the terminal condition
- **D.** Services to primarily aid in the performance of activities of daily living
- **E.** Nutritional supplements, vitamins, minerals and non-prescription drugs
- **F.** Medical supplies unrelated to the palliative care to be provided
- **G.** Services for which any other benefits apply.

Provider Responsibilities
The hospice provider is responsible for:

- **A.** Verifying member eligibility

- **B.** Obtaining authorization to provide hospice services before hospice care is initiated
- **C.** Notifying the health plan of any significant change in the member's status or condition including revisions to treatment plans and goals
- **D.** Requesting each change in the level of hospice service including discharge from hospice.

Background

Hospice is a coordinated, integrated program developed by a multidisciplinary team of professionals to provide end-of-life care, which is primarily focused on relieving pain *and* symptoms specifically related to the terminally ill diagnosis of members with a life expectancy of six months or less. Most hospice services are provided at home,[1] by a licensed certified hospice provider, under the direction of an attending physician, who may be the member's primary care physician or the hospice medical director. Hospice services are provided under a plan of care designed by the multidisciplinary team to meet the needs of members who are terminally ill, as well as their families.

Hospice services include skilled nursing, homemaker and home health aide services, physician services, physical, occupational and speech therapy, medical social services, volunteer services, nutritional, spiritual, psychosocial/supportive and bereavement counseling related to the management of the terminal illness. Hospice includes drugs and biologics related to the management of the terminal illness, to relieve pain, provide hydration and to deliver enterals as a primary source of nutrition. Durable medical equipment and medical supplies are also included in hospice, when related to the management of a terminal illness.

Appendices

Appendix A: Palliative Performance Scale (PPS)

PPS Level	Ambulation	Activity & Evidence of Disease	Self-care	Intake	Conscious Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
80%	Full	Normal activity with effort Some evidence of disease	Full	Normal or reduced	Full
70%	Reduced	Unable normal job/work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance needed	Normal or reduced	Full or confusion
50%	Mainly sit/lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or confusion

[1] National Hospice and Palliative Care Organization, Facts and Figures: Hospice Care in America, 2011 Edition

PPS Level	Ambulation	Activity & Evidence of Disease	Self-care	Intake	Conscious Level
40%	Mainly in bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or drowsy +/- confusion
30%	Totally bed bound	Unable to do any activity Extensive disease	Total care	Normal or reduced	Full or drowsy +/- confusion
20%	Totally bed bound	Unable to do any activity Extensive disease	Total care	Minimal to sips	Full or drowsy +/- confusion
10%	Totally bed bound	Unable to do any activity Extensive disease	Total care	Mouth care only	Full or drowsy +/- confusion
0%	Death				

Appendix B: Karnofsky Performance Status Scale (KPS) Definitions Rating (%) Criteria

Activity Level	Score	Detailed Activity Level
Able to carry on normal activity and to work; no special care needed.	100	Normal no complaints; no evidence of disease.
	90	Able to carry on normal activity; minor signs or symptoms of disease.
	80	Normal activity with effort; some signs or symptoms of disease.
Unable to work; able to live at home and care for most personal needs; varying amount of assistance needed.	70	Cares for self; unable to carry on normal activity or to do active work.
	60	Requires occasional assistance, but is able to care for most of his personal needs.
	50	Requires considerable assistance and frequent medical care.
Unable to care for self; requires equivalent of institutional or hospital care; disease may be progressing rapidly.	40	Disabled; requires special care and assistance.
	30	Severely disabled; hospital admission is indicated although death not imminent.
	20	Very sick; hospital admission necessary; active supportive treatment necessary.
	10	Moribund; fatal processes progressing rapidly.

Appendix C: Functional Assessment Staging Test (FAST) for Alzheimer's disease

Stage	Stage Name	Characteristic
1	Normal aging	No deficits
2	Possible mild cognitive impairment	Subjective functional deficit
3	Mild cognitive impairment	Objective functional deficit interferes with a person's most complex tasks
4	Mild dementia	IADLs become affected, such as bill paying, cooking, cleaning, traveling
5	Moderate dementia	Needs help selecting proper attire

6a	Moderately severe dementia	Needs help putting on clothes
6b	Moderately severe dementia	Needs help bathing
6c	Moderately severe dementia	Needs help toileting
6d	Moderately severe dementia	Urinary incontinence
6e	Moderately severe dementia	Fecal incontinence
7a	Severe dementia	Speaks 5-6 words during day
7b	Severe dementia	Speaks only 1 word clearly
7c	Severe dementia	Can no longer walk
7d	Severe dementia	Can no longer sit up
7e	Severe dementia	Can no longer smile
7f	Severe dementia	Can no longer hold up head

Coding Implications

The following codes are for informational purposes only. They are current at time of review of this policy. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
T2042	Hospice routine home care; per diem
T2043	Hospice continuous home care; per 15 minutes
T2044	Hospice inpatient respite care, per diem
T2045	Hospice general inpatient care; per diem
T2046	Hospice long-term care, room and board only; per diem
G0337	Hospice evaluation and counseling services, pre-election
Revenue Code	
0651	Hospice routine home care; per diem
0652	Hospice continuous home care, per 15 minutes
0655	Hospice inpatient respite care, per diem
0656	Hospice general inpatient, non-respite care, per diem
0658	Hospice room and board, nursing facility
0657	Hospice charges for services furnished to patients by physician or nurse practitioner employees, or physicians or nurse practitioners receiving compensation from the hospice. Physician services performed by a nurse practitioner require the addition of the modifier GV in conjunction with revenue code 0657.

Reviews, Revisions, and Approvals	Date	Approval Date
Policy reorganized into severity of illness and intensity of service criteria; added appendices	07/14	07/14
Converted into new policy template, bibliography reviewed and updated	07/15	07/15

Reviews, Revisions, and Approvals	Date	Approval Date
References reviewed and updated. Limited codes in Coding Implications to only those that should be billed for hospice services.	07/16	07/16
References reviewed and updated.	07/17	07/17

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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CENTENE Corporation

Clinical Policy: Assistive Reproductive Technology

Reference Number: CP.MP.55
Effective Date: 05/13
Last Review Date: 04/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Diagnostic infertility services to determine the cause of infertility and treatment is covered only when specific coverage is provided under the terms of a member's benefit plan. All coverage is subject to the terms and conditions of the plan. The following discussion is applicable only to members whose Plan covers infertility services.

Infertility is defined as the condition of an individual who is unable to conceive or produce conception during a period of 1 year if the female is age 35 or younger or during a period of 6 months if the female is over the age of 35. For purposes of meeting the criteria for infertility in this section, if a person conceives but is unable to carry that pregnancy to live birth, the period of time she attempted to conceive prior to achieving that pregnancy shall be included in the calculation of the 1 year or 6 month period, as applicable.

Assisted Reproductive Technologies (ART) encompass a variety of clinical treatments and laboratory procedures which include the handling of human oocytes, sperm or embryos, with the intent of establishing pregnancy.

The following services are considered medically necessary when performed solely for the treatment of infertility in an individual in whom fertility would naturally be expected and when meeting the accompanying ART criteria in the Policy/Criteria section.

Females:

1. FDA approved medications (including specialty injectables): clomiphene, aromatase inhibitors, estrogens, corticosteroids, progestins, metformin, and prolactin inhibitors, gonadotropin releasing hormone (GnRH) agonists, gonadotropins, and gonadotropin releasing hormone (GnRH) antagonists.
2. Infertility surgery: surgical laparoscopy; ovarian wedge resection or ovarian drilling; removal of myomas, uterine septa, cysts, ovarian tumors, and polyps; open or laparoscopic resection, vaporization, or fulguration of endometriosis implants; adhesiolysis; laparoscopic cystectomy; hysteroscopic adhesiolysis; removal of fallopian tubes; hysteroscopic or fluoroscopic tubal cannulation (fimbrioplasty); selective salpingography plus tubal catheterization, or transcervical balloon tuboplasty, and tubal anastomosis.
3. Artificial insemination (AI); intrauterine insemination (IUI) and intracervical insemination.
4. In vitro fertilization with embryo placement (IVF-EP).
5. Gamete intrafallopian transfer (GIFT).
6. Zygote intrafallopian transfer (ZIFT).
7. Intracytoplasmic sperm injection (ICSI) with or without assisted hatching.

8. Short duration (up to 1 year) cryopreservation of embryo(s) while individual is under active infertility treatment.

Males:

1. FDA approved medications, including specialty injectables, Clomiphene, corticosteroids, antiestrogens, prolactin inhibitors, cabergoline, thyroid hormone replacement, androgens, aromatase inhibitors (testolactone), gonadotropin releasing hormone (GnRH), and gonadotropins.
2. Infertility surgery: varicocelectomy (spermatic vein ligation), transurethral resection of the ejaculatory ducts (TURED), orchiopexy, surgical reconstruction or repair of the vas or epididymis surgery such as vasovasostomy, epididymovasostomy, epididymectomy.
3. Testicular sperm extraction (TESE), micro-TESE, and epididymal sperm extraction.
4. Impotence treatments.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that ART is **medically necessary** for the following indications when the basic and treatment-specific criteria in **A** and **B** are met.

Authorized infertility benefits are covered for a maximum of six cycles for any given ART procedure. The six cycle limit per lifetime applies to canceled cycles and previous cycles not covered by the health plan.

A. Basic Criteria- meets all of the following:

1. ART for females is performed by a physician board-certified or board eligible in reproductive endocrinology and for males is a board-certified or board eligible urologist;
2. Member is presumably fertile and has documentation of an inability to conceive during a period of 12 menstrual cycles of exposure to sperm, or 6 cycles for women ≥ age 35. Or, for females without male partners, inability to conceive after 12 IUI cycles for women under age 35 or 6 IUI cycles for women ≥ age 35, using normal quality sperm;
3. For female members ≥ 35 years, demonstration of adequate ovarian reserve. This is defined as a normal clomiphene citrate challenge test (CCCT) in the past 6 months:
   a. Cycle days 3 and/or 10 FSH levels < 15 mIU/ml and the day 3 estradiol level < 80pg/mL;
4. Infertility is unrelated to voluntary sterilization or failed reversal of voluntary sterilization of either partner. Evidence of such includes:
   a. In the case of vasectomy reversal – there must be two recent normal semen analyses within the past 3 months (sperm count > 20 million/ml; motility > 50% and normal morphology – > 14% normal forms by Krüger classification or > 30% normal forms by WHO criteria);
   b. In the case of previous tubal ligation with reanastamosis, documentation by hysterosalpingogram of unilateral or bilateral tubal patency.

B. Treatment-Specific Criteria:

1. Artificial Insemination/IUI- meets all of the following:
   a. Unilateral or bilateral tubal patency, and one of the following
      i. Mild male factor infertility;
      ii. Cervical factors;
      iii. Unexplained infertility;
      iv. Sperm antibodies;
      v. Mild endometriosis;
      vi. Unable to, or would find it very difficult to, have vaginal intercourse because of a clinically diagnosed physical disability or psychosexual problem who are using partner or donor sperm;
      vii. Couples in which the male partner is HIV positive and undergoing sperm washing.

2. IVF
   a. Inadequate number of frozen embryos available for transfer: < 3 for women age < 35 years, or < 4 for women age ≥ 35 years; and one of the following:
      i. Barrier to fertilization, one of the following:
         a) Bilateral fallopian tube absence or obstruction due to prior tubal disease (not voluntary sterilization);
         b) Severe endometriosis which failed medical and surgical therapy;
         c) Severe male factor infertility that has failed conservative treatments (TMS <10 million and/or normal morphology of ≤ 1% by Krüger/≤ 5% by WHO criteria); or
      ii. IUI failure - one of the following:
         a) For women ≤ 39 years old, failure of 3 cycles of IUI with gonadotropin stimulation required;
         b) For women age 40-42, failure of 1-2 cycles of IUI with gonadotropin stimulation.

3. Conversion from IUI to IVF- meets both of the following:
   a. For women < 40 years of age, if a medicated IUI cycle results in an estradiol level of > 1000 pg/ml and the production of at least 3 follicles ≥ 16mm or 4-8 follicles > 14 mm in diameter, conversion of the IUI to IVF is considered medically necessary;
   b. If converted to an IVF cycle, the member needs to complete the required number of IUI/gonadotropin cycles for her age/lab status before consideration of further IVF.

4. Frozen Embryo Transfers (FET)*- meets both of the following:
   a. Frozen embryos must be used prior to authorization of additional IVF cycles in one of the following circumstances:
      i. Women < 35 with at least 3 embryos available for transfer;
      ii. Women ≥ 35 with at least 4 embryos available for transfer;

      *If member continues to qualify for infertility, FET with less than this number of embryos available for transfer is considered medically necessary.

5. GIFT/ZIFT- meets all of the following:
   a. Member has at least one patent fallopian tube;
   b. Failure of required number of IUI cycles as per IVF criteria;
   c. Justification that GIFT/ZIFT is preferable to standard IVF must be provided.

6. ICSI- meets one of the following:
   a. Less than 2 million motile spermatozoa per ejaculate;
   b. Anti-spermatozoan antibodies shown to be contributing to infertility;
   c. Prior or repeated fertilization failure with standard IVF protocols (< 50% fertilization);
   d. Washed sperm limited in number and quality;
   e. Obstruction of the male reproductive tract not amenable to repair necessitating MESA or TESE (does not include obstruction due to voluntary sterilization);
   f. Abnormal morphology (≤ 1% normal forms by Kruger; ≤ 5% normal forms by WHO);
   g. Specific spermatozoan defects impairing spermatozoa-oocyte interaction.

7. Assisted Hatching- meets both of the following:
   a. Women ≥ 38 years old;
   b. ≥ 2 failed IVF cycles with poor quality embryos.

8. Donor egg cycle- meets all of the following:
   a. Has an approved ART cycle and one of the following:
      i. Congenital or surgical absence of ovaries;
      ii. Premature ovarian failure (menopause before age 40);
      iii. Premature diminished ovarian reserve (CCCT day 3 or 10 FSH ≥ 15 in women ≤ 35);
      iv. Ovarian failure following chemotherapy or radiation therapy;
      v. Previously failed IVF in a woman age 40-42;
      vi. Gonadal dysgenesis including Turner Syndrome;
      vii. High risk of transmitting genetic disorder from female.

9. TESE, micro-TESE and epididymal sperm extraction – applies only if the male partner is a covered member. Meets the following:
   a. Male with obstructive or non-obstructive azoospermia.

10. Donor sperm:
    a. Has an approved ART cycle and one of the following:
       i. Bilateral congenital absence of the vas deferens (BCAVD);
       ii. Obstructive azoospermia;
       iii. Female without a male partner;
       iv. High risk of transmitting an infectious disease from male partner (such as HIV);
       v. High risk of transmitting a genetic disorder in the male partner to the offspring;

vi. Non-obstructive azoospermia confirmed through MESA/TESA;
vii. Severe rhesus isoimmunization;
viii. Previous radiation or chemotherapy resulting in abnormal semen analysis;
viii. Two abnormal semen analyses (by Krüger or WHO classification) at least 30 days apart.

11. Cryopreservation of sperm:
    a. Short term storage (up to 90 days after sample obtained or 90 days after the last approved infertility treatment) for a male member already in active infertility treatment who:
        i. Is undergoing medical treatment (like cancer treatment) that will result in infertility, or
        ii. Has undergone an approved MESA or TESE procedure.

12. Cryopreservation of embryos:
    a. Short term storage (up to 90 days after last approved infertility treatment) of embryos if:
        i. Embryos could not be transferred due to high risk of multiple gestation, or
        ii. Embryos could not be transferred due to a potential adverse impact on maternal health (i.e., severe hyper-stimulation syndrome, etc.)

13. Cryopreservation of eggs (oocytes):
    a. Short-term storage (up to 90 days after collection or 90 days after the last approved infertility treatment) for a female member already in active infertility treatment who is undergoing medical treatment (like cancer treatment) that will result in infertility.

II. It is the policy of health plans affiliated with Centene Corporation® that ART is **not medically necessary** for the following indications:
- **A.** Any experimental infertility procedure, until the procedure becomes recognized as non-experimental;
- **B.** Surrogacy;
- **C.** Reversal of voluntary sterilization;
- **D.** Commercially available over-the-counter home test kits, including but not limited to ovulation prediction and pregnancy test kits;
- **E.** Infertility treatment needed as a result of prior voluntary sterilization or unsuccessful sterilization reversal procedure;
- **F.** A partner's infertility services when a partner in not a member;
- **G.** A member who is medically infertile due to natural aging (>50 years) or for women who are menopausal;
- **H.** Gender selection, chromosomal studies of donor sperm or egg.

Background

IVF-EP

In vitro fertilization involves fertilization of an egg with sperm in a dish in a laboratory, rather than inside a women's body. The resulting embryo is placed into the uterus later. One cycle of IVF-EP includes:

- Ovulation stimulation and monitoring- the woman starts ovulation drugs to stimulate the ovaries to produce multiple eggs. Ovulation drugs are given over period of 8-14 days. During this time the woman is monitored for follicular development with frequent ultrasounds and blood tests. The eggs are retrieved before ovulation occurs.
- Oocyte (egg) retrieval is usually accomplished by ultrasound guided aspiration performed in the office.
- Sperm preparation and capacitation- sperm are placed together with eggs and stored in an incubator.
- Embryo transfer- including frozen embryo transfer (FET) involves embryo transfer to the uterus any time between one to six days after egg retrieval, or after cryopreservation in FET.

GIFT
A laparoscope is used to aspirate one or more mature oocytes from the ovaries. Oocytes are then mixed with sperm and transferred to the fallopian tube via a catheter. GIFT, although more invasive than IVF, may be an appropriate choice in patients who, for religious or personal reasons, do not wish to have embryos in the laboratory. It is also appropriate for those who have failed donor insemination or require laparoscopy for other reasons. The success rate is similar to those with IVF.

ZIFT
This procedure involves placement of fertilized eggs (zygotes) or embryos into the fallopian tube. It is analogous to GIFT in that laparoscopy is needed to place the zygotes in the fallopian tubes. Whereas overall success rates are similar to IVF, ZIFT may offer some advantages to patients with difficult trans-cervical embryo transfer, uterine abnormalities (such as those caused by DES exposure), or recurrent failure with standard IVF.

ICSI
Intra-cytoplasmic sperm injection involves injecting the sperm into the egg in a dish in the laboratory to fertilize it, rather than letting sperm penetrate the egg naturally. Embryos are then transferred to the uterus as in usual IVF.

ICSI should be available to patients with previously failed fertilization who demonstrate either abnormal or normal semen profiles and to patients with spermatozoa concentration and motility too low to expect any success with conventional IVF. Patients should be counseled carefully regarding the outcomes and potential risks of ICSI. If there is a risk of adverse neonatal outcome associated with ICSI, it appears to be small.

Assisted Hatching:
"Hatching" is a natural process in which an embryo expands and eventually breaks through the zona pellucida in order to implant on the surface of the endometrium (the lining of the uterus). "Assisted hatching" refers to a laboratory procedure whereby the zona pellucida around the day 3 embryo is mechanically or chemically opened to assist the embryo in hatching from the zona

about three days later. The procedure may improve the percentage of embryos that implant in selected cases with poor prognosis (eg, 2 failed IVF cycles and poor embryo quality and older women, but its use is still controversial).

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2016, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Infertility Services Requiring Prior Authorization if a covered benefit

CPT® Codes	CPT Code Descriptions
58321	Artificial insemination; intra-cervical insemination (ICI)
58322	Artificial insemination; intra-uterine insemination (IUI)
58323	Sperm washing for artificial insemination
58970	Follicle puncture for oocyte retrieval, any method (IVF)
58974	Embryo transfer, intrauterine (IVF-ET)
58976	Gamete, zygote, or embryo intrafallopian tube transfer; any method (GIFT)
89250	Culture of oocyte(s)/embryo(s), less than 4 days;
89251	Culture of oocyte(s)/embryo(s), less than 4 days; with co-culture of oocyte(s)/ embryo(s)
89253	Assisted embryo hatching, microtechniques (any method)
89254	Oocyte identification from follicular fluid
89255	Preparation of embryo for transfer (any method)
89257	Sperm identification from aspiration (other than seminal fluid)
89258	Cryopreservation; embryo(s)
89259	Cryopreservation; sperm
89260	Sperm isolation; simple prep (eg, sperm wash and swim-up) for insemination or diagnosis with semen analysis
89261	Sperm isolation; complex prep (eg, Percoll gradient, albumin gradient for insemination or diagnosis with semen analysis
89264	Sperm identification from testis tissue, fresh or cryopreserved
89268	Insemination of oocytes
89272	Extended culture of oocyte(s)/embryo(s), 4-7 days
89280	Assisted oocyte fertilization, microtechnique, less than or equal to 10 oocytes
89281	Assisted oocyte fertilization, microtechiques; greater than 10 oocytes.
89290	Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis); less than or equal to 5 embryos
89291	Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis); greater than 5 embryos
89337	Cryopreservation, mature oocyte(s)

CPT® Codes	CPT Code Descriptions
89352	Thawing of cryopreserved; embryo(s)
89353	Thawing of cryopreserved; sperm/semen, each aliquot
89356	Thawing of cryopreserved; oocytes, each aliquot

HCPCS Codes	HCPCS Code Descriptions
S4011	In vitro fertilization; including but not limited to identification and incubation of mature oocytes, fertilization with sperm, incubation of embryo(s), and subsequent visualization for determination
S4013	Complete cycle, gamete intrafallopian transfer (GIFT), case rate
S4014	Complete cycle, zygote intrafallopian transfer (ZIFT), case rate
S4015	Complete in vitro fertilization cycle, not otherwise specified, case rate
S4016	Frozen in vitro fertilization cycle, case rate
S4017	Incomplete cycle, treatment canceled prior to stimulation, case rate
S4018	Frozen embryo transfer procedure canceled before transfer, case rate
S4020	In vitro fertilization procedure canceled before aspiration, case rate
S4021	In vitro fertilization procedure canceled after aspiration, case rate
S4022	Assisted oocyte fertilization, case rate
S4023	Donor egg cycle, incomplete, case rate
S4025	Donor services for in vitro fertilization (sperm or embryo), case rate
S4026	Procurement of donor sperm from sperm bank
S4028	Microsurgical epididymal sperm aspiration (MESA)
S4035	Stimulated intrauterine insemination (IUI), case rate
S4037	Cryopreserved embryo transfer, case rate

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10 Codes	ICD-10 Code Descriptions
B20	Human immunodeficiency virus (HIV) disease
E28.310	Symptomatic premature menopause
E89.40	Asymptomatic postprocedural ovarian failure
E89.41	Symptomatic postprocedural ovarian failure
N46.01	Organic azoospermia
N46.021	Azoospermia due to drug therapy
N46.023	Azoospermia due to infection
N46.024	Azoospermia due to radiation
N46.025	Azoospermia due to systemic disease
N46.029	Azoospermia due to extratesticular causes
N46.11	Organic oligospermia
N46.121	Oligospermia due to drug therapy
N46.122	Oligospermia due to infection
N46.123	Oligospermia due to obstruction of efferent ducts
N46.124	Oligospermia due to radiation

N46.125	Oligospermia due to systemic disease
N46.129	Oligospermia due to extratesticular causes
N80.0-N80.4	Endometriosis (uterus, fallopian tube, pelvic peritoneum, rectovaginal septum and vagina)
N97.0	Female infertility associated with anovulation
N97.1	Female infertility of tubal origin
N97.2	Female infertility of uterine origin
N97.8	Female infertility of other origins
Q50.01	Congenital absence of ovary, unilateral
Q50.02	Congenital absence of ovary., bilateral
Q50.6	Other congenital malformations of fallopian tube and broad ligament
Q55.3	Atresia of vas deferens
Q96.0-Q96.8	Turner's syndrome
Z31.0	Encounter for reversal of previous sterilization
Z31.41	Encounter for fertility testing
Z31.430	Encounter of female for testing for genetic disease carrier status for procreative management
Z31.440	Encounter of male for testing for genetic disease carrier status for procreative management
Z31.441	Encounter for testing of male partner of patient with recurrent pregnancy loss
Z31.448	Encounter for other genetic testing of male for procreative management

Reviews, Revisions, and Approvals	Date	Approval Date
Under basic criteria, clarified that men were to be treated by board-certified urologist Added IVF, Conversion from IUI to IVF and FET criteria Restructured sections to more closely resemble other Centene clinical policy Removed Authorization Protocols section	03/14	
Added TESE, micro-TESE, and epididymal sperm extraction Added "board eligible" on page 3 under requirements for treatment provided by board certified physician	04/14	05/14
Clarified criteria language to indicate number of criteria required for each procedure	11/14	
Additional language clarification to aid in conversion to Interqual Custom Content	12/14	

Reviews, Revisions, and Approvals	Date	Approval Date
Combined inability to conceive for females with and without partners into one bullet point under I.B Removed FSH requirements from II.B.3 as this is covered in basic criteria	04/15	04/15
Added clomiphene and aromatase inhibitors to FDA approved medications for female infertility. IUI- added "unable to have vaginal intercourse" and male partner is HIV positive as indications, per NICE guidelines. IVF- clarified wording in 2.a. Donor egg cycle- added indications for ovarian failure post chemo/radiation, gonadal dysgenesis, and high risk of transmitting genetic disorder from female partner. Donor sperm: added following indications: obstructive azoospermia, high risk of transmitting infectious disease from male partner, female without a male partner, high risk of transmitting genetic disorder from male partner, rhesus isoimmunization and female without male partner. Took out requirement that male partner be a covered member. Added indication for cryopreservation of oocytes per ASRM guidelines. Background- added "or after cryopreservation in FET" to the last bullet in the IVF section. Added CPT codes for oocyte cryopreservation and thawing. Reviewed by specialist.	04/16	04/16
References reviewed and updated. ICD-10 codes added.	04/17	04/17

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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CENTENE Corporation

Clinical Policy: Ventriculectomy and Cardiomyoplasty

Reference Number: CP.MP.56
Effective Date: 05/13 Revision Log
Last Review Date: 03/17

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Guidelines to determine medical necessity for ventriculectomy and cardiomyoplasty procedures as a treatment for severe chronic heart failure

Policy/Criteria

It is the policy of health plans affiliated with Centene Corporation® that that ventriculectomy and cardiomyoplasty procedures are considered **experimental and/or investigational** and are therefore not medically necessary.

Background

Heart failure is the final common path of myocardial dysfunction in most types of cardiac disease. Treatment options for heart failure include both medical and surgical therapy and surgical treatment, including ventricular assist devices (VADs), coronary revascularization, valve repair or replacement, total artificial heart, and heart transplantation. Heart transplantation has become the standard treatment for eligible patients with severe, irreversible biventricular failure unresponsive to medical or surgical treatment. Several surgical approaches have been explored as alternative treatments for patients with end-stage heart failure.

Surgical options to reduce the size of the enlarged left ventricle and improve cardiac function include partial left ventriculectomy, also known as the Batista procedure. Partial left ventriculectomy involves removing an elliptical section of the ventricle to improve cardiac output in patients who have severe chronic heart failure. Multiple studies have found minor improvements in measures of heart function and clinical status in the short term, with high mortality rates, high recurrences of symptomatic heart failure, and fatal arrhythmias (Stolf et al., 1998; Startling et al., 2000; Franco-Cereceda et al., 2001). As such, this procedure has fallen out of use (Fang, 2015).

Dynamic cardiomyoplasty is a surgical procedure in which a latissimus dorsi muscle flap is transposed into the chest and wrapped around the ventricles of the failing heart. This skeletal muscle flap is then electrically stimulated to contract in synchrony with ventricular systole. Over time, pacing of the skeletal muscle may produce morphologic, molecular and functional changes in the skeletal muscle, including notable reduction in muscle fatigue with repeated stimulation. Cardiomyoplasty has been found to be of some benefit to stage III heart failure patients; however, these patients could be well-managed with other interventions with less risk. Additionally, stage IV patients who have fewer effective interventions available had unacceptably high post-operative mortality risk (Leier, 1996) after cardiomyoplasty. Due to these considerations, this operation is very rarely used (Fang, 2015).

CENTENE Corporation

CLINICAL POLICY
Ventriculectomy and Cardiomyoplasty

Reviews, Revisions, and Approvals	Date	Approval Date
Policy Developed		05/13
References reviewed and updated	04/14	05/14
References reviewed and updated	03/15	03/15
Converted to new template References reviewed and updated	02/16	03/16
References reviewed and updated	03/17	03/17

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CLINICAL POLICY
Ventriculectomy and Cardiomyoplasty

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CLINICAL POLICY
Ventriculectomy and Cardiomyoplasty

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CENTENE Corporation

Clinical Policy: Lung Transplantation

Reference Number: CP.MP.57
Effective Date: 02/14
Last Review Date: 11/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Medical necessity criteria for the review of lung transplantation requests.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that lung transplant for members with chronic, end-stage lung disease who have failed maximal medical therapy is **medically necessary** when all of the following criteria are met:

A. High (> 50%) risk of death from lung disease within 2 years if lung transplantation is not performed.

B. High (> 80%) likelihood of surviving at least 90 days after lung transplantation.

C. High (> 80%) likelihood of 5-year post-transplant survival from a general medical perspective provided that there is adequate graft function.

D. Does not have ANY of the following absolute contraindications:
1. Malignancy in the past two years, except for non-melanoma localized skin cancer that has been treated appropriately;
2. Untreatable significant dysfunction of another major organ system unless combined organ transplantation can be performed;
3. Uncorrected atherosclerotic disease with suspected or confirmed end-organ ischemia or dysfunction and/or coronary artery disease not amenable to revascularization;
4. Acute medical instability, including, but not limited to, acute sepsis, acute viral respiratory infection, myocardial infarction, and liver failure;
5. Uncorrectable bleeding diathesis;
6. Chronic infection with highly virulent and/or resistant microbes that are poorly controlled pre-transplant;
7. Evidence of active *Mycobacterium tuberculosis* infection and/or smear-positive non-tuberculous mycobacterial infection;
8. Significant chest wall/spinal deformity expected to cause severe restriction after transplantation;
9. Class II or III obesity (body mass index $\geq$ 35.0 kg/m^2);
10. Current non-adherence to medical therapy or a history of repeated or prolonged episodes of non-adherence to medical therapy that are perceived to increase the risk of non-adherence after transplantation;
11. Psychiatric or psychological condition associated with the inability to cooperate or comply with medical therapy;
12. Absence of an adequate or reliable social support system;

13. Severely limited functional status with poor rehabilitation potential;
14. Substance abuse or dependence (including tobacco and alcohol) without convincing evidence of risk reduction behaviors, such as meaningful and/or long-term participation in therapy for substance abuse and/or dependence. Serial blood and urine testing may be used to verify abstinence from substances that are of concern;
    a. Documentation of abstinence from smoking for 6 months before consideration to be eligible for transplant.

E. Has one of the following disease states and meets its corresponding criteria (not an all-inclusive list):
1. *Adult Members, Age ≥ 18:*
    a. Interstitial Lung Disease and any of the following:
        i. Decline in forced vital capacity (FVC) ≥ 10% during 6 months of follow-up (note: a 5% decline is associated with a poorer prognosis and may warrant listing);
        ii. Decline in diffusing capacity of the lung for carbon monoxide (DLCO) ≥15% during 6 months of follow-up;
        iii. Desaturation to < 88% or distance < 250 m on 6-minute-walk test (6MWT) or > 50 m decline in 6MWT distance over a 6-month period;
        iv. Pulmonary hypertension on right heart catheterization or 2-dimensional echocardiography;
        v. Hospitalization because of respiratory decline, pneumothorax, or acute exacerbation;
    b. Cystic fibrosis (CF) or other causes of bronchiectasis, and any of the following:
        i. Chronic respiratory failure and one of the following:
            a) With hypoxia alone (partial pressure of oxygen [PaO_2] < 8 kPa or < 60 mm Hg);
            b) With hypercapnia (partial pressure of carbon dioxide [$PaCO_2$] > 6.6 kPa or > 50 mmHg);
        ii. Long-term non-invasive ventilation therapy;
        iii. Pulmonary hypertension;
        iv. Frequent hospitalization with a clinical trajectory of worsening quality of life and lung function;
        v. Rapid lung function decline;
        vi. World Health Organization Functional Class IV.
    c. Chronic obstructive pulmonary disease (COPD), and any of the following:
        i. BODE index (includes BMI, degree of airflow obstruction, degree of dyspnea, and exercise capacity) ≥ 7;
        ii. FEV1 (forced expiratory volume in 1 second) < 15 to 20% of predicted;
        iii. Three or more severe exacerbations during the preceding year;
        iv. One severe exacerbation with acute hypercapnic respiratory failure;
        v. Moderate to severe pulmonary hypertension;
    d. Pulmonary vascular diseases and any of the following:
        i. New York Heart Association (NYHA) Functional Class III or IV despite a trial of at least 3 months of combination therapy including prostanoids;
        ii. Cardiac index of < 2 liters/min/m2;

iii. Mean right atrial pressure > 15 mm Hg;
iv. 6MWT of < 350 m;
v. Development of significant hemoptysis, pericardial effusion, or signs of progressive right heart failure (renal insufficiency, increasing bilirubin, brain natriuretic peptide, or recurrent ascites);

e. Eisenmenger syndrome with pulmonary hypertension despite therapy aimed at avoiding polycythemia, iron deficiency and dehydration, and the associated profound hypoxemia and impaired quality of life;
f. Lymphangioleiomyomatosis and any of the following:
   i. Severe impairment in lung function and exercise capacity (e.g., VO2 max <50% predicted);
   ii. Hypoxemia at rest;
g. Primary lung graft failure or bronchiolitis obliterans.

2. *Pediatric Members, Age < 18:*
   a. Cystic fibrosis, and any of the following:
      i. Progressive lung disease and disability despite optimal medical therapy;
      ii. FEV1 < 30%;
      iii. Increasingly frequent hospitalizations;
      iv. Hypoxemia, (PaO_2 < 8 kPa or < 60 mm Hg);
      v. Hypercapnia, ($PaCO_2$ > 6.6 kPa or > 50 mmHg);
   b. Idiopathic pulmonary arterial hypertension, and any of the following:
      i. NYHA or WHO functional class III or IV despite vasodilator therapy;
      ii. Low exercise tolerance with 6MWT < 350 meters;
      iii. Uncontrolled syncope;
      iv. Hemoptysis;
      v. Right heart failure;
      vi. Failure to respond to vasodilator therapy;
   c. Pulmonary vascular disease and failure to respond to medical management;
   d. Eisenmenger syndrome with pulmonary hypertension despite therapy aimed at avoiding polycythemia, iron deficiency and dehydration, and the associated profound hypoxemia and impaired quality of life;
   e. Surfactant dysfunction disorders with unrelenting respiratory failure, or progressive interstitial lung disease with respiratory insufficiency, unresponsive to medical interventions;
   f. Bronchopulmonary dysplasia, and any of the following:
      i. Extended time requiring ventilator support without clinical improvement;
      ii. Pulmonary hypertension unresponsive to oxygen therapy;
      iii. Repeated episodes of respiratory failure without improvement in clinical trajectory over time, despite good medical support;
      iv. Progressive pulmonary hypertension;
   g. Diffuse Parenchymal Lung Disease, and any of the following:
      i. Disease progression despite optimal management;
      ii. Poor quality of life;
   h. Primary lung graft failure or bronchiolitis obliterans.

CLINICAL POLICY
Lung Transplantation

Background
Lung transplantation is an accepted therapy for the management of a range of severe lung disorders. Single, double, and lobar-lung transplants have all been performed successfully for carefully selected patients with end-stage pulmonary disease. The most common disease processes for which lung transplants are performed include COPD, idiopathic pulmonary fibrosis, cystic fibrosis, pulmonary arterial hypertension, and sarcoidosis.

COPD is one of the most common lung diseases and is the most common indication for lung transplantation. Chronic bronchitis and emphysema are the two main forms of COPD, both most commonly caused from smoking. Non-smokers with an alpha-1 antitrypsin deficiency can also develop emphysema. These conditions are the most common indications for single lung transplants. Cystic fibrosis, emphysema, and alpha-1 antitrypsin deficiency are the most common indications for double lung transplant, or sequential replacement of both lungs.

The most common indications for pediatric lung transplants include pulmonary vascular disease, bronchiolitis obliterans, bronchopulmonary dysplasia, graft failure due to viral pneumonitis, and CF.

Coding Implications
This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2017, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
32851	Lung transplant, single; without cardiopulmonary bypass
32852	Lung transplant, single; with cardiopulmonary bypass
32853	Lung transplant, double (bilateral sequential or en bloc); without cardiopulmonary bypass
32854	Lung transplant, double (bilateral sequential or en bloc); with cardiopulmonary bypass

HCPCS Codes	Description
S2060	Lobar lung transplantation
S2152	Solid organ(s), complete or segmental, single organ or combination of organs; deceased or living donor (s), procurement, transplantation, and related complications; including: drugs; supplies; hospitalization with outpatient follow-up; medical/surgical, diagnostic, emergency, and rehabilitative services, and the number of days of pre- and post-transplant care in the global definition

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
C96.6	Unifocal Langerhans-cell histiocytosis
D86.0	Sarcoidosis of lung
E84.0-E84.9	Cystic fibrosis
E88.01	Alpha-1-antitrypsin deficiency
I27.0	Primary pulmonary hypertension
I27.2	Pulmonary hypertension due to lung diseases and hypoxia
I27.83	Eisenmenger's syndrome
I27.89	Other specified pulmonary heart disease
I27.9	Pulmonary heart disease, unspecified
J41.8	Mixed simple and mucopurulent chronic bronchitis
J42	Unspecified chronic bronchitis
J43.0-J43.9	Emphysema
J44.0-J44.9	Other chronic obstructive pulmonary disease
J47.0-J47.9	Bronchiectasis
J60	Coal worker's Pneumoconiosis
J61	Pneumoconiosis due to asbestos and other mineral fibers
J62.0-J62.8	Pneumoconiosis due to dust containing silica
J63.0-J63.6	Pneumoconiosis due to other inorganic dusts
J84.10	Pulmonary fibrosis, unspecified
J84.111-J84.17	Idiopathic interstitial pneumonia
J84.81	Lymphangioleiomyomatosis
J84.82	Adult pulmonary Langerhans cell histiocytosis
J84.83	Surfactant mutations of the lung
J84.89	Other specified interstitial pulmonary disease
J98.2	Interstitial emphesema
J99	Respiratory disorders in diseases classified elsewhere
P27.0-P27.9	Chronic respiratory disease originating in the perinatal period
Q21.8	Other congenital malformations of cardiac septa
Q33.0-Q33.9	Congenital malformations of the lung
T86.810-T86.819	Complications of lung transplant
Z99.89	Dependence on other enabling machines and devices

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed Specialist review	01/14	02/14
References reviewed and updated	02/15	02/15
Converted into new policy template, references reviewed and updated	02/16	

Reviews, Revisions, and Approvals	Date	Approval Date
Updated criteria to match 2014 International Guidelines for the Selection of Lung Transplant Candidates: updated likelihood of survival and absolute contraindications; updated cystic fibrosis criteria; updated COPD criteria; combined diseases together that classify as interstitial lung disease; updated PAH to pulmonary vascular diseases and associated criteria;	03/16	03/16
Added pediatric specific criteria. Added "acute viral respiratory infection" to I.D.4. and "and/or smear-positive non-tuberculous mycobacterial infection" to I.D.7. Added "with a clinical trajectory of worsening quality of life and lung function" to adult cystic fibrosis criteria for frequent hospitalization. Removed background regarding lobar-lung transplant. Added HCPCS and ICD-10 code tables. Reviewed by external pediatric pulmonologist.	10/16	11/16
Added Eisenmenger syndrome as a qualifying condition for adult transplant. Added that the list of qualifying conditions for transplant is not all-inclusive. Added primary lung graft failure and bronchiolitis obliterans as an indication for adult and pediatric transplant since ISHLT guidelines recommend retransplant in certain cases. Updated coding. Added time frame for which smoking cessation should be documented.	11/17	11/17

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Important Reminder

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CLINICAL POLICY
Lung Transplantation

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CENTENE Corporation

Clinical Policy: Intestinal and Multivisceral Transplant

Reference Number: CP.MP.58
Effective Date: 02/14
Last Review Date: 09/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Medical necessity criteria for the review of intestinal and multivisceral transplant requests

Policy/Criteria
It is the policy of health plans affiliated with Centene Corporation® that any of the intestinal and/or multivisceral transplantation procedures listed in **I** are **medically necessary** for pediatric and adult members to restore function in those with irreversible intestinal failure when meeting the criteria in section **II**:

I. Transplantation Procedures
- **A.** Isolated *intestinal transplantation is indicated* for members who have only isolated intestinal failure and no liver disease.
- **B.** Combined *intestinal and liver transplant is indicated* in those with intestinal failure and end stage liver disease.
- **C.** *Multivisceral transplant is indicated* in those with intestinal failure and the presence of neuropathy or extensive mesenteric thrombosis.

II. Procedure Criteria: Members must have one of the indications in **A** and none of the contraindications in **B**:
- **A.** Indications, any one of the following:
  1. Failure of total parenteral nutrition (TPN) as indicated by one of the following:
     - a. Impending or overt liver failure due to TPN, indicated by elevated serum bilirubin and/or liver enzymes, splenomegaly, thrombocytopenia, gastro-esophageal varices, coagulopathy, peristomal bleeding, or hepatic fibrosis/cirrhosis;
     - b. Thrombosis of ≥ 2 central veins, including jugular, subclavian, and femoral veins;
     - c. Two or more episodes of systemic sepsis due to line infection, per year, or one episode of septic shock, acute respiratory distress syndrome, and/or line related fungemia;
     - d. Frequent episodes of dehydration despite IV fluid supplementation;
     - e. Other complications leading to loss of vascular access;
  2. High risk of death if transplant is not performed;
  3. Severe short bowel syndrome (gastrostomy, duodenostomy, residual small bowel <10 cm in infants and <20 cm in adults);
  4. Frequent hospitalizations for complications directly related to intestinal failure;
  5. Significant hepatic cirrhosis associated with diffuse post-mesenteric thrombosis;
- **B.** Does not have ANY of the following contraindications:
  1. Malignancy in the past two years, except for non-melanoma localized skin cancer that has been treated appropriately;

2. Untreatable significant dysfunction of another major organ system, unless combined organ transplantation can be performed;
3. Presence of other GI diseases;
4. Acute medical instability, including, but not limited to, acute sepsis or myocardial infarction;
5. Uncorrectable bleeding diathesis;
6. Chronic infection with highly virulent and/or resistant microbes that are poorly controlled pre-transplant;
7. Current non-adherence to medical therapy or a history of repeated or prolonged episodes of non-adherence to medical therapy that are perceived to increase the risk of non-adherence after transplantation;
8. Psychiatric or psychological condition associated with the inability to cooperate or comply with medical therapy;
9. Absence of an adequate or reliable social support system;
10. Severely limited functional status with poor rehabilitation potential;
11. Substance abuse or dependence (including tobacco and alcohol) without convincing evidence of risk reduction behaviors, such as meaningful and/or long-term participation in therapy for substance abuse and/or dependence. Serial blood and urine testing may be used to verify abstinence from substances of concern.

Background

Intestinal transplantation is a therapeutic option for patients with intestinal failure. Intestinal failure is the loss of absorptive capacity of the small bowel secondary to severe primary gastrointestinal disease or surgically induced short bowel syndrome (SBS). The normal small intestine length varies widely, ranging from 3 to 8 meters. SBS occurs when there is approximately < 200 cm of small bowel remaining.

Multi-visceral transplantation includes the stomach, duodenum, pancreas, liver, and small intestine. A modified version excludes the liver if the recipient's liver is normal. A kidney transplant is occasionally included if the recipient has end-stage renal disease.

Common indications for intestinal transplantation in children include:

- Small bowel atresia
- Gastroschisis
- Aganglionosis (Hirschsprung's disease)
- Infections such as necrotizing enterocolitis and mesenteric ischemia
- Intestinal pseudo-obstruction
- Microvillus inclusion disease
- Short gut syndrome
- Trauma
- Crohn's disease
- Midgut volvulus
- Massive resection secondary to tumor

Common indications for intestinal transplantation in adults include:

- Short gut syndrome
- Mesenteric ischemia following thrombosis, embolism, volvulus, or trauma
- Crohn's disease
- Small bowel tumors
- Small bowel secretory disorders
- Tumors of mesenteric root and retroperitoneum
- Trauma
- Volvulus

- Pseudo-obstruction
- Radiation enteritis

Guideline Recommendations
The British Society of Gastroenterology (2006) recommends: patients with SBS, including irreversible intestinal failure, expected to die prematurely on TPN, should be referred for consideration of short bowel transplant where appropriate.

The American Society of Transplantation (AST, 2001) issued a position paper on indications for pediatric intestinal transplantation. The AST recommends intestinal transplantation only for TPN-dependent children with intestinal failure who have or are likely to develop life-threatening TPN-related complications such as liver disease, recurrent sepsis, and threatened loss of central venous access. The AST stated that intestinal transplantation should not be performed solely because of continued dependence on TPN.

Coding Implications
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CPT® Codes	Description
44135	Intestinal allotransplantation; from cadaver donor
44136	Intestinal allotransplantation; from living donor
44715	Backbench standard preparation of cadaver or living donor intestine allograft prior to transplantation, including mobilization and fashioning of the superior mesenteric artery and vein
44720	Backbench reconstruction of cadaver or living donor intestine allograft prior to transplantation; venous anastomosis, each
44721	Backbench reconstruction of cadaver or living donor intestine allograft prior to transplantation; arterial anastomosis, each
47143	Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary, and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation; without trisegment or lobe split
47144	Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary, and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation; with trisegment split of

CPT® Codes	Description
	whole liver graft into two partial liver grafts (i.e., left lateral segment (segments II and III) and right trisegment (segments I and IV through VIII)
47145	Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary, and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation; with lobe split of whole liver graft into two partial liver grafts (i.e., left lobe (segments II, III, and IV) and right lobe (segments I and V through VIII)
47146	Backbench reconstruction of cadaver or living donor liver graft prior to allotransplantation; venous anastomosis, each
47147	Backbench reconstruction of cadaver or living donor liver graft prior to allotransplantation; arterial anastomosis, each

HCPCS Codes	Description
S2053	Transplantation of small intestine and liver allografts
S2054	Transplantation of multivisceral organs
S2055	Harvesting of donor multivisceral organs, with preparation and maintenance of allografts; from cadaver donor
S2152	Solid organs(s), complete or segmental, single organ or combination of organs; deceased or living donor(s), procurement, transplantation, and related complications; including: drugs; supplies; hospitalization with outpatient follow-up; medical/surgical, diagnostic, emergency, and rehabilitative services; and the number of days of pre- and post-transplant care in the global definition

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
A41.9	Other sepsis
K50.00-K52.9	Non-infective colitis and enteritis
K55.0-K57.93	Diseases of intestines (Vascular disorders of intestines)
K70.0-K77	Diseases of liver
P76.8	Other specified intestinal obstruction of newborn
P77.1-P77.9	Necrotizing enterocolitis of newborn
Q41.0-Q41.9	Congenital absence, atresia an stenosis of small intestine
R65.20-R65.21	Severe sepsis
S35.299(A/D/S)	Unspecified injury of branches of celiac and mesenteric artery, initial, subsequent encounter and sequela
T86.850-T86.859	Complications of intestine transplant
Z94.82	Intestine transplant status

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed Specialist review (Surgical Transplant)	02/14	02/14
References reviewed and updated Formatting and template updated	02/15	02/15
Minor language updates for clarification References reviewed and updated Formatting and template updated	02/16	02/16
Consolidated criteria from HN policy. Edited contraindications to be more consistent across transplant policies: Changed substance abuse to substance abuse or dependence, and added option for blood/urine testing if needed; added bleeding diatheses; reworded other contraindications for clarity. Added ICD-10 Codes. Added additional CPT and HCPCS codes.	8/16	09/16
References reviewed and updated. Some re-wording for clarity.	09/17	09/17

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CENTENE Corporation

Clinical Policy: Dental Anesthesia

Reference Number: CP.MP.61
Effective Date: 06/13
Last Review Date: 06/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Medical necessity guidelines for dental anesthesia in the inpatient or ambulatory surgery setting

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that requests for *general anesthesia or IV sedation in an inpatient setting or ambulatory surgery center when services are not available in the provider office* are considered **medically necessary** when any of the following are met:
   A. Member is younger than eight (8) years of age with a dental condition that requires repairs of significant complexity (e.g., multiple amalgam and/or resin-based composite restorations, pulpal therapy, extractions, or any combination of these or other dental procedures); *or*
   B. Member exhibits physical, intellectual, or medically-compromised conditions, for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, cannot be expected to provide a humane and successful result and which, under general anesthesia, may be expected to produce a superior result; *or*
   C. Member needs local anesthesia with dental treatment but the local anesthesia is/will be ineffective because of acute infection, anatomic variation, or allergy; *or*
   D. Member is extremely uncooperative, fearful, anxious, or uncommunicative with dental needs of such magnitude or clinically apparent and functionally threatening to the well-being of the individual that treatment should not be postponed or deferred, and the lack of treatment can be expected to result in dental or oral pain, infection, loss of teeth, or other increased oral or dental morbidity or mortality; *or*
   E. Member has sustained oral-facial and/or dental trauma, for which treatment under local anesthesia would be ineffective or compromised.

Background

Sedation and anesthesia for dental procedures performed on patients in nontraditional settings, such as acute inpatient facility or ambulatory surgery center, have increased over the past several years. Providers must be qualified and appropriately trained individuals in accordance with state regulations and professional society guidelines.

All locations that administer general anesthesia must be equipped with anesthesia emergency drugs, appropriate resuscitation equipment, and properly trained staff to skillfully respond to anesthetic emergencies. Locations covered under this policy are acute care inpatient facilities and ambulatory surgery centers.

General anesthesia allows for the safe and humane provision of dental diagnostic and surgically invasive procedures. General anesthesia is only necessary for a small subset of members but is

an effective, efficacious, and safe way to provide necessary treatment. Those included in this subset are children who may be cognitively immature, highly anxious or fearful, have special needs, or medically compromised and unable to receive treatment in a traditional office setting.

Withholding of general anesthesia can result in less access to quality oral health care and long term consequences. Less effective management of these members may increase avoidance behaviors of oral health professionals in the future and increase care being sought in the emergency department. Improved diagnostic yield and greater quality of procedures improves the cost-effectiveness of general anesthesia over local anesthesia in some children.

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CPT® Codes	Description
00170	Anesthesia for intraoral procedures, including biopsy; not otherwise specified
00190	Anesthesia for procedures on facial bones or skull; not otherwise specified

HCPCS Codes	Description
D9223	Deep sedation/general anesthesia – each 15 minute increment
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis
D9243	Intravenous moderate (conscious) sedation/analgesia – each 15 minute increment
D9248	Non-intravenous conscious sedation

Reviews, Revisions, and Approvals	Date	Approval Date
References reviewed and updated	05/14	06/14
Added examples of significantly complex dental procedures in policy section	05/15	06/15
Policy updated to new template References reviewed and updated	06/16	06/16
References reviewed and updated	05/17	06/17

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CLINICAL POLICY
Dental Anesthesia

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CENTENE Corporation

Clinical Policy: Hyperhidrosis Treatments

Reference Number: CP.MP.62
Effective Date: 05/13
Last Review Date: 04/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Hyperhidrosis is defined as excessive sweating beyond a level required to maintain normal body temperature in response to heat exposure or exercise.

Refer to CP.PHAR.09 Botulinum Toxins for requests for Botox or Dysport.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that treatment with iontophoresis (electrophoresis, Drionic device) is **medically necessary** when *all* of the following criteria are met:
- A. Diagnosis of primary hyperhidrosis;
- B. Member has developed medical complications, such as skin maceration with secondary skin infections; *or* has a significant constant disruption of professional and/or social life (e.g., recurrent changing of clothes, affecting job/social promotion, etc.) which has occurred because of excessive sweating;
- C. Is unresponsive or unable to tolerate at least one of the pharmacotherapies prescribed for excessive sweating (e.g., anticholinergics, beta-blockers, or benzodiazepines);
- D. Failed a 6-month trial of conservative management including the adherent application of aluminum chloride hexahydrate [Drysol by prescription] or topical agents have resulted in a severe rash;
- E. Has none of the following contraindications:
  1. Cardiac pacemaker;
  2. Cardiac arrhythmias;
  3. Pregnancy (hyperhidrosis often improves during pregnancy);
  4. Metal implants, depending on it size and position (may divert the electric current);
  5. Cracked skin near the treatment area.

II. It is the policy of health plans affiliated with Centene Corporation® that endoscopic thoracic sympathectomy (ETS) for palmar and axillary hyperhidrosis and surgical excision of axillary sweat glands for axillary hyperhidrosis are **medically necessary** when *all* of the following criteria are met:
- A. Meets all of the iontophoresis criteria above;
- B. Has persistent and severe primary hyperhidrosis;
- C. Has failed iontophoresis;
- D. Has failed a trial of botulinum toxin.

Note: The normal line of medical therapy is:
1. Drysol, then botox for axillary hyperhidrosis
2. Drysol, then iontophoresis for palmoplantar hyperhidrosis

3. Other treatments are third-line therapies (iontophoresis and surgery for axillary hyperhidrosis, and Botox and surgery for palmoplantar hyperhidrosis).

III. All other treatments for hyperhidrosis, including, but not limited to, microwave therapy, are considered **investigational and not medically necessary.**

Background

Hyperhidrosis can be classified as either primary or secondary. Primary focal hyperhidrosis is idiopathic in nature and is defined as excessive sweating induced by sympathetic hyperactivity in selected areas that is not associated with an underlying disease process. The most common locations are underarms (axillary hyperhidrosis), hands (palmar hyperhidrosis), and feet (plantar hyperhidrosis). Primary focal hyperhidrosis is a condition that is characterized by visible, excessive sweating of at least 6 months' duration without apparent cause. Hyperhidrosis can ruin clothing, produce emotional distress, and lead to occupational disability.

Secondary hyperhidrosis can result from a variety of drugs, such as tricyclic antidepressants, selective serotonin reuptake inhibitors (SSRIs), or underlying diseases/conditions, such as febrile diseases, diabetes mellitus, or menopause. Secondary hyperhidrosis is usually generalized or craniofacial sweating. Secondary gustatory hyperhidrosis is excessive sweating on ingesting highly spiced foods. This trigeminovascular reflex typically occurs symmetrically on scalp or face and predominately over forehead, lips, and nose. Secondary facial gustatory sweating, in contrast, is usually asymmetrical and occurs independently of the nature of the ingested food. This phenomenon frequently occurs after injury or surgery in the region of the parotid gland.

A variety of therapies have been investigated for primary hyperhidrosis, including topical therapy with aluminum chloride, iontophoresis, intradermal injections of botulinum toxin type A, endoscopic transthoracic sympathectomy, and surgical excision of axillary sweat glands. Thoracic sympathectomy is an invasive procedure intended to arrest the symptoms of hyperhidrosis. Treatment of secondary hyperhidrosis focuses on the treatment of the underlying cause, such as discontinuing certain drugs or hormone replacement therapy as a treatment of menopausal symptoms.

Microwave energy has been proposed for the treatment of primary axillary hyperhidrosis. The miraDry System (Mirimar Labs, Inc) is an FDA approved device indicated for treatment of primary axillary hyperhidrosis. It is not indicated for treating hyperhidrosis related to other body areas or generalized hyperhidrosis. The evidence supporting the safety and efficacy of microwave energy for the treatment of primary axillary hyperhidrosis is limited, thus it is considered investigational and not medically necessary. Most of the studies are limited by small sample size with data on long-term health outcomes lacking.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2016, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for

informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
32664	Thoracoscopy, surgical; with thoracic sympathectomy
64650	Chemodenervation of eccrine glands; both axillae
64653	other area(s) (e.g., scalp, face, neck), per day
64802 – 64823	Sympathectomy sympathetic nerves
97024	Application of a modality to 1 or more areas; diathermy (eg, microwave)
97033	Application of a modality to 1 or more areas; iontophoresis, each 15 minutes

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
L74.510-L74.519	Primary focal hyperhidrosis
L74.52	Secondary hyperhidrosis
R61	Generalized hyperhidrosis

Reviews, Revisions, and Approvals	Date	Approval Date
Policy Developed Specialist review	04/13	05/13
Removed all surgical treatments except ETS and excision of sweat glands Updated coding implications	04/14	05/14
Removed Botox and Dysport from policy, refer to CP.PHAR.09 Botulinum Toxins	04/15	04/15
Policy converted to new template References reviewed and updated	04/16	04/16
Added microwave therapy for treatment of hyperhidrosis as investigational. Specified in I.A. and II.B. that diagnosis must be primary hyperhidrosis. References reviewed and updated. ICD 10 codes added.	04/17	04/17

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Important Reminder

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The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

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This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for

members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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CENTENE Corporation

Clinical Policy: Medical Necessity Criteria

Reference Number: CP.MP.68
Effective Date: 06/13
Last Review Date: 09/17 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Medical necessity criteria and related definitions.

Policy/Criteria
Health plans affiliated with Centene Corporation® will use the following guidelines to make medical necessity decisions (numbered in order of significance) on a case-by-case basis, based on the information provided on the member's health status:

A. Federal law (e.g., National Coverage Determinations (NCD), Local Coverage Determinations (LCD), and Medicare Coverage Articles for programs under Federal oversight such as Medicare);
B. State law/guidelines (e.g., when State requirements trump or exceed federal requirements);
C. Plan-specific clinical policy;
D. Centene clinical policy;
E. If no Plan- or Centene-specific clinical policy exists, then nationally recognized decision support tools such as InterQual® Clinical Decision Support Criteria or MCG (formerly Milliman Care Guidelines®) criteria are used;
F. In the case of no guidance from A-E, additional information that the applicable Health Plan Medical Director will consider, when available, includes:
    1. Reports from peer reviewed medical literature, where a higher level of evidence and study quality is more strongly considered in determinations;
    2. Professional standards of safety and effectiveness recognized in the US for diagnosis, care, or treatment;
    3. Nationally recognized drug compendia resources such as Facts & Comparisons®, DRUGDEX®, and The National Comprehensive Cancer Network® (NCCN®) Guidelines
    4. Medical association publications;
    5. Government-funded or independent entities that assess and report on clinical care decisions and technology such as Agency for Healthcare Research and Quality (AHRQ), Hayes Technology Assessment, Up-To-Date, Cochrane Reviews, National Institute for Health and Care Excellence (NICE), etc.;
    6. Published expert opinions;
    7. Opinion of health professionals in the area of specialty involved;
    8. Opinion of attending provider in case at hand.

CLINICAL POLICY
Medical Necessity Criteria

Only appropriate practitioners can make the decision to deny coverage of a requested service based on medical necessity guidelines. Practitioner types appropriate for making the following types of denial decisions include*:

Provider type allowed to make denial decisions:	
Provider Type	**Denial Decision**
Physicians, all types	Medical, behavioral healthcare, pharmaceutical, dental, chiropractic, vision, and physical therapy denials
Doctoral-level clinical psychologists or certified addiction-medicine specialists	Behavioral healthcare denials
Pharmacists	Pharmaceutical denials
Dentists	Dental denials
Chiropractors	Chiropractic denials
Physical therapists	Physical therapy denials

*State mandates may alter which practitioner types are appropriate for denial decisions.

Definitions
Unless defined differently by the members' Benefit Plan Contract or the applicable provider agreement, the Health Plan uses the following definitions:

A. **Medically necessary** or medical necessity shall mean health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are:
   1. In accordance with generally accepted standards of medical practice;
   2. Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient's illness, injury, or disease; and
   3. Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

   Medically necessary health care services may not include experimental and/or investigational technologies or carve-out days.

B. **Generally accepted standards of medical practice** means standards that are based upon credible scientific evidence published in peer-reviewed medical literature recognized by the medical community at large or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

C. **Experimental and/or investigational technologies** are defined as any drugs, procedures, treatments, devices, supplies, and other health care services ("Service") that are any of the following:
   1. It is currently the subject of active and credible evaluation (e.g., clinical trials or research) to determine:

   a. Clinical efficacy, *or*
   b. Therapeutic value or beneficial effects on health outcomes, *or*
   c. Benefits beyond any established medical based alternatives.
2. It does not have final clearance from applicable governmental regulatory bodies (such as the US Food and Drug Administration "FDA") and unrestricted market approval for use in the treatment of a specified medical condition or the condition for which authorization of the Service is requested and is the subject of an active and credible evaluation.
3. The most recent peer-reviewed scientific studies published or accepted for publication by nationally recognized medical journals do not conclude, or are inconclusive in finding, that the Service is safe and effective for the treatment of the condition for which authorization of the Service is requested.

D. **Not medically necessary and not investigational**: evaluations and clinical recommendations that are assessed according to the scientific quality of the supporting evidence and rational (e.g., national medical associations, independent panels, or technology assessment organizations). A service is considered not medically necessary and not investigational when:
   1. There are no studies of the service described in recent, published peer-reviewed medical literature, *or*
   2. There are no active or ongoing credible evaluations being undertaken of the service which has previously been considered not medically necessary, *or*
   3. There is conclusive evidence in published peer-reviewed medical literature that the service is not effective, *or*
   4. There are no peer-reviewed scientific studies published or accepted for publication by nationally recognized medical journals that demonstrate the safety and efficacy of the use of the service, *or*
   5. It is contraindicated.

E. In relation to inpatient stays, **carve-out days** are defined as non-medically necessary inpatient hospital days that occur during an approved admission (i.e., the inpatient stay was prolonged unnecessarily). Examples of circumstances giving rise to a carve-out day(s) include, but are not limited to:
   1. A day in which a member meets concurrent inpatient criteria, and needs a service during the stay (e.g., imaging, surgery, etc.), but the service is not performed on the earliest possible date for reasons unrelated to the member's clinical condition (e.g., MRI machine is down, operating room time is not available or patient is bumped off schedule, a specialist did not come in to perform a consult, etc.);
   2. A day that is solely "social" in nature (e.g., the member is waiting for foster placement, discharge instructions, etc.);
   3. A day at the end of a stay in which discharge criteria are met but the member is not discharged (due to, e.g., a transportation problem, DME not delivered to the home, staff too busy to discharge the member, provider did not come in to write discharge order, the member is waiting for a SNF placement, etc.).
   4. A day of care that is or appears to be necessitated by quality of care issues or largely preventable issues [e.g., complication due to wrong medication dose, central line-associated blood stream infections (which can include PICC lines and both tunneled and non-tunneled central lines), ventriculitis or meningitis in a patient with a reservoir who is

receiving taps in place of a shunt and who is 2000 grams or greater in weight; infections with resistant hospital flora such as MRSA (methicillin resistant Staphylococcus aureus) or VRE (vancomycin resistant enterococcus), etc.].

F. The terms "**never events,**" "**serious reportable events,**" and "**non-reimbursable serious hospital-acquired conditions**" all refer to serious adverse events occurring in facilities that are largely preventable and of concern to both the public and to health care providers. Based on the benefit plan contract, the event and services resulting directly from a never event may not be a covered benefit and/or may be non-reimbursable. Examples of such events include:
   1. Surgery on wrong body part
   2. Surgery on wrong patient
   3. Wrong surgery on patient
   4. Retained foreign body after surgery
   5. Death/disability associated with intravascular air embolism
   6. Death/disability associated with incompatible blood
   7. Death/disability associated with hypoglycemia
   8. Stage 3 or 4 pressure ulcers after admission
   9. Death/disability associated with electric shock
   10. Death/disability associated with a burn incurred within facility
   11. Death/disability associated with a fall within facility

Background

Centene clinical policies are intended to be reflective of current scientific research and clinical thinking. They are developed with oversight of board-certified physicians and practitioners, reviewed on an annual basis for appropriateness and approved by the Centene Clinical Policy Committee. The Clinical Policy Committee is composed of physicians and other medical and operational representatives, as appropriate, from Centene Corporate and each Plan to assist in the identification of need, development, revision, and/or review of clinical policy. Clinical policies include medical, behavioral health, medical pharmacy benefits, durable medical equipment and devices. These policies include but are not limited to:

- New and emerging technologies
- New uses for existing technologies
- Clinical guidelines for the evaluation and treatment of specific conditions
- Criteria used in the authorization of drugs included on a Plan prior authorization list
- Clinical/medical criteria or information used in pre- or post-service review

InterQual criteria are proprietary and cannot be publicly published and/or distributed. On an individual member basis, the specific criteria document used to make a medical necessity determination can be made available upon request. Registered providers can obtain the appropriate InterQual SmartSheet™ by logging in to the secure provider portal. The InterQual SmartSheet can be submitted with your authorization request to help expedite the process.

McKesson Corporation is the owner/licensor of the InterQual Clinical Decision Support Criteria and related software. McKesson has prepared this Work for exclusive use of its licensees of software applications embodying the Clinical Content. This Work contains confidential and trade secret information of McKesson and is provided to licensees who have an existing license agreement in force only under the time-limited license as provided under that license agreement.

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The MCG guideline(s) and products are not intended to be used without the judgment of a qualified health care provider with the ability to take into account the individual circumstances of each patient's case.

References

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Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed	06/13	06/13
Added definitions for experimental/investigational, carve-out days, and serious adverse events; information about clinical policy committee	08/13	10/13
Move LCD from #2 to #1 in Policy section	07/14	10/14
Added Plan specific policy under Policy/Criteria Converted into new template	10/15	10/15
Added Medicare Coverage Articles under criteria A. Redefined experimental/investigational per Health Net definition and added definition of not medically necessary and not investigational. Added footnote that the types of practitioners able to make a coverage denial may be mandated by specific states.	09/16	09/16
Clarified in provider/denial decision table that these are denial decisions *allowed* to be made by a given provider, instead of *requiring* a certain provider. Added PT as a denial decision allowed to be made by an MD.	09/17	09/17

Important Reminder

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CLINICAL POLICY
Medical Necessity Criteria

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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CENTENE Corporation

Clinical Policy: Proton and Neutron Beam Therapy

Reference Number: CP.MP.70
Effective Date: 03/14
Last Review Date: 03/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Proton beam therapy (PBT) is a form of external beam radiation therapy (EBRT) that utilizes protons (positively charged subatomic particles) to precisely target a specific tissue mass. Proton beams can penetrate deep into tissues to reach tumors, while delivering less radiation to surrounding tissues. This may make PBT more effective for inoperable tumors, or for those areas in which damage to healthy tissue would pose an unacceptable risk.

Neutron beam therapy (NBT) is a less widely available form of EBRT which utilized neutrons. Its clinical use is very limited due to difficulties in the delivery of this treatment modality.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that proton and neutron beam therapy is **medically necessary** for the following indications:
- **A.** Ocular tumors with no distant metastasis; or
- **B.** Primary or metastatic tumors of the spine where the spinal cord tolerance may be exceeded with conventional treatment or where the spinal cord has previously been irradiated; or
- **C.** Tumors that approach or are located at the base of the skull, including but not limited to: chordoma or chondrosarcoma; or
- **D.** Primary hepatocellular cancer treated in a hypofractionated regimen; or
- **E.** Primary or benign solid tumors in members ≤ 18 years old; or
- **F.** Members with genetic syndromes making total volume of radiation minimization crucial such as but not limited to NF-1 patients and retinoblastoma.

II. It is the policy of health plans affiliated with Centene Corporation that NBT **is medically necessary** in the treatment of salivary gland tumors considered surgically unresectable or for a patient who is medically inoperable

III. All other indications for PBT and NBT are considered **not medically necessary** as insufficient evidence exists to recommend proton beam therapy as superior to other treatments available.

Background

PBT is an important method of treatment used in managing malignant disease with a well-defined target. Unlike x-rays, protons cause little damage to the tissues they pass through to reach their destination. Their energy is released after traveling a specified distance, thus delivering more radiation to the tumor and doing less damage to the nearby normal tissue.

Because of this, PBT may be more useful for tumors with distinct edges rather than those whose edges are mixed with normal tissue.

The American Society of Radiation Oncology (ASTRO) evaluated the evidence of use of PBT up until November 2009. The use of PBT was evaluated for CNS tumors, gastrointestinal malignancies, lung, head and neck, prostate, and pediatric tumors. Data evaluated did not provide sufficient evidence to support PBT for lung cancer, head and neck cancer, GI malignancies, and pediatric non-CNS malignancies. For hepatocellular carcinoma and prostate cancers, evidence supports the efficacy of PBT, but there is no support that it is a superior treatment to other external beam radiation therapy approaches. For pediatric CNS malignancies, PBT appears to be superior to other EBRT approaches, but more data is needed to determine the most appropriate approach. For large ocular melanomas and chordomas, evidence supports there to be a benefit of PBT over other EBRT approaches. Current evidence is limited for PBT indications and more robust clinical trials are needed to determine the appropriate clinical setting for its use.

National Comprehensive Cancer Network
Guidelines from NCCN regarding PBT in the treatment of head and neck cancer state, "Achieving high conformal dose distributions is especially important for patients whose primary tumors are periocular in location and/or invade the orbit, skull base, and/or cavernous sinus; extend intracranially or exhibit extensive perineural invasion; and who are being treated with curative intent and/or who have long life expectancies following treatment. Non-randomized single institution clinical reports and systematic comparisons demonstrate safety and efficacy of PBT in the above mentioned specific clinical scenarios."[12]

NBT utilizes neutrons, rather than photons, to destroy tumor cells. Neutrons are much heavier than photons and appear to be more effective at causing damage to very dense tumors. It is however more clinically difficult to generate neutron particles, so it has not gained wide acceptance for treatment. It has most commonly been studied in salivary gland tumors which are either unable to be removed completely or for recurrent disease.

National Comprehensive Cancer Network
Guidelines from NCCN regarding NBT in the treatment of unresectable salivary gland tumors note that data supports the use of neutron therapy, although there are few published studies.

Coding Implications
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CPT Codes for proton beam therapy considered medically necessary for indications listed in this policy

CPT Codes	Description
77520	Proton treatment; simple, without compensation
77522	Proton treatment delivery; simple, with compensation
77523	Proton treatment delivery; intermediate
77525	Proton treatment delivery; complex

ICD-10-CM diagnosis codes that support coverage criteria for proton beam therapy
+ Indicates a code requiring an additional character

ICD-10-CM Code	Description
C22.0 – C22.8	Malignant neoplasm of liver and intrahepatic ducts
C41.0	Malignant neoplasm of bones of skull and face
C41.2	Malignant neoplasm of vertebral column
C69.00 – C69.92	Malignant neoplasm of eye and adnexa
C70.0 – C70.9	Malignant neoplasm of meninges
C71.0 – C71.9	Malignant neoplasm of cerebrum, except lobes and ventricles
C72.0 – C72.9+	Malignant neoplasm of spinal cord
C75.1 – C75.3	Malignant neoplasm of pituitary, craniopharyngeal duct, and pineal gland
C79.31	Secondary malignant neoplasm of brain
C79.4 – C79.49+	Secondary malignant neoplasm of other and unspecified parts of nervous system
D32.0 – D32.9	Benign neoplasm of meninges
D33.0 – D33.9	Benign neoplasm of brain and other parts of central nervous system
D35.2	Benign neoplasm of pituitary gland
D44.3	Neoplasm of uncertain behavior of pituitary gland
D44.4	Neoplasm of uncertain behavior of craniopharyngeal duct

CPT Codes for neutron beam therapy considered medically necessary for indications listed in this policy

CPT Codes	Description
77422	High energy neutron radiation treatment delivery; single treatment area using a single port or parallel-opposed ports with no blocks or simple blocking.
77423	High energy neutron radiation treatment delivery; 1 or more isocenter(s) with coplanar or non-coplanar geometry with blocking and/or wedge, and/or compensator(s)

ICD-10-CM codes considered medically necessary for neutron beam therapy for adults

ICD-10-CM Code	Description
C06.9	Malignant neoplasm of mouth, unspecified site (minor salivary gland, unspecified site)
C08.0 – C08.9	Malignant neoplasm of other and unspecified major salivary glands

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed	03/14	03/14
Removed re-irradiation from I.A Changed policy/criteria to Disease State only. Changed I.A.2 from list of tumors to spinal tumors language Added tumors of the base of the skull to I.A.3 for clarification Removed pituitary and sinus tumors Updated background information	02/15	03/15
Added hepatocellular tumors and members with genetic syndromes to Criteria I Updated background information Updated template	03/16	03/16
Added ICD-10 CM codes	06/16	
References reviewed and updated. ICD-10 codes updated	02/17	03/17

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CLINICAL POLICY
Proton and Neutron Beam Therapy

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CENTENE Corporation

Clinical Policy: Long Term Care Placement

Reference Number: CP.MP.71
Effective Date: 05/14
Last Review Date: 05/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Nursing home care includes both long term residential care and short-term post-acute or rehabilitative care. This policy addresses long term care (LTC) placement ranging from basic custodial care to more intense care needed due to dementia or other complex medical needs. Skilled services require the skills of qualified technical or professional health personnel such as registered nurses, licensed vocational nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that long term care placement is **medically necessary** for the following indications:

A. Custodial/Non-Skilled Care 1
B. Dementia/Wandering Care 2
C. Dementia with Behaviors Care 3
D. Dialysis Care 4
E. Respiratory Care 5
F. Ventilator Care 5
G. Bariatric Care 6

A. Custodial/Non-Skilled Care

Care that does not meet the criteria for skilled nursing, skilled rehabilitation, or the specialized care services included later in this policy is considered custodial care, or non-skilled care. Custodial care can be maintenance care provided by family members, health aides or other unlicensed individuals when an individual has reached the maximum level of physical or mental function and still requires assistance.

Custodial care is primarily for those who need supervision with activities of daily living (ADLs) or supervision for safety or behavior management. Areas of ADLs include bathing, dressing, toileting, transferring, and eating. These are generally personal needs rather than medical and are not specific to an illness or injury. Other factors that should be considered when determining need for custodial care include ability to communicate, cognitive status, behavior and ability to self-administer medications.

1. Placement Criteria: In determining whether an individual needs to receive custodial care, factors to consider are the level of care and medical supervision required. The

decision is not based on diagnosis, type of condition, degree of functional limitation or rehabilitation potential. If multiple levels of custodial care are available at a facility, the level of need should be evaluated to determine which level of care is appropriate. Examples of different levels of care *could include*:

a. Intermediate-Light Care
   Member is dependent for **up to two** activities of daily living, intermittent supervision and/or occasional behavior management.
b. Intermediate-Moderate Care
   Member is dependent for **three or four** activities of daily living, frequent supervision and/or behavior management.
c. Intermediate-Heavy Care
   The resident is dependent for all **five** areas of daily living listed above, constant supervision and/or behavior management.

2. Discharge Criteria
   a. Member is independent or requires only limited assistance with ADLs which could be provided by a home caregiver on an intermittent basis;
   b. Patient or caregiver is able and willing to meet care needs including:
      i. Managing medication regimen;
      ii. Transfers and ambulation;
      iii. Home exercise program and/or prescribed therapy program;
   c. Home environment is safe and accessible;
   d. Appropriate equipment/devices are prearranged.

B. Dementia/Wandering Care

Service Goal: To ensure the provision of residential care for demented members in need of a protective environment for wandering behavior.

1. Placement Criteria - the member must meet the following admission criteria:
   a. The member has a diagnosis of dementia (includes Alzheimer's disease), organic brain syndrome, or other diagnoses affecting their cognitive ability such as traumatic brain injury; and
   b. Member has failed to adequately improve with appropriate psychiatric evaluation and treatment attempts; and c or d
   c. In a *residential setting*, there is documentation that the member exhibits problematic wandering behavior which endangers the member or other residents and is characterized by one or more of the following:
      i. Repeatedly exits through outside doors;
      ii. Frequently wanders into off-limit areas such as the kitchen, laundry, storage, maintenance, resident rooms and other off-limit areas without responding to redirection;
      iii. Is unable to find their way back to their own room after a wandering episode;
   d. In *home and community based services* (HCBS) setting, there is documentation that the member exhibits problematic wandering behavior characterized by one or more of the following:
      i. Repeatedly wanders away from home, requiring local police, or others to

return them because of confusion about which house in the neighborhood is theirs;
ii. Requires the family or other caregiver to lock the member in the house when leaving the member unattended to prevent them from getting out and lost;
iii. Unsafe driving despite actions taken by family or authorities.

2. Intensity of Service – the member must be provided with all of the following:
   a. Secure living area indoors and outdoors by means of locks and/or electronically controlled access;
   b. Activities appropriate for persons with dementia;
   c. All services, medications, supplies and equipment necessary to manage the needs of the member.

3. Discharge Criteria
   a. Member no longer meets placement criteria, and b or c;
   b. Member is able to be safely managed in a lower level of care, or
   c. Member requires higher level of care than what is able to be provided.

C. Dementia with Behaviors Care

Service Goal: To ensure the provision of residential care for members with cognitive impairments in need of a protective environment for significant behaviors.

1. Placement Criteria - the member must meet all of the following admission criteria:
   a. The member has a diagnosis of dementia (includes Alzheimer's disease), organic brain syndrome, or other diagnoses affecting their cognitive ability such as traumatic brain injury; and
   b. The member has failed to adequately improve with appropriate psychiatric evaluation and treatment attempts; and
   c. Documentation that the member exhibits problematic behavior on a daily basis which endangers the member, or other residents, that cannot be managed in a traditional nursing facility or in an HCBS setting as characterized by one or more of the following:
      i. Repeated attempts to exit through an outside door, repeatedly banging on locked door (unable to redirect);
      ii. Physical aggression toward other residents;
      iii. Suicide attempts or other self-injurious behaviors;
      iv. Throwing things in an uncontrolled manner and unable to redirect;
      v. Yelling continuously for several hours during the day or night despite treatments for pain and non-pharmacological interventions;
      vi. Repeatedly throwing self out of a wheelchair or out of bed, or throwing self to floor, requiring increased staffing for safety concerns;
      vii. Displaying sexualized behaviors, including attempts to inappropriately touch other residents;
      viii. Misuse/abuse of medications, alcohol and drugs;
      ix. Mental disorders such as psychosis or depression, not manageable at a lower level of care;

x. Two documented attempts to step member down from dementia/wandering unit have been attempted and failed causing an exacerbation of symptoms and increased behaviors.

2. Intensity of Service – the member must be provided with all of the following:
   a. Secure living area indoors and outdoors by means of locks and/or electronically controlled access that is separate from the areas of other facility residents, and
   b. Staff ability to directly observe and supervise the member at all times, and
   c. Psychiatric nursing care services with observation and assessment of members' changing condition, and
   d. Activities appropriate for persons with dementia, and
   e. All services, medications, supplies and equipment necessary to manage the needs of the member.

3. Discharge Criteria
   a. Member no longer meets placement criteria, and b or c;
   b. Member is able to be safely managed in a lower level of care, or
   c. Member requires higher level of care than what is able to be provided.

D. Dialysis Care

Service Goal: To provide skilled nursing, residential care, and supervision for members with high acuity and specialized dialysis needs.

1. Placement Criteria – the member must meet the following admission criteria:
   a. Member requires dialysis and is unable to attend in an outpatient setting due to a medical condition such as pericarditis, pneumonia or other infection, gastrointestinal bleeding, confusion or dementia, or hemodynamic instability; and
   b. Member is unable to sit up for 4 hours at a time and one of the following:
      i. The member has a wound that prohibits outpatient dialysis, or
      ii. The member has to use a Hoyer lift for transfers.

2. Intensity of Service – the member must be provided with:
   a. Dialysis treatment as prescribed by a nephrologist, and
   b. Evaluation and monitoring of member's condition on an on-going basis, and
   c. Relevant diagnostic studies and reporting of results to ordering physician on a timely basis, and
   d. All services, medications, supplies and equipment necessary to manage the needs of the member.

3. Discharge Criteria
   a. Member no longer meets placement criteria, and b or c;
   b. Member is able to be safely managed in a lower level of care, or
   c. Member requires higher level of care than what is able to be provided.

E. Respiratory Care

Service Goal: To provide skilled nursing, residential care, and supervision for members requiring respiratory care who need nursing services on a 24-hour basis, but who do not require hospital care under the daily direction of a physician.

1. Placement Criteria – the member must meet the following admission criteria:
   a. The member requires 3 or more of the following in a 24-hour period performed by the facility licensed staff:
      i. Tracheostomy care twice a day and as needed;
      ii. Tracheal suctioning every 4 hours and as needed;
      iii. Aerosol therapy, cool mist FIO2 28% or greater;
      iv. Chest physical therapies - percussion and postural drainage;
      v. CPAP/BIPAP continuous or during sleep;
      vi. CPAP or PSV setting on a ventilator;
      vii. Mechanical ventilation < 6 hours in a calendar day, without weaning in progress.

2. Intensity of Service – the member must be provided with:
   a. Respiratory therapy needs as prescribed by member's physician, and
   b. Evaluation and monitoring of member's condition on an on-going basis, and
   c. Relevant diagnostic studies and reporting of results to ordering physician on a timely basis, and
   d. All services, medications, supplies and equipment necessary to manage the needs of the member.

3. Discharge Criteria
   a. Member no longer meets placement criteria, and b or c;
   b. Member is able to be safely managed in a lower level of care, or
   c. Member requires higher level of care than what is able to be provided.

F. Ventilator Care

Service Goal: To provide skilled nursing care, residential care, and supervision for members who are dependent on mechanical ventilation to sustain life and who need nursing services on a 24-hour basis, but do not require hospital care under the daily direction of a physician.

1. Placement Criteria – the member must meet the following admission criteria:
   a. Requires mechanical ventilation for ≥ 6 hours per day to sustain life. Acceptable setting modes for ventilator care include:
      i. Assist control (AC), or
      ii. Spontaneous intermittent mandatory ventilation (SIMV); OR
   b. The member requires < 6 hours of mechanical ventilation and weaning from the ventilator is in progress.

2. Intensity of Service – the member must be provided with:
   a. Mechanical ventilation needs as prescribed by member's physician, and

b. Evaluation and monitoring of member's condition on an on-going basis, and
c. Relevant diagnostic studies and reporting of results to ordering physician on a timely basis, and
d. All services, medications, supplies and equipment necessary to manage the needs of the member.

3. Discharge Criteria
   a. Member no longer meets placement criteria, and b or c;
   b. Member is able to be safely managed in a lower level of care, or
   c. Member requires higher level of care than what is able to be provided.

G. Bariatric Care

Service Goal: To provide skilled nursing care, residential care, and supervision for members with high acuity and specialized care due to extreme obesity.

1. Placement Criteria – the member must meet both of the following:
   a. BMI $\geq$ 50 kg/m^2, and
   b. Member is unable to change position, ambulate, or transfer without hands on assistance from three or more caregivers.

2. Intensity of Service – the member must be provided with:
   a. Nutritional counseling to assist with appropriate caloric needs, and
   b. Physical, occupational or restorative therapies tailored to the member, and
   c. An ongoing, multidisciplinary approach to weight loss, and
   d. All services, medications, supplies and bariatric equipment necessary to manage the needs of the member.

3. Discharge Criteria
   a. Member no longer meets placement criteria, and b or c;
   b. Member is able to be safely managed in a lower level of care, or
   c. Member requires higher level of care than what is able to be provided.

Background

Nursing home care accounts for a substantial portion of health care costs for older individuals. For individuals who reside in these facilities, room and board costs are generally paid for by Medicaid, long term care insurance, or out-of-pocket by individuals and their families. Short-stay nursing home care, such as after an acute inpatient admit for rehabilitation, is generally paid by the skilled nursing facility benefit, most often through Medicare.

Per Medicare, a patient whose inpatient stay is based solely on the need for skilled rehabilitation services would meet the daily basis requirement when they need and receive those services, even if these therapy services are offered just 5 or 6 days a week, as long as you need and get the therapy services each day they're offered.

The need for basic custodial care is not based on the medical need of an individual, rather the need for assistance with ADLs, or supervision for safety or behavior management. However,

when there are complex medical needs or the need for more intense supervision, different levels of care within a nursing home facility exist.

A comprehensive geriatric assessment evaluates the individual's functional, physical, cognitive, emotional, and psychosocial status. The Omnibus Reconciliation Act of 1987 (OBRA) requires that nursing homes complete a comprehensive assessment at the time of admission in order to develop a comprehensive treatment plan. Information from this assessment and treatment plan will help determine the level of care that the individual requires upon admission.

Ongoing assessment of an individual's status is required to ensure the appropriate level of care is maintained to ensure patient needs are met. Observation of an individual's status changes can be observed by both facility staff and the family/friends of the individual. Family meetings are an important component of care to serve as a means of learning and sharing information. Medical decision making and advanced care planning should be shared by the facility and medical staff as well as the family. Changes in an individual's status should also be shared with the Health Plan Case Manager to ensure proper placement.

Definitions
Custodial care provides services that assist a member with ADLs such as assistance with walking, bathing, dressing, feeding, toileting, and supervision of medication that can normally be self-administered. Services can be provided by someone who is not a trained medical or paramedical personnel.

Coding Implications
This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2016, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
90960	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age or older, with 4 or more face to face visits by a physician or other qualified health care professional per month
90961	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age or older, with 2-3 face to face visits by a physician or other qualified health care professional per month
90962	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age or older, with 1 face to face visit by a physician or other qualified health care professional per month
94004	Ventilation assist and management, assist of pressure or volume preset ventilators for assisted or controlled breathing, nursing facility, per day

CPT® Codes	Description
94660	Continuous Positive Airway Pressure Ventilation (CPAP), initiation and management

HCPCS Codes	Description
E0470	Respiratory assist device, bi-level pressure capability, without back up rate feature, used with noninvasive interface, eg. nasal or facial mask (intermittent assist device with continuous airway pressure device)
E0471	Respiratory assist device, bi-level pressure capabil**ity, with back up rate feature,** used with noninvasive interface, eg. nasal or facial mask (intermittent assist device with continuous airway pressure device)
E0472	Respiratory assist device, bi-level pressure capability, with back up rate feature, used with invasive interface, eg, tracheostomy tube (intermittent assist device with continuous positive pressure airway device.

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
F01.50-F09	Mental disorders due to physiological conditions (eg. dementia)
F10.10-F19.99	Mental and behavioral disorders due to psychoactive substance use
G30.1-G32.89	Other degenerative diseases of nervous system (eg. Alzheimer's disease)
J69.10-J96.12	Chronic respiratory failure
S06.0X0-S06.9X9 (use A, D or S as 7th digit)	Intracranial injury (includes traumatic brain injury)
X71.0XX-X83.8XX (use A, D or S as 7th digit)	Intentional self-harm (eg. includes purposely self-inflicted injury and suicide)
Z71.41	Alcohol abuse counseling and surveillance of alcoholic
Z71.51	Drug abuse counseling and surveillance of drug abuser

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed and reviewed by specialist.		05/14
References reviewed and updated.		05/15
References reviewed and updated; converted to new template.	05/16	05/16
Coding implications added. Policy compared to Health Net policy. No criteria changes made	8/16	
Changed wording in B.1.iii for clarification. References reviewed and updated	05/17	05/17

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CENTENE Corporation

Clinical Policy: Home Sleep Testing

Reference Number: CP.MP.75
Effective Date: 02/15
Last Review Date: 02/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Medical necessity criteria for home sleep testing (HST), also referred to as unattended portable monitoring and out-of-center sleep testing, for the diagnosis of obstructive sleep apnea (OSA) in adulthood**.** HST is a diagnostic tool that can be used to diagnose simple OSA. It can be used as an alternative to an in-facility, overnight, attended polysomnogram (PSG) in members with a high probability for moderate to severe OSA.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that *initial HST* performed with a Type 2 or Type 3 device is **medically necessary** when meeting the following criteria:

A. Performed in conjunction with a comprehensive sleep evaluation;
B. Sleep center performing the test is accredited by AASM or Joint Commission;
C. Age ≥ 18 and ≤ 65 years;
D. High pretest probability of moderate to severe OSA, as indicated by excessive daytime sleepiness which impacts daily activities that is not explained by other factors (e.g., medication, drugs, alcohol, psychiatric disorder) and at least one other factor:
   1. Witnessed apnea;
   2. Sleep-disruptive snoring;
   3. Gasping or snorting while sleeping;
   4. Obesity (BMI ≥30 kg/m^2) or increased neck circumference (>17 inches men, >16 inches women);
E. Has none of the following contraindications to HST:
   1. Moderate to severe pulmonary disease (e.g., COPD with class III or IV heart failure,[4] asthma, O_2 dependent);
   2. Neuromuscular disease;
   3. Congestive heart failure;
   4. Hypoventilation syndromes; [4]
   5. Suspected or diagnosed central sleep apnea, periodic limb movement disorder, insomnia, parasomnias, circadian rhythm disorders, or narcolepsy;
   6. Physical or cognitive inability to appropriately use the equipment or does not have someone able to assist with the equipment;
   7. Previous technically suboptimal home sleep study.

II. *Follow up HST* performed with a Type 2 or Type 3 device is medically necessary when meeting the following criteria:

A. For assessment of one of the following:
   1. Effectiveness of surgery or oral appliances or devices (i.e., CPAP/BiPAP); or

2. Re-evaluate the diagnosis of OSA and the need for continuing a device following significant weight loss (loss of ≥ 10% of body weight) since the most recent study.

B. Has none of the following contraindications to HST:
1. Moderate to severe pulmonary disease (e.g., COPD, asthma, oxygen-dependence);
2. Neuromuscular disease;
3. Congestive heart failure;
4. Suspected or diagnosed central sleep apnea, periodic limb movement disorder, insomnia, parasomnias, circadian rhythm disorders, or narcolepsy;
5. Physical or cognitive inability to appropriately use the equipment or does not have someone able to assist with the equipment;
6. Previous technically suboptimal home sleep study.

III. HST is considered **not medically necessary** when performed with a Type 4 device or for any other indications not listed above.

Background

Polysomnography (PSG) is the most commonly used test in the diagnosis of specific sleep disorders, primarily OSA. Monitoring typically includes activity of the brain, chin, eyes, chest wall, and limbs; heart rate and rhythm; airflow through the nose and mouth; oxygen saturation; snoring loudness; sleep position; and fragmentation of sleep.

There are four types of monitoring devices which may be used for sleep studies. Type 1 devices are used in the sleep center, technician attended, for an overnight PSG. Type 2 devices can record the same variables as type 1 devices but can also be used outside of a sleep center and do not require a technician to be present. Type 3 devices measure between four and seven physiologic parameters, including two respiratory variables, a cardiac variable, and oxygen saturation by pulse oximetry. Measurement of these variables generally provides adequate information for the evaluation of most sleep apneas. Type 4 devices differ by definition and may only record one to 3 variables. Generally, Type 4 devices provide insufficient data for an accurate diagnosis of OSA.[4]

Portable monitoring is a more convenient and lower cost tool for diagnosing OSA in those members who are highly suspected of having moderate to severe OSA. Advantages include that the members are able to perform the test in the comfort of their own homes, the HST system is less costly than the complete PSG system, and a technician is not required for completion of the test. Fewer physiologic variables are measured with HST in comparison with PSG, however, so proper patient selection is necessary to take full advantage of the value of this technology. The Portable Monitoring Task Force of the American Academy of Sleep Medicine (AASM) recommends portable monitoring for the diagnosis of OSA in conjunction with a comprehensive sleep evaluation (2007). [5]

Furthermore, several studies have established HST as being similar to PSG in the diagnosis and treatment of OSA. Rosen and colleagues conducted a large, multisite randomized trial of lab-based PSG versus HST (2012). They found that HST performed similarly to PSG for diagnosis and treatment of patients with moderate to severe OSA, and that it was well-accepted by patients (Rosen et al., 2012). These findings are consistent with multiple other studies conducted in a

similar fashion by Whitelaw, et al. (2005), Mulgrew, et al. (2007), Berry, et al. (2008), and Skomro, et al. (2010). Most studies on HST included subjects who were under 65 and over 18 and who did not have significant comorbidities (Collop, et al., 2007, p. 740). [1 5 8 9 10 11]

For HST, the AASM stipulates that an experienced sleep technician, sleep technologist, or appropriately-trained healthcare practitioner must apply HST sensors or directly educate the patient in the correct application of sensors. [5]

Per the AASM, HST should not be used in patients who have comorbid medical conditions that predispose to sleep-related breathing disorders. This includes patients with significant respiratory disease such as chronic obstructive pulmonary disease (COPD) patients with class III or IV heart failure (because they are predisposed to Cheyne-Stokes breathing), and patients with hypoventilation syndromes. [4]

Coding Implications

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CPT® Codes	Description
95800	Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (e.g., by airflow or peripheral arterial tone), and sleep time
95801	Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation, and respiratory analysis (e.g., by airflow or peripheral arterial tone)
95806	Sleep study, unattended, simultaneous recording of, heart rate, oxygen saturation, respiratory airflow, and respiratory effort (e.g., thoracoabdominal movement)

HCPCS Codes	Description
G0398	Home sleep study test (HST) with type II portable monitor, unattended; minimum of 7 channels: EEG, EOG, EMG, ECG/heart rate, airflow, respiratory effort and oxygen saturation
G0399	Home sleep test (HST) with type III portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ECG/heart rate and 1 oxygen saturation

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Codes	Description
E66.9	Obesity, unspecified
G47.00	Insomnia, unspecified
G47.30	Sleep apnea, unspecified
G47.33	Obstructive sleep apnea (adult) (pediatric)
G47.9	Sleep disorder, unspecified
R06.83	Snoring

Reviews, Revisions, and Approvals	Date	Approval Date
Reviewed by IM and PUD specialists Policy developed		2/15
Updated template References reviewed and updated Background information added regarding who should apply HST sensors.	2/16	2/16
Updated template References reviewed and updated ICD-10 CM Diagnosis Codes added Background information added regarding HST with comorbid conditions	2/17	2/17

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CENTENE Corporation

Clinical Policy: NICU Discharge Guidelines

Reference Number: CP.MP.81
Effective Date: 06/13
Last Review Date: 09/17 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Infants who require neonatal admission remain at increased risk for morbidity and mortality following discharge. These infants require comprehensive discharge planning to ensure a smooth transition from the neonatal intensive care unit (NICU) and reduce morbidity and mortality after discharge.

Policy/Criteria

It is the policy of health plans affiliated with Centene Corporation® that infants are considered medically ready for discharge if the following physiologic competencies are met:

I. Sufficient nutrition to support appropriate growth

A. A consistent pattern of weight gain via the current nutritional route should be demonstrated for preterm infants or term infants > 1 week of age. The weight itself should not be a criterion for discharge. Early hospital discharge is safe and feasible for very-low-birth-weight infants when behavioral and parental criteria, rather than achieved weight, serve as discharge indicators [1-4]. Typically 3 days of weight gain are sufficient to determine a consistent pattern.

B. For term infants discharged before 1 week of age, there should be a demonstrated absence of excessive weight loss > 7% of birth weight. Term infants often have a 5-7% weight loss in the first week of life with an expectation that they will be back to birth weight by 10-14 days of age.

C. The nutritional product, enteric or intravenous, should be appropriate for the nutritional needs of the infant.

D. Support and training should be provided to the family in order to assure successful nutrition and growth for the infant following discharge.

E. Every effort should be made to have the infant on full oral nutrition at the time of discharge with the following exceptions. [4,6-8]

1. Gavage feeding has been used safely in the home setting for infants who cannot feed well enough orally. This should be considered when feeding is the last issue requiring continued hospitalization. Appropriate feeding evaluation, family assessment and therapeutic interventions should be completed prior to discharge.
2. Infants with minimal or no ability to feed orally or the expectation of such are candidates for long-term gastrostomy tube feedings. Gastrostomy tube placement may be prior to NICU discharge or after a short-term trial of nasogastric (NG)/oral feeds at home.
3. Infants with inadequate ability to absorb calories (short gut) require intravenous (IV) total parenteral nutrition (TPN) as a nutritional source. Home TPN can be considered when [4,10-11]:

a. The patient's fluid and electrolyte requirements have stabilized as evidenced by physician documentation.
b. The caregiver has an appropriate setting to administer the TPN (designated "clean" area).
c. There is adequate refrigeration to store the TPN safely.
d. The caregiver has received administration training including the indications for TPN, basic instruction on getting the solutions ready for use, catheter care, dressing changes, and information on the intravenous pump.

F. All education related to nutrition should be completed and any required special equipment (e.g., pumps) be placed in the home prior to discharge.
G. Consultations (e.g. gastroenterology and nutrition) for infants with special nutritional requirements (e.g., long term TPN, metabolic formulas, long term enteric pump feeding) should be completed prior to discharge.
H. Arrangements for home visits and follow-up appointments related to special nutritional situations should be made prior to discharge.

II. The ability to maintain normal body temperature in a home environment

A. Infant needs to demonstrate the ability to maintain normal body temperature (>36.4 C axillary) while clothed in an open bed/crib with normal ambient temperature (23.9 to 25º C).
B. Weaning from an isolette should be considered when an infant with stable cardiopulmonary state reaches >1600 grams and is able to be swaddled. [20, 21]

III. Mature respiratory control

A. Preterm infants typically demonstrate mature respiratory control by 36-37 weeks post gestational age. Occasionally maturation of respiratory control can be delayed to up to 44 weeks. For guidelines for discharge of infants with apnea of prematurity, please see separate Apnea and Bradycardia policy.
B. Infants typically are safe to discharge when they are stable on room air. Exceptions include: [4, 12-16]
   1. Infants with bronchopulmonary dysplasia (BPD) can be discharged on low flow nasal cannula at any oxygen concentration as long as the flow is 1.0 LPM (liters per minute) or less. Home oxygen therapy for infants with BPD has been used safely to achieve earlier hospital discharge.
   2. Infants with a tracheostomy and requiring positive pressure ventilation will be deemed ready for discharge to home when ventilator settings are stable utilizing a home ventilator when fraction of inspired O_2 is $\leq$ 40%. Home ventilation requires qualified personnel to provide care at the bedside. Home nursing support will be needed for at least part of the day in most cases.
C. An assessment of cardiorespiratory stability in a car seat is recommended prior to discharge for infants born at < 37 weeks gestation or with other risk factors for respiratory compromise (e.g. neuromuscular, orthopedic problems).
D. Use of home cardiorespiratory monitors should be reserved for infants with ongoing medical conditions that place them at risk for apnea, airway obstruction, or hypoxia. An assessment should be completed to determine which type of home monitoring system is

appropriate (pulse oximetry monitor, cardiorespiratory monitor). Conditions may include:

1. Pharmacological treatment of respiratory immaturity or continued apnea at term or near term gestation.
2. Need for home oxygen therapy. (may require the need for home pulse oximetry monitoring)
3. Tracheostomy or other risk of airway obstruction.
4. Need for other technology associated with cardiorespiratory impairment such as mechanical ventilation.

E. All parents should be encouraged to attend infant CPR class. If cardiorespiratory monitoring is to be used in the home, infant CPR training is a requirement for discharge.

IV. Other Considerations

A. Screening Tests
   1. State-mandated metabolic screening testing should be completed.
   2. Screening for retinopathy of prematurity per AAP guidelines should be performed (or arranged as outpatient) with an opthalmologist skilled in the evaluation of the retina of the preterm infant, with adequate follow-up for patients with active disease.
   3. Hearing screening should be completed prior to discharge with follow-up plans for infants requiring a full audiology assessment.

B. Immunizations
   1. Infants should receive appropriate immunizations per AAP guidelines before discharge (or arranged as an outpatient) based on their post-natal age.
   2. Specialized immunizations, when indicated (e.g. respiratory syncytial virus prophylaxis) should be administered prior to discharge.
   3. Every effort should be made to assure that parents and caretakers have been immunized against pertussis with the TDaP vaccine.

C. Home/Foster Care Environment
   In cases of foster care placement, Case Worker contact information should be identified. The Case Worker should be involved and kept updated as to the discharge plans.
   1. The home/foster care environment should be deemed safe and accessible.
   2. The parent or caregiver should be able to demonstrate the ability to manage the care of the infant.

D. Bilirubin Levels
   1. Bilirubin levels need to be in an acceptable range based on hours of life and risk factors.

<u>Authorization Protocol</u>

As an infant stabilizes, a lower level of care for medical reasons is appropriate. If there are no significant medical issues necessitating continued stay in Level I, II, III or IV nursery, the transitional care nursery level should be approved for the following.

A. Completion of an approved duration of antibiotic treatment *(Please reference CP.MP.85 Neonatal Sepsis Management Guidelines).*
   1. Infants should be free of serious infection prior to discharge.
   2. Length of antibiotic therapy for proven or suspected infections is variable and should be individualized.

3. In selected cases, completion of a course of parenteral antibiotics at home may be appropriate if the patient is otherwise clinically well (asymptomatic), the home situation is adequate, the parents agree, and a home infusion company experienced in neonatal IV therapy or short-term intramuscular therapy is contracted.
4. The responsible physician (neonatologist, primary care pediatrician) and back-up health care facility (NICU, community hospital) should be clarified to the family and home care agency prior to discharge.

B. Weaning of O_2 for a BPD patient or periodic O_2 needed for a patient that is progressing toward discharge on room air as supported by physician documentation.
C. Tube feeding < 50% of daily caloric requirement and progressing toward discharge on all oral feedings as supported by physician documentation. Short term home NG feedings should be considered particularly when the infant is term or near term gestation.
D. Apnea or bradycardia monitoring with a new significant episode in the last 5 days and not planning to go home on a monitor (*Please reference CP.MP.82 NICU Apnea Bradycardia Guidelines*).
E. Reference *CP.MP.86 NAS Guidelines for drug withdrawal treatment guidelines* for concerns of drug withdrawal.

Parent discharge teaching and rooming in should be timed to be completed coincidentally with the achievement of medical stability not after achieving medical stability.

Review for Level I or transitional care nursery days for social reasons such as discharge teaching, awaiting foster placement, inappropriate maternal behavior/poor bonding, unsafe home environment or maternal lengthened postpartum course, illness or disability must be sent to the medical director for review. These days may be denied as not medically necessary if Benefit Plan Contract does not include coverage for social days as medically necessary.

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed and reviewed by Neonatologist	04/13	06/13
Updated to clarify language for social day approval/denial	09/13	10/13
Updated authorization protocol to reflect 2014 Interqual language	07/14	
Updated references in policy to appropriate policy numbers Section III.B.2 updated vent settings to FIO2 requirement only per Specialist review Reviewed by Neonatalogist	09/14	10/14
Converted into new template Removed 'appropriate to authorize days', and changed Interqual to nationally recognized support tool in Authorization Protocol section	10/15	10/15
IIA: Changed degrees in Fahrenheit to degrees in Celsius. III.B.2.: changed fraction of inhaled oxygen to ≤ 40%. IV.A.2. added that the ROP screening be conducted by an ophthalmologist skilled in evaluation of the preterm infant.	10/16	10/16
References reviewed and updated.	09/17	09/17

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CENTENE Corporation

Clinical Policy: NICU Apnea Bradycardia Guidelines

Reference Number: CP.MP.82
Effective Date: 06/13
Last Review Date: 06/17 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

The purpose of this guideline is to assist with continuing care, discharge planning, and the transition to outpatient and home care of babies affected by ongoing neonatal apnea and bradycardia events. It will also serve as a guideline for the approval of continued stay for Neonatal admissions. The recommendations below are based primarily off of meta-analyses and practice patterns, as there are few controlled trials in this area.

Policy/Discharge Criteria

I. Significant cardiorespiratory events

Infants should demonstrate maturity of respiratory control without episodes of **clinically significant** cardiorespiratory events (apnea and bradycardia) for a 5 day period prior to discharge, or possibly longer if born at <28 weeks gestation. Clinically significant cardiorespiratory events include any of the following:

A. Apnea ≥ 20 seconds;
B. Apnea < 20 seconds with bradycardia of < 80 beats per minute (may consider using a heart rate decrease > 33.3% below baseline for older, more mature infants or those with a lower baseline heart rate);
C. Apnea < 20 seconds with valid, prolonged oxygen desaturations < 85% (excludes transient oxygen desaturation < 85% unless requiring supplemental oxygen to resolve);
D. Any event (not associated with feedings) that results in bradycardia < 70 beats per minute;
E. Any event requiring stimulation, artificial ventilation (bagging or intubation), or supplemental oxygen support to restore normal breathing, heart rate, and oxygenation.

Note: Cardiorespiratory events associated with feeding are not uncommon in premature infants due to incoordination of sucking, swallowing and breathing. The significance of these events needs to be assessed individually (e.g., severity of bradycardia, degree of desaturation, intervention(s) required, etc.). Episodes associated with oral feedings may not be the same as episodes recorded while sleeping. Parents should be instructed in the technique of identifying feeding problems and correcting them. Infant may be sent home on a cardiorespiratory monitor if he or she is having non-clinically significant, self-limited apnea spells (without color change or severe bradycardia) and not requiring stimulation to breathe again.

II. Caffeine

If caffeine citrate is used, it may often be discontinued by 32 - 34 weeks corrected gestational age (CGA) as long as the infant is not having clinically significant episodes of apnea/bradycardia/desaturation at rest. Caffeine has a relatively long half-life and levels may be therapeutic in preterm infants for as long as 7 days or more after discontinuation. It is

appropriate to observe an infant for 7 days after the withdrawal of caffeine but, since the discontinuation should occur well before discharge, a "caffeine countdown" should not typically prolong the date of discharge.

III. Home Cardiorespiratory Monitoring

A. Use of home cardiorespiratory monitors should be reserved for infants with ongoing medical conditions that place them at risk for apnea, airway obstruction, or hypoxemia. Such conditions may include:
   1. Pharmacological treatment of respiratory immaturity or continued apnea at term or near-term gestation (apnea of prematurity or apnea of infancy);
   2. Need for home oxygen therapy (may require the need for home pulse oximetry monitoring);
   3. Tracheostomy or other risk of airway obstruction;
   4. Need for other technology associated with cardiorespiratory impairment such as mechanical ventilation;
B. An assessment should be completed to determine which type of home monitoring system is appropriate (pulse oximetry monitor vs. cardiorespiratory monitor);
C. Infants going home with cardiorespiratory monitoring may be discharged prior to being free of clinically significant events for a 5 day period;
D. All parents should be encouraged to attend infant CPR class. If cardiorespiratory monitoring is to be used in the home, infant CPR training is a requirement for discharge;
E. All parents should be encouraged to room-in overnight in order to familiarize themselves with the baby's habits on the monitor the evening before discharge home;
F. An assessment of cardiorespiratory stability in a car seat is recommended prior to discharge for infants born at < 37 weeks gestation or with other risk factors for respiratory compromise (e.g. neuromuscular, orthopedic problems).

Other Considerations

If significant events continue to near-term or longer, then an evaluation for other causes of apnea may be completed. In cases where events appear to be associated with gastro-esophageal reflux, appropriate anti-reflux measures may be indicated. If the institution of anti-reflux measures appears to resolve the issues of bradycardia or apnea, it may not be necessary to keep the infant for additional 5 days of observation.

If nasal cannula airflow is introduced to address apnea/bradycardia events, the infant should be free of clinically significant events for 5 days on the same level of support contemplated for the child's discharge.

Background

Apnea of prematurity is a common condition of premature infants, often closely associated with bradycardia. The condition often results in prolonged lengths of stay in the neonatal intensive care units, as well as considerable parental anxiety. There is little objective evidence to recommend one

The Committee on Fetus and Newborn has defined apnea of prematurity as a cessation of breathing that lasts for at least 20 seconds or is of shorter duration but accompanied by bradycardia, cyanosis or pallor in an infant younger than 37 weeks' gestational age. The majority

of preterm infants often cease to have apnea by 37 weeks' post-conceptional age, however infants born at 24 to 28 weeks gestation have frequently been found to have apnea that persists longer, often to 44 weeks post-conceptional age.

Episodes of bradycardia may be associated with oral feedings and also with apnea events that occur while sleeping. Bradycardia associated with feeding that resolves with interruption of feeding is generally not regarded as a reason to delay discharge. Pathologic bradycardia (not associated with feeding) may be treated with pharmacologic or non-pharmacologic therapy. Non-pharmacologic measures include supplemental oxygen, artificial ventilation and physical stimulation.

When considering pharmacologic treatment, the most common agent used today is caffeine citrate. Loading doses of 20mg/kg have been used based on current references. Because of the relatively long half-life of caffeine citrate, as much as 87 hours in infants of < 33 weeks' gestation, caffeine citrate has been ideal for once a day dosing in most babies. Also, because of the relatively large therapeutic index, the drug has been found to be relatively safe. Maintenance dosing begins 24 hours after the loading dose at 5-8 mg/kg daily. If there is no clinical improvement in the number of significant events, then a caffeine level may be obtained. A target level of 10-20ug/ml is sought.

Reviews, Revisions, and Approvals	Date	Approval Date
Policy created Specialist review – Neonatal Pulmonologist	06/13	06/13
Updated coding indications	05/14	06/14
Reformatted sections with more specific headings called out Added apnea indications to significant respiratory events section Removed section about significant events continuing near term Removed authorization protocol and coding implications section	06/15	06/15
Added under *I* that infants <28 weeks gestation might need a longer event-free period prior to discharge. *I.E.* added heart rate. Added under *III* that parents should be encouraged to room overnight with infant before discharge. Removed "continuous nasogastric feeding" under *III* as cardiorespiratory monitoring would only detect late complications of aspiration. Minor wording changes made throughout policy for clarity. Specialist reviewed.	06/16	06/16
References reviewed and updated. Changed wording in *I* for clarity. Added statement to description that guidelines are based on practice patterns and meta-analyses, due to lack of controlled trials.	06/17	06/17

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Important Reminder

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CENTENE Corporation

Clinical Policy: Carrier Screening in Pregnancy

Reference Number: CP.MP.83
Effective Date: 07/13
Last Review Date: 07/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

This policy outlines medical necessity criteria for cystic fibrosis (CF) and spinal muscular atrophy (SMA) carrier testing.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that CF carrier screening (CPT® code 81220) or SMA carrier screening (81401) is **medically necessary** for women who are pregnant and meet the following criteria:
   A. No prior CF or SMA screening results are available, and
   B. Pregnancy ≤ 22 weeks gestation, and
   C. Underwent pretest counseling.

II. It is the policy of Centene Corporation that CF or SMA carrier screening anytime other than during pregnancy and for requests for CF screening CPT® codes 81221 – 81224 during pregnancy is **medically necessary** when meeting the most current version of the relevant nationally recognized decision support tools.

Authorization Protocols

Requests for prior authorization will be accepted up to 5 business days after specimen collection and reviewed for medical necessity based on the above stated criteria.

Background

CF is a genetic disorder that causes the body to make thick, sticky secretions that clog the lungs and other organs such as the digestive system. More than 10 million Americans are carriers of a defective CF gene and show no symptoms of the disease. CF is a recessive disorder, therefore, an abnormal gene must be inherited from both parents in order for the child to develop CF. Carrier testing may provide an early indication as to whether a fetus might either be a carrier or might develop CF.

SMA is an autosomal recessive disorder that causes degeneration of spinal cord motor neurons which leads to atrophy of the skeletal muscles. People with SMA experience overall weakness in the voluntary muscles, as well as trouble breathing and swallowing. Approximately 6 million Americans are carriers for SMA, with 1 in 6,000 to 1 in 10,000 live births being diagnosed with SMA. SMA is the leading genetic cause of infant mortality. Most cases of SMA result from both parents being carriers, but approximately 2% of cases are the result of a new gene mutation.

For either CF or SMA, if the maternal screening test is positive, the father of the baby must also be tested to determine if he is a carrier. If negative, no further testing is needed. If both the mother and father test positive for a defective gene, the infant will most likely be a carrier like

the parents (50% chance). However, there is a 25% chance that the infant will have the disease. If both parents are carriers, chorionic villus sampling or amniocentesis can be performed to see whether the fetus has the disease. Since these are both invasive procedures that carry a slight risk to the fetus, further testing should only be performed if and when the course of the pregnancy will be altered based on results of the testing.

Coding Implications

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CPT® Codes	Description
81220	CFTR (cystic fibrosis transmembrane conductance regulator (eg. Cystic fibrosis) gene analysis; common variants (eg. ACMG/ACOG guidelines)
81221	known family variants
81222	Duplication/deletion variants
81223	Full gene sequence
81224	Intron 8 poly-T analysis (eg, male infertility)
81401	Molecular pathology procedure level 2 (used for SMA carrier testing)

Reviews, Revisions, and Approvals	Date	Approval Date
Specific InterQual and MCG criteria removed and replaced with standard nationally recognized language under Policy/Criteria section.	02/14	
References reviewed	06/14	06/14
References reviewed	07/15	07/15
References reviewed and updated. Minor wording changes made to background.	07/16	07/16
Removed requirement for biological father to be available for testing. Added 5 day allowance for authorization.	10/16	10/16
Changed title to reflect content change. Added criteria and background information for carrier screening for SMA.	07/17	07/17

References

1. The American College of Obstetricians and Gynecologists. Carrier screening for genetic conditions. Committee Opinion, Committee on Genetics, No 691, March 2017.
2. The American College of Obstetricians and Gynecologists. Frequently asked questions FAQ171 Pregnancy. Accessed online at: http://www.acog.org/~/media/For%20Patients/faq171.pdf?dmc=1&ts=20130624T1134297985.

3. Cystic Fibrosis Foundation. CF Genetics. Accessed online at: http://www.cff.org/AboutCF/Testing/Genetics/.
4. Spinal Muscular Atrophy Foundation. Overview. Accessed online at: http://www.smafoundation.org/about-sma/

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CLINICAL POLICY
Carrier Screening in Pregnancy

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CENTENE Corporation

Clinical Policy: Cell-free Fetal DNA Testing

Reference Number: CP.MP.84
Effective Date: 08/13
Last Review Date: 06/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Cell-free fetal DNA testing is a screening test of the woman's blood taken after 10 weeks of pregnancy. It measures the relative amount of free fetal DNA and indicates if the fetus is at increased risk of having Down syndrome (trisomy 21), Edwards syndrome (trisomy 18) and Patau syndrome (trisomy 13).

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that one cell-free fetal DNA test per pregnancy is **medically necessary** for members meeting all of the following criteria:
- **A.** Underwent pretest counseling, *and*
- **B.** Current pregnancy not a multiple gestation, *and*
- **C.** Current pregnancy between 10 and 22 weeks gestation at the time the blood was drawn, *and*
- **D.** High risk for fetal aneuploidy as evidenced by one of the following:
  1. Maternal age ≥ 35 years at delivery, *or*
  2. Maternal history of a child affected with trisomy, *or*
  3. Abnormal ultrasound findings, *or*
  4. Positive test result for aneuploidy, including first trimester, sequential, or integrated screen, or quadruple screen, *or*
  5. A parent carrying a balanced Robertsonian translocation with increased risk of trisomy 13 or trisomy 21.

II. It is the policy that cell-free fetal DNA testing for any indication not listed above is considered **not medically necessary**.

Authorization Protocols

Requests for prior authorization will be accepted up to 5 business days after specimen collection and reviewed for medical necessity based on the above stated criteria.

Background

Cell-free fetal DNA testing offers a new screening tool for fetal aneuploidy. Fragments of fetal DNA, known as cell-free fetal DNA, comprise approximately 3-13% of the total cell free maternal DNA. Since its discovery in 1997, techniques for identification and analysis of cell-free fetal DNA have rapidly advanced and the range of genetic traits identifiable using these process will continue to grow.

There are limitations of cell-free fetal DNA testing and they should be discussed during pre-test counseling. The decision for testing should be an active and informed choice of the mother. Pre-

test counseling should also include review of the family history and possible baseline ultrasound to confirm viability, single gestation, gestational dating and review for anomalies. If a fetal structural anomaly is identified on ultrasound exam, diagnostic testing or cell-free DNA screening should be offered. Also, the mother needs to be aware that a negative cell-free fetal DNA test result does not assure an unaffected pregnancy. Invasive prenatal testing and genetic counseling should be offered for any patient with a positive test result.

Conventional screening methods remain the most appropriate choice for most women in the general obstetric population. While the sensitivity and specificity in the general obstetrics population is similar to the high-risk population, the positive predictive value is lower given the low prevalence of aneuploidy in the general population. Conventional screening methods allow for higher detection rates of chromosome abnormalities that occur at a higher rate in the general population as well as other adverse pregnancy outcomes. There is still limited data on the cost-effectiveness of cell-free fetal DNA testing in the general obstetric population.

Coding Implications

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CPT® Codes	Description
81420	Fetal chromosomal aneuploidy (eg, trisomy 21, monosomy X) genomic sequence analysis panel, circulating cell-free fetal DNA in maternal blood, must include analysis of chromosomes 13, 18, and 21
81422	Fetal chromosomal microdeletion(s) genomic sequence analysis (eg, DiGeorge syndrome, Cri-du-chat syndrome), circulating cell-free fetal DNA in maternal blood
81507	Fetal aneuploidy (trisomy 21, 18, and 13) DNA sequence analysis of selected regions using maternal plasma, algorithm reported as a risk score for each trisomy.
81479	Unlisted molecular pathology procedure
0009M	Fetal aneuploidy (trisomy 21, and 18) DNA sequence analysis of selected regions using maternal plasma, algorithm reported as a risk score for each trisomy

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed, specialist reviewed	07/13	08/13
Added to criteria current pregnancy between 10 and 20 weeks gestation and only one per pregnancy	06/14	07/14

Reviews, Revisions, and Approvals	Date	Approval Date
Updated coding implications	01/15	
Changed criteria to allow testing up to 22 weeks of pregnancy	03/15	03/15
Removed high-risk indication of ultrasound findings, updated background	07/15	07/15
Added CPT codes 81420 and 81479 as these are codes billed by providers for cell free fetal DNA testing	10/15	
Policy converted to new template. References reviewed and updated.	07/16	07/16
Added the statement that cell-free fetal DNA testing for any indication not listed above is considered **not medically necessary**.	03/17	
Added abnormal ultrasound findings as an indication. References reviewed and updated. Updated CPT codes.	05/17	06/17

References

1. The American College of Obstetricians and Gynecologists Committee on Practice Bulletins-Obstetrics, Committee on Genetics, and Society for Maternal-Fetal Medicine. Practice Bulletin: Screening for Fetal Aneuploidy. Number 163, May 2016.
2. The American College of Obstetricians and Gynecologists Committee on Genetics and Society for Maternal-Fetal Medicine Publications Committee. Committee Opinion: Cell-free DNA screening for fetal aneuploidy. Number 640, September 2015. (Published ahead of print)
3. Sayres L, et al. Cell-free fetal DNA testing: A pilot study of obstetric healthcare provider attitudes towards clinical implementation. Prenat Diagn. 2011 November; 31(11): 1070–1076. Doi:10.1002/pd.2835.
4. Palomaki GE, Messerlian GM, Halliday JV. Prenatal screening for common aneuploidies using cell-free DNA. In: UpToDate, Wilkins-Haug (Ed), UpToDate, Waltham, MA. Accessed May 31, 2017.

Important Reminder

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CENTENE Corporation

Clinical Policy: Neonatal Sepsis Management

Reference Number: CP.MP.85
Effective Date: 08/13
Last Review Date: 09/17 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Through the increased incidence of intra-partum antibiotics, early-onset neonatal sepsis is occurring less frequently. However, it continues to be a common cause of neonatal morbidity and mortality. The CDC (Centers for Disease Control and Prevention) defines early onset sepsis as a blood or cerebrospinal fluid culture-proven infection occurring within the first seven days of life.

Group B Streptococcus (GBS) remains the leading cause of neonatal sepsis. More than half of GBS cases occur in infants of mothers with negative GBS cultures, emphasizing the need to remain vigilant for signs of sepsis in all newborns. These infants require comprehensive assessment and treatment, as well as discharge planning, in order to ensure timely treatment in an effort to reduce morbidity and mortality.[2]

Policy/Criteria

It is the policy of Health Plans affiliated with Centene Corporation that the management of neonatal sepsis is **medically necessary** at the indicated level of care for the following circumstances:

I. Episode Day 1

A. Well-appearing infants who are on 48 hours of antibiotics pending blood culture results are appropriate for level II (rev code 172) nursery.
B. Symptomatic infants are appropriate for level III (rev code 173) nursery when meeting the following criteria:
   1. Hypotonia, lethargy, or poor oral feeding; and
   2. Temp ≥100.4˚F or ≤ 96.8˚F (≥ 38.0˚ or ≤ 36.0˚C); and
   3. On 48 hours of antibiotics pending blood culture results or treatment of positive blood cultures.

II. Episode Day 2 and Subsequent

A. Infants with negative cultures who are determined to require antibiotics beyond 48 hours may be approved at a transitional care or level I nursery (rev code 171) once antibiotics are the only intervention necessitating continued stay and if outpatient antibiotics are inappropriate or unmanageable.
B. Symptomatic infants are appropriate for level III (rev code 173) nursery when meeting the following criteria:
   1. Hypotonia, lethargy, or poor oral feeding; and
   2. Temp ≥100.4˚F or ≤ 96.8˚F (≥ 38.0˚ or ≤ 36.0˚C); and
   3. On 48 hours of antibiotics pending blood culture results or treatment of positive blood cultures.
C. Asymptomatic infants on 48 hours of antibiotics pending blood culture results for ≤ 2 days are appropriate for Level II (rev code 172) nursery.

D. Asymptomatic infants with a positive blood culture and no other indications are appropriate for transitional care or level I nursery (rev code 171).

Once the culture and sensitivity results are known and antibiotic therapy is established, a medically stable infant should be transitioned to a lower level of care for treatment completion if no other indications exist that require the current level of care. Transitional care nursery should be considered if antibiotics cannot safely be administered at home or at home with home health care.

III. Discharge criteria, with or without home antibiotics, meets all, as applicable:

A. Member is clinically stable; and
B. Home situation is assessed and deemed adequate; and
C. Parent or caretaker is agreeable with the plan of care; and
D. If going home with antibiotics, the following are met:
   1. A home infusion company is contracted which is experienced in neonatal IV(intravenous) therapy or short-term intramuscular therapy; and
   2. Secure IV access is in place if chosen; and
   3. The responsible physician (neonatologist, primary care pediatrician) and back-up health care facility (neonatal intensive care unit [NICU], community hospital) should be clarified to the family and home care agency prior to discharge.

Background

I. Identification and treatment of mother during pregnancy and labor[1]

A. Women with GBS isolated in the urine at any time during the current pregnancy or who had a previous infant with invasive GBS disease should receive intrapartum antibiotic prophylaxis. Third trimester screening for GBS colonization is not needed in this population.
B. Women with symptomatic or asymptomatic GBS urinary tract infection (UTI) detected during pregnancy should be treated according to current standards of care for UTI during pregnancy and should receive intrapartum antibiotic prophylaxis to prevent early-onset GBS disease.
C. All other pregnant women, including those with a scheduled cesarean delivery, should be screened at 35-37 weeks' gestation for vaginal and rectal GBS colonization.
D. At the time of labor or rupture of membranes, intrapartum antibiotic prophylaxis should be given to all pregnant women who tested positive for GBS colonization, including those undergoing cesarean delivery. If cesarean delivery is performed before onset of labor on a woman with intact amniotic membranes, prophylaxis need not be given.
E. When screening results are not available at the time of labor and delivery, intrapartum antibiotic prophylaxis should be given to women who are <37 weeks and 0 days' gestation, have a duration of membrane rupture ≥18 hours, or have a temperature of ≥100.4° F (≥38.0°C).
F. In the absence of GBS UTI, antimicrobial agents should not be used before the intrapartum period to eradicate GBS genitorectal colonization because such treatment has not been shown to be effective in eliminating carriage or preventing neonatal disease and can have adverse consequences.

G. Prophylactic intrapartum antibiotics for GBS is not recommended as a routine practice for cesarean deliveries performed before labor onset in women with intact amniotic membranes, regardless of the GBS colonization status of the woman or the gestational age of the pregnancy. The use of perioperative prophylactic antibiotics to prevent infectious complications of cesarean delivery should not be altered or affected by GBS status. Health-care providers should inform women of their GBS screening test result and the recommended interventions.

II. *Identification and Treatment of the newborn* [(1)]

A. Any infant with signs of sepsis should receive a full diagnostic evaluation and antibiotic therapy pending the results of the evaluation. The evaluation should include a blood culture; CBC including white blood cell differential and platelet count; and chest radiograph if any abnormal respiratory signs are present.
B. A lumbar puncture should only be performed if the infant is stable enough to tolerate the procedure and (1) infant has a positive blood culture, (2) infant has a high probability of sepsis on the basis of clinical signs or laboratory values, or (3) infant does not clinically improve when treated with appropriate antibiotic therapy. Therapy for the infant should include antimicrobial agents active against GBS (including IV ampicillin), as well as other organisms that might cause neonatal sepsis, such as E. coli, et al.
C. Any symptomatic infant without risk factors for infection, who improves over the first 6 hours of life, may not require treatment but must be monitored closely.
D. Well-appearing infants whose mothers had suspected chorioamnionitis should undergo a limited evaluation and receive antibiotic therapy pending culture results. The evaluation should include a blood culture and a CBC including white blood cell differential and platelet count, but no routine chest radiograph or lumbar puncture is needed in this case. Consultation with obstetric providers to assess whether chorioamnionitis was suspected is important to determine neonatal management.
E. Well-appearing infants whose mothers had no chorioamnionitis and no indication for GBS prophylaxis should be managed according to routine clinical care.
F. Well-appearing infants whose mothers had no chorioamnionitis and no indication for GBS prophylaxis but with suspected infection due to slightly abnormal lab results may receive 48 hours of antibiotics pending blood cultures. They would otherwise be managed according to routine care.
G. Well-appearing infants of any gestational age whose mothers had indications for GBS prophylaxis and received adequate intrapartum GBS prophylaxis (≥4 hours of penicillin, ampicillin, or cefazolin before delivery) should be observed for ≥48 hours and no routine diagnostic testing is recommended. Such infants may be discharged home as early as 24 hours after delivery if the infant is medically stable, ready access to medical care exists, and a person able to comply fully with instructions for home observation will be present.
H. For well-appearing infants born to mothers who had an indication for GBS prophylaxis but received no or inadequate prophylaxis, if the infant is well-appearing and ≥37 weeks and 0 days' gestational age and the duration of membrane rupture before delivery was <18 hours, the infant should be observed for ≥48 hours, and no routine diagnostic testing is recommended. If the infant is well-appearing and either <37 weeks and 0 days' gestational age or the duration of membrane rupture before delivery was ≥18 hours, then

the infant should undergo a limited evaluation (a blood culture and CBC including white blood cell differential and platelet count) and observation for ≥48 hours.

I. Antibiotics use for more than 2 days should not be based solely on elevated C-reactive protein (CRP). Evidence for CRP as a screening test for neonatal sepsis suggests that although the negative predictive value is high, the positive predictive value is low, particularly among healthy-appearing term infants. CRP levels are most useful in combination with other tests as a part of a sepsis screen.

III. General Considerations

A. Stable infants at 35 weeks gestational age or older who are treated for sepsis should be discharged the same day the antibiotics are discontinued.
B. For ruling out sepsis due to perinatal risk factors, 48 hours of antibiotic administration is considered appropriate pending culture results and evaluation of lab data.
C. Antibiotics should be continued beyond 48 hours in infants with negative cultures if there are continued clinical symptoms suggestive of sepsis or meningitis or other abnormal lab data.

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed, Neonatologist reviewed	08/13	08/13
Renamed "Authorization Protocol" to Policy/Criteria and reformatted text to episode days and discharge criteria Remaining information moved to background. Background updated regarding timing of lumbar puncture Updated nursery levels based on updated Interqual criteria nursery leveling Neonatologist reviewed	09/14	09/14
References reviewed and updated Converted to new template Neonatologist reviewed	09/15	09/15
Clarified bullets under III.D. No criteria change	04/16	
References reviewed and updated. Minor wording changes for clarification.	08/16	09/16
References reviewed and updated.	09/17	09/17

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CENTENE Corporation

Clinical Policy: Neonatal Abstinence Syndrome Guidelines

Reference Number: CP.MP.86
Effective Date: 10/13
Last Review Date: 10/17 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Maternal drug use and intrauterine exposure of the fetus during pregnancy can lead to drug withdrawal in the infant after delivery. Clinically important neonatal withdrawal most commonly results from intrauterine opioid exposure. The constellation of withdrawal symptoms related to opioid drug use is known as neonatal abstinence syndrome (NAS). Signs of withdrawal will develop in 55 - 94% of neonates exposed to opioids in utero. Maternal use of central nervous system depressants (e.g., benzodiazepines, barbiturates and alcohol) and other drugs also results in signs of neonatal symptoms/withdrawal in exposed infants.

Typical signs of withdrawal from specific drugs occur based on the half-lives of elimination of the drug. Maternal use of multiple drugs during pregnancy will also have an impact on the onset and severity of NAS. In general though, if one week has elapsed between the last maternal opioid use and delivery, the incidence of NAS is relatively low. Table 1 below lists common drugs abused along with the typical onset of NAS symptoms.

Table 1. Common Drug NAS Symptom Onset

Drug	Typical onset
Heroin	Within 24 hrs with delay up to 5-7 days or later
Methadone	24-72 hrs with delay up to 5-7 days later
Morphine & Hydrocodone	Within 3 days
Buprenorphine	Within 40 hrs
Ethanol	3-12 hrs
Barbiturate	4-7 days with delay up to 14 days
Diazepam	12 days
Chlordiazepoxide	21 days

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that the management of neonatal abstinence syndrome is **medically necessary** at the indicated level of care for the following circumstances:

- **A.** Asymptomatic infants at risk for NAS
  1. Infants at risk for NAS due to maternal drug history are appropriate in Transitional level or level 1 nursery for 4 to 7 days for observation, depending on the drugs used during pregnancy (see Table 1 above).
- **B.** Symptomatic infants
  1. Symptomatic infants should be managed using the appropriate nationally recognized clinical decision support tools.
  2. Once the infant is weaned to a 6 hour dosing interval, home-based withdrawal therapy may be considered if no more than 2 scores are ≥ 8 or 1 score is > 10 in the prior 48

hours and all of the following discharge criteria are met. The home environment, caregiver, and support team must be taken into consideration.

C. Discharge Criteria

Prior to discharge home with home health, the following must be met:

1. Infant is clinically stable and meets all of the following criteria:
   a. Infant is taking oral feeds and gaining weight satisfactorily; *and*
   b. Infant is physiologically stable with normal vital signs including blood pressure; *and*
   c. Infant is showing neurobehavioral recovery evidenced by reaching full alert state, responding to social stimuli, and consolable with appropriate measures
2. Home situation is assessed and deemed adequate
3. Parent or caretaker is agreeable with the plan of care
4. Appropriate transportation is available for follow up appointments
5. Home care services are arranged for nursing assessments
6. The responsible physician (neonatologist, primary care pediatrician) and back-up health care facility (NICU, community hospital) should be clarified to the family and home care agency prior to discharge

II. It is the policy of health plans affiliated with Centene Corporation® that if the infant is clinically stable but remains in the nursery due to social issues, these days are considered **not medically necessary** unless there is a benefit coverage requiring such days.

Background

The diagnosis and management of NAS is briefly described below. The presentation of NAS is widely variable in the onset of symptoms and types and severity of clinical manifestations. Universal screening and subsequent close observation of high risk neonates is essential for timely diagnosis and treatment of the neonate.

A. *Screening* – the following screening steps should be taken

1. Universal screening for maternal drug abuse
2. Maternal toxicology testing in known or suspected cases of NAS based on any of the following characteristics: (note – legal implications of testing and need for consent from the mother may vary among states)
   a. Known history of maternal substance abuse
   b. Maternal engagement in high risk behaviors,
   c. Disclosure of recent substance abuse
   d. Acting in an intoxicated manner on admission or during office visits
   e. Previous unexplained late fetal demise, repeated spontaneous abortion
   f. Precipitous labor, placental abruption, hypertensive episodes, severe mood swings
   g. Cerebrovascular accidents, myocardial infarction
3. Newborn urine and/or meconium screening can be performed for recent substance abuse.
   a. False-negatives may occur more commonly with urine testing due to urinary excretion of most drugs being relatively short.
   b. Meconium screening yields false-negatives less frequently than urine screening; however results are not typically available for days to weeks.
   c. Umbilical cord tissues samples may become a more viable screening tool in infants suspected of in utero exposure.

B. Observation/Assessment

1. Infants at risk for NAS should be observed in the neonatal nursery for signs of consistent withdraw. The modified Finnegan's Neonatal Abstinence Scoring Tool is the predominant assessment tool used in the United States for quantifying the severity of neonatal withdrawal signs.
2. Timing and severity of withdrawal symptoms depends upon the maternal drug(s) used and last time of use. Duration of neonatal nursery observation should be dependent on the half-life of the drug based on maternal drug use history.
   a. For example, maternal use of a drug with a short half-life of 4 hours (e.g. hydrocodone) indicates an infant may be safely discharged if there are no signs of withdrawal by 3 days of age.
   b. Maternal use of a drug with a prolonged half-life (e.g. methadone) indicates an infant should be observed for a minimum of 5 to 7 days.

C. Diagnosis

1. Withdrawal symptoms such as seizures, fever, irritability, and poor feeding can all be signs of other conditions. Appropriate assessment and diagnostic tests are necessitated to differentiate NAS from other diagnoses.
2. Clinical diagnosis is made based on maternal history of drug use and neonatal screening, observation, and assessment findings.

D. Treatment

1. Nonpharmacologic
   a. Infants showing early signs of withdrawal should have treatment directed at minimizing environmental stimuli. This includes placing the infant in a dark, quiet environment, careful positioning and comfort techniques such as swaddling, responding early to an infant's signals, and frequent small feedings of calorically dense formula or fortified breast milk.
   b. Careful observation for signs of fever, dehydration or weight loss.
   c. Ensure adequate sleep and caloric intake.
   d. Additional supportive care such as IV fluids, electrolyte replacement and gavage feedings may be indicated to stabilize the infant in the acute phase and obviate the need for pharmacologic intervention.
   e. Breast feeding has been associated with less severe NAS and should be encouraged in mothers who are adherent to a supervised drug treatment program.
2. Pharmacologic
   a. Pharmacologic therapy should be reserved for the infants with moderate to severe signs of NAS, and to relieve complications of such, when nonpharmacologic support is ineffective. Drug withdrawal may be life-threatening, but it is ultimately a self-limited process and unnecessary pharmacologic treatment prolongs exposure to harmful drugs. Studies have only shown clear benefits of pharmacologic therapy for the short-term amelioration of clinical signs of NAS. Long term benefits or harm have not been clearly studied.
   b. The optimal screening score for the initiation of pharmacologic therapy is not clearly defined. However, pharmacologic therapy is generally started for the neonate who has 3 or more consecutive scores above 8 or 2 scores of 11 or greater despite adequate supportive care.
   c. Indications for pharmacologic therapy include:

i. Seizures
ii. Poor feeding with failure to gain weight
iii. Inability to sleep despite nonpharmacologic treatment
iv. Fever unrelated to another source
v. Significant diarrhea and/or vomiting resulting in weight loss or hypovolemia

d. When nonpharmacologic treatment fails, the recommended first drug of choice is an opioid, either morphine or methadone. The second drug of choice is phenobarbital if the opiate does not control symptoms. Paregoric and diazepam are no longer recommended.
e. The general course of opioid therapy is determined by the response of the infant based on abstinence scoring. If the infant remains symptomatic based on abstinence scoring, an increased dose is indicated. Once the infant responds to therapy with a decrease in scoring and weight gain is established, weaning of the medication can begin. Metabolic demands need to be considered as part of the weaning process. The rate of wean is dependent on the infant's clinical status with use of the abstinence score facilitating this process.
f. Weaning may occur every 24 to 48 hours for infants on single drug regimens and no more frequently than every 48 hours for infants on multiple drug regimens or those who have recently failed a wean. The use of clinical judgment in the management of pharmacotherapy is vital.

Prematurity
Preterm infants have been found to be at lower risk of drug withdrawal with less severe and/or prolonged courses of NAS. Several possible causes of this effect include relation to developmental immaturity of the CNS in preterm infants, lower total drug exposure, less fat depots of the drug, or possibly that the severity of NAS is more difficult to determine in preterm infants due to scoring tools being developed for full-term infants.

Opioids
The clinical presentation of NAS is dependent on multiple variables, including opioid used; maternal drug use history; maternal, placental and infant metabolism; and other factors. Because opioid receptors focus in the central nervous system (CNS) and gastrointestinal (GI) tract, the majority of NAS symptoms reflect CNS irritability, autonomic over-reactivity, and GI tract dysfunction. Excess stimuli and hunger exacerbate the perceived severity of NAS.

Cocaine and other CNS stimulants
Neurobehavioral symptoms from intrauterine exposure to CNS stimulants such as cocaine and amphetamine frequently occur on the second or third day postnatal. Symptoms include irritability, hyperactivity, tremors, high-pitched cry, and excessive sucking. However, since cocaine and its metabolites can be detected in the neonatal urine for up to 7 days postnatal, symptoms may reflect drug effect rather than withdrawal. Pharmacological treatment of infants with neurobehavioral symptoms due to intrauterine cocaine exposure has not been carefully evaluated, thus no standard of care exists.

Selective serotonin reuptake inhibitors

CLINICAL POLICY
Neonatal Abstinence Syndrome Guidelines

Selective serotonin reuptake inhibitors (SSRIs) are the most common class of anti-depressants used to treat depression in the general population and during pregnancy. Studies have linked third trimester use of SSRIs to a group of symptoms including continuous crying, irritability, jitteriness, and/or restlessness, shivering, fever, tremors, hypertonia or rigidity, tachypnea or respiratory distress, feeding difficulty, sleep disturbance, hypoglycemia, and seizures. Onset of these symptoms generally begins several hours to several days after birth and subsides within 1 to 2 weeks. It is not clear if these symptoms are a reflection of serotonin syndrome or SSRI withdrawal. Clinicians should arrange for early follow up after hospital discharge for infants at risk from the effects of SSRI exposure in utero.

Reviews, Revisions, and Approvals	Date	Approval Date
Policy created; reviewed by Neonatologist	10/13	10/13
Changed Policy/Criteria from Episode Days to Asymptomatic and Symptomatic infants criteria Updated criteria for symptomatic infants to refer to decision support tool criteria Updated Asymptomatic infants criteria to allow for observation in nursery according to maternal drug history Reviewed by Neonatologist	10/14	10/14
Converted into new template Clarified language in Policy/Criteria section I.B.2 Added short explanative paragraph at beginning of Background section	10/15	10/15
References reviewed and updated. Reviewed by neonatologist.	09/16	10/16
Changed minimum days of observation to 4 in 1.A, to reflect the half-life of common drugs contributing to NAS. References reviewed and updated.	10/17	10/17

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CLINICAL POLICY
Neonatal Abstinence Syndrome Guidelines

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CENTENE Corporation

Clinical Policy: Inhaled Nitric Oxide

Reference Number: CP.MP.87
Effective Date: 08/13
Last Review Date: 09/17 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Inhaled Nitric Oxide (iNO) is a selective pulmonary vasodilator in which its mechanism of action results in smooth muscle relaxation. Several studies have suggested that iNO improves oxygenation, particularly in trials of term and near-term neonates with hypoxic respiratory failure. iNO has been shown to reduce the need for ECMO (extracorporeal membrane oxygenation) without increasing neurodevelopmental, behavioral, or medical abnormalities at 2 years of age.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that iNO therapy is **medically necessary** for the following indications:

A. *Initiation* of therapy
   1. Hypoxic respiratory failure in newborns ≥ 34 weeks gestational age at birth with all:
      a. Pulmonary artery hypertension (PAH) diagnosed by echocardiogram that excluded congenital heart disease (CHD), *and*
      b. Conventional therapies such as mechanical ventilation, administration of high concentrations of oxygen (80-100%), high-frequency ventilation, induction of alkalosis, neuromuscular blockade, and sedation have failed or are expected to fail; *and*
      c. Oxygen index (OI) ≥ 25. The OI is calculated as the mean airway pressure divided by the partial pressure of arterial oxygen times 100; *and*
      d. Response seen with administration of up to 40 ppm trial of iNO (defined as a PaO2 increase ≥ 20 mm Hg or a 20% decrease in OI.
   2. Perioperative management of pulmonary hypertension in infants and children with CHD, must meet all:
      a. iNO therapy for vasodilation is used in response to cardiac bypass surgery to repair a congenital heart defect that is causing PAH, *and*
      b. iNO is delivered directly to the lungs via endotracheal tube.

B. Continuation of iNO therapy in newborns
   1. Member continues to require iNO as evidenced by a continued O2 requirement of 80-100%, or
   2. A weaning protocol is being initiated after a 4-6 hour period of stability indicated by O2 requirement decreased to 60-80% or OI ≤ 10; *and*
      a. The iNO has been used for 1 week or less

II. It is the policy of health plans affiliated with Centene Corporate that iNO is **not medically necessary** for any other indications such as preterm infants < 34 weeks gestation, acute bronchiolitis, bronchopulmonary dysplasia (BPD), congenital diaphragmatic hernia (CDH),

adult respiratory distress syndrome or acute lung injury, treatment in adults with positive vaso-reactivity testing, post-op cardiac surgery in adults, and vaso-occlusive crises in members with sickle cell disease because safety and effectiveness have not been established.

Treatment Regimen
The American Academy of Pediatrics (AAP) recommends that iNO should only be administered according to a formal protocol that has been approved by the Food and Drug Administration (FDA) and the institutional review board and with informed consent. Use should be limited to sites with multisystem support, including on-site ECMO capability. If ECMO is not available on-site, a timely transfer needs to be arranged to a collaborating ECMO center without interruption of iNO therapy.

Since no one standard protocol has been issued for iNO treatment, the following is one guideline to assist in determining appropriate initiation and continuation of treatment. The recommended starting dose of iNO for term infants is 20ppm. A positive response generally occurs in less than 30 minutes with a PaO_2 increase ≥20 mmHg (or 20% decrease in OI). If there is no response, the dose may be increased up to 40 ppm. In premature infants, the initial dose used in studies was 10 ppm with an increase up to 20 ppm in non-responders. Doses of up to 80 ppm have been used, but the potential for increasing toxicity without additional benefits occurs at doses greater than 40 ppm.

Per Peliowski, weaning can occur following improvement in oxygenation and after a 4 to 6 hour period of stability, during which the inspired oxygen concentration is decreased to 60% to 80%, or the OI falls to ≤10. At 4-6 hour intervals, the dose can be decreased by 50%, as long as the OI remains ≤10. When stability is maintained at iNO dose of 5 ppm, weaning should occur by 1 ppm every 4 hours and discontinued at 1 ppm if oxygenation status remains with <60% oxygen with PaO_2 consistently >50 mmHg. If deterioration occurs during or after weaning occurs, the dose should be increased to the previous level or iNO restarted. Once the infant stabilizes again, weaning should occur more slowly, taking place over a 24 to 48 hour period.

In general, patients who responded to iNO therapy typically require treatment for 3-4 days, with randomized trials demonstrating 90% of treated infants were off iNO therapy within one week of initiation. Patients should be monitored for potential toxic effects by measuring the serum methemoglobin concentration, levels of nitrogen dioxide at the airway opening, and ambient air contamination. Decreased platelet aggregation, increased risk of bleeding and surfactant dysfunction can also occur from iNO toxicity.

Background
A large and well-designed multicenter trial was conducted by the Neonatal Research Network in 235 infants with gestational age ≥34 weeks who had severe hypoxic respiratory failure (OI ≥25) and did not have CDH. Infants were randomly assigned to iNO or control (100% oxygen). Fewer infants in the treatment group died within 120 days or received ECMO therapy, (46% versus 64%; relative risk 0.72, 95% CI 0.57-0.91) compared to control. This difference was entirely due to decreased requirement for ECMO (39% versus 54%); there was no difference between groups in mortality.

In a systemic review by the Cochrane database, similar findings of fewer requirements for ECMO and no difference in mortality were noted. Fourteen randomized trials were found in term or near term infants with hypoxia. iNO improved oxygenation in approximately 50% of the treated infants. Within 30 to 60 minutes of beginning therapy, PaO_2 increased by a mean of 53 mmHg and OI decreased by a mean of 15.1. Outcome did not appear to be affected by whether infants had echocardiographic evidence of persistent pulmonary hypertension. No benefit was noted in those with CDH, indeed there is a suggestion that outcome was slightly worsened.

In preterm infants <35 weeks gestation, a systematic review by the Cochrane database found 14 randomized controlled trials of iNO. The authors concluded that iNO as a rescue therapy for the very ill ventilated preterm infant does not appear to be effective and may increase the risk of severe intraventricular hemorrhage. Later use to prevent BPD does not appear to be effective. Early routine use of iNO in mildly sick preterm infants may improve survival without BPD and decrease serious brain injury; further studies are needed to confirm these findings.

iNO has been well-studied in patients with acute lung injury and acute respiratory distress syndrome (ALI/ARDS). While iNO may improve oxygenation temporarily, it has not been shown to improve clinically important outcomes such as duration of mechanical ventilation, 28-day mortality or one-year survival. Furthermore, iNO does not improve oxygenation in all patients and the factors that may predict a good response are still uncertain.

In a systemic review by the Cochrane database, results from 5 randomized controlled trials found that iNO did not demonstrate any statistically significant effect on mortality and transiently improved oxygenation (up to 72 hours) in patients with hypoxemic respiratory failure. Further trials are needed to assess other clinically relevant end points and provide further stratification for treatment. In an updated Cochrane database review, the evidence was insufficient to support iNO in any category of critically ill adults and children with acute respiratory distress syndrome . Although, iNO results in a transient improvement in oxygenation, it does not reduce mortality and may be harmful, as it seems to increase renal impairment.[23]

A Cochrane Summary for the use of iNO for pulmonary hypertension (PH) following surgery in infants and children with congenital heart disease found no benefit of it to assist in recovery. In the four randomized trials reviewed, there was no difference found in mortality or other outcomes reviewed. Due to the minimal data that was available, the authors found it difficult to draw valid conclusions regarding effectiveness and safety of this treatment in the select population. In a later study, iNO was effective in reducing the risk of development of PH crisis in PAH-CHD patients after cardiac repair in a placebo-controlled study [16] . Infants with PAH-CHD receiving iNO had fewer PH crises and shorter postoperative courses without concomitant side effects related to the medication.

Research on iNO use in adults with PH is limited to case reports and small case series, which leaves the impact of iNO on survival uncertain. It has been found to successfully stabilize a variety of acutely ill and hemodynamically compromised patients with severe PH, but the outcomes data are limited and thus cannot be considered standard of care. Acute vasodilator testing is the only well established and widely accepted use of iNO in patients with PAH.

Patients with a positive vasoreactivity test are candidates for a trial of calcium channel blocker therapy

INO has numerous potential harms that must be considered when determining the risks and benefits of treatment. These potential harms include renal dysfunction, DNA strand breakage and base alterations which are potentially mutagenic, immunosuppression that could increase the risk of nosocomial infection, and a possible increase in methemoglobin and NO2 concentrations, which must be monitored frequently. Also, iNO may produce toxic free radicals; however, it is unknown if these are more harmful than ongoing exposure to high fractions of inspired oxygen.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2017, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
94799	Unlisted pulmonary service or procedure

HCPCS Codes	Description
N/A	

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
I27.0	Primary pulmonary hypertension
I27.2	Other secondary pulmonary hypertension
P07.37	Preterm newborn, gestational age 34 completed weeks
P07.38	Preterm newborn, gestational age 35 completed weeks
P07.39	Preterm newborn, gestational age 36 completed weeks
P22.0	Respiratory distress syndrome of newborn
P28.5	Respiratory failure of newborn
P29.3	Persistent fetal circulation
Q21.0	Ventricular septal defect
Q21.2	Atrial septal defect

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed, Neonatologist reviewed	08/13	08/13
Split criteria into initiation and continuation of therapy	08/14	09/14

Reviews, Revisions, and Approvals	Date	Approval Date
Added Treatment Regimen section Neonatologist reviewed		
Literature researched and bibliography updated Converted to new template Neonatologist reviewed	09/15	09/15
Updated template and disclaimer language	03/16	
Added criteria for iNO therapy in perioperative management for PAH in pediatrics. Reviewed by Pediatric Cardiology, Adult Cardiology, and Neonatologist.	08/16	09/16
References reviewed and updated. ICD-10 and CPT codes added.	09/17	09/17

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Important Reminder

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CLINICAL POLICY
Inhaled Nitric Oxide

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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CENTENE Corporation

Clinical Policy: Sickle Cell Disease Observation

Reference Number: CP.MP.88
Effective Date: 09/13
Last Review Date: 09/17 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Medical necessity criteria for sickle cell disease observation status.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that the observation level of care is **medically necessary** for members who do not meet inpatient status criteria per a nationally recognized clinical decision making support tool, but who meet the following criteria:

A. Episode Day 1:

1. Intractable pain despite routine home therapy (including narcotics, heat, massage, rest, etc.), *and*
2. Suboptimal improvement in pain following at least 4-6 hours of intravenous (IV) or intramuscular (IM) analgesic treatment in the emergency department (ED) or an alternate outpatient setting, *and*
3. Requires continued IV or IM analgesic treatment and/or IV fluids for pain management.

B. Episode Day 2:

Any days beyond episode day one in observation that do not meet inpatient criteria must be reviewed by a physician. Lack of scheduled or continuous dosing of analgesics and adequate IV fluids indicate suboptimal treatment of a vaso-occlusive pain crisis.

C. Discharge Criteria:

1. Pain is controlled with oral analgesics; *and*
2. Adequate oral intake; *and*
3. Patient educated on comprehensive pain plan tailored to his/her individual needs.

Background

Episodes of acute pain are the most common type of vaso-occlusive event in sickle cell disease (SCD). An acute pain episode is the most common reason for individuals with SCD to seek medical attention. Pain can be triggered by things such as stress, weather conditions, dehydration, infection, menses, and alcohol consumption, but most episodes have no identified cause. The pain most commonly affects the back, chest, extremities, and abdomen, but can occur in any area of the body. Pain ranges from mild to excruciating and can be accompanied by objective clinical signs such as fever, swelling, tenderness, tachypnea, hypertension, nausea and vomiting.

Every individual with SCD should have an established pain plan tailored to his or her needs. These plans should outline how to appropriately manage their pain at home and include pre-

defined thresholds for the use of opioids and when to contact their health care providers. When adequate relief is not achievable in the home, patients often present to the ED for treatment.

When patients present to the ED with acute pain, other causes of the pain should be excluded, particularly infection, prior to developing a treatment strategy. An acute pain crisis is best managed with optimal hydration and aggressive pain relief. IV fluid resuscitation and analgesics can be effectively administered in the observation setting when efforts at treating the pain episode at home are unsuccessful and the pain is not severe enough to warrant an inpatient admission.

Reviews, Revisions, and Approvals	Date	Approval Date
References reviewed and updated	09/14	09/14
Changed language in II.A from referred to Medical Director to reviewed by a physician Converted into new template	09/15	09/15
References reviewed and updated. Clarified in I. that the member does not meet inpatient status "per a nationally recognized clinical decision making support tool."	09/16	09/16
References reviewed and updated.	09/17	09/17

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CLINICAL POLICY
Sickle Cell Disease Observation

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CENTENE Corporation

Clinical Policy: Genetic Testing

Reference Number: CP.MP.89
Effective Date: 11/13
Last Review Date: 06/17 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
This policy includes criteria for making medical necessity determinations for genetic tests when specific criteria are not available for the requested genetic test. Genetic testing is the analysis of human DNA, RNA, or chromosomes in order to detect heritable disease-related genotypes, mutations, phenotypes, or karyotypes for clinical purposes. Such purposes include predicting risk of disease, identifying carriers, and establishing prenatal and clinical diagnosis or prognosis. There are currently more than 1000 genetic disorders for which genetic testing is available on a clinical or research basis

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that genetic testing is **medically necessary** when *all* the following criteria are met:
- A. The member displays clinical features, or is at direct risk of inheriting the mutation in question, *and*
- B. The test results will be used to develop a clinically useful approach or course of treatment or to cease unnecessary monitoring or treatments for the individual being tested. Clinically useful test results allow providers to do at least one of the following:
  1. Inform interventions that could prevent or delay disease onset,
  2. Detect disease at an earlier stage when treatment is more effective,
  3. Manage the treatable progression of an established disease,
  4. Treat current symptoms significantly affecting a member's health,
  5. Guide decision making for the member's current or planned pregnancy; *and*
- C. The genetic disorder could not be diagnosed through completion of conventional diagnostic studies, pedigree analysis and genetic counseling consistent with the community standards.

Note: *When using testing panels, including but not limited to, multiple genes or multiple conditions, and in cases where a tiered approach/method is clinically available, testing would be covered ONLY for the number of genes or tests deemed medically necessary to establish a diagnosis.*

II. It is the policy of health plans affiliated with Centene Corporation that all other requests for genetic testing not meeting the above stated criteria, including genetic banking/DNA storage, are considered **not medically necessary**.

Authorization Protocol
Requests for prior authorization will be accepted up to 5 business days following specimen collection and will be reviewed for medical necessity based on the above stated criteria.

Testing in Children
Testing in children should take into account the availability of evidenced based risk reduction strategies and the probability of developing a serious medical condition during childhood. Unless there is a clinical intervention appropriate in childhood, parents should be encouraged to defer genetic testing for adult-onset conditions until adulthood. Advocating for the best interests of the child is necessary until he/she is able to make the personal choice to have genetic testing. [5]

Background
Genetic testing identifies changes in chromosomes, genes or proteins. Genetic testing results can confirm or rule out a suspected genetic condition or can help determine a person's chance of developing or passing on a genetic disorder. Test results can direct a person towards appropriate prevention, monitoring and treatment options. There are three methods used for genetic tests: gene tests, chromosomal tests and biochemical tests. Gene tests look at DNA or RNA taken from blood or body fluids such as saliva or other tissue. These tests can look for large changes, such as missing or added sections of a gene, or small changes, such as a missing, added, or altered chemical base within a DNA strand. They can also detect genes with too many copies, those that are too active, turned off, or lost entirely. Genes can be tested using DNA probes or rely on DNA or RNA sequencing.

Chromosomal tests look at features of chromosomes for changes such as pieces being deleted, expanded, or switched to a different chromosomal location. There are two types of chromosomal tests, karyotype and FISH (florescent *in situ* hybridization) analysis. A karyotype test gives a picture of all of a person's chromosomes and can identify changes in chromosome number and large changes in DNA structure. FISH analysis can identify irregularities in certain regions of chromosomes using fluorescent DNA probes. Additionally, FISH analysis can identify small changes that can be missed by overall karyotype testing.

Biochemical tests measure the amount or activity of proteins or particular enzymes. Genes contain the DNA code for making proteins. An abnormal amount or activity of proteins can indicate that genes are not working normally. These tests are most commonly used for newborn screening to detect conditions such as phenylketonuria (PKU).

Reviews, Revisions, and Approvals	Date	Approval Date
Added 5 day allowance for retro auth reviews	07/14	
Updated background information	11/14	11/14
Updated genetic testing description Removed adequately interpreted from criteria Clarified use of results criteria point to point out 'clinically useful' testing	01/15	02/15
Added for "the member's current or planned" pregnancy to policy/criteria section B	06/15	06/15
Converted to new template. Added "to inform interventions that could prevent or delay disease onset, to detect disease at an earlier stage when treatment is more effective" to criteria. Added recommendation that unless there is an intervention appropriate in childhood, parents defer genetic testing for adult onset conditions until adulthood per ASHG guidelines.	06/16	06/16

Reviews, Revisions, and Approvals	Date	Approval Date
References reviewed and updated. Added the following note: "When using testing panels, including but not limited to, multiple genes or multiple conditions, and in cases where a tiered approach/method is clinically available, testing would be covered ONLY for the number of genes or tests deemed medically necessary to establish a diagnosis."	06/17	06/17

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Important Reminder

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The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

CLINICAL POLICY
Genetic Testing

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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CENTENE Corporation

Clinical Policy: Digital Breast Tomosynthesis

Reference Number: CP.MP.90
Effective Date: 11/11
Last Review Date: 10/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Digital breast tomosynthesis (DBT) (three-dimensional [3-D] mammography) is a non-invasive imaging technique used for the screening and diagnosis of breast cancer. Tomosynthesis combines the use of tomography and 3-D reconstruction with breast imaging to improve the visibility of breast lesions.

Policy/Criteria

It is the policy of health plans affiliated with Centene Corporation® that DBT alone or combined with digital mammography (DM) for breast imaging is **not medically necessary.** There is a lack of evidence that DBT alone reduces breast cancer mortality. The benefits of DBT and DM combined are not proven to offset the risks and burden of increased radiation exposure (approximately double the radiation dosage), prolonged breast imaging time, and increased time to analyze imaging**.**

Background

There currently are no large prospective studies to justify routine use of DBT, but the technique shows promise in preliminary studies in screening women with dense breast tissue and with high risk for breast cancer.

DBT is a modification of DM. Tomosynthesis is a 3-D imaging technique that involves acquiring images of a stationary compressed breast at multiple angles during a short scan. The individual images are projections through the breast at different angles and are reconstructed into a series of thin, high-resolution slices that can be displayed in a variety of formats. While the breast is positioned and compressed similarly to a standard mammogram, images are captured through a number of different x-ray source angles. Objects at different heights in the breast project differently for each angle. The data are then reconstructed to generate images that enhance objects from a given height by appropriate shifting of the projections relative to one another.

The U.S. Preventative Services Task Force (2016) concluded that the evidence on DBT as a primary screening method for breast cancer is insufficient, and the balance of benefits and harms cannot be determined. The American Congress of Obstetricians and Gynecologists (ACOG, 2015) states that there is not sufficient evidence that DBT leads to meaningful outcome benefits (e.g., reduction in breast cancer mortality) in women with dense breasts and no other risk factors. ACOG's 2013 practice bulletin says that while results are promising, further study is needed to determine whether DBT is a cost-effective approach capable of replacing digital mammography alone as the first-line screening modality of choice for breast cancer screening. The National Comprehensive Cancer Network states that "multiple studies show a combined use of digital mammography and tomosynthesis appears to improve cancer detection and decreased call back rates. Of note, most studies used double the dose of radiation. The radiation dose can be

minimized by synthetic 2-D reconstruction." However, it is thought that few centers currently have the capability for synthetic 2-D reconstruction.

It should be noted that for any new mammography technology, such as DBT, the Mammography Quality Standards Act (MQSA) requires that all health care professionals obtain eight hours of training prior to using new mammography technology on patients.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2017, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT®* Codes	Description
77061	Digital breast tomosynthesis; unilateral
77062	Digital breast tomosynthesis; bilateral
77063	Screening digital breast tomosynthesis, bilateral

HCPCS Codes	Description
G0279	Diagnostic digital breast tomosynthesis, unilateral or bilateral

Reviews, Revisions, and Approvals	Date	Approval Date
References and coding implications reviewed and updated; specialist reviewed	10/14	10/14
References reviewed and updated	10/15	10/15
Added G0279 to coding implications	04/16	
References reviewed and updated; added supporting background information.	09/16	10/16
References reviewed and updated.	10/17	10/17

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CENTENE Corporation

Clinical Policy: Obstetrical Home Care Programs

Reference Number: CP.MP.91
Effective Date: 01/14
Last Review Date: 01/17

Revision Log
Coding Implications

See Important Reminder **at the end of this policy for important regulatory and legal information.**

Description
Medical necessity criteria for obstetrical home health programs offered by vendors such as Alere Women's and Children's Health, LLC (Alere).

Policy/Criteria
I. It is the policy of health plans affiliated with Centene Corporation® that obstetrical home health services are **medically necessary** for members meeting the following criteria:

A. *Obstetrical Nurse Assessment* 1
B. *Metoclopramide or Ondansetron Infusion Therapy* 1
C. *Hydration Therapy – 1 to 4 liters* 1
D. *Diabetes in Pregnancy Clinical Management Program (case rate)* 2
E. *Obstetrical Diabetes Management - Daily Insulin Injections* 3
F. *Obstetrical Diabetes Management – Insulin Pump* 3
G. *Hypertensive Disorders in Pregnancy Program for Gestational Hypertension* 3
H. *Hypertensive Disorders in Pregnancy Program for Preeclampsia* 3
I. *Preterm Labor Management Program* 4
J. *Dietary Analysis* 4
K. *Hydroxyprogesterone Caproate (Makena) Administration Nursing Visit* 4

A. *Obstetrical Nurse Assessment*
An obstetrical nurse assessment is considered **medically necessary** when provided with any of the services listed in B to K.

B. *Metoclopramide or Ondansetron Infusion Therapy*
See CP.MP.34 Hyperemesis Gravidarum Treatment policy for medical necessity guidelines for metoclopramide or ondansetron therapy.

If member meets criteria per policy, home visits are considered **medically necessary** for the same period as the infusion therapy is approved, generally 7 to 14 days of therapy based on clinical information.

C. *Hydration Therapy – 1 to 4 liters*
Hydration therapy is **medically necessary** for members who could benefit from close surveillance for the onset of dehydration. Examples of diagnoses include:

1. Hyperemesis gravidarum
2. Malabsorption
3. Diagnosis, such as flu or GI virus, which impairs the patient's ability to maintain fluid and/or food in the system

An initial course of up to 14 days is considered medically necessary. Additional courses of 7 to 14 day spans are considered medically necessary until the member is stable and no longer needs therapy.

D. *Diabetes in Pregnancy Clinical Management Program (case rate)*
The diabetes in pregnancy clinical management program is **medically necessary** for pregnant members with *one* of the following:

1. Type 2 diabetes in pregnancy with need for diet and exercise control with or without oral glycemic agents and non-insulin dependent; or
2. Gestational diabetes mellitus (GDM) with need for diet and exercise control with or without oral glycemic agents. GDM is diagnosed in pregnant women who have *one* of the following:
   a. Plasma glucose (PG) values that meet or exceed the values listed below in the one-step 75 g Oral Glucose Tolerance Test (OGTT); or
   b. At least two abnormal results during the two-step, 100 gram OGTT with the minimum lab values listed below:

2017 American Diabetes Association (ADA) Guidelines	
One-Step Strategy- per International Association of Diabetes and Pregnancy Study Groups (IADPSG)	**Two-Step Strategy- per Carpenter and Coustan or National Diabetes Data Group**
Step 1: 75-g OGTT with PG measurement fasting and at 1 h and 2 h, at 24-28 weeks in women not previously diagnosed with overt diabetes • Perform OGTT in the morning after overnight fast (≥8 h) • GDM diagnosis made if PG values meet or exceed: o Fasting: 92 mg/dL (5.1 mmol/L) o 1 h: 180 mg/dL (10.0 mmol/L) o 2 h: 153 mg/dL (8.5 mmol/L)	• Step 1: 50-g Glucose Loading Test (nonfasting) with PG measurement at 1 h (Step 1), at 24-28 weeks in women not previously diagnosed with overt diabetes o If PG at 1 h after load is ≥140 mg/dL (7.8 mmol/L), proceed to 100-g OGTT (Step 2) • Step 2: 100-g OGTT while patient is fasting. GDM diagnosis made when two or more PG levels meet or exceed: o Fasting: 95 mg/dL or 105 mg/dL (5.3/5.8) o 1 hr: 180 mg/dL or 190 mg/dL (10.0/10.6) o 2 hr: 155 mg/dL or 165 mg/dL (8.6/9.2) o 3 hr: 140 mg/dL or 145 mg/dL (7.8/8.0)

E. *Obstetrical Diabetes Management - Daily Insulin Injections*
Obstetrical diabetes management with daily insulin injections is **medically necessary** for pregnant members with both:
1. Gestational or pre-gestational diabetes and unable to reach target goals through diet and activity;
2. Daily insulin injections.

An initial course of 14 days is considered medically necessary. Additional courses of 7 to 14 day spans are considered medically necessary until the member is able to self-manage blood sugar and insulin injections.

F. *Obstetrical Diabetes Management – Insulin Pump*
Obstetrical diabetes management with an insulin pump is **medically necessary** for pregnant members who have had a new insulin pump approved based on the appropriate medical necessity criteria.

An initial course of 14 days is considered medically necessary. An additional course of 14 days is considered medically necessary until the member is able to self-manage blood sugar and insulin pumps.

G. *Hypertensive Disorders in Pregnancy Program for Gestational Hypertension*
The gestational hypertension program is **medically necessary** for members with one of the following:
1. Elevated or unstable blood pressure; or
2. Member who could benefit from education and surveillance for the potential onset of hypertension. Categories of such members could include:
   a. Previous episode of hypertension during previous pregnancy
   b. Chronic hypertension
   c. Multiple gestation
   d. Diabetes

An initial course of 14 days in one month is considered medically necessary (in general, *daily* visits are not necessary). If member remains pregnant, an additional 7 days is considered medically necessary.

H. *Hypertensive Disorders in Pregnancy Program for Preeclampsia*
The preeclampsia program is **medically necessary** for pregnant members who are diagnosed with preeclampsia characterized by the diagnostic criteria in **1** and **2**, OR **3**:
1. Blood pressure
   a. ≥ 140 mm Hg systolic or ≥ 90 mm Hg diastolic on two occasions at least 4 hours apart after 20 weeks gestation in a woman with a previously normal blood pressure, or
   b. ≥ 160 mm Hg systolic or ≥ 110 mm Hg diastolic on 2 occasions at least 15 minutes apart.

   AND

2. Proteinuria
   a. ≥ 300 mg per 24-hour urine collection (or this amount extrapolated from a timed collection); or
   b. Protein/creatinine ratio ≥ 0.3 mg/dL; or
   c. Dipstick reading of 1+ (used only if other quantitative methods not available).

   OR

3. In the absence of proteinuria, new onset hypertension and the new onset of any of the following:
   a. Thrombocytopenia- platelet count <100,000/microliter;
   b. Renal insufficiency- serum creatinine concentrations greater than 1.1 mg/dL or a doubling of the serum creatinine concentration in the absence of other renal disease;
   c. Impaired liver function- elevated blood concentrations of liver transaminases to twice normal concentration;
   d. Pulmonary edema;
   e. Cerebral or visual symptoms.

An initial course of 7 days is considered medically necessary. If member remains pregnant, an additional 7 days is considered medically necessary.

I. *Preterm Labor Management Program*
The preterm labor management program is **medically necessary** for pregnant members diagnosed with preterm labor. Early signs and symptoms of preterm labor can include menstrual-like cramping; mild, irregular contractions; low back ache; pressure sensation in the vagina; or vaginal discharge of mucus, which may be clear, pink, or slightly bloody.

An initial course of 3 visits in 1 week is considered medically necessary for assessment and education. Ongoing visits are considered not medically necessary.

J. *Dietary Analysis*
A dietary analysis is **medically necessary** for members with a diagnosis of obesity or malnutrition.

K. *Hydroxyprogesterone Caproate (Makena) Administration Nursing Visit*
The Makena nurse administration and care management program is **medically necessary** for members who meet the criteria for Makena per CP.PHAR.14 and who require weekly home nursing visit due to any of the following circumstances:

1. High risk of non-compliance based on an identified concern or previous noncompliance;
2. Member is on restricted activity and weekly travel to the doctor's office for injections is potentially harmful;
3. Member is physically unable to make weekly trips for injections or does not have adequate access to reliable transportation (either personal or through a transportation benefit).

Makena nurse administration in the home is medically necessary for as many weeks as Makena has been approved.

II. It is the policy of health plans affiliated with Centene Corporation that the following services provided by a home health vendor are considered **not medically necessary**:

A. Betamethasone therapy via multiple repeat courses or intermittent injections;
B. Multiple gestation management (refer to individual program for identified risk factor);
C. Continuous heparin infusion therapy;
D. Patient administered nonstress test or fetal heart rate monitoring;
E. Gestational diabetes clinical management program for oral meds;
F. Preterm premature rupture of membranes (PPROM) management.

Background

Alere™ Women's Health OB Homecare programs include risk assessment and education for identifying pregnant women at risk for complications, case management and homecare services for high-risk pregnancies. Obstetrical homecare services include providers, diagnostics, devices and timely and actionable information that help women make smarter healthcare decisions.

Medically Necessary Services:

Diabetes in Pregnancy Clinical Management Program

Although universal screening criteria for gestational diabetes mellitus (GDM) has not been established, the 100g OGTT has most often been used to diagnose gestational diabetes according to the Carpenter and Coustan or National Diabetes Data Group criteria (Gupta et al., 2015). In 2008, the landmark Hyperglycemia and Adverse Pregnancy Outcomes (HAPO) study established a relationship between pregnancy outcomes and values on a 75g OGTT (HAPO Study Cooperative Research Group, 2008). The World Health Organization, ADA, and the Endocrine Society of the USA endorse the 75g OGTT diagnostic criteria proposed by the IADPSG, which was based on data from the HAPO study (Gupta et al., 2015).

Gestational Hypertension Program

The American College of Obstetricians and Gynecologists (ACOG) Task Force on Hypertension in Pregnancy recommends that patients with gestational hypertension or preeclampsia without severe features monitor blood pressure twice weekly, self-monitor fetal movement daily, and have platelet counts and liver enzymes assessed weekly, although they do not specifically mention outpatient versus inpatient care (ACOG Hypertension Taskforce, 2013). Few studies have evaluated whether outpatient care is a viable option for preeclamptic patients, although two small studies found positive results (Norwitz & Repke, 2015). In addition, a systematic review of three studies found no difference in clinical outcomes for mothers or babies receiving care in antenatal day units versus inpatient care (Dowswell, Middleton & Weeks, 2009). The National

Institute for Health and Clinical Excellence recommends outpatient management of preeclampsia and hypertension in pregnancy for mild and moderate hypertension, up to 159/109 mm Hg (AHRQ, 2011).

Preterm Labor Management Program
There is little research on the management of women after an episode of preterm labor. One underpowered study found no benefit to hospital care versus discharge home in the proportion of deliveries ≥36 weeks (Caritis & Simhan, 2015). It is thus recommended that the decision to manage a woman with preterm labor as an inpatient or outpatient should be made on a case by case basis, in conjunction with factors such as cervical dilation, vaginal bleeding, fetal status and travel time to the appropriate level of care (Caritis & Simhan, 2015).

Not Medically Necessary Services:
Betamethasone therapy via intermittent injections
ACOG recommends a single course of corticosteroids for women with premature rupture of membranes (PROM) between 24 and 37 weeks, as it reduces the risk of neonatal mortality, respiratory distress syndrome, intraventricular hemorrhage and necrotizing enterocolitis (ACOG No. 160, p. 5). However, ACOG does not recommend multiple repeated injections as weekly administration is associated with lower birthweight and head circumference (ACOG No. 160, p. 5). A Cochrane meta-review of repeat doses of antenatal corticosteroids states that there was lower incidence of respiratory distress and serious infant health problems in the first few weeks after birth, but no evidence of harm or benefit in early childhood. Furthermore, repeat doses of corticosteroids were associated with lower birthweight and head circumference, as ACOG noted, although these reductions were small (Crowther et al. 2015). Crowther and colleagues conclude by recommending further research on the long term benefits and risks of repeat doses of antenatal corticosteroids for the woman and infant (Crowther et al. 2015).

Preterm Premature Rupture of Membranes Management
A Cochrane systematic review of two small studies concludes that the majority of women should be managed in the hospital after PPROM (Dowswell, & Mousa, 2014, p. 11). Although the two studies suggest that outcomes are similar between women and babies managed at home or inpatient, the evidence is not sufficient to make a recommendation regarding the safety of home care for PPROM (Abou El Senoun, Dowswell, & Mousa, 2014, p. 11). ACOG sites the same studies and also notes that the evidence is insufficient, adding that the increased risk of sudden infection and umbilical cord compression with PPROM make hospital surveillance the appropriate management (ACOG Practice Bulletin 160, p. 6).

Coding Implications
Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
A09	Infectious gastroenteritis and colitis, unspecified
D69.59	Other secondary thrombocytopenia
E86.0	Dehydration
K90.4	Malabsorption due to intolerance, not elsewhere classified
O10.011-O10.019	Pre-existing essential hypertension complicating pregnancy
O10.411-O01.419	Pre-existing secondary hypertension complicating pregnancy
O10.011-O10.919	Unspecified pre-existing hypertension complicating pregnancy
O10.1-O10.9	Pre-existing hypertension with pre-eclampsia
O14.00-O14.03	Mild to moderate pre-eclampsia
O16.1-O16.9	Unspecified maternal hypertension
O21.0-O21.9	Excessive vomiting in pregnancy
O24.410-O24.419	Gestational diabetes mellitus in pregnancy
O25.1-O25.13	Malnutrition in pregnancy
O60.00-O60.03	Preterm labor without delivery
O99.210-O99.213	Obesity complicating pregnancy

HCPCS Codes	Alere specific program codes
S9123	Nursing care, in the home; by registered nurse, per hour
S9140	Diabetic management program, follow up-visit to non-MD provider
S9208	Home management of preterm labor, includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem (do not use this code with any home infusion per diem code)
S9211	Home management of gestational hypertension, includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem (do not use this code with any home infusion per diem code)
S9213	Home management of preeclampsia, includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem (do not use this code with any home infusion per diem code)

HCPCS Codes	Alere specific program codes
S9214	Home management of gestational diabetes, includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem (do not use this code with any home infusion per diem code)
S9374	Home infusion therapy, hydration therapy; one liter per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
S9375	Home infusion therapy, hydration therapy; more than one liter but no more than two liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
S9376	Home infusion therapy, hydration therapy; more than two liters but no more than three liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
S9377	Home infusion therapy, hydration therapy; more than three liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
S9470	Nutritional counseling, dietician visit
S9560	Home injectable therapy; hormonal therapy (e.g., leuprolide, goserelin), including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem

Reviews, Revisions, and Approvals	Date	Approval Date
Policy Created Reviewed by Specialist	01/14	01/14
Updated approval timeframes Removed diagnostic criteria in preeclampsia program regarding “in the absence of proteinuria” as these members should be hospitalized	01/15	01/15
Updated template Updated Gestational Diabetes Diagnostic Criteria Removed NST/FHT indications In I.G, changed visits to days Added Betamethasone therapy “via multiple repeated doses” to not medically necessary criteria Added additional background information	01/16	01/16
Added criteria for Makena administration in the home. Added H.3. as alternative criteria for preeclampsia, per 2013 ACOG Hypertension in Pregnancy Task Force Report.	09/16	09/16
References reviewed and updated, no criteria changes	01/17	01/17

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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CENTENE Corporation

Clinical Policy: Acupuncture

Reference Number: CP.MP.92
Effective Date: 12/13
Last Review Date: 11/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Acupuncture involves the manual and/or electrical stimulation of thin, solid, metallic needles inserted into the skin. Acupuncture has been studied for the treatment of many conditions, but some of the more common and studied indications include pain, nausea and vomiting, hypertension, chronic obstructive pulmonary disease, allergic rhinitis and addictive behavior.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that, when a covered benefit under the member's benefit plan contract, needle acupuncture is **medically necessary** when provided by a licensed acupuncturist or other appropriately licensed practitioner for whom acupuncture is within the practitioner's scope of practice and who has specific acupuncture training or credentialing and *any of the following* conditions:

- **A.** Postoperative or chemotherapy induced nausea and vomiting;
- **B.** Nausea and vomiting of pregnancy;
- **C.** Chronic low back, neck, or shoulder pain;
- **D.** Chronic migraines or moderate to severe chronic tension headaches, defined as headaches >14 days per month for more than 3 months;
- **E.** Pain from clinically diagnosed osteoarthritis of the knee.

An initial course of 6 visits over 1 month is considered medically necessary. If improvement in the condition occurs following the initial course of treatment, an additional 6 visits over 2 months is considered medically necessary to maintain improvement.

II. All other indications are considered experimental/investigational and **not medically necessary**.

Background

Acute conditions typically are treated 2 to 3 times a week for two to three weeks then frequency is gradually reduced until treatment is no longer needed. Generally treatment will last for 2 to 3 months. There is insufficient evidence in studies to establish a defined treatment protocol for any condition.

Acupuncture is an ancient treatment originating in China approximately 2000 years ago. It is one of the oldest medical procedures in the world. It is a form of complementary and alternative medicine (CAM) that has been more commonly practiced in the United States beginning in 1971. Acupuncture theory is largely grounded in two major Chinese philosophies, Confucianism and Taoism. The two philosophies emphasize the importance of nature and for humans to integrate and abide by these laws rather than to resist them. The goal of the clinician is to maintain the body's harmonious balance both internally and in relation to the external environment. It is

believed treatment should not be solely symptom focused, so treatment is usually very individualized and two patients with the same symptoms often do not get the same treatment.

Three important concepts of acupuncture are qi, yin/yang, and the Five Elements: wood, water, fire, earth, and metal. Qi is often translated as "vital energy". It is felt to permeate all things, may assume different forms, and travel through meridians located on the body. Disturbances in the flow of qi, such as stagnant, depleted, collapsed or rebellious, are believed to cause disease. Yin and yang are complementary opposites. Yin represents more material, dense states of matter and yang represents more immaterial, rarefied states of matter. The relationship between the two is dynamic and cyclic. The acupuncturist must employ a series of qualitative assessments to establish a patient's present balance of yin and yang. The Five Elements represent different basic processes, qualities or phases of a cycle. Each can generate or counteract another element. Most vital organs, acupuncture meridians, emotions, and other health-related variable are assigned an element, providing a global description of the balancing dynamics seen in each person.

These principles are used by the acupuncturist to diagnose and treat individuals based on the nature of the imbalance. The aim is to shift the constitution towards balance with the use of various interventions, acupuncture being one important option.

The diagnostic evaluation of the acupuncturist may be extensive and complex, incorporating assessment of practically everything, including skin, complexion, bones, channels, smells, sounds, mental state, preferences, emotions, demeanor, and body build. Once the diagnosis is established, fine metal needles are inserted into precisely defined points to correct disruption in harmony. Needles are removed after being in place for 10 to 15 minutes while the patient lies relaxed. Treatments can occur one to two times a week and the total number of sessions is variable dependent on the condition, disease severity and chronicity.

There are many proposed models for the mechanism of action of the effects of acupuncture; however the data have been either too inconsistent or inadequate to draw significant conclusions. The theory in regards to the analgesic effect of acupuncture, associates the neurotransmitter effects such as endorphin release at both the spinal and supraspinal levels. Functional MRI studies have demonstrated various physiologic effects, associating acupuncture points with changes in brain MRI signals. Another theory is that acupuncture points are associated with anatomic locations of loose connective tissue.

Evidence from a number of randomized, blinded, placebo-controlled studies indicate that acupoint stimulation can be effective in the management of *postoperative nausea and vomiting*, particularly in women, with mixed results in pediatric populations. Acupoint stimulation for women undergoing chemotherapy also reduced nausea and vomiting in some studies, but no effect was reported in a study involving both men and women. The evidence regarding alleviation of morning sickness by acupoint stimulation is limited, less rigorous than for postoperative nausea and vomiting, and ambiguous.

Recent data on acupuncture for *postoperative dental pain* is limited, but earlier evidence indicated promising results for this use. Data was most promising for pain relief following tooth extraction.

There are a number of randomized controlled trials that establish improvement in *headache* frequency, intensity, response, use of relief medication and quality of life relative to usual care and relief treatment only. However, the trials failed to demonstrate that acupuncture is more effective than sham acupuncture. Results were ambiguous regarding efficacy of acupuncture relative to prophylactic drug treatment. There was insufficient evidence available to conclude the efficacy of acupuncture compared with nonpharmacological interventions.

Acupuncture for *osteoarthritis pain* appears to be effective, particularly for pain in the knee. Recent literature has shown relief of pain and improved function in osteoarthritis of the knee for patients treated with acupuncture.

Acupuncture has been studied for a variety of other reasons, but studies and evidence does not currently support its use for indications such as, but not limited to, arm pain, temporomandibular joint dysfunction, menstrual cramps and fibromyalgia.

Coding Implications

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CPT®* Codes	Description
97810	Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
97811	Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with reinsertion of needles(s)
97813	Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
97814	Acupuncture, 1 or more needles; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with reinsertion of needles(s)

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

+ Indicates a code(s) requiring an additional character

ICD-10-CM Code	Description
G43.001-G43.919	Migraine
G44.221-G209	Chronic tension- type headache
M17.0-M17.9	Osteoarthritis of knee
M25.511-M25.519	Pain in shoulder
M50.00-M54.9+	Other dorsopathies
O21.0-O21.9	Excessive vomiting in pregnancy
R11.0-R11.2+	Nausea and vomiting

Reviews, Revisions, and Approvals	Date	Approval Date
Bibliography reviewed and updated	11/14	12/14
Reworded medically necessary timeframes. No criteria changes made	01/15	
Reformatted criteria, adopted new template Reference reviewed and no criteria changes made	12/15	12/15
Integrated with Health Net acupuncture policy. Removed (adults and children) from I.A; removed acute post-operative dental pain; maintained neck and shoulder pain, and only osteoarthritis of knee. Did not incorporate list of investigational procedures since it is not all inclusive.	10/16	11/16
References reviewed and updated. Changed continuation criteria to remove statement that continued treatment after the initial 2 months is not medically necessary.	11/17	11/17

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CENTENE Corporation

Clinical Policy: Bone-Anchored Hearing Aid

Reference Number: CP.MP.93
Effective Date: 12/13
Last Review Date: 12/17

Coding Implications
Revision Log

See Important Reminder **at the end of this policy for important regulatory and legal information.**

Description

Bone-anchored hearing aids (BAHAs) are an alternative to conventional hearing aids when physical or medical complications prevent adequate functional improvement in hearing. Sound quality of BAHAs is superior to, and pain/discomfort is largely diminished, when compared to traditional air-conduction hearing aids.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that BAHAs are **medically necessary** for members with all of the following indications:

A. *Implantable device* for age ≥ 5 years; or *head band device* for age < 5 years or for members medically unable to have an implant;
B. Unilateral or bilateral conductive hearing loss; or unilateral or bilateral mixed conductive and sensorineural hearing loss; or unilateral sensorineural hearing loss;
C. Pure tone average bone conduction threshold (measured at 0.5, 1, 2, and 3kHz) ≤ 70 dBHL (decibels hearing level) and an unaided speech discrimination score not worse than 60%;
D. One of the following indications:
   1. Congenital or surgically induced malformations of the ear canal such that it does not exist or cannot accommodate a standard air-conduction hearing aid,
   2. Chronic infection or dermatitis of the middle or outer ear that is exacerbated by a standard air-conduction hearing aid,
   3. Allergic reactions to standard air-conduction hearing aids,
   4. Single-sided deafness occurred after removal of an acoustic neuroma, from trauma, or from a viral or vascular insult,
   5. Tumors of the external canal and/or tympanic cavity.

II. BAHAs for any other indication are considered **not medically necessary** because effectiveness has not been established.

Background

Hearing loss affects up to 20 percent of the population in the United States (Lin, Niparko, and Ferrucci, 2011). According to Blanchfield, et al., as many as 738,000 people in the U.S. experience severe to profound hearing loss, with 8% of these under age 18 (2001). Although the reliability and effectiveness of hearing aids have improved over time, there are still limitations to conventional air-conduction hearing aids.

Physical and medical complications such as chronic ear infections and canal deformities can make it difficult to impossible for some to wear hearing aids. Poorly fitting ear molds can lead to bothersome feedback and inadequate functional gain. Implantable hearing devices can

improve reliability and functional gain over the standard air-conduction hearing aids when some of these issues exist.

Bone-anchored hearing aids are indicated for people with conductive hearing loss, mixed hearing loss, or unilateral profound sensorineural hearing loss to achieve improved auditory acuity by transmitting the sound directly through the bone into the inner ear. There are three devices currently available for use and the appropriate device is selected based upon the patient's hearing level.

A BAHA consists of a titanium implant surgically inserted into the skull attached to an abutment of which a small portion protrudes through the skin and forms a snap attachment point for a removable bone conduction hearing aid or processor. Children are typically about six years of age before an implantable BAHA is feasible because 3 to 4 mm of bone is needed to ensure osseointegration. The processor is adjusted to the patient's level of hearing, much like in a traditional hearing aid fitting. When complications occur, the majority of them are related to skin issues around the implant. Proper skin care and hygiene at the surgical and abutment sites are essential to maintain good skin integrity.

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CPT®* Codes	Description
69710	Implantation or replacement of electromagnetic bone conduction hearing device in temporal bone
69711	Removal or repair of electromagnetic bone conduction hearing device in temporal bone
69714	Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy
69715	Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy
69717	Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy
69718	Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy

HCPCS Codes	Description
L8613	Ossicular Implant
L8690	Auditory osseointegrated device, includes all internal and external components
L8691	Auditory osseointegrated device, external sound processor, replacement
L8693	Auditory osseointegrated device abutment, any length, replacement only

ICD-10-CM Diagnosis Codes

ICD-10-CM Code	Description
H60.00-H62.8X9	Diseases of external ear
H61.001- H61.039	Chondritis and perichondritis of external ear
H65.20- H65.23	Chronic serous otitis media
H65.30- H65.33	Chronic mucoid otitis media
H65.411- H65.499	Other chronic non-suppurative otitis media
H71.00- H71.93	Cholesteatoma of middle ear
H800.00- H80.93	Otosclerosis
H90.11-H90.8	Conductive and sensorineural hearing loss
H91.01- H91.93	Other and unspecified hearing loss
Q16.0- Q16.9	Congenital malformation of ear causing impairment of hearing

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed, specialist reviewed	11/13	12/13
Added the indication for soft headbands for children <6 yrs and those unable to have an implant	11/14	12/14
Reworded policy/criteria for clarity Updated template	12/15	1215
Updated template, added dermatitis to criteria I.D.2, added criteria I.D.5: “tumors of the external canal and/or tympanic cavity”. Updated hearing loss statistics in background.	11/16	12/16
References reviewed and updated.	11/17	12/17

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CLINICAL POLICY
Bone-Anchored Hearing Aid

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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CENTENE Corporation

Clinical Policy: Clinical Trials

Reference Number: CP.MP.94
Effective Date: 01/14
Last Review Date: 12/17 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Medical necessity guidelines for routine costs of clinical trials in accordance with Centers for Medicare & Medicaid (CMS) and the Patient Protection and Affordable Care Act (PPACA) requirements.

Policy/Criteria
It is the policy of health plans affiliated with Centene Corporation® that routine costs of a qualifying clinical trial and services used to diagnose and treat complications arising from participating in a qualifying clinical trial are **medically necessary** based upon the following guidelines and limitations:

I. *Routine costs in a clinical trial include all items and services generally considered medically necessary and a covered benefit to Plan members that are provided in either the experimental or control arms and include:*
- A. Items or services that are typically provided absent a clinical trial, and
- B. Items or services required solely for the provision of the investigational item or service (e.g., administration of a non-covered chemotherapy agent), the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- C. Items or services needed for reasonable and necessary care arising from the provision of an investigational item or service – in particular, for the diagnosis or treatment of complications.

II. *Excluded costs/services*
- A. The investigational item or service itself, and
- B. Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient (e.g., monthly CT scans for a condition usually requiring only a single scan); and
- C. Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

III. *Administrative limitations*
- A. All applicable Plan limitations for coverage of out-of-network care applies to routine costs in a clinical trial; and
- B. All existing utilization management guidelines apply to routine care for members in clinical trials, including prior-authorization and notification requirements; and

IV. *Qualifying clinical trials must meet the following:*
- A. The clinical trial must have a written protocol that describes a scientifically sound study and be approved by all relevant institutional review boards (IRBs); and

B. The subject or purpose of the trial must be the evaluation of an item or service that falls within a covered benefit category (i.e. physician's service, durable medical equipment, diagnostic test, et al); and
C. The trial must have therapeutic intent and not solely designed to test toxicity or disease pathophysiology; and
D. Trials of therapeutic interventions must enroll patients with the diagnosed disease; trials of diagnostic interventions may enroll healthy patients in order to have a proper control group.
E. Trials must be federally-funded or approved by one of the following groups:
   1. Agency for Healthcare Research and Quality (AHRQ)
   2. Centers for Disease Control and Prevention (CDC)
   3. Centers for Medicare and Medicaid Services (CMS)
   4. National Institutes of Health (NIH)
   5. A cooperative group or center of any of the above listed entities or the Department of Defense (DoD) or Department of Veterans Affairs (VA); OR
   6. A qualified nongovernmental research entity identified in the guidelines issued by the NIH for center support grants; OR
   7. The Departments of VA, DoD, or Energy (DoE) if the trial has been reviewed and approved through a system of peer review comparable to the system used by the NIH and that ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review; OR
   8. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); OR
   9. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Background
This policy was adapted from Medicare Coverage ~ Clinical Trials, Final National Coverage Decision policy.

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed	12/13	01/14
References reviewed	01/15	01/15
Converted into new template Added parameters for what qualifies as a "qualified clinical trial" in IV.E	01/16	01/16
References reviewed	12/16	12/16
References reviewed	11/17	12/17

References
1. Centers for Medicare and Medicaid. National coverage determination for routine costs in clinical trials (301.1). 2007 Oct 9. http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=1&ncdver=2&bc=BAABAAAAAAAA&
2. US Department of Health and Human Services. HHS.gov/HealthCare. About the law. Available at URL address: http://www.hhs.gov/healthcare/rights/index.html
3. US National Institutes of Health. ClinicalTrials.gov. http://clinicaltrials.gov/ct2/home

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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CENTENE Corporation

Clinical Policy: Gender Reassignment Surgery

Reference Number: CP.MP.95
Effective Date: 11/14
Last Review Date: 11/17

Coding Implications
Revision Log

See Important Reminder **at the end of this policy for important regulatory and legal information.**

Description

Services for gender reassignment most often include hormone treatment, counseling, psychotherapy, complete hysterectomy, bilateral mastectomy, chest reconstruction or augmentation as appropriate, genital reconstruction, facial hair removal, and certain facial plastic reconstruction. Not every individual will require each intervention so necessity needs to be considered on an individualized basis. This criteria outlines medical necessity criteria for gender reassignment surgery *when such services are included under the members' benefit plan contract provisions.*

Policy/Criteria

It is the policy of Health Plans affiliated with Centene Corporation® that the gender reassignment surgeries listed in section III are considered **medically necessary** for members when diagnosed with gender dysphoria per criteria in section I and when meeting the eligibility criteria in section II.

I. Gender Dysphoria Criteria, meets A and B

A. Marked incongruence between the member's experienced/expressed gender and assigned gender, of at least 6 month's duration, as *indicated by two or more* of the following:
   1. Marked incongruence between the member's experienced/expressed gender and primary and/or secondary sex characteristics;
   2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender;
   3. A strong desire for the primary and/or secondary sex characteristics of the other gender;
   4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender);
   5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender);
   6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender); AND

B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

II. Eligibility Criteria, meets all

A. Age ≥ 18 years,
   1. Exception: in adolescent female to male patients < 18 years, chest surgery may be considered after one year of testosterone treatment;

B. Capacity to make a fully informed decision and to consent for treatment;

C. If significant medical or mental health concerns present, they must be reasonably well controlled;

D. Evidence the member has lived at least 12 continuous months in a gender role that is congruent with their gender identity;
E. Documentation that member has completed 12 continuous months of cross-sex hormone therapy of the desired gender, unless medically contraindicated (not required for mastectomy in female to male except for those < 18 years);
F. A written referral letter from a qualified mental health practitioner *containing all* of the following:
   1. Members general identifying characteristics;
   2. Results of psychosocial assessment, including any diagnoses;
   3. Duration of referring health professional's relationship with the member, including type of evaluation and therapy or counseling to date;
   4. An explanation that criteria for surgery have been met, and a brief description of clinical rationale for supporting the member's request for surgery;
   5. A statement that informed consent has been obtained from the member;
   6. A statement that the mental health professional is willing and available for coordination of care.
   7. The degree to which the member has followed the standards of care to date and the likelihood of future compliance
G. If the request is for genital reassignment surgery, a second referral letter from a consulting psychologist or psychiatrist is required.

III. Gender reassignment surgeries considered medically necessary when meeting above criteria

A. Procedures for transwomen (male to female) include:
- Orchiectomy
- Penectomy
- Vaginoplasty
- Urethroplasty
- Mammaplasty

B. Procedures for transmen (female to male) include:
- Mastectomy
- Salpingo-oophorectomy
- Vaginectomy
- Vulvectomy
- Metoidoplasty
- Phalloplasty
- Hysterectomy
- Urethroplasty
- Scrotoplasty
- Testicular prosthesis

IV. It is the policy of Health Plans affiliated with Centene Corporation that the following procedures, when used to improve the gender specific appearance of a member undergoing gender reassignment are **not medically necessary** as they are considered cosmetic in nature (not an all-inclusive list):
- Abdominoplasty
- Blepharoplasty
- Drugs for hair loss or growth
- Face lift
- Facial implants and bone reconstruction

- Hair removal/electrolysis (except for removal of hair on skin graft donor site prior to use in genital reassignment surgery)
- Hair transplantation
- Liposuction
- Mastopexy
- Prosthetic or filler substances to alter contour
- Removal of redundant skin
- Rhinoplasty
- Skin resurfacing
- Thyroid chondroplasty
- Voice modification surgery

Background

Gender identity is a person's deepest inner sense of being female or male, which for many is established by the age of 2 – 3 years. *Gender nonconformity* refers to the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex.[5] *Gender dysphoria* refers to the discomfort or distress that is cause by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics)[3,6]. Only some transsexual, transgender, and gender-nonconforming people experience gender dysphoria at some point in their lives.

Treatment to assist people with gender dysphoria is available and can help to find the gender identity and role that is comfortable for them. Treatment is very individualized and may or may not involve gender reassignment surgery or body modification. Treatment options include changes in gender expression and role; hormone therapy to feminize or masculinize the body; surgery to change primary and/or secondary sex characteristics; and psychotherapy. Many people who receive treatment for gender dysphoria will find a gender role and expression that is comfortable for them, regardless if they differ from the sex assigned them at birth.

Guidelines from the World Professional Association for Transgender Health, Inc (WPATH) recommend that genital surgery not be carried out until patients reach the legal age of majority in a given country, and have lived continuously for at least 12 months in the gender role that is congruent with their gender identity. The age threshold should be seen as a minimum criterion and not an indication in and of itself for active intervention.[11] The guidelines note, however, that chest surgery in female to male patients could be carried out earlier, preferably after ample time of living in the desired gender role and after one year of testosterone treatment. The intent of this suggested sequence is to give adolescents sufficient opportunity to experience and socially adjust in a more masculine gender role, before undergoing irreversible surgery. However, different approaches may be more suitable, depending on an adolescent's specific clinical situation and goals for gender identity expression.[11]

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2017, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage.

CLINICAL POLICY
Gender Reassignment Surgery

Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT codes that may be considered part of gender reassignment surgery.
This code list does not indicate if a procedure is or is not considered medically necessary.

CPT®* Codes	Description
11950-11954	Subcutaneous injection of filling material (eg, collagen)
11960	Insertion of tissue expander(s) for other than breast, including subsequent expansion
11970	Replacement of tissue expander with permanent prosthesis
14000	Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less
14040	Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm
14041	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm
15100	Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)
15120	Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm etc
15121	Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children
15200	Full thickness graft, free, including direct closure of donor site, trunk; 20 sq cm or less
15570	Formation of direct or tubed pedicle, with or without transfer; trunk
15574	Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet
15600	Delay of flap or sectioning of flap (division and inset); at trunk
15620	Delay of flap or sectioning of flap (division and inset); at forehead, cheeks, chin, neck, axillae, genitalia, hands, or feet
15757	Free skin flap with microvascular anastomosis
15758	Free fascial flap with microvascular anastomosis
15775	Punch graft for hair transplant; 1 to 15 punch grafts
15776	Punch graft for hair transplant; more than 15 punch grafts
15780-15783	Dermabrasion
15786	Abrasion; single lesion (eg, keratosis, scar)
15787	Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure)
15788	Chemical peel, facial; epidermal
15789	Chemical peel, facial; dermal
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal

CPT®* Codes	Description
15820-15823	Blepharoplasty
15824	Rhytidectomy; forehead
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)
15826	Rhytidectomy; glabellar frown lines
15828	Rhytidectomy; cheek, chin, and neck
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15832-15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy)
15876-15879	Suction assisted lipectomy
17380	Electrolysis epilation, each 30 minutes
19303	Mastectomy, simple, complete
19304	Mastectomy, subcutaneous
19316	Mastopexy
19324	Mammaplasty, augmentation; without prosthetic implant
19325	Mammaplasty, augmentation; with prosthetic implant
19350	Nipple/areola reconstruction
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121	Genioplasty; sliding osteotomy, single piece
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21125	Augmentation, mandibular body or angle; prosthetic material
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	Osteoplasty, facial bones; reduction
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
21270	Malar augmentation, prosthetic material
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	Rhinoplasty, primary; including major septal repair
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
31599	Unlisted procedure, larynx
31899	Unlisted procedure, trachea, bronchi

CLINICAL POLICY
Gender Reassignment Surgery

CPT®* Codes	Description
44145	Colectomy, partial; with coloproctostomy (low pelvic anastomosis)
53410	Urethroplasty, 1-stage reconstruction of male anterior urethra
53415	Urethroplasty, transpubic or perineal, 1-stage, for reconstruction or repair of prostatic or membranous urethra
53420	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; first stage
53425	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; second stage
53430	Urethroplasty reconstruction female urethra
53460	Urethromeatoplasty, with partial excision of distal urethral segment (Richardson type procedure)
54125	Amputation of penis; complete
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)
54401	Insertion of penile prosthesis; inflatable (self-contained)
54405	Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir
54406	Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis
54408	Repair of component(s) of a multi-component, inflatable penile prosthesis
54410	Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session
54411	Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue
54415	Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis, without replacement of prosthesis
54416	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session
54417	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue
54520	Orchiectomy simple with or without testicular prosthesis, scrotal or inguinal approach
54660	Insertion testicular prosthesis (separate procedure)
54690	Laparoscopy, surgical; orchiectomy
55175	Scrotoplasty; simple
55180	Scrotoplasty; complicated
55970	Intersex surgery; male to female
55980	Intersex surgery; female to male
56625	Vulvectomy simple; complete
56800	Plastic repair of introitus
56805	Clitoroplasty intersex state
56810	Perineoplasty, repair of perineum, nonobstetrical (separate procedure)
57106	Vaginectomy, partial removal of vaginal wall;

CLINICAL POLICY
Gender Reassignment Surgery

CPT®* Codes	Description
57107	Vaginectomy, partial removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)
57110	Vaginectomy complete removal vaginal wall
57111	Vaginectomy, complete removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)
57291	Construction artificial vagina; without graft
57292	Construction artificial vagina; with graft
57295	Revision (including removal) of prosthetic vaginal graft; vaginal approach
57296	Revision (including removal) of prosthetic vaginal graft; open abdominal approach
57335	Vaginoplasty intersex state
57426	Revision (including removal) of prosthetic vaginal graft, laparoscopic approach
58150	Total abdominal hysterectomy (corpus and cervix) with or without removal of tube(s), with or without removal of ovary(s)
58260	Vaginal hysterectomy, for uterus 250 g or less
58262	Vaginal hysterectomy uterus 250 g or less; with removal of tube(s) and/or ovary (s)
58263	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s), with repair of enterocele
58267	Vaginal hysterectomy, for uterus 250 g or less; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control
58270	Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele
58275	Vaginal hysterectomy, with total or partial vaginectomy
58285	Vaginal hysterectomy, radical (Schauta type operation)
58290	Vaginal hysterectomy, for uterus greater than 250 g
58291	Vaginal hysterectomy uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58292	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s), with repair of enterocele
58293	Vaginal hysterectomy, for uterus greater than 250 g; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control
58294	Vaginal hysterectomy, for uterus greater than 250 g; with repair of enterocele
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less;
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58550	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary (s)

CPT®* Codes	Description
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58572	Laparoscopy, surgical, with total hysterectomy for uterus greater than 250 g
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58661	Laparoscopy surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)
58940	Oophorectomy, partial or total, unilateral or bilateral
58999	Unlisted procedure, female genital system (nonobstetrical)
64856	Suture of major peripheral nerve, arm or leg, except sciatic; including transposition
64892	Nerve graft (includes obtaining graft), single strand, arm or leg; up to 4 cm length
64896	Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot; more than 4 cm length
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)

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ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
F64.0 - F64.9	Gender identity disorders
Z87.890	Personal history of sex reassignment

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed; specialist reviewed	11/14	11/14
Criteria II.D changed to 'Evidence the member lived' instead of requirement to complete Criteria II.E added note that hormone therapy not required for mastectomy in female to male	11/15	11/15
Added to II.F: The degree to which the member has followed the standards of care to date and the likelihood of future compliance. Changed mammaplasty to medically necessary for transwomen Updated coding tables	11/16	11/16
Added to II.A.1: Exception: in adolescent female to male patients < 18 years, chest surgery may be considered after one year of testosterone treatment.	11/17	11/17

CLINICAL POLICY
Gender Reassignment Surgery

Reviews, Revisions, and Approvals	Date	Approval Date
Revised II E to reiterate that cross-sex hormone in mastectomy for female to male is required for those < 18 years. Codes reviewed and updated		

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Important Reminder

CLINICAL POLICY
Gender Reassignment Surgery

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CLINICAL POLICY
Gender Reassignment Surgery

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Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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CENTENE Corporation

Clinical Policy: Ambulatory Electroencephalography

Reference Number: CP.MP.96
Effective Date: 09/15
Last Review Date: 09/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Ambulatory electroencephalogram (EEG) testing in the outpatient setting (*e.g.*, at home) is a diagnostic test used to evaluate an individual in whom a seizure disorder is suspected but not conclusively confirmed by the person's medical history, physical examination, and a previous routine or standard (awake and asleep) EEG.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that ambulatory EEG is **medically necessary** following an inconclusive or nondiagnostic standard (awake and asleep) EEG for any of the following indications:
- **A.** To investigate episodic events where epilepsy is suspected but the history, examination, and routine EEG do not resolve the diagnostic uncertainties;
- **B.** To confirm epilepsy in those individuals experiencing suspected nonepileptic events or for classification of seizure type;
- **C.** To differentiate between neurological and cardiac related episodes;
- **D.** To adjust antiepileptic medication levels;
- **E.** To localize seizure focus for enhanced patient management;
- **F.** To identify and medicate absence seizures;
- **G.** To differentiate between epileptic and sleep disorder-related episodes; and/or
- **H.** To evaluate seizures precipitated by naturally occurring cyclic events or environmental stimuli that are not reproducible in the hospital or clinic setting.

II. It is the policy of health plans affiliated with Centene Corporation that ambulatory EEG is considered **not medically necessary** for studies of unattended, non-cooperative patients.

Ambulatory EEG (CPT code 95950 or 95953) should always be preceded by an awake and drowsy/sleep EEG (CPT code 95816, 95819, 95822 or 95827).

Background

In most instances, a standard EEG performed at a clinic or outpatient epilepsy facility can identify brain activity specific to seizures; however, when routine EEG is inconclusive and the clinical history strongly suggests seizure activity, an ambulatory EEG may be indicated. An ambulatory EEG may increase the chance of detecting an epileptiform abnormality in these individuals and significantly impact clinical management. An estimated 12% to 25% of individuals who previously had a normal or non-diagnostic routine EEG have epileptiform activity on ambulatory EEG. [3]

Clinical events known as psychogenic nonepileptic spells (PNES) (previously referred to as pseudoseizures) are nonepileptic seizures where the person perceives altered movement, emotion,

sensation, or an experience similar to those involved with epilepsy. These events are without an EEG-documented ictal association. PNES occur in as many as 20% of persons evaluated at inpatient epilepsy monitoring centers and in 5% to 20% of outpatient populations. Both PNES and epileptic seizures are concurrent in an estimated 10% to 60% of individuals with epilepsy. [3]

Ambulatory EEG recordings can be utilized in the evaluation and differential diagnosis of other conditions, including cardiac arrhythmias, sleep disorders, syncope, and transient ischemic attacks, if these episodes are not diagnosed by conventional studies. It may also allow an estimate of seizure frequency, which may at times help to evaluate the effectiveness of a drug and determine its appropriate dosage.

Ambulatory EEG testing provides a continuous recording of the brain's electrical activity that can range from several hours to several days (typically 48 hours to 72 hours). In the outpatient setting (physician office, clinic), a set of electrodes with leads is secured to the person's scalp and a digital recording unit is attached to the waist or a shoulder harness. Currently, portable recordings of up to 32 channels can record computer-assisted spike and seizure detection rates over several days. Event detection computer software is designed to increase the chance of recording an ictal event during a seizure or interictal epileptiform discharges occurring between seizures, during the person's routine daily activities and sleep. The person being tested and observers (family members, caregiver) have the opportunity to "tag" portions of the recording during clinical events using a push button device to signal when an observable event occurs.

The gold standard for evaluating the large amount of data collected by a computer-assisted system is visual analysis at the end of the testing period by a highly trained individual.[3] Digital analysis of an EEG can used to diagnose neurological conditions when routine EEG outcomes and neurological imaging are inconclusive to confirm suspicious but nondiagnostic symptoms. Digital analysis of an EEG requires the analysis of an EEG using quantitative analytical techniques such as data selection, quantitative software processing, and dipole source analysis.

Coding Implications

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CPT®* Codes	Description
95950	Monitoring for identification and lateralization of cerebral seizure focus, electroencephalographic (eg, 8 channel EEG) recording and interpretation, each 24 hours

CPT®* Codes	Description
95953	Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG, electroencephalographic (EEG) recording and interpretation, each 24 hours, unattended

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
F44.5	Conversion disorder with seizures or convulsions
G40.001- G40.B19	Epilepsy and recurrent seizures
R25.0 – R25.8	Abnormal involuntary movements
R56.1	Post-traumatic seizures
R56.9	Unspecified convulsions

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed	09/15	09/15
Converted to new policy template. Removed the following as Not Medically Necessary indications per specialist review: studies of neonates and studies to localize seizure focus in the presence of bilateral foci or rapid generalization. Reviewed by neurologist/sleep medicine specialist.	09/16	09/16
References reviewed and updated.	09/17	09/17

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CLINICAL POLICY
Ambulatory EEG

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CENTENE Corporation

Clinical Policy: Testing for Select Genitourinary Conditions

Reference Number: CP.MP.97
Effective Date: 06/16
Last Review Date: 09/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Various diagnostic methods are available to identify the etiology of the signs and symptoms of vaginitis. The purpose of this policy is to define medical necessity criteria for the diagnostic evaluation of vaginitis in members ≥ 13 years of age. This policy also defines unnecessary amplified DNA- (deoxyribonucleic acid) probe testing for genitourinary conditions.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that the following diagnostic tests for symptomatic women for the evaluation of vaginitis are **medically necessary** for members age ≥ 13 based on the following indications:
   A. Microscopy with wet mount, KOH mount, and vaginal pH;
   B. Assay for sialidase activity;
   C. Direct DNA probe tests to detect the presence of *Candida, Gardnerella vaginalis* and *Trichomoniasis vaginalis;*
   D. DNA Amplification probe testing for trichomonas vaginalis.

II. It is the policy of health plans affiliated with Centene Corporation that screening of asymptomatic pregnant women for bacterial vaginosis (BV) to reduce the incidence of pre-term birth or other complications of pregnancy is **not medically necessary** as there is no evidence that treatment of BV in asymptomatic pregnant women reduces these complications.[9]

III. It is the policy of health plans affiliated with Centene Corporation that unspecified amplified DNA-probe testing for genitourinary conditions for asymptomatic women during routine exams, contraceptive management care, or pregnancy care is considered **not medically necessary** for members age ≥ 13 as it has not been shown to improve clinical outcomes over direct DNA-probe testing.

IV. It is the policy of health plans affiliated with Centene Corporation that unspecified amplified DNA-probe testing for the diagnostic evaluation of symptomatic women for the following genitourinary conditions is considered **not medically necessary** for members age ≥ 13 as it has not been shown to improve clinical outcomes over direct DNA-probe testing:
   A. Acute vaginitis or vulvitis (≤ 4 episodes per year);
   B. Gynecologic and obstetric conditions triggered by etiologies other than complicated vaginitis inducing mechanisms as listed in Table 5, including:
      1. Urinary tract infections;
      2. Pelvic inflammatory disease;
      3. Inflammatory disorders of the vagina, vulva, and perineum;
      4. Irregular menstruation or abnormal uterine and vaginal bleeding;

5. Dysmenorrhea;
6. Complications with pregnancy, including all of the following:
   a. Pre-term labor;
   b. Ectopic pregnancy;
   c. High risk pregnancy.

Background

The 3 diseases most frequently associated with vaginitis are BV, (caused by replacement of the vaginal flora by an overgrowth of anaerobic bacteria, including *Prevotella* sp., *Mobiluncus* sp., *Gardnerella vaginalis*, *Ureaplasma*, *Mycoplasma*, and numerous fastidious or uncultivated anaerobes), trichomoniasis (caused by *Trichomonas vaginalis*), and candidiasis (usually caused by *Candida albicans*). [3]

Various diagnostic methods are available to identify the etiology of the signs and symptoms of vaginitis. The cause of vaginal symptoms might be determined by testing of pH, for the presence of amines by the use of a potassium hydroxide (KOH) test, and microscopic examination of fresh samples of the discharge. The pH of the vaginal secretions can be determined by narrow-range pH paper; an elevated pH (*i.e.*, >4.5) is common with BV or trichomonas. Because pH testing is not highly specific, the discharge should be further examined microscopically with both a saline and KOH solution. [3]

The saline-solution specimen might yield motile *T. vaginalis* or clue cells (*i.e.*, epithelial cells with borders obscured by small bacteria), which are characteristic of BV, whereas the presence of white blood cells without evidence of trichomonads or yeast in this solution is suggestive of cervicitis. The KOH specimen typically is used to identify the yeast or pseudohyphae of *Candida* species. However, the absence of trichomonads or pseudohyphae in KOH samples does not rule out these infections, because the sensitivity of microscopy is approximately 40-75%.[4]

In settings where pH paper, KOH, and microscopy are not available or are inconclusive, alternative, commercially available, point-of-care tests, such as commercially available direct DNA-probe tests, or clinical laboratory testing, can be used to diagnose vaginitis. The presence of objective signs of vulvar inflammation in the absence of vaginal pathogens after laboratory testing, along with a minimal amount of discharge, suggests the possibility of mechanical, chemical, allergic, or other noninfectious irritation of the vulva. [5]

Bacterial Vaginosis

BV is a polymicrobial clinical syndrome resulting from replacement of the normal hydrogen peroxide-producing *Lactobacillus* species in the vagina with high concentrations of anaerobic bacteria (*e.g.*, *Prevotella* sp. and *Mobiluncus* sp.), *G. vaginalis*, *Ureaplasma*, *Mycoplasma*, and numerous fastidious or uncultivated anaerobes. BV is the most prevalent cause of vaginal discharge or malodor; however, in a nationally representative survey, most women with BV were asymptomatic. [3]

BV can be diagnosed by the use of clinical criteria (*i.e.*, Amsel's Diagnostic Criteria) or Gram stain (considered the gold standard laboratory method for diagnosing BV). If a Gram stain is not available, clinical criteria can be used and require 3 of the following symptoms or signs:

- Homogeneous, thin, white discharge that smoothly coats the vaginal walls;
- Presence of clue cells on microscopic examination;
- pH of vaginal fluid >4.5;
- A fishy odor of vaginal discharge before or after addition of 10% KOH (*i.e.*, the whiff test). [8]

Detection of 3 of these criteria has been correlated with results by Gram stain. Other tests, including a DNA probe-based test for high concentrations of *G. vaginalis* (Affirm VP III, Becton Dickinson, Sparks, Maryland), and the OSOM BVBlue test have acceptable performance characteristics compared with Gram stain. [3] The BVBlue test is a colorimetric test for enzymes (sialidase) produced by BV organisms. Culture of *G. vaginalis* is not recommended as a diagnostic tool, because 50% of women in the general population will culture positively for *G. vaginalis*. Use of the proline-aminopeptidase test card (Pip Activity TestCard) is no longer recommended because of low sensitivity and specificity. [8]

Trichomoniasis
Trichomoniasis is caused by the protozoan *Trichomonas vaginalis*. Some women have symptoms characterized by a diffuse, malodorous, yellow-green vaginal discharge with vulvar irritation. However, many women have minimal or no symptoms. Because of the high prevalence of trichomoniasis in clinical and nonclinical settings, testing for *T. vaginalis* should be performed in women seeking care for vaginal discharge. Screening for *T. vaginalis* in women can be considered in those at high risk for infection (*i.e.*, women who have new or multiple partners, have a history of sexually transmitted infections [STIs], exchange sex for payment, and use injection drugs). [3]

Diagnosis of vaginal trichomoniasis is usually performed by microscopy of vaginal secretions, but this method has a sensitivity of only approximately 60% - 70% and requires immediate evaluation of wet preparation slide for optimal results. U.S. Food and Drug Administration (FDA)-cleared tests for trichomoniasis in women include OSOM Trichomonas Rapid Test (Genzyme Diagnostics, Cambridge, Massachusetts), an immunochromatographic capillary flow dipstick technology, and the Affirm VP III (Becton Dickenson, San Jose, California), a nucleic acid probe test that evaluates for *T. vaginalis*, *G. vaginalis*, and *C. albicans*. Each of these tests, which are performed on vaginal secretions, have a sensitivity >83% and a specificity >97%. Both tests are considered point-of-care diagnostics. The results of the OSOM Trichomonas Rapid Test are available in approximately 10 minutes, whereas results of the Affirm VP III are available within 45 minutes. Although these tests tend to be more sensitive than those requiring vaginal wet preparation, false positives might occur, especially in populations with a low prevalence of disease. [3]

Nucleic acid amplification tests (NAAT) detect RNA (ribonucleic acid) by transcription-mediated amplification polymerase chain reaction (PCR) or reverse transcriptase, are highly sensitive and specific, and have become the accepted gold standard for the diagnosis of Trichomonas vaginalis. Test limitations include the need for instrumentation and laboratory analysis. If NAAT is not available for trichomonas, rapid antigen tests or DNA probe tests can be used as an alternative.[8]

Vulvovaginal Candidiasis
Vulvovaginal candidiasis (VVC) usually is caused by *C. albicans*, but occasionally is caused by other *Candida* species or yeasts. Typical symptoms of VVC include pruritus, vaginal soreness, dyspareunia, external dysuria, and abnormal vaginal discharge. None of these symptoms is specific for VVC. An estimated 75% of women will have at least 1 episode of VVC, and 40%–45% will have 2 or more episodes within their lifetime. On the basis of clinical presentation, microbiology, host factors, and response to therapy, VVC can be classified as either uncomplicated or complicated. [3]

A diagnosis of *Candida* vaginitis is suggested clinically by the presence of external dysuria and vulvar pruritus, pain, swelling, and redness. Signs include vulvar edema, fissures, excoriations, or thick, curdy vaginal discharge. The diagnosis can be made in a woman who has signs and symptoms of vaginitis when either 1) a wet preparation (saline, 10% KOH) or Gram stain of vaginal discharge demonstrates yeasts, hyphae, or pseudohyphae or 2) a culture or other test yields a yeast species. *Candida* vaginitis is associated with a normal vaginal pH (<4.5), and therefore, pH testing is not a useful diagnostic tool. Use of 10% KOH in wet preparations improves the visualization of yeast and mycelia by disrupting cellular material that might obscure the yeast or pseudohyphae. Examination of a wet mount with KOH preparation should be performed for all women with symptoms or signs of VVC, and women with a positive result should receive treatment. For women with negative wet mounts who are symptomatic, vaginal cultures for *Candida* should be considered. If the wet mount is negative and *Candida* cultures cannot be done, empiric treatment can be considered for symptomatic women with any sign of VVC on examination. Identifying *Candida* by culture in the absence of symptoms or signs is not an indication for treatment because approximately 10%-20% of women harbor *Candida* species and other yeasts in the vagina. VVC can occur concomitantly with STIs. Most healthy women with uncomplicated VVC have no identifiable precipitating factors. [3]

Complicated or recurrent vulvovaginal candidiasis (RVVC) is usually defined as 4 or more episodes of symptomatic VVC in 1 year, and affects a small percentage of women (<5%). The pathogenesis of RVVC is poorly understood, and most women with RVVC have no apparent predisposing or underlying conditions. Vaginal cultures should be obtained from patients with RVVC to confirm the clinical diagnosis and to identify unusual species (including nonalbicans species), particularly *Candida glabrata*. Although *C. glabrata* and other nonalbicans *Candida* species are observed in 10%-20% of patients with RVVC, *C. glabrata* does not form pseudohyphae or hyphae and is not easily recognized on microscopy. [3]

VVC occurs more frequently and has greater persistence, but not greater severity, in HIV-(human immunodeficiency virus) infected women with very low CD4 counts and high viral load. However, this population is likely to manifest other acquired immune deficiency syndrome – related sentinel conditions. HIV testing of women only for the indication of recurrent vulvovaginal candidiasis is not justified, given that this condition is common in women without HIV. [8]

DNA-probe tests have been developed to directly detect the presence of *Candida*, *Trichomonas* and *G. vaginalis*. Since *G. vaginalis* is a normal part of the vaginal flora, the DNA probe test is designed to be relatively insensitive, detecting only pathogenic levels of *G. vaginalis*. DNA

probes amplified by PCR testing can also detect these pathogens. In PCR tests, the sample is treated with enzymes that amplify specific regions of the DNA. After amplification, the number of DNA fragments is quantified. PCR testing has proven to be the most accurate diagnostic method in recent studies; however PCR testing has not been shown to improve clinical outcomes over direct DNA-probe testing.

Pediatric Patients
Girls less than 13 years of age tend to have a different etiology for vaginitis than do older girls, due to the lack of estrogenization of the vagina, and the consequential alkalinity and vaginal atrophy.[5] Common causes of vulvovaginal symptoms may include respiratory organisms such as group A streptococci and *Hemophilus influenzae*, as well as enteric and sexually transmitted pathogens. Pinworms or foreign bodies may also lead to vaginitis in the this population.[5] [6]

Centers for Disease Control and Prevention
Screening for *T. vaginalis* in women can be considered in those at high risk for infection (i.e., women who have new or multiple partners, have a history of STIs, exchange sex for payment, and use injection drugs). [3]

Recommends the gram stain as the gold standard for diagnosis of bacterial vaginosis, and recommend use of Amsel's criteria if a gram stain is not available. [3]

U.S. Preventive Services Task Force
This organization does not recommend screening for bacterial vaginosis in pregnant women at low-risk for pre-term delivery. [9]

Coding Implications
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Table 1. CPT codes considered medically necessary per this policy

CPT®* Codes	Description
82120	Amines, vaginal fluid, qualitative
83986	pH; body fluid, not otherwise specified
87210	Smear, primary source with interpretation; wet mount for infectious agents (eg, saline, India ink, KOH preps)
87480	Infectious agent detection by nucleic acid (DNA or RNA); Candida species, direct probe technique
87510	Infectious agent detection by nucleic acid (DNA or RNA); Gardnerella vaginalis, direct probe technique

CPT®* Codes	Description
87660	Infectious agent detection by nucleic acid (DNA or RNA); Trichomonas vaginalis, direct probe technique
87905	Infectious agent enzymatic activity other than virus (eg, sialidase activity in vaginal fluid)

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Table 2. ICD-10-CM Diagnosis codes that support medical necessity per this policy

ICD-10-CM Code	Description
A59.01	Trichomonal vulvovaginitis
B37.3	Candidiasis of vulva and vagina
F11.10 - F11.19	Opioid abuse [injection drug use]
F11.20 – F11.29	Opioid dependence [injection drug use]
F14.10 – F14.19	Cocaine abuse [injection drug use]
F14.20 – F14.29	Cocaine dependence [injection drug use]
F15.10 – F15.19	Other stimulant abuse [injection drug use]
F15.20 – F15.29	Other stimulant dependence [injection drug use]
F18.10 – F18.19	Inhalant abuse
F18.20 – F18.29	Inhalant dependence
F19.10 – F19.19	Other psychoactive substance abuse
F19.20 – F19.29	Other psychoactive substance dependence
L29.2, L29.3	Pruritus of genitals
N76.0 – N76.3	Vaginitis and vulvitis
N77.1	Vaginitis, vulvitis, and vulvovaginitis in diseases classified elsewhere
O23.511– O23.93	Infection of genitourinary tract in pregnancy
Z11.2*	Encounter for screening for other bacterial diseases
Z11.8*	Encounter for screening for other infectious and parasitic diseases (Trichomonas)
Z13.89*	Encounter for screening for other genitourinary disorders
Z72.51 – Z72.53	High risk sexual behavior [exchange of sex for payment, new or multiple partners]
Z86.19	Personal history of other infectious and parasitic diseases [history of STDs]

*ICD-10 codes Z11.2, Z11.8, and Z11.89 should be used with one of the drug abuse or dependence codes in the F series above.

Table 3. Procedure codes considered not medically necessary unless an exception is noted in this policy.

CPT Codes	Description
87481	Infectious agent detection by nucleic acid (DNA or RNA); Candida species, amplified probe technique

CPT Codes	Description
87511	Infectious agent detection by nucleic acid (DNA or RNA); Gardnerella vaginalis, amplified probe technique

Table 4. Procedure codes considered not medically necessary when billed with an ICD-10-CM code listed in Table 5 below.

CPT Codes	Description
87798	Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; amplified probe technique, each organism

Table 5. ICD-10-CM Diagnosis codes considered not medically necessary when billed with CPT code 87798 per this policy.

ICD-10-CM Code	Description
N39.0	Urinary tract infection, site not specified
N72	Inflammatory disease of cervix uteri
N76.0	Acute vaginitis
N76.2	Acute vulvitis
N89.8	Other specified noninflammatory disorders of vagina
N89.9	Noninflammatory disorder of vagina, unspecified
N90.89	Other specified noninflammatory disorders of vulva and perineum
N90.9	Noninflammatory disorder of vulva and perineum, unspecified
N91.0 – N91.5	Absent, scanty and rare menstruation
N92.0	Excessive, frequent and irregular menstruation
N93.0	Postcoital and contact bleeding
N93.8	Other specified abnormal uterine and vaginal bleeding
N93.9	Abnormal uterine and vaginal bleeding, unspecified
N94.3	Premenstrual tension syndrome
N94.4 – N94.6	Dysmenorrhea
N94.89	Other specified conditions associated with female genital organs and menstrual cycle
N94.9	Unspecified condition associated with female genital organs and menstrual cycle
V22.0 – V22.2	Normal pregnancy
V23.41	Pregnancy with history of pre-term labor
V23.42	Pregnancy with history of ectopic pregnancy
V23.49	Pregnancy with other poor obstetric history
V23.5	Pregnancy with other poor reproductive history
V23.7	Insufficient prenatal care
V23.81 – V23.89	Other high risk pregnancy
V23.9	Unspecified high-risk pregnancy

ICD-10-CM Code	Description
V24.0 – V24.2	Postpartum care and examination
V25.01 – V25.09	General counseling and advice for contraceptive management
V25.11 – V25.13	Encounter for insertion or removal of intrauterine contraceptive device
V25.40 – V25.49	Surveillance of previously prescribed contraceptive methods
V25.5	Insertion of implantable subdermal contraceptive
V25.8	Other specified contraceptive management
V25.9	Unspecified contraceptive management
V28.3	Encounter for routine screening for malformation using ultrasonics
V28.4	Screening for fetal growth retardation using ultrasonics
V28.6	Screening for Streptococcus B
V28.81 – V28.89	Other specified antenatal screening
V28.9	Unspecified antenatal screening
V30.00 – V30.01	Single liveborn, born in hospital
V72.31	Routine gynecological examination
V72.40 – V72.42	Pregnancy examination or test
V72.60	Laboratory examination, unspecified
V74.5	Venereal disease
Z00.00	Encounter for general adult medical examination without abnormal findings
Z00.8	Encounter for other general examination
Z01.419	Encounter for gynecological examination (general) (routine) without abnormal findings
Z11.3	Encounter for screening for infections with a predominantly sexual mode of transmission
Z11.51	Encounter for screening for human papillomavirus (HPV)
Z22.330	Carrier of Group B streptococcus
Z23	Encounter for immunization
Z30.011 – Z30.019	Encounter for initial prescription of contraceptives
Z30.02	Counseling and instruction in natural family planning to avoid pregnancy
Z30.09	Encounter for other general counseling and advice on contraception
Z30.40 – Z30.9	Encounter for surveillance of contraceptives
Z32.00	Encounter for pregnancy test
Z33.1	Pregnant state, incidental
Z34.00 – Z34.03	Encounter for supervision of normal first pregnancy
Z34.80 – Z34.83	Encounter for supervision of other normal pregnancy
Z34.90 – Z34.93	Encounter for supervision of normal pregnancy, unspecified
Z36	Encounter for antenatal screening of mother
Z38.00 – Z38.01	Single liveborn infant, born in hospital

CLINICAL POLICY
Testing for Select GU Conditions

ICD-10-CM Code	Description
Z38.30 – Z38.31	Twin liveborn infant, born in hospital
Z38.61 – Z38.69	Other multiple liveborn infant, born in hospital
Z39.0 – Z39.2	Encounter for maternal postpartum care and examination
Z3A.00 – Z3A.49	Weeks of gestation
Z975	Presence of (intrauterine) contraceptive device

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed, reviewed by specialist.	06/16	06/16
Added age restriction of ≥ 13, with supporting background information.	08/16	
Removed trichomonas from 1.A. section listing criteria for direct DNA probe. Added to 'background information' under bacterial vaginosis that the use of the proline-aminopeptidase test card (Pip Activity TestCard) is no longer recommended because of low sensitivity and specificity. Removed CPT code for detection of trichomonas- 87661 from the not medically necessary code tables.	06/17	06/17
Added CPT 87798 – not otherwise specified amplified DNA probe as not medically necessary when performed for indications listed in the policy related to GU conditions, asymptomatic women, and asymptomatic women during pregnancy. Slight rewording of criteria with no clinical implications. Renamed to "Testing for Select Genitourinary Conditions." Reviewed by external OB/Gyn.	08/17	09/17

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Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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CENTENE Corporation

Clinical Policy: Urodynamic Testing

Reference Number: CP.MP.98
Effective Date: 10/15
Last Review Date: 10/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Urodynamic testing is an important part of the comprehensive evaluation of voiding dysfunction. The clinician must exercise clinical judgment in the appropriate selection of urodynamic tests following an appropriate evaluation and symptom characterization. The purpose of this policy is to define medical necessity criteria for commonly used urodynamic studies.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that urodynamic testing is **medically necessary** to assist in the diagnosis of urologic dysfunction with any of the following indications:

- **A.** Uncertain diagnosis and inability to develop an appropriate initial treatment plan based on the clinical diagnostic evaluation; or
- **B.** Failure to respond to an adequate therapeutic trial; or
- **C.** Consideration of urologic surgical intervention, particularly if previous surgery failed or if the patient is a high surgical risk; or
- **D.** Presence of other comorbid conditions such as:
  1. Incontinence associated with recurrent symptomatic urinary tract infection;
  2. Persistent symptoms of difficult bladder emptying;
  3. History of previous anti-incontinence surgery or radical pelvic surgery;
  4. Symptomatic pelvic prolapse;
  5. Abnormal post-void-residual urinalysis;
  6. Diabetes mellitus with secondary urinary incontinence; or
  7. Neurological conditions affecting voiding function (neurogenic bladder) such as multiple sclerosis, Parkinson's disease, and spinal cord lesions or injury.

II. It is the policy of health plans affiliated with Centene Corporation that urodynamic testing in the following cases is considered **not medically necessary**:

- **A.** More than one cystometrogram (CPT codes 51725 or 51726) or uroflowmetry study (CPT codes 51736 or 51741) per visit.
- **B.** The use of any urodynamic testing for screening in asymptomatic patients, except for evaluation of neurogenic bladder.

Background

Lower urinary tract symptoms, which include urinary incontinence, are a common and significant source of impaired quality of life and comorbidity in a large number of adults and children. Commonly, patients presenting with lower urinary tract symptoms have overlapping symptoms and conditions, making an isolated or homogeneous source of symptoms rare. Clinicians evaluating these disorders collectively utilize history, physical examination, questionnaires and testing data in the evaluation of symptoms.[3] Cystometrogram, uroflowmetry,

urethral pressure profile, and voiding pressure studies, among others, are used to identify abnormal voiding patterns in symptomatic patients with disorders of urinary flow. Each of the urodynamic studies has benefits and limitations that must be understood for each specific clinical application.

In clinical practice, the role of invasive urodynamic testing is not clearly defined. Urologists generally accept that conservative or empiric, non-invasive treatments may be instituted without urodynamic testing. Conservative treatments for urinary incontinence include pelvic muscle exercises (Kegel exercise), behavioral therapies such as bladder training and/or biofeedback, and pharmacotherapies (e.g., anticholinergic agents, musculotropic relaxants, calcium channel blockers, tricyclic antidepressants, or a combination of anticholinergic, antispasmodic medications and tricyclic antidepressants). Specifically, urge incontinence is more effectively managed with peripherally acting receptor agonists or antagonists, while stress incontinence is better controlled by pelvic muscle exercises, behavioral therapies, or corrective surgery.[4]

Urodynamic studies are indicated only after an initial evaluation is performed that, at minimum, includes an appropriate history, physical exam, and urinalysis with microscopy. Infection, if present, should be treated and effectiveness of treatment observed before further diagnostic (urodynamic) testing or other therapeutic interventions are undertaken.

Many types of urodynamic testing require urethral catheterization and include cystometry, pressure flow studies (PFS), and urethral function testing. Such testing subjects patients to risks of urethral instrumentation including infection, urethral trauma, and pain. Thus, the clinician must weigh whether urodynamic tests offer additional diagnostic benefit beyond symptom assessment, physical examination, and other diagnostic testing. A cystometrogram is used to distinguish bladder outlet obstruction from other voiding dysfunctions.

- In a simple cystometrogram (CPT code 51725), the physician inserts a pressure catheter into the bladder and using a manometer, records the pressure and flow in the lower urinary tract.
- A complex cystometrogram (CPT code 51726) uses a transurethral catheter to fill the bladder with water or gas while simultaneously obtaining rectal pressure and a transducer measures intravesical pressure.
- CPT code 51727 reports a complex cystometrogram performed in conjunction with a measurement of urethral pressure studies.
- CPT code 51728 reports a complex cystometrogram performed in conjunction with a measurement of voiding pressure studies.
- CPT code 51729 reports a complex cystometrogram performed in conjunction with a measurement of voiding pressure studies and urethral pressure studies.
- Voiding pressure studies (CPT code 51797) measure the effort the patient makes while voiding. This measurement includes the pressure required and the subsequent urine flow.

Uroflowmetry and ultrasound post-void residual (PVR) studies may be appropriate noninvasive tests given the clinical scenario and the options for treatment.[3]

- In simple uroflowmetry (CPT code 51736), a stopwatch is used to record the volume of the flow of urine over time.

- Complex uroflowmetry (CPT code 51741) uses electronic equipment to measure and record the volume of urine flow over time.
- Measurement of residual urine and/or bladder emptying capacity (CPT code 51798) is accomplished using ultrasound after voiding.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2017, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. The following is a list of procedures codes for which coverage may be provided when billed with a diagnosis code(s) that supports medical necessity criteria (see list of ICD-10-CM codes supporting medical necessity further below). They are current at time of review of this policy. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT®* Codes	Description
51725	Simple cystometrogram (CMG)(eg, spinal manometer)
51726	Complex cystometrogram (ie, calibrated electronic equipment)
51727	Complex cystometrogram (ie, calibrated electronic equipment; with urethral pressure profile studies (i.e., urethral closure pressure profile), any technique
51728	Complex cystometrogram (ie, calibrated electronic equipment; with voiding pressure studies (ie, bladder voiding pressure), any technique
51729	Complex cystometrogram (ie, calibrated electronic equipment; with voiding pressure studies (ie, bladder voiding pressure) and urethral pressure profile studies (ie, urethral closure pressure profile), any technique
51736	Simple uroflowmetry (UFR)(eg, stop-watch flow rate, mechanical uroflowmeter)
51741	Complex uroflowmetry (eg, calibrated electronic equipment)
+51797	Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal (List separately in addition to code for primary procedure)
51798	Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging

ICD-10-CM Diagnosis Codes that Support Medical Necessity

ICD-10-CM Code	Description
E10.69	Type 1 diabetes mellitus with other specified complications
E11.69	Type 2 diabetes mellitus with other specified complication
G20	Parkinson's disease
G35	Multiple sclerosis
G37.3	Acute transverse myelitis in demyelinating disease of central nervous system

ICD-10-CM Code	Description
G83.4	Cauda equina syndrome
N30.10-N30.11	Interstitial cystitis, chronic
N30.20-N30.21	Other chronic cystitis
N31.0-N31.9	Neuromuscular dysfunction of bladder, not elsewhere classified
N32.0-N32.89	Other disorders of bladder
N39.0-N39.8	Other disorders of urinary system
N81.0-N81.9	Female genital prolapse
Q05.0-Q05.9	Spina bifida
Q06.0-Q06.9	Other congenital malformations of spinal cord
Q07.0-Q07.9	Other congenital malformations of nervous system
R33.8	Other retention of urine
R33.9	Retention of urine, unspecified
R39.81	Functional urinary incontinence
S34.0-S34.9XXS	Injury of lumbar and sacral spinal cord and nerves at abdomen, lower back and pelvis level

In addition to the above ICD-10 codes, the following additional diagnosis codes support medical necessity for CPT code 51798.

ICD-10-CM Code	Description
N13.8	Other obstructive and reflux uropathy
N40.1	Benign prostatic hyperplasia with lower urinary tract symptoms
N40.3	Nodular prostate with lower urinary tract symptoms
R33.0-R33.9	Retention of urine
R35.0	Frequency of micturition

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed	09/15	10/15
Removed ICD-10 codes R34, R39.0 – R39.16 due to no support in literature	02/16	
References reviewed and updated Updated ICD-10 code list	10/16	10/16
References reviewed and updated. Added ICD-10-CM E10.69, E11.69, and S34.0 – S34.9XXS	09/17	10/17

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CENTENE Corporation

Clinical Policy: Wheelchair Seating

Reference Number: CP.MP.99
Effective Date: 10/15
Last Review Date: 10/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that special wheelchair seating cushions are **medically necessary** for the following indications:

A. A general use seat cushion (E2601, E2602) and a general use wheelchair back cushion (E2611-E2612) for an approved manual wheelchair or power wheelchair with a sling or solid seat or back.

B. A skin-protection seat cushion (E2603, E2604, E2622, E2623) with both of the following:
   1. The member has an approved manual wheelchair or power wheelchair with a sling/solid seat/back; and
   2. The member has either of the following:
      a. Current pressure ulcer or past history of a pressure ulcer (see "ICD-10-CM Diagnosis Codes That Support Medical Necessity" section below) on the area of contact with the seating surface; or
      b. Absent or impaired sensation in the area of contact with the seating surface or inability to carry out a functional weight shift due to one of the following diagnoses: spinal cord injury resulting in quadriplegia or paraplegia, other spinal cord disease, multiple sclerosis, other demyelinating disease, cerebral palsy, anterior horn cell diseases including amyotrophic lateral sclerosis, post-polio paralysis, traumatic brain injury resulting in quadriplegia, spina bifida, childhood cerebral degeneration, Alzheimer's disease, Parkinson's disease, muscular dystrophy, hemiplegia, Huntington's chorea, idiopathic torsion dystonia, athetoid cerebral palsy, arthrogryposis, osteogenesis imperfecta, spinocerebellar disease or transverse myelitis (see "ICD-10-CM Diagnosis Codes That Support Medical Necessity" section below).

C. A positioning seat cushion (E2605, E2606), positioning back cushion (E2613-E2616, E2620, E2621), and positioning accessory (E0955-E0957, E0960) with both of the following:
   1. The member has an approved manual wheelchair or power wheelchair with a sling/solid seat/back; and
   2. The member has significant postural asymmetries that are due to one of the diagnoses listed in the skin-protection seat cushion criterion 2b above or to one of the following diagnoses: monoplegia of the lower limb due to stroke, traumatic brain injury or other etiology, spinocerebellar disease, above knee leg amputation, osteogenesis imperfecta, or transverse myelitis (see "ICD-10-CM Diagnosis Codes That Support Medical Necessity" section below).

D. A headrest (E0955) when the member has an approved manual tilt-in-space, manual semi or fully reclining back on a manual wheelchair, a manual fully reclining back on a power wheelchair, or power tilt and/or recline power seating system.

E. A combination skin-protection and positioning seat cushion (E2607, E2608, E2624, E2625) for a member who meets the criteria for both a skin-protection seat cushion and a positioning seat cushion.
F. A custom fabricated seat cushion (E2609) if criteria (1) and (3) below are met. A custom fabricated back cushion (E2617) if criteria (2) and (3) below are met:
   1. The member meets all of the criteria for a prefabricated skin-protection seat cushion or positioning seat cushion;
   2. The member meets all of the criteria for a prefabricated positioning back cushion;
   3. There is a comprehensive, written evaluation by a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT), which clearly explains why a prefabricated seating system is not sufficient to meet the member's seating and positioning needs. The PT or OT must have no financial relationship with the supplier.

II. It is the policy of health plans affiliated with Centene Corporation that special wheelchair cushions and accessories are **not medically necessary** for the following indications:
A. A general use seat cushion (E2601, E2602) if the member has a power-operated vehicle (POV) or a power wheelchair with a captain's chair seat.
B. A separate seat, back cushion, headrest, and/or other positioning accessories if the member has a POV or power wheelchair with a captain's chair seat. Power wheelchair bases that do not include a captain's chair model are: K0839, K0840, K0843, K0860-, K0864, K0870, K0871, K0879, K0880, K0886, K0890, K0891.
C. A seat or back cushion that is provided for use with a transport chair (E1037, E1038).
D. Powered seat cushion (E2610) for any indication as effectiveness has not been established.

Background
Careful consideration should be given to anticipated or potential changes in the person's function or psychosocial role changes. For instance, when working with an individual with a progressive disease process such as a multiple sclerosis (MS) or amyotrophic lateral sclerosis (ALS), the wheelchair must meet current and potential needs as the disease progresses. Likewise, a child or adolescent certainly may have growth or other anthropomorphic changes. This should be taken into consideration when ordering a new chair or related equipment.[3]

The evaluating provider should ascertain the individual's level of bowel and bladder control. Certain types of cushions are better suited for patients who are frequently incontinent. During the examination, the evaluating provider should question the patient about any past skin breakdown. Once a patient has had a decubitus ulcer, his or her skin is at best 80% the strength that it was prior to the ulcer.[3] Such a patient will be more susceptible to skin breakdown in the future, and use of a previous seating system that induced or contributed to the skin breakdown should be avoided.

The evaluating provider needs to record the method and frequency of achieving pressure relief in order to prescribe a system that does not unknowingly remove a part of the wheelchair that previously provided pressure relief.

Coding Implications

CLINICAL POLICY
Wheelchair Seating

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Seat Cushions

HCPCS Codes	Description
E2601	General use wheelchair seat cushion, width less than 22 inches, any depth
E2602	General use wheelchair seat cushion, width 22 inches or greater, any depth
E2603	Skin protection wheelchair seat cushion, width less than 22 inches, any depth
E2604	Skin protection wheelchair seat cushion, width 22 inches or greater, any depth
E2605	Positioning wheelchair seat cushion, width less than 22 inches, any depth
E2606	Positioning wheelchair seat cushion, width 22 inches or greater, any depth
E2607	Skin protection and positioning wheelchair seat cushion, width less than 22 inches, any depth
E2608	Skin protection and positioning wheelchair seat cushion, width 22 inches or greater, any depth
E2609	Custom fabricated wheelchair seat cushion, any size
E2622	Skin protection wheelchair seat cushion, adjustable, width less than 22 inches, any depth
E2623	Skin protection wheelchair seat cushion, adjustable, width 22 inches or greater, any depth
E2624	Skin protection and positioning wheelchair seat cushion, adjustable, width less than 22 inches, any depth
E2625	Skin protection and positioning wheelchair seat cushion, adjustable, width 22 inches or greater, any depth

Back Cushions

HCPCS Codes	Description
E2611	General use wheelchair back cushion, width less than 22 inches, any height, including any type mounting hardware
E2612	General use wheelchair back cushion, width 22 inches or greater, any height, including any type mounting hardware
E2613	Positioning wheelchair back cushion, posterior, width less than 22 inches, any height, including any type mounting hardware
E2614	Positioning wheelchair back cushion, posterior, width 22 inches or greater, any height, including any type mounting hardware
E2615	Positioning wheelchair back cushion, posterior-lateral, width less than 22 inches, any height, including any type mounting hardware
E2616	Positioning wheelchair back cushion, posterior-lateral, width 22 inches or greater, any height, including any type mounting hardware
E2617	Custom fabricated wheelchair back cushion, any size, including any type mounting hardware

HCPCS Codes	Description
E2620	Positioning wheelchair back cushion, planar back with lateral supports, width less than 22 inches, any height, including any type mounting hardware
E2621	Positioning wheelchair back cushion, planar back with lateral supports, width 22 inches or greater, any height, including any type mounting hardware

Positioning Accessories

HCPCS Codes	Description
E0955	Wheelchair accessory, headrest, cushioned, any type, including fixed mounting hardware, each
E0956	Wheelchair accessory, lateral trunk or hip support, any type, including fixed mounting hardware, each
E0957	Wheelchair accessory, medial thigh support, any type, including fixed mounting hardware, each
E0960	Wheelchair accessory, shoulder harness/straps or chest strap, including any type mounting hardware
E0966	Manual wheelchair accessory, headrest extension, each
E1028	Wheelchair accessory, manual swing-away, retractable or removable mounting hardware for joystick, other control interface or positioning accessory

Miscellaneous

HCPCS Codes	Description
A9900	Miscellaneous DME supply, accessory, and/or service component of another HCPCS code
E2231	Manual wheelchair accessory, solid seat support base (replaces sling seat), includes any type mounting hardware
E2291	Back, planar, for pediatric size wheelchair including fixed attaching hardware
E2292	Seat, planar, for pediatric size wheelchair including fixed attaching hardware
E2293	Back, contoured, for pediatric size wheelchair including fixed attaching hardware
E2294	Seat, contoured, for pediatric size wheelchair including fixed attaching hardware
E2619	Replacement cover for wheelchair seat cushion or back cushion, each
K0108	Wheelchair component or accessory, not otherwise specified

Not Medically Necessary Procedure Codes

The following is a list of procedures codes which are NOT medically necessary, unless an exception is noted in this policy.

HCPCS Codes	Description
E0992	Manual wheelchair accessory, solid seat insert
E2610	Wheelchair Seat cushion, powered

HCPCS Codes	Description
K0669	Wheelchair accessory, wheelchair seat or back cushion, does not meet specific code criteria or no written coding verification from DME PDAC

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

The following is a list of diagnosis codes that support medical necessity for procedure code(s) E2603, E2604, E2622, and E2623.

ICD-10-CM Code	Description
B91	Sequelae of poliomyelitis
E75.00	GM2 gangliosidosis, unspecified
E75.01	Sandhoff disease
E75.02	Tay-Sachs disease
E75.09	Other GM2 gangliosidosis
E75.10	Unspecified gangliosidosis
E75.11	Mucolipidosis IV
E75.19	Other gangliosidosis
E75.23	Krabbe disease
E75.25	Metachromatic leukodystrophy
E75.29	Other sphingolipidosis
E75.4	Neuronal ceroid lipofuscinosis
F84.2	Rett's syndrome
G04.1	Tropical spastic paraplegia
G04.89	Other myelitis
G10	Huntington's disease
G11.0	Congenital nonprogressive ataxia
G11.1	Early-onset cerebellar ataxia
G11.2	Late-onset cerebellar ataxia
G11.3	Cerebellar ataxia with defective DNA repair
G11.4	Hereditary spastic paraplegia
G11.8	Other hereditary ataxias
G11.9	Hereditary ataxia, unspecified
G12.0	Infantile spinal muscular atrophy, type I [Werdnig-Hoffman]
G12.1	Other inherited spinal muscular atrophy
G12.20	Motor neuron disease, unspecified
G12.21	Amyotrophic lateral sclerosis
G12.23	Primary lateral sclerosis
G12.24	Familial motor neuron disease
G12.25	Progressive spinal muscle atrophy
G12.29	Other motor neuron disease
G12.8	Other spinal muscular atrophies and related syndromes
G12.9	Spinal muscular atrophy, unspecified
G14	Postpolio syndrome
G20	Parkinson's disease

ICD-10-CM Code	Description
G21.4	Vascular parkinsonism
G24.1	Genetic torsion dystonia
G30.0	Alzheimer's disease with early onset
G30.1	Alzheimer's disease with late onset
G30.8	Other Alzheimer's disease
G30.9	Alzheimer's disease, unspecified
G31.81	Alpers disease
G31.82	Leigh's disease
G32.0	Subacute combined degeneration of spinal cord in diseases classified elsewhere
G32.81	Cerebellar ataxia in diseases classified elsewhere
G32.89	Other specified degenerative disorders of nervous system in diseases classified elsewhere
G35	Multiple sclerosis
G36.0	Neuromyelitis optica [Devic]
G37.0	Diffuse sclerosis of central nervous system
G37.1	Central demyelination of corpus callosum
G37.2	Central pontine myelinolysis
G37.3	Acute transverse myelitis in demyelinating disease of central nervous system
G37.4	Subacute necrotizing myelitis of central nervous system
G37.5	Concentric sclerosis [Balo] of central nervous system
G37.8	Other specified demyelinating diseases of central nervous system
G37.9	Demyelinating disease of central nervous system, unspecified
G71.0	Muscular dystrophy
G71.2	Congenital myopathies
G80.0	Spastic quadriplegic cerebral palsy
G80.1	Spastic diplegic cerebral palsy
G80.2	Spastic hemiplegic cerebral palsy
G80.3	Athetoid cerebral palsy
G80.4	Ataxic cerebral palsy
G80.8	Other cerebral palsy
G80.9	Cerebral palsy, unspecified
G81.00	Flaccid hemiplegia affecting unspecified side
G81.01	Flaccid hemiplegia affecting right dominant side
G81.02	Flaccid hemiplegia affecting left dominant side
G81.03	Flaccid hemiplegia affecting right nondominant side
G81.04	Flaccid hemiplegia affecting left nondominant side
G81.10	Spastic hemiplegia affecting unspecified side
G81.11	Spastic hemiplegia affecting right dominant side
G81.12	Spastic hemiplegia affecting left dominant side
G81.13	Spastic hemiplegia affecting right nondominant side
G81.14	Spastic hemiplegia affecting left nondominant side

ICD-10-CM Code	Description
G81.90	Hemiplegia, unspecified affecting unspecified side
G81.91	Hemiplegia, unspecified affecting right dominant side
G81.92	Hemiplegia, unspecified affecting left dominant side
G81.93	Hemiplegia, unspecified affecting right nondominant side
G81.94	Hemiplegia, unspecified affecting left nondominant side
G82.20	Paraplegia, unspecified
G82.21	Paraplegia, complete
G82.22	Paraplegia, incomplete
G82.50	Quadriplegia, unspecified
G82.51	Quadriplegia, C1-C4 complete
G82.52	Quadriplegia, C1-C4 incomplete
G82.53	Quadriplegia, C5-C7 complete
G82.54	Quadriplegia, C5-C7 incomplete
G93.89	Other specified disorders of brain
G93.9	Disorder of brain, unspecified
G94	Other disorders of brain in diseases classified elsewhere
G95.0	Syringomyelia and syringobulbia
G95.11	Acute infarction of spinal cord (embolic) (nonembolic)
G95.19	Other vascular myelopathies
G99.2	Myelopathy in diseases classified elsewhere
I69.051	Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting right dominant side
I69.052	Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting left dominant side
I69.053	Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting right non-dominant side
I69.054	Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting left non-dominant side
I69.059	Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting unspecified side
I69.151	Hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting right dominant side
I69.152	Hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting left dominant side
I69.153	Hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting right non-dominant side
I69.154	Hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting left non-dominant side
I69.159	Hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting unspecified side
I69.251	Hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting right dominant side

ICD-10-CM Code	Description
I69.252	Hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting left dominant side
I69.253	Hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting right non-dominant side
I69.254	Hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting left non-dominant side
I69.259	Hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting unspecified side
I69.351	Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side
I69.352	Hemiplegia and hemiparesis following cerebral infarction affecting left dominant side
I69.353	Hemiplegia and hemiparesis following cerebral infarction affecting right non-dominant side
I69.354	Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side
I69.359	Hemiplegia and hemiparesis following cerebral infarction affecting unspecified side
I69.851	Hemiplegia and hemiparesis following other cerebrovascular disease affecting right dominant side
I69.852	Hemiplegia and hemiparesis following other cerebrovascular disease affecting left dominant side
I69.853	Hemiplegia and hemiparesis following other cerebrovascular disease affecting right non-dominant side
I69.854	Hemiplegia and hemiparesis following other cerebrovascular disease affecting left non-dominant side
I69.859	Hemiplegia and hemiparesis following other cerebrovascular disease affecting unspecified side
I69.951	Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side
I69.952	Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left dominant side
I69.953	Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right non-dominant side
I69.954	Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side
I69.959	Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting unspecified side
L89.130	Pressure ulcer of right lower back, unstageable
L89.131	Pressure ulcer of right lower back, stage 1
L89.132	Pressure ulcer of right lower back, stage 2
L89.133	Pressure ulcer of right lower back, stage 3
L89.134	Pressure ulcer of right lower back, stage 4

ICD-10-CM Code	Description
L89.140	Pressure ulcer of left lower back, unstageable
L89.141	Pressure ulcer of left lower back, stage 1
L89.142	Pressure ulcer of left lower back, stage 2
L89.143	Pressure ulcer of left lower back, stage 3
L89.144	Pressure ulcer of left lower back, stage 4
L89.150	Pressure ulcer of sacral region, unstageable
L89.151	Pressure ulcer of sacral region, stage 1
L89.152	Pressure ulcer of sacral region, stage 2
L89.153	Pressure ulcer of sacral region, stage 3
L89.154	Pressure ulcer of sacral region, stage 4
L89.200	Pressure ulcer of unspecified hip, unstageable
L89.201	Pressure ulcer of unspecified hip, stage 1
L89.202	Pressure ulcer of unspecified hip, stage 2
L89.203	Pressure ulcer of unspecified hip, stage 3
L89.204	Pressure ulcer of unspecified hip, stage 4
L89.210	Pressure ulcer of right hip, unstageable
L89.211	Pressure ulcer of right hip, stage 1
L89.212	Pressure ulcer of right hip, stage 2
L89.213	Pressure ulcer of right hip, stage 3
L89.214	Pressure ulcer of right hip, stage 4
L89.220	Pressure ulcer of left hip, unstageable
L89.221	Pressure ulcer of left hip, stage 1
L89.222	Pressure ulcer of left hip, stage 2
L89.223	Pressure ulcer of left hip, stage 3
L89.224	Pressure ulcer of left hip, stage 4
L89.300	Pressure ulcer of unspecified buttock, unstageable
L89.301	Pressure ulcer of unspecified buttock, stage 1
L89.302	Pressure ulcer of unspecified buttock, stage 2
L89.303	Pressure ulcer of unspecified buttock, stage 3
L89.304	Pressure ulcer of unspecified buttock, stage 4
L89.310	Pressure ulcer of right buttock, unstageable
L89.311	Pressure ulcer of right buttock, stage 1
L89.312	Pressure ulcer of right buttock, stage 2
L89.313	Pressure ulcer of right buttock, stage 3
L89.314	Pressure ulcer of right buttock, stage 4
L89.320	Pressure ulcer of left buttock, unstageable
L89.321	Pressure ulcer of left buttock, stage 1
L89.322	Pressure ulcer of left buttock, stage 2
L89.323	Pressure ulcer of left buttock, stage 3
L89.324	Pressure ulcer of left buttock, stage 4
L89.41	Pressure ulcer of contiguous site of back, buttock and hip, stage 1
L89.42	Pressure ulcer of contiguous site of back, buttock and hip, stage 2
L89.43	Pressure ulcer of contiguous site of back, buttock and hip, stage 3

ICD-10-CM Code	Description
L89.44	Pressure ulcer of contiguous site of back, buttock and hip, stage 4
L89.45	Pressure ulcer of contiguous site of back, buttock and hip, unstageable
M62.3	Immobility syndrome (paraplegic)
M62.89	Other specified disorders of muscle
Q05.0	Cervical spina bifida with hydrocephalus
Q05.1	Thoracic spina bifida with hydrocephalus
Q05.2	Lumbar spina bifida with hydrocephalus
Q05.3	Sacral spina bifida with hydrocephalus
Q05.4	Unspecified spina bifida with hydrocephalus
Q05.5	Cervical spina bifida without hydrocephalus
Q05.6	Thoracic spina bifida without hydrocephalus
Q05.7	Lumbar spina bifida without hydrocephalus
Q05.8	Sacral spina bifida without hydrocephalus
Q05.9	Spina bifida, unspecified
Q07.00	Arnold-Chiari syndrome without spina bifida or hydrocephalus
Q07.01	Arnold-Chiari syndrome with spina bifida
Q07.02	Arnold-Chiari syndrome with hydrocephalus
Q07.03	Arnold-Chiari syndrome with spina bifida and hydrocephalus
Q67.8	Other congenital deformities of chest
Q68.1	Congenital deformity of finger(s) and hand
Q74.3	Arthrogryposis multiplex congenita
Q78.0	Osteogenesis imperfecta

ICD-10-CM Diagnosis Codes That Support Medical Necessity

The following is a list of diagnosis codes that support medical necessity for procedure code(s) E0956, E0957, E0960, E2605, E2606, E2613-E2617, E2620 and E2621.

ICD-10-CM Code	Description
B91	Sequelae of poliomyelitis
E75.00	GM2 gangliosidosis, unspecified
E75.01	Sandhoff disease
E75.02	Tay-Sachs disease
E75.09	Other GM2 gangliosidosis
E75.10	Unspecified gangliosidosis
E75.11	Mucolipidosis IV
E75.19	Other gangliosidosis
E75.23	Krabbe disease
E75.25	Metachromatic leukodystrophy
E75.29	Other sphingolipidosis
E75.4	Neuronal ceroid lipofuscinosis
F84.2	Rett's syndrome
G04.1	Tropical spastic paraplegia

ICD-10-CM Code	Description
G04.89	Other myelitis
G10	Huntington's disease
G11.0	Congenital nonprogressive ataxia
G11.1	Early-onset cerebellar ataxia
G11.2	Late-onset cerebellar ataxia
G11.3	Cerebellar ataxia with defective DNA repair
G11.4	Hereditary spastic paraplegia
G11.8	Other hereditary ataxias
G11.9	Hereditary ataxia, unspecified
G12.0	Infantile spinal muscular atrophy, type I [Werdnig-Hoffman]
G12.1	Other inherited spinal muscular atrophy
G12.20	Motor neuron disease, unspecified
G12.21	Amyotrophic lateral sclerosis
G12.23	Primary lateral sclerosis
G12.24	Familial motor neuron disease
G12.25	Progressive spinal muscle atrophy
G12.29	Other motor neuron disease
G12.8	Other spinal muscular atrophies and related syndromes
G12.9	Spinal muscular atrophy, unspecified
G14	Postpolio syndrome
G20	Parkinson's disease
G21.4	Vascular parkinsonism
G24.1	Genetic torsion dystonia
G30.0	Alzheimer's disease with early onset
G30.1	Alzheimer's disease with late onset
G30.8	Other Alzheimer's disease
G30.9	Alzheimer's disease, unspecified
G31.81	Alpers disease
G31.82	Leigh's disease
G32.0	Subacute combined degeneration of spinal cord in diseases classified elsewhere
G32.81	Cerebellar ataxia in diseases classified elsewhere
G32.89	Other specified degenerative disorders of nervous system in diseases classified elsewhere
G35	Multiple sclerosis
G36.0	Neuromyelitis optica [Devic]
G36.1	Acute and subacute hemorrhagic leukoencephalitis [Hurst]
G36.8	Other specified acute disseminated demyelination
G36.9	Acute disseminated demyelination, unspecified
G37.0	Diffuse sclerosis of central nervous system
G37.1	Central demyelination of corpus callosum
G37.2	Central pontine myelinolysis

ICD-10-CM Code	Description
G37.3	Acute transverse myelitis in demyelinating disease of central nervous system
G37.4	Subacute necrotizing myelitis of central nervous system
G37.5	Concentric sclerosis [Balo] of central nervous system
G37.8	Other specified demyelinating diseases of central nervous system
G37.9	Demyelinating disease of central nervous system, unspecified
G71.0	Muscular dystrophy
G71.2	Congenital myopathies
G80.0	Spastic quadriplegic cerebral palsy
G80.1	Spastic diplegic cerebral palsy
G80.2	Spastic hemiplegic cerebral palsy
G80.3	Athetoid cerebral palsy
G80.4	Ataxic cerebral palsy
G80.8	Other cerebral palsy
G80.9	Cerebral palsy, unspecified
G81.00	Flaccid hemiplegia affecting unspecified side
G81.01	Flaccid hemiplegia affecting right dominant side
G81.02	Flaccid hemiplegia affecting left dominant side
G81.03	Flaccid hemiplegia affecting right nondominant side
G81.04	Flaccid hemiplegia affecting left nondominant side
G81.10	Spastic hemiplegia affecting unspecified side
G81.11	Spastic hemiplegia affecting right dominant side
G81.12	Spastic hemiplegia affecting left dominant side
G81.13	Spastic hemiplegia affecting right nondominant side
G81.14	Spastic hemiplegia affecting left nondominant side
G81.90	Hemiplegia, unspecified affecting unspecified side
G81.91	Hemiplegia, unspecified affecting right dominant side
G81.92	Hemiplegia, unspecified affecting left dominant side
G81.93	Hemiplegia, unspecified affecting right nondominant side
G81.94	Hemiplegia, unspecified affecting left nondominant side
G82.20	Paraplegia, unspecified
G82.21	Paraplegia, complete
G82.22	Paraplegia, incomplete
G82.50	Quadriplegia, unspecified
G82.51	Quadriplegia, C1-C4 complete
G82.52	Quadriplegia, C1-C4 incomplete
G82.53	Quadriplegia, C5-C7 complete
G82.54	Quadriplegia, C5-C7 incomplete
G83.10	Monoplegia of lower limb affecting unspecified side
G83.11	Monoplegia of lower limb affecting right dominant side
G83.12	Monoplegia of lower limb affecting left dominant side
G83.13	Monoplegia of lower limb affecting right nondominant side
G83.14	Monoplegia of lower limb affecting left nondominant side

ICD-10-CM Code	Description
G93.89	Other specified disorders of brain
G93.9	Disorder of brain, unspecified
G94	Other disorders of brain in diseases classified elsewhere
G95.0	Syringomyelia and syringobulbia
G95.11	Acute infarction of spinal cord (embolic) (nonembolic)
G95.19	Other vascular myelopathies
G99.2	Myelopathy in diseases classified elsewhere
I69.041	Monoplegia of lower limb following nontraumatic subarachnoid hemorrhage affecting right dominant side
I69.042	Monoplegia of lower limb following nontraumatic subarachnoid hemorrhage affecting left dominant side
I69.043	Monoplegia of lower limb following nontraumatic subarachnoid hemorrhage affecting right non-dominant side
I69.044	Monoplegia of lower limb following nontraumatic subarachnoid hemorrhage affecting left non-dominant side
I69.049	Monoplegia of lower limb following nontraumatic subarachnoid hemorrhage affecting unspecified side
I69.051	Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting right dominant side
I69.052	Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting left dominant side
I69.053	Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting right non-dominant side
I69.054	Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting left non-dominant side
I69.059	Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting unspecified side
I69.141	Monoplegia of lower limb following nontraumatic intracerebral hemorrhage affecting right dominant side
I69.142	Monoplegia of lower limb following nontraumatic intracerebral hemorrhage affecting left dominant side
I69.143	Monoplegia of lower limb following nontraumatic intracerebral hemorrhage affecting right non-dominant side
I69.144	Monoplegia of lower limb following nontraumatic intracerebral hemorrhage affecting left non-dominant side
I69.149	Monoplegia of lower limb following nontraumatic intracerebral hemorrhage affecting unspecified side
I69.151	Hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting right dominant side
I69.152	Hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting left dominant side

ICD-10-CM Code	Description
I69.153	Hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting right non-dominant side
I69.154	Hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting left non-dominant side
I69.159	Hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting unspecified side
I69.241	Monoplegia of lower limb following other nontraumatic intracranial hemorrhage affecting right dominant side
I69.242	Monoplegia of lower limb following other nontraumatic intracranial hemorrhage affecting left dominant side
I69.243	Monoplegia of lower limb following other nontraumatic intracranial hemorrhage affecting right non-dominant side
I69.244	Monoplegia of lower limb following other nontraumatic intracranial hemorrhage affecting left non-dominant side
I69.249	Monoplegia of lower limb following other nontraumatic intracranial hemorrhage affecting unspecified side
I69.251	Hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting right dominant side
I69.252	Hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting left dominant side
I69.253	Hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting right non-dominant side
I69.254	Hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting left non-dominant side
I69.259	Hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting unspecified side
I69.341	Monoplegia of lower limb following cerebral infarction affecting right dominant side
I69.342	Monoplegia of lower limb following cerebral infarction affecting left dominant side
I69.343	Monoplegia of lower limb following cerebral infarction affecting right non-dominant side
I69.344	Monoplegia of lower limb following cerebral infarction affecting left non-dominant side
I69.349	Monoplegia of lower limb following cerebral infarction affecting unspecified side
I69.351	Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side
I69.352	Hemiplegia and hemiparesis following cerebral infarction affecting left dominant side
I69.353	Hemiplegia and hemiparesis following cerebral infarction affecting right non-dominant side

ICD-10-CM Code	Description
I69.354	Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side
I69.359	Hemiplegia and hemiparesis following cerebral infarction affecting unspecified side
I69.841	Monoplegia of lower limb following other cerebrovascular disease affecting right dominant side
I69.842	Monoplegia of lower limb following other cerebrovascular disease affecting left dominant side
I69.843	Monoplegia of lower limb following other cerebrovascular disease affecting right non-dominant side
I69.844	Monoplegia of lower limb following other cerebrovascular disease affecting left non-dominant side
I69.849	Monoplegia of lower limb following other cerebrovascular disease affecting unspecified side
I69.851	Hemiplegia and hemiparesis following other cerebrovascular disease affecting right dominant side
I69.852	Hemiplegia and hemiparesis following other cerebrovascular disease affecting left dominant side
I69.853	Hemiplegia and hemiparesis following other cerebrovascular disease affecting right non-dominant side
I69.854	Hemiplegia and hemiparesis following other cerebrovascular disease affecting left non-dominant side
I69.859	Hemiplegia and hemiparesis following other cerebrovascular disease affecting unspecified side
I69.941	Monoplegia of lower limb following unspecified cerebrovascular disease affecting right dominant side
I69.942	Monoplegia of lower limb following unspecified cerebrovascular disease affecting left dominant side
I69.943	Monoplegia of lower limb following unspecified cerebrovascular disease affecting right non-dominant side
I69.944	Monoplegia of lower limb following unspecified cerebrovascular disease affecting left non-dominant side
I69.949	Monoplegia of lower limb following unspecified cerebrovascular disease affecting unspecified side
I69.951	Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side
I69.952	Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left dominant side
I69.953	Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right non-dominant side
I69.954	Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side

ICD-10-CM Code	Description
I69.959	Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting unspecified side
Q05.0	Cervical spina bifida with hydrocephalus
Q05.1	Thoracic spina bifida with hydrocephalus
Q05.2	Lumbar spina bifida with hydrocephalus
Q05.3	Sacral spina bifida with hydrocephalus
Q05.4	Unspecified spina bifida with hydrocephalus
Q05.5	Cervical spina bifida without hydrocephalus
Q05.6	Thoracic spina bifida without hydrocephalus
Q05.7	Lumbar spina bifida without hydrocephalus
Q05.8	Sacral spina bifida without hydrocephalus
Q05.9	Spina bifida, unspecified
Q07.00	Arnold-Chiari syndrome without spina bifida or hydrocephalus
Q07.01	Arnold-Chiari syndrome with spina bifida
Q07.02	Arnold-Chiari syndrome with hydrocephalus
Q07.03	Arnold-Chiari syndrome with spina bifida and hydrocephalus
Q78.0	Osteogenesis imperfecta
S78.011A	Complete traumatic amputation at right hip joint, initial encounter
S78.011D	Complete traumatic amputation at right hip joint, subsequent encounter
S78.011S	Complete traumatic amputation at right hip joint, sequela
S78.012A	Complete traumatic amputation at left hip joint, initial encounter
S78.012D	Complete traumatic amputation at left hip joint, subsequent encounter
S78.012S	Complete traumatic amputation at left hip joint, sequela
S78.019A	Complete traumatic amputation at unspecified hip joint, initial encounter
S78.019D	Complete traumatic amputation at unspecified hip joint, subsequent encounter
S78.019S	Complete traumatic amputation at unspecified hip joint, sequela
S78.021A	Partial traumatic amputation at right hip joint, initial encounter
S78.021D	Partial traumatic amputation at right hip joint, subsequent encounter
S78.021S	Partial traumatic amputation at right hip joint, sequela
S78.022A	Partial traumatic amputation at left hip joint, initial encounter
S78.022D	Partial traumatic amputation at left hip joint, subsequent encounter
S78.022S	Partial traumatic amputation at left hip joint, sequela
S78.029A	Partial traumatic amputation at unspecified hip joint, initial encounter
S78.029D	Partial traumatic amputation at unspecified hip joint, subsequent encounter
S78.029S	Partial traumatic amputation at unspecified hip joint, sequela
S78.111A	Complete traumatic amputation at level between right hip and knee, initial encounter
S78.111D	Complete traumatic amputation at level between right hip and knee, subsequent encounter
S78.111S	Complete traumatic amputation at level between right hip and knee, sequela
S78.112A	Complete traumatic amputation at level between left hip and knee, initial encounter

ICD-10-CM Code	Description
S78.112D	Complete traumatic amputation at level between left hip and knee, subsequent encounter
S78.112S	Complete traumatic amputation at level between left hip and knee, sequela
S78.119A	Complete traumatic amputation at level between unspecified hip and knee, initial encounter
S78.119D	Complete traumatic amputation at level between unspecified hip and knee, subsequent encounter
S78.119S	Complete traumatic amputation at level between unspecified hip and knee, sequela
S78.121A	Partial traumatic amputation at level between right hip and knee, initial encounter
S78.121D	Partial traumatic amputation at level between right hip and knee, subsequent encounter
S78.121S	Partial traumatic amputation at level between right hip and knee, sequela
S78.122A	Partial traumatic amputation at level between left hip and knee, initial encounter
S78.122D	Partial traumatic amputation at level between left hip and knee, subsequent encounter
S78.122S	Partial traumatic amputation at level between left hip and knee, sequela
S78.129A	Partial traumatic amputation at level between unspecified hip and knee, initial encounter
S78.129D	Partial traumatic amputation at level between unspecified hip and knee, subsequent encounter
S78.129S	Partial traumatic amputation at level between unspecified hip and knee, sequela
S78.911A	Complete traumatic amputation of right hip and thigh, level unspecified, initial encounter
S78.911D	Complete traumatic amputation of right hip and thigh, level unspecified, subsequent encounter
S78.911S	Complete traumatic amputation of right hip and thigh, level unspecified, sequela
S78.912A	Complete traumatic amputation of left hip and thigh, level unspecified, initial encounter
S78.912D	Complete traumatic amputation of left hip and thigh, level unspecified, subsequent encounter
S78.912S	Complete traumatic amputation of left hip and thigh, level unspecified, sequela
S78.919A	Complete traumatic amputation of unspecified hip and thigh, level unspecified, initial encounter
S78.919D	Complete traumatic amputation of unspecified hip and thigh, level unspecified, subsequent encounter
S78.919S	Complete traumatic amputation of unspecified hip and thigh, level unspecified, sequela
S78.921A	Partial traumatic amputation of right hip and thigh, level unspecified, initial encounter

ICD-10-CM Code	Description
S78.921D	Partial traumatic amputation of right hip and thigh, level unspecified, subsequent encounter
S78.921S	Partial traumatic amputation of right hip and thigh, level unspecified, sequela
S78.922A	Partial traumatic amputation of left hip and thigh, level unspecified, initial encounter
S78.922D	Partial traumatic amputation of left hip and thigh, level unspecified, subsequent encounter
S78.922S	Partial traumatic amputation of left hip and thigh, level unspecified, sequela
S78.929A	Partial traumatic amputation of unspecified hip and thigh, level unspecified, initial encounter
S78.929D	Partial traumatic amputation of unspecified hip and thigh, level unspecified, subsequent encounter
S78.929S	Partial traumatic amputation of unspecified hip and thigh, level unspecified, sequela
S88.011A	Complete traumatic amputation at knee level, right lower leg, initial encounter
S88.011D	Complete traumatic amputation at knee level, right lower leg, subsequent encounter
S88.011S	Complete traumatic amputation at knee level, right lower leg, sequela
S88.012A	Complete traumatic amputation at knee level, left lower leg, initial encounter
S88.012D	Complete traumatic amputation at knee level, left lower leg, subsequent encounter
S88.012S	Complete traumatic amputation at knee level, left lower leg, sequela
S88.019A	Complete traumatic amputation at knee level, unspecified lower leg, initial encounter
S88.019D	Complete traumatic amputation at knee level, unspecified lower leg, subsequent encounter
S88.019S	Complete traumatic amputation at knee level, unspecified lower leg, sequela
S88.021A	Partial traumatic amputation at knee level, right lower leg, initial encounter
S88.021D	Partial traumatic amputation at knee level, right lower leg, subsequent encounter
S88.021S	Partial traumatic amputation at knee level, right lower leg, sequela
S88.022A	Partial traumatic amputation at knee level, left lower leg, initial encounter
S88.022D	Partial traumatic amputation at knee level, left lower leg, subsequent encounter
S88.022S	Partial traumatic amputation at knee level, left lower leg, sequela
S88.029A	Partial traumatic amputation at knee level, unspecified lower leg, initial encounter
S88.029D	Partial traumatic amputation at knee level, unspecified lower leg, subsequent encounter
S88.029S	Partial traumatic amputation at knee level, unspecified lower leg, sequela
S88.911A	Complete traumatic amputation of right lower leg, level unspecified, initial encounter

ICD-10-CM Code	Description
S88.911D	Complete traumatic amputation of right lower leg, level unspecified, subsequent encounter
S88.911S	Complete traumatic amputation of right lower leg, level unspecified, sequela
S88.912A	Complete traumatic amputation of left lower leg, level unspecified, initial encounter
S88.912D	Complete traumatic amputation of left lower leg, level unspecified, subsequent encounter
S88.912S	Complete traumatic amputation of left lower leg, level unspecified, sequela
S88.919A	Complete traumatic amputation of unspecified lower leg, level unspecified, initial encounter
S88.919D	Complete traumatic amputation of unspecified lower leg, level unspecified, subsequent encounter
S88.919S	Complete traumatic amputation of unspecified lower leg, level unspecified, sequela
S88.921A	Partial traumatic amputation of right lower leg, level unspecified, initial encounter
S88.921D	Partial traumatic amputation of right lower leg, level unspecified, subsequent encounter
S88.921S	Partial traumatic amputation of right lower leg, level unspecified, sequela
S88.922A	Partial traumatic amputation of left lower leg, level unspecified, initial encounter
S88.922D	Partial traumatic amputation of left lower leg, level unspecified, subsequent encounter
S88.922S	Partial traumatic amputation of left lower leg, level unspecified, sequela
S88.929A	Partial traumatic amputation of unspecified lower leg, level unspecified, initial encounter
S88.929D	Partial traumatic amputation of unspecified lower leg, level unspecified, subsequent encounter
S88.929S	Partial traumatic amputation of unspecified lower leg, level unspecified, sequela
Z89.511	Acquired absence of right leg below knee
Z89.512	Acquired absence of left leg below knee
Z89.519	Acquired absence of unspecified leg below knee
Z89.611	Acquired absence of right leg above knee
Z89.612	Acquired absence of left leg above knee
Z89.619	Acquired absence of unspecified leg above knee
Z89.621	Acquired absence of right hip joint
Z89.622	Acquired absence of left hip joint
Z89.629	Acquired absence of unspecified hip joint

ICD-10-CM Diagnosis Codes That Support Medical Necessity

CLINICAL POLICY
Wheelchair Seating

The following is a list of diagnosis codes that support medical necessity for procedure code(s) E2607, E2608, E2624, E2625.

ICD-10-CM Code	Description
B91	Sequelae of poliomyelitis
E75.00	GM2 gangliosidosis, unspecified
E75.01	Sandhoff disease
E75.02	Tay-Sachs disease
E75.09	Other GM2 gangliosidosis
E75.10	Unspecified gangliosidosis
E75.11	Mucolipidosis IV
E75.19	Other gangliosidosis
E75.23	Krabbe disease
E75.25	Metachromatic leukodystrophy
E75.29	Other sphingolipidosis
E75.4	Neuronal ceroid lipofuscinosis
F84.2	Rett's syndrome
G04.1	Tropical spastic paraplegia
G04.89	Other myelitis
G10	Huntington's disease
G11.0	Congenital nonprogressive ataxia
G11.1	Early-onset cerebellar ataxia
G11.2	Late-onset cerebellar ataxia
G11.3	Cerebellar ataxia with defective DNA repair
G11.4	Hereditary spastic paraplegia
G11.8	Other hereditary ataxias
G11.9	Hereditary ataxia, unspecified
G12.0	Infantile spinal muscular atrophy, type I [Werdnig-Hoffman]
G12.1	Other inherited spinal muscular atrophy
G12.20	Motor neuron disease, unspecified
G12.21	Amyotrophic lateral sclerosis
G12.23	Primary lateral sclerosis
G12.24	Familial motor neuron disease
G12.25	Progressive spinal muscle atrophy
G12.29	Other motor neuron disease
G12.8	Other spinal muscular atrophies and related syndromes
G12.9	Spinal muscular atrophy, unspecified
G14	Postpolio syndrome
G20	Parkinson's disease
G21.4	Vascular parkinsonism
G24.1	Genetic torsion dystonia
G30.0	Alzheimer's disease with early onset
G30.1	Alzheimer's disease with late onset
G30.8	Other Alzheimer's disease
G30.9	Alzheimer's disease, unspecified

ICD-10-CM Code	Description
G31.81	Alpers disease
G31.82	Leigh's disease
G32.0	Subacute combined degeneration of spinal cord in diseases classified elsewhere
G32.81	Cerebellar ataxia in diseases classified elsewhere
G32.89	Other specified degenerative disorders of nervous system in diseases classified elsewhere
G35	Multiple sclerosis
G36.0	Neuromyelitis optica [Devic]
G36.1	Acute and subacute hemorrhagic leukoencephalitis [Hurst]
G36.8	Other specified acute disseminated demyelination
G36.9	Acute disseminated demyelination, unspecified
G37.0	Diffuse sclerosis of central nervous system
G37.1	Central demyelination of corpus callosum
G37.2	Central pontine myelinolysis
G37.3	Acute transverse myelitis in demyelinating disease of central nervous system
G37.4	Subacute necrotizing myelitis of central nervous system
G37.5	Concentric sclerosis [Balo] of central nervous system
G37.8	Other specified demyelinating diseases of central nervous system
G37.9	Demyelinating disease of central nervous system, unspecified
G71.0	Muscular dystrophy
G71.2	Congenital myopathies
G80.0	Spastic quadriplegic cerebral palsy
G80.1	Spastic diplegic cerebral palsy
G80.2	Spastic hemiplegic cerebral palsy
G80.3	Athetoid cerebral palsy
G80.4	Ataxic cerebral palsy
G80.8	Other cerebral palsy
G80.9	Cerebral palsy, unspecified
G81.00	Flaccid hemiplegia affecting unspecified side
G81.01	Flaccid hemiplegia affecting right dominant side
G81.02	Flaccid hemiplegia affecting left dominant side
G81.03	Flaccid hemiplegia affecting right nondominant side
G81.04	Flaccid hemiplegia affecting left nondominant side
G81.10	Spastic hemiplegia affecting unspecified side
G81.11	Spastic hemiplegia affecting right dominant side
G81.12	Spastic hemiplegia affecting left dominant side
G81.13	Spastic hemiplegia affecting right nondominant side
G81.14	Spastic hemiplegia affecting left nondominant side
G81.90	Hemiplegia, unspecified affecting unspecified side
G81.91	Hemiplegia, unspecified affecting right dominant side
G81.92	Hemiplegia, unspecified affecting left dominant side

ICD-10-CM Code	Description
G81.93	Hemiplegia, unspecified affecting right nondominant side
G81.94	Hemiplegia, unspecified affecting left nondominant side
G82.20	Paraplegia, unspecified
G82.21	Paraplegia, complete
G82.22	Paraplegia, incomplete
G82.50	Quadriplegia, unspecified
G82.51	Quadriplegia, C1-C4 complete
G82.52	Quadriplegia, C1-C4 incomplete
G82.53	Quadriplegia, C5-C7 complete
G82.54	Quadriplegia, C5-C7 incomplete
G93.89	Other specified disorders of brain
G93.9	Disorder of brain, unspecified
G94	Other disorders of brain in diseases classified elsewhere
G95.0	Syringomyelia and syringobulbia
G95.11	Acute infarction of spinal cord (embolic) (nonembolic)
G95.19	Other vascular myelopathies
G99.2	Myelopathy in diseases classified elsewhere
I69.051	Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting right dominant side
I69.052	Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting left dominant side
I69.053	Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting right non-dominant side
I69.054	Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting left non-dominant side
I69.059	Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting unspecified side
I69.151	Hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting right dominant side
I69.152	Hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting left dominant side
I69.153	Hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting right non-dominant side
I69.154	Hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting left non-dominant side
I69.159	Hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting unspecified side
I69.251	Hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting right dominant side
I69.252	Hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting left dominant side
I69.253	Hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting right non-dominant side

ICD-10-CM Code	Description
I69.254	Hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting left non-dominant side
I69.259	Hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting unspecified side
I69.351	Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side
I69.352	Hemiplegia and hemiparesis following cerebral infarction affecting left dominant side
I69.353	Hemiplegia and hemiparesis following cerebral infarction affecting right non-dominant side
I69.354	Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side
I69.359	Hemiplegia and hemiparesis following cerebral infarction affecting unspecified side
I69.851	Hemiplegia and hemiparesis following other cerebrovascular disease affecting right dominant side
I69.852	Hemiplegia and hemiparesis following other cerebrovascular disease affecting left dominant side
I69.853	Hemiplegia and hemiparesis following other cerebrovascular disease affecting right non-dominant side
I69.854	Hemiplegia and hemiparesis following other cerebrovascular disease affecting left non-dominant side
I69.859	Hemiplegia and hemiparesis following other cerebrovascular disease affecting unspecified side
I69.951	Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side
I69.952	Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left dominant side
I69.953	Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right non-dominant side
I69.954	Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side
I69.959	Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting unspecified side
M62.3	Immobility syndrome (paraplegic)
M62.89	Other specified disorders of muscle
Q05.0	Cervical spina bifida with hydrocephalus
Q05.1	Thoracic spina bifida with hydrocephalus
Q05.2	Lumbar spina bifida with hydrocephalus
Q05.3	Sacral spina bifida with hydrocephalus
Q05.4	Unspecified spina bifida with hydrocephalus
Q05.5	Cervical spina bifida without hydrocephalus
Q05.6	Thoracic spina bifida without hydrocephalus

ICD-10-CM Code	Description
Q05.7	Lumbar spina bifida without hydrocephalus
Q05.8	Sacral spina bifida without hydrocephalus
Q05.9	Spina bifida, unspecified
Q07.00	Arnold-Chiari syndrome without spina bifida or hydrocephalus
Q07.01	Arnold-Chiari syndrome with spina bifida
Q07.02	Arnold-Chiari syndrome with hydrocephalus
Q07.03	Arnold-Chiari syndrome with spina bifida and hydrocephalus
Q67.8	Other congenital deformities of chest
Q68.1	Congenital deformity of finger(s) and hand
Q74.3	Arthrogryposis multiplex congenita
Q78.0	Osteogenesis imperfecta

ICD-10-CM Diagnosis Codes That Support Medical Necessity

The following is a list of diagnosis codes that support medical necessity for procedure code(s) E2607, E2608, E2624, E2625 for patients with pressure ulcers, ICD-10-CM codes L89.130, L89.131, L89.132, L89.133, L89.134, L89.140, l89.141, L89.142, L89.143, L89.144, L89.150, L89.151, L89.152, L89.153, L89.154, , L89.200, L89.201, L89.202, L89.203, L89.204, L89.210, L89.211, L89.212, L89.213, L89.214, L89.220, L89.221, L89.222, L89.223, L89.224, L89.300, L89.301, L89.302, L89.303, L89.304, L89.310, L89.311, L89.312, L89.313, L89.314, L89.320, L89.321, L89.322, L89.323, L89.324, L89.41, L89.42, L89.43, L89.44, L89.45. The applicable diagnosis code for pressure ulcer must be billed with one of the codes below

ICD-10-CM Code	Description
G83.10	Monoplegia of lower limb affecting unspecified side
G83.11	Monoplegia of lower limb affecting right dominant side
G83.12	Monoplegia of lower limb affecting left dominant side
G83.13	Monoplegia of lower limb affecting right nondominant side
G83.14	Monoplegia of lower limb affecting left nondominant side
I69.041	Monoplegia of lower limb following nontraumatic subarachnoid hemorrhage affecting right dominant side
I69.042	Monoplegia of lower limb following nontraumatic subarachnoid hemorrhage affecting left dominant side
I69.043	Monoplegia of lower limb following nontraumatic subarachnoid hemorrhage affecting right non-dominant side
I69.044	Monoplegia of lower limb following nontraumatic subarachnoid hemorrhage affecting left non-dominant side
I69.049	Monoplegia of lower limb following nontraumatic subarachnoid hemorrhage affecting unspecified side
I69.141	Monoplegia of lower limb following nontraumatic intracerebral hemorrhage affecting right dominant side

ICD-10-CM Code	Description
I69.142	Monoplegia of lower limb following nontraumatic intracerebral hemorrhage affecting left dominant side
I69.143	Monoplegia of lower limb following nontraumatic intracerebral hemorrhage affecting right non-dominant side
I69.144	Monoplegia of lower limb following nontraumatic intracerebral hemorrhage affecting left non-dominant side
I69.149	Monoplegia of lower limb following nontraumatic intracerebral hemorrhage affecting unspecified side
I69.241	Monoplegia of lower limb following other nontraumatic intracranial hemorrhage affecting right dominant side
I69.242	Monoplegia of lower limb following other nontraumatic intracranial hemorrhage affecting left dominant side
I69.243	Monoplegia of lower limb following other nontraumatic intracranial hemorrhage affecting right non-dominant side
I69.244	Monoplegia of lower limb following other nontraumatic intracranial hemorrhage affecting left non-dominant side
I69.249	Monoplegia of lower limb following other nontraumatic intracranial hemorrhage affecting unspecified side
I69.341	Monoplegia of lower limb following cerebral infarction affecting right dominant side
I69.342	Monoplegia of lower limb following cerebral infarction affecting left dominant side
I69.343	Monoplegia of lower limb following cerebral infarction affecting right non-dominant side
I69.344	Monoplegia of lower limb following cerebral infarction affecting left non-dominant side
I69.349	Monoplegia of lower limb following cerebral infarction affecting unspecified side
I69.841	Monoplegia of lower limb following other cerebrovascular disease affecting right dominant side
I69.842	Monoplegia of lower limb following other cerebrovascular disease affecting left dominant side
I69.843	Monoplegia of lower limb following other cerebrovascular disease affecting right non-dominant side
I69.844	Monoplegia of lower limb following other cerebrovascular disease affecting left non-dominant side
I69.849	Monoplegia of lower limb following other cerebrovascular disease affecting unspecified side
I69.941	Monoplegia of lower limb following unspecified cerebrovascular disease affecting right dominant side
I69.942	Monoplegia of lower limb following unspecified cerebrovascular disease affecting left dominant side

ICD-10-CM Code	Description
I69.943	Monoplegia of lower limb following unspecified cerebrovascular disease affecting right non-dominant side
I69.944	Monoplegia of lower limb following unspecified cerebrovascular disease affecting left non-dominant side
I69.949	Monoplegia of lower limb following unspecified cerebrovascular disease affecting unspecified side
Q78.0	Osteogenesis imperfecta
S78.011A	Complete traumatic amputation at right hip joint, initial encounter
S78.011D	Complete traumatic amputation at right hip joint, subsequent encounter
S78.011S	Complete traumatic amputation at right hip joint, sequela
S78.012A	Complete traumatic amputation at left hip joint, initial encounter
S78.012D	Complete traumatic amputation at left hip joint, subsequent encounter
S78.012S	Complete traumatic amputation at left hip joint, sequela
S78.019A	Complete traumatic amputation at unspecified hip joint, initial encounter
S78.019D	Complete traumatic amputation at unspecified hip joint, subsequent encounter
S78.019S	Complete traumatic amputation at unspecified hip joint, sequela
S78.021A	Partial traumatic amputation at right hip joint, initial encounter
S78.021D	Partial traumatic amputation at right hip joint, subsequent encounter
S78.021S	Partial traumatic amputation at right hip joint, sequela
S78.022A	Partial traumatic amputation at left hip joint, initial encounter
S78.022D	Partial traumatic amputation at left hip joint, subsequent encounter
S78.022S	Partial traumatic amputation at left hip joint, sequela
S78.029A	Partial traumatic amputation at unspecified hip joint, initial encounter
S78.029D	Partial traumatic amputation at unspecified hip joint, subsequent encounter
S78.029S	Partial traumatic amputation at unspecified hip joint, sequela
S78.111A	Complete traumatic amputation at level between right hip and knee, initial encounter
S78.111D	Complete traumatic amputation at level between right hip and knee, subsequent encounter
S78.111S	Complete traumatic amputation at level between right hip and knee, sequela
S78.112A	Complete traumatic amputation at level between left hip and knee, initial encounter
S78.112D	Complete traumatic amputation at level between left hip and knee, subsequent encounter
S78.112S	Complete traumatic amputation at level between left hip and knee, sequela
S78.119A	Complete traumatic amputation at level between unspecified hip and knee, initial encounter
S78.119D	Complete traumatic amputation at level between unspecified hip and knee, subsequent encounter
S78.119S	Complete traumatic amputation at level between unspecified hip and knee, sequela

ICD-10-CM Code	Description
S78.121A	Partial traumatic amputation at level between right hip and knee, initial encounter
S78.121D	Partial traumatic amputation at level between right hip and knee, subsequent encounter
S78.121S	Partial traumatic amputation at level between right hip and knee, sequela
S78.122A	Partial traumatic amputation at level between left hip and knee, initial encounter
S78.122D	Partial traumatic amputation at level between left hip and knee, subsequent encounter
S78.122S	Partial traumatic amputation at level between left hip and knee, sequela
S78.129A	Partial traumatic amputation at level between unspecified hip and knee, initial encounter
S78.129D	Partial traumatic amputation at level between unspecified hip and knee, subsequent encounter
S78.129S	Partial traumatic amputation at level between unspecified hip and knee, sequela
S78.911A	Complete traumatic amputation of right hip and thigh, level unspecified, initial encounter
S78.911D	Complete traumatic amputation of right hip and thigh, level unspecified, subsequent encounter
S78.911S	Complete traumatic amputation of right hip and thigh, level unspecified, sequela
S78.912A	Complete traumatic amputation of left hip and thigh, level unspecified, initial encounter
S78.912D	Complete traumatic amputation of left hip and thigh, level unspecified, subsequent encounter
S78.912S	Complete traumatic amputation of left hip and thigh, level unspecified, sequela
S78.919A	Complete traumatic amputation of unspecified hip and thigh, level unspecified, initial encounter
S78.919D	Complete traumatic amputation of unspecified hip and thigh, level unspecified, subsequent encounter
S78.919S	Complete traumatic amputation of unspecified hip and thigh, level unspecified, sequela
S78.921A	Partial traumatic amputation of right hip and thigh, level unspecified, initial encounter
S78.921D	Partial traumatic amputation of right hip and thigh, level unspecified, subsequent encounter
S78.921S	Partial traumatic amputation of right hip and thigh, level unspecified, sequela
S78.922A	Partial traumatic amputation of left hip and thigh, level unspecified, initial encounter
S78.922D	Partial traumatic amputation of left hip and thigh, level unspecified, subsequent encounter
S78.922S	Partial traumatic amputation of left hip and thigh, level unspecified, sequela

ICD-10-CM Code	Description
S78.929A	Partial traumatic amputation of unspecified hip and thigh, level unspecified, initial encounter
S78.929D	Partial traumatic amputation of unspecified hip and thigh, level unspecified, subsequent encounter
S78.929S	Partial traumatic amputation of unspecified hip and thigh, level unspecified, sequela
S88.011A	Complete traumatic amputation at knee level, right lower leg, initial encounter
S88.011D	Complete traumatic amputation at knee level, right lower leg, subsequent encounter
S88.011S	Complete traumatic amputation at knee level, right lower leg, sequela
S88.012A	Complete traumatic amputation at knee level, left lower leg, initial encounter
S88.012D	Complete traumatic amputation at knee level, left lower leg, subsequent encounter
S88.012S	Complete traumatic amputation at knee level, left lower leg, sequela
S88.019A	Complete traumatic amputation at knee level, unspecified lower leg, initial encounter
S88.019D	Complete traumatic amputation at knee level, unspecified lower leg, subsequent encounter
S88.019S	Complete traumatic amputation at knee level, unspecified lower leg, sequela
S88.021A	Partial traumatic amputation at knee level, right lower leg, initial encounter
S88.021D	Partial traumatic amputation at knee level, right lower leg, subsequent encounter
S88.021S	Partial traumatic amputation at knee level, right lower leg, sequela
S88.022A	Partial traumatic amputation at knee level, left lower leg, initial encounter
S88.022D	Partial traumatic amputation at knee level, left lower leg, subsequent encounter
S88.022S	Partial traumatic amputation at knee level, left lower leg, sequela
S88.029A	Partial traumatic amputation at knee level, unspecified lower leg, initial encounter
S88.029D	Partial traumatic amputation at knee level, unspecified lower leg, subsequent encounter
S88.029S	Partial traumatic amputation at knee level, unspecified lower leg, sequela
S88.911A	Complete traumatic amputation of right lower leg, level unspecified, initial encounter
S88.911D	Complete traumatic amputation of right lower leg, level unspecified, subsequent encounter
S88.911S	Complete traumatic amputation of right lower leg, level unspecified, sequela
S88.912A	Complete traumatic amputation of left lower leg, level unspecified, initial encounter
S88.912D	Complete traumatic amputation of left lower leg, level unspecified, subsequent encounter
S88.912S	Complete traumatic amputation of left lower leg, level unspecified, sequela

ICD-10-CM Code	Description
S88.919A	Complete traumatic amputation of unspecified lower leg, level unspecified, initial encounter
S88.919D	Complete traumatic amputation of unspecified lower leg, level unspecified, subsequent encounter
S88.919S	Complete traumatic amputation of unspecified lower leg, level unspecified, sequela
S88.921A	Partial traumatic amputation of right lower leg, level unspecified, initial encounter
S88.921D	Partial traumatic amputation of right lower leg, level unspecified, subsequent encounter
S88.921S	Partial traumatic amputation of right lower leg, level unspecified, sequela
S88.922A	Partial traumatic amputation of left lower leg, level unspecified, initial encounter
S88.922D	Partial traumatic amputation of left lower leg, level unspecified, subsequent encounter
S88.922S	Partial traumatic amputation of left lower leg, level unspecified, sequela
S88.929A	Partial traumatic amputation of unspecified lower leg, level unspecified, initial encounter
S88.929D	Partial traumatic amputation of unspecified lower leg, level unspecified, subsequent encounter
S88.929S	Partial traumatic amputation of unspecified lower leg, level unspecified, sequela
Z89.511	Acquired absence of right leg below knee
Z89.512	Acquired absence of left leg below knee
Z89.519	Acquired absence of unspecified leg below knee
Z89.611	Acquired absence of right leg above knee
Z89.612	Acquired absence of left leg above knee
Z89.619	Acquired absence of unspecified leg above knee
Z89.621	Acquired absence of right hip joint
Z89.622	Acquired absence of left hip joint
Z89.629	Acquired absence of unspecified hip joint

ICD-10-CM Diagnosis Codes That Support Medical Necessity

The following is a list of diagnosis codes that support medical necessity for procedure code E2609.

ICD-10-CM Code	Description
B91	Sequelae of poliomyelitis
E75.00	GM2 gangliosidosis, unspecified
E75.01	Sandhoff disease
E75.02	Tay-Sachs disease

ICD-10-CM Code	Description
E75.09	Other GM2 gangliosidosis
E75.10	Unspecified gangliosidosis
E75.11	Mucolipidosis IV
E75.19	Other gangliosidosis
E75.23	Krabbe disease
E75.25	Metachromatic leukodystrophy
E75.29	Other sphingolipidosis
E75.4	Neuronal ceroid lipofuscinosis
F84.2	Rett's syndrome
G04.1	Tropical spastic paraplegia
G04.89	Other myelitis
G10	Huntington's disease
G11.0	Congenital nonprogressive ataxia
G11.1	Early-onset cerebellar ataxia
G11.2	Late-onset cerebellar ataxia
G11.3	Cerebellar ataxia with defective DNA repair
G11.4	Hereditary spastic paraplegia
G11.8	Other hereditary ataxias
G11.9	Hereditary ataxia, unspecified
G12.0	Infantile spinal muscular atrophy, type I [Werdnig-Hoffman]
G12.1	Other inherited spinal muscular atrophy
G12.20	Motor neuron disease, unspecified
G12.21	Amyotrophic lateral sclerosis
G12.23	Primary lateral sclerosis
G12.24	Familial motor neuron disease
G12.25	Progressive spinal muscle atrophy
G12.29	Other motor neuron disease
G12.8	Other spinal muscular atrophies and related syndromes
G12.9	Spinal muscular atrophy, unspecified
G14	Postpolio syndrome
G20	Parkinson's disease
G21.4	Vascular parkinsonism
G24.1	Genetic torsion dystonia
G30.0	Alzheimer's disease with early onset
G30.1	Alzheimer's disease with late onset
G30.8	Other Alzheimer's disease
G30.9	Alzheimer's disease, unspecified
G31.81	Alpers disease
G31.82	Leigh's disease
G32.0	Subacute combined degeneration of spinal cord in diseases classified elsewhere
G32.81	Cerebellar ataxia in diseases classified elsewhere

ICD-10-CM Code	Description
G32.89	Other specified degenerative disorders of nervous system in diseases classified elsewhere
G35	Multiple sclerosis
G36.0	Neuromyelitis optica [Devic]
G36.1	Acute and subacute hemorrhagic leukoencephalitis [Hurst]
G36.8	Other specified acute disseminated demyelination
G36.9	Acute disseminated demyelination, unspecified
G37.0	Diffuse sclerosis of central nervous system
G37.1	Central demyelination of corpus callosum
G37.2	Central pontine myelinolysis
G37.3	Acute transverse myelitis in demyelinating disease of central nervous system
G37.4	Subacute necrotizing myelitis of central nervous system
G37.5	Concentric sclerosis [Balo] of central nervous system
G37.8	Other specified demyelinating diseases of central nervous system
G37.9	Demyelinating disease of central nervous system, unspecified
G71.0	Muscular dystrophy
G71.2	Congenital myopathies
G80.0	Spastic quadriplegic cerebral palsy
G80.1	Spastic diplegic cerebral palsy
G80.2	Spastic hemiplegic cerebral palsy
G80.3	Athetoid cerebral palsy
G80.4	Ataxic cerebral palsy
G80.8	Other cerebral palsy
G80.9	Cerebral palsy, unspecified
G81.00	Flaccid hemiplegia affecting unspecified side
G81.01	Flaccid hemiplegia affecting right dominant side
G81.02	Flaccid hemiplegia affecting left dominant side
G81.03	Flaccid hemiplegia affecting right nondominant side
G81.04	Flaccid hemiplegia affecting left nondominant side
G81.10	Spastic hemiplegia affecting unspecified side
G81.11	Spastic hemiplegia affecting right dominant side
G81.12	Spastic hemiplegia affecting left dominant side
G81.13	Spastic hemiplegia affecting right nondominant side
G81.14	Spastic hemiplegia affecting left nondominant side
G81.90	Hemiplegia, unspecified affecting unspecified side
G81.91	Hemiplegia, unspecified affecting right dominant side
G81.92	Hemiplegia, unspecified affecting left dominant side
G81.93	Hemiplegia, unspecified affecting right nondominant side
G81.94	Hemiplegia, unspecified affecting left nondominant side
G82.20	Paraplegia, unspecified
G82.21	Paraplegia, complete
G82.22	Paraplegia, incomplete

ICD-10-CM Code	Description
G82.50	Quadriplegia, unspecified
G82.51	Quadriplegia, C1-C4 complete
G82.52	Quadriplegia, C1-C4 incomplete
G82.53	Quadriplegia, C5-C7 complete
G82.54	Quadriplegia, C5-C7 incomplete
G83.10	Monoplegia of lower limb affecting unspecified side
G83.11	Monoplegia of lower limb affecting right dominant side
G83.12	Monoplegia of lower limb affecting left dominant side
G83.13	Monoplegia of lower limb affecting right nondominant side
G83.14	Monoplegia of lower limb affecting left nondominant side
G93.89	Other specified disorders of brain
G93.9	Disorder of brain, unspecified
G94	Other disorders of brain in diseases classified elsewhere
G95.0	Syringomyelia and syringobulbia
G95.11	Acute infarction of spinal cord (embolic) (nonembolic)
G95.19	Other vascular myelopathies
G99.2	Myelopathy in diseases classified elsewhere
I69.041	Monoplegia of lower limb following nontraumatic subarachnoid hemorrhage affecting right dominant side
I69.042	Monoplegia of lower limb following nontraumatic subarachnoid hemorrhage affecting left dominant side
I69.043	Monoplegia of lower limb following nontraumatic subarachnoid hemorrhage affecting right non-dominant side
I69.044	Monoplegia of lower limb following nontraumatic subarachnoid hemorrhage affecting left non-dominant side
I69.049	Monoplegia of lower limb following nontraumatic subarachnoid hemorrhage affecting unspecified side
I69.051	Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting right dominant side
I69.052	Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting left dominant side
I69.053	Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting right non-dominant side
I69.054	Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting left non-dominant side
I69.059	Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting unspecified side
I69.141	Monoplegia of lower limb following nontraumatic intracerebral hemorrhage affecting right dominant side
I69.142	Monoplegia of lower limb following nontraumatic intracerebral hemorrhage affecting left dominant side

ICD-10-CM Code	Description
I69.143	Monoplegia of lower limb following nontraumatic intracerebral hemorrhage affecting right non-dominant side
I69.144	Monoplegia of lower limb following nontraumatic intracerebral hemorrhage affecting left non-dominant side
I69.149	Monoplegia of lower limb following nontraumatic intracerebral hemorrhage affecting unspecified side
I69.151	Hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting right dominant side
I69.152	Hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting left dominant side
I69.153	Hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting right non-dominant side
I69.154	Hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting left non-dominant side
I69.159	Hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting unspecified side
I69.241	Monoplegia of lower limb following other nontraumatic intracranial hemorrhage affecting right dominant side
I69.242	Monoplegia of lower limb following other nontraumatic intracranial hemorrhage affecting left dominant side
I69.243	Monoplegia of lower limb following other nontraumatic intracranial hemorrhage affecting right non-dominant side
I69.244	Monoplegia of lower limb following other nontraumatic intracranial hemorrhage affecting left non-dominant side
I69.249	Monoplegia of lower limb following other nontraumatic intracranial hemorrhage affecting unspecified side
I69.251	Hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting right dominant side
I69.252	Hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting left dominant side
I69.253	Hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting right non-dominant side
I69.254	Hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting left non-dominant side
I69.259	Hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting unspecified side
I69.341	Monoplegia of lower limb following cerebral infarction affecting right dominant side
I69.342	Monoplegia of lower limb following cerebral infarction affecting left dominant side
I69.343	Monoplegia of lower limb following cerebral infarction affecting right non-dominant side

ICD-10-CM Code	Description
I69.344	Monoplegia of lower limb following cerebral infarction affecting left non-dominant side
I69.349	Monoplegia of lower limb following cerebral infarction affecting unspecified side
I69.351	Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side
I69.352	Hemiplegia and hemiparesis following cerebral infarction affecting left dominant side
I69.353	Hemiplegia and hemiparesis following cerebral infarction affecting right non-dominant side
I69.354	Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side
I69.359	Hemiplegia and hemiparesis following cerebral infarction affecting unspecified side
I69.841	Monoplegia of lower limb following other cerebrovascular disease affecting right dominant side
I69.842	Monoplegia of lower limb following other cerebrovascular disease affecting left dominant side
I69.843	Monoplegia of lower limb following other cerebrovascular disease affecting right non-dominant side
I69.844	Monoplegia of lower limb following other cerebrovascular disease affecting left non-dominant side
I69.849	Monoplegia of lower limb following other cerebrovascular disease affecting unspecified side
I69.851	Hemiplegia and hemiparesis following other cerebrovascular disease affecting right dominant side
I69.852	Hemiplegia and hemiparesis following other cerebrovascular disease affecting left dominant side
I69.853	Hemiplegia and hemiparesis following other cerebrovascular disease affecting right non-dominant side
I69.854	Hemiplegia and hemiparesis following other cerebrovascular disease affecting left non-dominant side
I69.859	Hemiplegia and hemiparesis following other cerebrovascular disease affecting unspecified side
I69.941	Monoplegia of lower limb following unspecified cerebrovascular disease affecting right dominant side
I69.942	Monoplegia of lower limb following unspecified cerebrovascular disease affecting left dominant side
I69.943	Monoplegia of lower limb following unspecified cerebrovascular disease affecting right non-dominant side
I69.944	Monoplegia of lower limb following unspecified cerebrovascular disease affecting left non-dominant side

ICD-10-CM Code	Description
I69.949	Monoplegia of lower limb following unspecified cerebrovascular disease affecting unspecified side
I69.951	Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side
I69.952	Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left dominant side
I69.953	Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right non-dominant side
I69.954	Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side
I69.959	Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting unspecified side
L89.130	Pressure ulcer of right lower back, unstageable
L89.131	Pressure ulcer of right lower back, stage 1
L89.132	Pressure ulcer of right lower back, stage 2
L89.133	Pressure ulcer of right lower back, stage 3
L89.134	Pressure ulcer of right lower back, stage 4
L89.140	Pressure ulcer of left lower back, unstageable
L89.141	Pressure ulcer of left lower back, stage 1
L89.142	Pressure ulcer of left lower back, stage 2
L89.143	Pressure ulcer of left lower back, stage 3
L89.144	Pressure ulcer of left lower back, stage 4
L89.150	Pressure ulcer of sacral region, unstageable
L89.151	Pressure ulcer of sacral region, stage 1
L89.152	Pressure ulcer of sacral region, stage 2
L89.153	Pressure ulcer of sacral region, stage 3
L89.154	Pressure ulcer of sacral region, stage 4
L89.200	Pressure ulcer of unspecified hip, unstageable
L89.201	Pressure ulcer of unspecified hip, stage 1
L89.202	Pressure ulcer of unspecified hip, stage 2
L89.203	Pressure ulcer of unspecified hip, stage 3
L89.204	Pressure ulcer of unspecified hip, stage 4
L89.210	Pressure ulcer of right hip, unstageable
L89.211	Pressure ulcer of right hip, stage 1
L89.212	Pressure ulcer of right hip, stage 2
L89.213	Pressure ulcer of right hip, stage 3
L89.214	Pressure ulcer of right hip, stage 4
L89.220	Pressure ulcer of left hip, unstageable
L89.221	Pressure ulcer of left hip, stage 1
L89.222	Pressure ulcer of left hip, stage 2
L89.223	Pressure ulcer of left hip, stage 3
L89.224	Pressure ulcer of left hip, stage 4

ICD-10-CM Code	Description
L89.300	Pressure ulcer of unspecified buttock, unstageable
L89.301	Pressure ulcer of unspecified buttock, stage 1
L89.302	Pressure ulcer of unspecified buttock, stage 2
L89.303	Pressure ulcer of unspecified buttock, stage 3
L89.304	Pressure ulcer of unspecified buttock, stage 4
L89.310	Pressure ulcer of right buttock, unstageable
L89.311	Pressure ulcer of right buttock, stage 1
L89.312	Pressure ulcer of right buttock, stage 2
L89.313	Pressure ulcer of right buttock, stage 3
L89.314	Pressure ulcer of right buttock, stage 4
L89.320	Pressure ulcer of left buttock, unstageable
L89.321	Pressure ulcer of left buttock, stage 1
L89.322	Pressure ulcer of left buttock, stage 2
L89.323	Pressure ulcer of left buttock, stage 3
L89.324	Pressure ulcer of left buttock, stage 4
L89.41	Pressure ulcer of contiguous site of back, buttock and hip, stage 1
L89.42	Pressure ulcer of contiguous site of back, buttock and hip, stage 2
L89.43	Pressure ulcer of contiguous site of back, buttock and hip, stage 3
L89.44	Pressure ulcer of contiguous site of back, buttock and hip, stage 4
L89.45	Pressure ulcer of contiguous site of back, buttock and hip, unstageable
Q05.0	Cervical spina bifida with hydrocephalus
Q05.1	Thoracic spina bifida with hydrocephalus
Q05.2	Lumbar spina bifida with hydrocephalus
Q05.3	Sacral spina bifida with hydrocephalus
Q05.4	Unspecified spina bifida with hydrocephalus
Q05.5	Cervical spina bifida without hydrocephalus
Q05.6	Thoracic spina bifida without hydrocephalus
Q05.7	Lumbar spina bifida without hydrocephalus
Q05.8	Sacral spina bifida without hydrocephalus
Q05.9	Spina bifida, unspecified
Q07.00	Arnold-Chiari syndrome without spina bifida or hydrocephalus
Q07.01	Arnold-Chiari syndrome with spina bifida
Q07.02	Arnold-Chiari syndrome with hydrocephalus
Q07.03	Arnold-Chiari syndrome with spina bifida and hydrocephalus
Q78.0	Osteogenesis imperfecta
S78.011A	Complete traumatic amputation at right hip joint, initial encounter
S78.011D	Complete traumatic amputation at right hip joint, subsequent encounter
S78.011S	Complete traumatic amputation at right hip joint, sequela
S78.012A	Complete traumatic amputation at left hip joint, initial encounter
S78.012D	Complete traumatic amputation at left hip joint, subsequent encounter
S78.012S	Complete traumatic amputation at left hip joint, sequela
S78.019A	Complete traumatic amputation at unspecified hip joint, initial encounter

ICD-10-CM Code	Description
S78.019D	Complete traumatic amputation at unspecified hip joint, subsequent encounter
S78.019S	Complete traumatic amputation at unspecified hip joint, sequela
S78.021A	Partial traumatic amputation at right hip joint, initial encounter
S78.021D	Partial traumatic amputation at right hip joint, subsequent encounter
S78.021S	Partial traumatic amputation at right hip joint, sequela
S78.022A	Partial traumatic amputation at left hip joint, initial encounter
S78.022D	Partial traumatic amputation at left hip joint, subsequent encounter
S78.022S	Partial traumatic amputation at left hip joint, sequela
S78.029A	Partial traumatic amputation at unspecified hip joint, initial encounter
S78.029D	Partial traumatic amputation at unspecified hip joint, subsequent encounter
S78.029S	Partial traumatic amputation at unspecified hip joint, sequela
S78.111A	Complete traumatic amputation at level between right hip and knee, initial encounter
S78.111D	Complete traumatic amputation at level between right hip and knee, subsequent encounter
S78.111S	Complete traumatic amputation at level between right hip and knee, sequela
S78.112A	Complete traumatic amputation at level between left hip and knee, initial encounter
S78.112D	Complete traumatic amputation at level between left hip and knee, subsequent encounter
S78.112S	Complete traumatic amputation at level between left hip and knee, sequela
S78.119A	Complete traumatic amputation at level between unspecified hip and knee, initial encounter
S78.119D	Complete traumatic amputation at level between unspecified hip and knee, subsequent encounter
S78.119S	Complete traumatic amputation at level between unspecified hip and knee, sequela
S78.121A	Partial traumatic amputation at level between right hip and knee, initial encounter
S78.121D	Partial traumatic amputation at level between right hip and knee, subsequent encounter
S78.121S	Partial traumatic amputation at level between right hip and knee, sequela
S78.122A	Partial traumatic amputation at level between left hip and knee, initial encounter
S78.122D	Partial traumatic amputation at level between left hip and knee, subsequent encounter
S78.122S	Partial traumatic amputation at level between left hip and knee, sequela
S78.129A	Partial traumatic amputation at level between unspecified hip and knee, initial encounter
S78.129D	Partial traumatic amputation at level between unspecified hip and knee, subsequent encounter
S78.129S	Partial traumatic amputation at level between unspecified hip and knee, sequela

ICD-10-CM Code	Description
S78.911A	Complete traumatic amputation of right hip and thigh, level unspecified, initial encounter
S78.911D	Complete traumatic amputation of right hip and thigh, level unspecified, subsequent encounter
S78.911S	Complete traumatic amputation of right hip and thigh, level unspecified, sequela
S78.912A	Complete traumatic amputation of left hip and thigh, level unspecified, initial encounter
S78.912D	Complete traumatic amputation of left hip and thigh, level unspecified, subsequent encounter
S78.912S	Complete traumatic amputation of left hip and thigh, level unspecified, sequela
S78.919A	Complete traumatic amputation of unspecified hip and thigh, level unspecified, initial encounter
S78.919D	Complete traumatic amputation of unspecified hip and thigh, level unspecified, subsequent encounter
S78.919S	Complete traumatic amputation of unspecified hip and thigh, level unspecified, sequela
S78.921A	Partial traumatic amputation of right hip and thigh, level unspecified, initial encounter
S78.921D	Partial traumatic amputation of right hip and thigh, level unspecified, subsequent encounter
S78.921S	Partial traumatic amputation of right hip and thigh, level unspecified, sequela
S78.922A	Partial traumatic amputation of left hip and thigh, level unspecified, initial encounter
S78.922D	Partial traumatic amputation of left hip and thigh, level unspecified, subsequent encounter
S78.922S	Partial traumatic amputation of left hip and thigh, level unspecified, sequela
S78.929A	Partial traumatic amputation of unspecified hip and thigh, level unspecified, initial encounter
S78.929D	Partial traumatic amputation of unspecified hip and thigh, level unspecified, subsequent encounter
S78.929S	Partial traumatic amputation of unspecified hip and thigh, level unspecified, sequela
S88.011A	Complete traumatic amputation at knee level, right lower leg, initial encounter
S88.011D	Complete traumatic amputation at knee level, right lower leg, subsequent encounter
S88.011S	Complete traumatic amputation at knee level, right lower leg, sequela
S88.012A	Complete traumatic amputation at knee level, left lower leg, initial encounter
S88.012D	Complete traumatic amputation at knee level, left lower leg, subsequent encounter
S88.012S	Complete traumatic amputation at knee level, left lower leg, sequela

ICD-10-CM Code	Description
S88.019A	Complete traumatic amputation at knee level, unspecified lower leg, initial encounter
S88.019D	Complete traumatic amputation at knee level, unspecified lower leg, subsequent encounter
S88.019S	Complete traumatic amputation at knee level, unspecified lower leg, sequela
S88.021A	Partial traumatic amputation at knee level, right lower leg, initial encounter
S88.021D	Partial traumatic amputation at knee level, right lower leg, subsequent encounter
S88.021S	Partial traumatic amputation at knee level, right lower leg, sequela
S88.022A	Partial traumatic amputation at knee level, left lower leg, initial encounter
S88.022D	Partial traumatic amputation at knee level, left lower leg, subsequent encounter
S88.022S	Partial traumatic amputation at knee level, left lower leg, sequela
S88.029A	Partial traumatic amputation at knee level, unspecified lower leg, initial encounter
S88.029D	Partial traumatic amputation at knee level, unspecified lower leg, subsequent encounter
S88.029S	Partial traumatic amputation at knee level, unspecified lower leg, sequela
S88.911A	Complete traumatic amputation of right lower leg, level unspecified, initial encounter
S88.911D	Complete traumatic amputation of right lower leg, level unspecified, subsequent encounter
S88.911S	Complete traumatic amputation of right lower leg, level unspecified, sequela
S88.912A	Complete traumatic amputation of left lower leg, level unspecified, initial encounter
S88.912D	Complete traumatic amputation of left lower leg, level unspecified, subsequent encounter
S88.912S	Complete traumatic amputation of left lower leg, level unspecified, sequela
S88.919A	Complete traumatic amputation of unspecified lower leg, level unspecified, initial encounter
S88.919D	Complete traumatic amputation of unspecified lower leg, level unspecified, subsequent encounter
S88.919S	Complete traumatic amputation of unspecified lower leg, level unspecified, sequela
S88.921A	Partial traumatic amputation of right lower leg, level unspecified, initial encounter
S88.921D	Partial traumatic amputation of right lower leg, level unspecified, subsequent encounter
S88.921S	Partial traumatic amputation of right lower leg, level unspecified, sequela
S88.922A	Partial traumatic amputation of left lower leg, level unspecified, initial encounter
S88.922D	Partial traumatic amputation of left lower leg, level unspecified, subsequent encounter

ICD-10-CM Code	Description
S88.922S	Partial traumatic amputation of left lower leg, level unspecified, sequela
S88.929A	Partial traumatic amputation of unspecified lower leg, level unspecified, initial encounter
S88.929D	Partial traumatic amputation of unspecified lower leg, level unspecified, subsequent encounter
S88.929S	Partial traumatic amputation of unspecified lower leg, level unspecified, sequela
Z89.511	Acquired absence of right leg below knee
Z89.512	Acquired absence of left leg below knee
Z89.519	Acquired absence of unspecified leg below knee
Z89.611	Acquired absence of right leg above knee
Z89.612	Acquired absence of left leg above knee
Z89.619	Acquired absence of unspecified leg above knee
Z89.621	Acquired absence of right hip joint
Z89.622	Acquired absence of left hip joint
Z89.629	Acquired absence of unspecified hip joint

Note: HCPCS codes E0955, E2601, E2602, E2611, E2612, and E2619 have no diagnosis-code restrictions.

Reviews, Revisions, and Approvals	Date	Approval Date
Policy created, Therapist reviewed	09/15	10/15
References reviewed and updated. Updated disclaimer language. Added ICD-10 codes per LCDs. Moved E0992 to not medically necessary codes per LCD.	09/16	10/16
References reviewed and updated as per LCD L33312, revised 1/1/17 2018 ICD-10 Code updates.	10/17	10/17

References

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

CLINICAL POLICY
Wheelchair Seating

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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CENTENE Corporation

Clinical Policy: Allergy Testing and Therapy

Reference Number: CP.MP.100
Effective Date: 02/16
Last Review Date: 02/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Allergy testing is performed to determine immunologic sensitivity or reaction to antigens for the purpose of identifying the cause of the allergic state. This policy addresses immediate (IgE-mediated) hypersensitivity and delayed (cell-mediated) hypersensitivity. Allergen immunotherapy is the repeated administration of specific allergens to patients with IgE-mediated conditions, for the purpose of providing protection against the allergic symptoms and inflammatory reactions associated with exposure to these allergens.

Please note: unit limitations for allergy testing and treatment are based on state specific guidelines (defined in the provider fee schedule). In the absence of state-specific rules, the CMS Medicaid/Medicare NCCI MUE limitations are applied.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that allergy testing is **medically necessary** for members with clinically significant allergic symptoms and the following indications:

- **A.** As part of a complete diagnostic evaluation by a licensed practitioner acting within their scope of practice to perform allergy and immunology services;
- **B.** Antigens include only those that are reasonably possible for the member to be exposed to;
- **C.** Chosen test and units allowed per year are as follows:
  1. *Percutaneous* testing (also called "scratch testing;" CPT 95004, 95017, 95018) for offending allergens such as pollen, molds, mites, dust, feathers, animal fur or dander, venoms, foods, or drugs.
  2. *Intracutaneous* (intradermal), *sequential and incremental testing* (CPT 95024, 95027, 95028) when percutaneous tests are negative;
  3. *Skin endpoint titration* (95027) for determining the starting dose for immunotherapy for members highly allergic to an inhalant allergen or hymenoptera venom allergy (insect stings);
  4. *In vitro testing* (CPT 86003, 86005);
  5. *Patch testing* (CPT 95044);
  6. If photo patch test(s) (CPT 95052) are performed (same antigen/same session) with patch or application test(s) (CPT 95044), only the photo patch tests should be reported;
  7. If photo tests (CPT 95056) are performed with patch or application test(s) (CPT 95044), only the photo tests should be reported.

II. It is the policy of health plans affiliated with Centene that allergy immunotherapy administered in a medical facility is **medically necessary** when meeting all of the following indications:

A. Positive skin test or serologic evidence of an IgE-mediated antibody for allergens which cause any of the following:
1. Allergic (extrinsic) asthma,
2. Dust mite atopic dermatitis,
3. Hymenoptera (bees, hornets, wasps, fire ants) allergic reactions,
4. Mold-induced allergic rhinitis,
5. Perennial allergic rhinitis,
6. Seasonal allergic rhinitis or conjunctivitis;

B. Symptoms of allergic rhinitis or asthma after natural exposure to the allergen; or a life-threatening allergy to insect stings (bees, hornets, wasps, and fire ants);

C. Avoidance or pharmacologic therapy does not control allergic symptoms or member has unacceptable side effects with pharmacologic therapy;

D. If rapid desensitization/rush immunotherapy is requested, it is only medically necessary for medication or hymenoptera (bees, hornets, wasps, fire ants) sensitivities;

E. Antigens are prepared by an allergist, immunologist, or otolaryngologist who has examined the patient.

III. It is the policy of health plans affiliated with Centene that the following are considered **not medically necessary** because safety or effectiveness have not been established:

A. Testing for the following antigens:
1. Newsprint
2. Tobacco smoke
3. Dandelion
4. Orris root
5. Phenol
6. Alcohol
7. Sugar
8. Yeast
9. Grain mill dust
10. Soybean dust (except when the patient has a known exposure to soybean dust such as a food processing plant)
11. Wool (unless patient has history of continuous exposure to sheep or unprocessed wool)
12. Marigold
13. Honeysuckle
14. Fiberglass
15. Green tea
16. Chalk.

B. The following tests for the evaluation allergic reactions:
1. Antigen leukocyte cellular antibody (ALCAT) automated food allergy testing
2. Applied kinesiology or Nambudripad's allergy elimination test (NAET (i.e., muscle strength testing or measurement after allergen ingestion)
3. Candidiasis test
4. Chemical analysis of body tissues (e.g., hair)
5. Chlorinated pesticides (serum)

6. Complement (total or components)
7. C-reactive protein
8. Cytokine and cytokine receptor assay
9. Cytotoxic testing for food, environmental or clinical ecological allergy testing (Bryans Test, ACT)
10. Electrodermal testing or electro-acupuncture
11. ELISA/Act qualitative antibody testing
12. Food immune complex assay (FICA)
13. Immune complex assay
14. Ingestion challenge food testing for diagnosing rheumatoid arthritis, depression, or respiratory disorders not associated with anaphylaxis or similar systemic reactions
15. In vitro metal allergy testing
16. Iridology
17. Leukocyte histamine release test (LHRT)/basophil histamine release test
18. Lymphocyte function assay
19. Lymphocytes (B or T subsets)
20. Lymphocyte Response Assay (LRA) by ELISA/ACT and Lymphocyte Mitogen Response Assays (LMRA) by ELISA/Act
21. Mediator release test (MRT)
22. Ophthalmic mucus membrane tests/conjunctival challenge test
23. Prausnitz-Kustner (P-K testing) passive cutaneous transfer test
24. Provocative and neutralization testing and neutralization therapy (sublingual, intracutaneous and subcutaneous) also referred to as the Rinkel Test, for food allergies, inhalants, and environmental chemicals because available evidence does not show these tests and therapies are effective.
25. Provocative nasal test
26. Pulse test (pulse response test, reaginic pulse test)
27. Rebuck skin window test
28. Sage Complement Antigen Test
29. Testing for multiple chemical sensitivity syndrome (a.k.a., idiopathic environmental intolerance [IEI], clinical ecological illness, clinical ecology, environmental illness, chemical AIDS, environmental/chemical hypersensitivity disease, total allergy syndrome, cerebral allergy, 20th century disease)
30. Testing of specific immunoglobulin G (IgG) (e.g., by Radioallergosorbent [RAST] or Enzyme-linked immunosorbent assay [ELISA])
31. Testing of total serum IgG, immunoglobulin A (IgA) and immunoglobulin M (IgM)

C. The following services in relation to allergy testing and immunotherapy:
1. Desensitization with commercially available extracts of poison ivy, poison oak, or poison sumac
2. Desensitization for hymenoptera sensitivity using whole body extracts, with the exception of venom extracts and fire ant extracts
3. Desensitization with bacterial vaccine (BAC: bacterial, antigen complex, streptococcus vaccine, staphylo/strepto vaccine, serobacterin, staphylococcus phage lysate)
4. Food allergenic extract immunotherapy

5. Intracutaneous desensitization (Rinkel Injection Therapy, RIT)
6. Neutralization therapy (intradermal and subcutaneous)
7. Repository emulsion therapy
8. Sublingual provocative therapy
9. Urine autoinjection (autogenous urine immunotherapy)
10. Allergen immunotherapy for the management of skin and mucous membrane disease such as urticaria, and Candida vulvovaginitis
11. Home administration of allergy immunotherapy
12. Ingestion challenge food testing performed by the patient in the home
13. Intradermal testing for food allergies
14. Food allergen testing for patients who present with gastrointestinal symptoms suggestive of food intolerance;
15. Rush immunotherapy for inhalant allergens.

Limitations

Allergy Testing

- Retesting with the same antigen(s) should rarely be necessary within a 3-year period. Exceptions include young children with negative skin tests or older children and adults with negative skin tests in the face of persistent symptoms;
- Routine repetition of skin tests is not indicated (e.g., annually);
- Measurements of total IgE levels (CPT code 82785-Gammaglobulin [immunoglobulin]; IgE) are not appropriate for most general allergies for the purpose of identifying the cause of the allergic state. Total serum IgE levels should not be billed unless evidence exists for allergic bronchopulmonary Aspergillosis (ABPA), select immunodeficiencies, such as the syndrome of hyper-IgE, eczematous dermatitis, atopic dermatitis in children and recurrent pyogenic infections, or in the evaluation for omalizumab therapy.
- Serial, repeat testing of total IgE will be subject to medical review.

Documentation Requirements

Medical record documentation (e.g., history & physical, office/progress notes, procedure report, test results) must include the following information:

- A complete medical and immunologic history and appropriate physical exam obtained by face-to-face contact with the patient;
- The medical necessity for performing the test;
- The test methodology used;
- The measurement (in mm) of reaction sizes of both wheal and erythema response (in vivo testing);
- The quantitative result (in kIU/L) for specific IgE testing (in vitro testing);
- The interpretation of the test results and how the results of the test will be used in the patient's plan of care.
- Periodic clinical evaluation of treatment benefits and, if no benefit within 12-24 months, other treatment options which should be considered.
- Clinical re-evaluation at 3 to 5 years to determine need for continuing immunotherapy.

Background

Allergy Testing

CLINICAL POLICY
Allergy Testing and Immunotherapy

Allergy is a form of exaggerated sensitivity or hypersensitivity to a substance that is either inhaled, ingested, injected, or comes in contact with the skin or eye. The term allergy is used to describe situations where hypersensitivity results from heightened or altered reactivity of the immune system in response to external substances. Allergic or hypersensitivity disorders may be manifested by generalized systemic reactions as well as localized reactions in any part of the body. The reactions may be acute, subacute, or chronic; immediate or delayed, and may be caused by a variety of offending agents (e.g., pollen, molds, mites, dust, feathers, animal fur or dander, venoms, foods, drugs). Allergy testing is performed to determine a patient's immunologic sensitivity or reaction to particular allergens for the purpose of identifying the cause of the allergic state.

Allergy testing must be a part of a complete diagnostic evaluation by a physician with specialized training in allergy and immunotherapy. A complete medical and immunologic history and appropriate physical examination must be done prior to performing diagnostic testing. The testing must be performed based on this history and a physical exam, which documents that the antigens being used for testing exist with a reasonable probability of exposure in the patient’s environment. The number of tests performed must be judicious and related to the history, physical findings, and clinical judgment specific to each individual.

In vivo immunologic tests have been shown to be reliable and valid diagnostic tools and include skin tests with standardized allergenic extracts by prick/puncture (percutaneous) and intradermal (intracutaneous) techniques, photo and patch testing, inhalation bronchial challenge testing, and ingestion challenge testing. Percutaneous testing remains the test of choice in most clinical situations where immediate hypersensitivity reactions are suspected. Percutaneous tests require medical supervision, since there is a small but significant risk of anaphylaxis. Overall, skin testing is quick, safe, and cost-effective.

Intradermal tests are usually performed when increased sensitivity is needed when percutaneous tests (CPT codes 95004, 95017, 95018) are negative and there is still a strong suspicion of allergen sensitivity. For intradermal testing, the clinician should narrow the area of investigation so that the minimal number of skin tests necessary for diagnosis is performed. Intradermal testing is appropriate when IgE-mediated reactions occur to inhalants, hymenoptera (insect stings), and specific drugs, such as penicillins and macroglobular agents. The usual testing program may include two concentrations of an extract: a weaker concentration and a stronger concentration. It would not be expected that three or more concentrations of one extract would be necessary. Skin end-point dilution testing is a variant of intradermal testing that analyzes the highest dilution of a substance that produces a reaction, and may be used to determine the starting dose(s) of allergen immunotherapy.

Delayed hypersensitivity skin testing measures the presence of activated T cells that recognize a certain substance. It has been commonly used in three ways: anergy testing, testing for infection with intracellular pathogens, and testing for sensitivity to contact allergens. Accurate testing for contact allergy requires careful attention to technique, and limitation of testing to the specific allergens known to be associated with a contact reaction.

Other skin tests include photo testing and patch testing. Photo testing is skin irradiation with a specific range of ultraviolet light. Photo tests are performed for the evaluation of photosensitivity disorders. Patch testing is indicated to evaluate a nonspecific dermatitis, allergic contact dermatitis, pruritus, and other dermatitis to determine the causative antigen. Photo Patch testing uses two patches, with one of them being irradiated with ultraviolet light half way through the occlusive period. It is indicated to evaluate unique allergies resulting from light exposure.

Inhalation bronchial challenge testing involves the inhalation of agents that can trigger respiratory responses. The agents include drugs that cause airway constriction, antigens and chemical sensitizers, usually related to occupational breathing problems. Generally, three measures of each determination (e.g., spirometry, prolonged post exposure evaluation of bronchospasm) are performed. The best of the three is accepted and represents one unit of service. A unit is defined as each set of three measurements.

Ingestion challenge test involves the administration of sequentially or incrementally larger doses of the test item. The test items may include food or antibiotics. The service is allowed once per patient encounter, regardless of the number of items tested, and includes evaluation of the patient's response to the test items.

Quantitative or semi-quantitative in vitro allergen specific IgE testing includes radioallergosorbent test (RAST), multiple radioallergosorbent tests (MAST), fluorescent allergosorbent test (FAST), enzyme-linked immunosorbent assay (ELISA) and ImmunoCAP. These tests detect specific IgE antibodies in the patient’s blood serum. In vitro testing (CPT codes 86003 and 86005) is appropriate under conditions where skin testing is not possible or is not reliable. Examples of indications for in vitro testing include:

- Severe dermatographism, ichthyosis or generalized eczema;
- Increased risk for anaphylactic response to skin testing based on clinical history (e.g., when an unusual allergen is not available as a licensed skin test extract);
- Inability to discontinue long-acting antihistamines, tricyclic antidepressants, or medications that may put the patient at undue risk if they are discontinued long enough to perform skin tests;
- Those with mental or physical impairments who are uncooperative;
- History is highly suggestive of an allergy and skin testing is negative or equivocal; or
- Evaluation of cross-reactivity between insect venoms.

Total serum IgE concentration testing is not indicated in all allergic patients, but should be reserved for those patients suspected of having allergic bronchopulmonary aspergillosis, immune deficiency disease (e.g., Wiskott-Aldrich syndrome, hyper-IgE staphylococcal abscess syndrome), IgE myeloma or pemphigoid, or for consideration of Xolair (omalizumab) administration in patients with moderate to severe asthma.

Allergen Immunotherapy

Allergen immunotherapy is effective for pollen, mold, animal allergens, cockroach, and dust mite. Immunotherapy is indicated for patients who show evidence of specific IgE antibodies to clinically relevant allergens and whose allergic symptoms warrant the time and risk of allergen immunotherapy. This includes those with allergic asthma, allergic conjunctivitis, allergic rhinitis,

or stinging insect hypersensitivity depending on the results of allergy testing (immediate hypersensitivity skin tests or in vitro tests for specific IgE). Initiating allergen immunotherapy may depend on the degree to which symptoms can be reduced by medication, the amount and type of medication required to control symptoms, and whether appropriate avoidance is possible.

There is limited data showing effectiveness in atopic dermatitis when this condition is associated with aeroallergen sensitivity. Immunotherapy should not be given to patients with negative results for specific IgE antibodies or those with positive test results for specific IgE antibodies that do not correlate with suspected triggers, clinical symptoms, or exposure.

Venom immunotherapy is indicated for patients who have anaphylaxis after an insect sting and a positive skin test or other documented IgE sensitivity to specific insect venom. Patients with delayed systemic reactions with symptoms of anaphylaxis or serum sickness and with a positive skin test or presence of venom specific IgE by in vitro testing are also recommended for treatment.

Rapid desensitization is indicated in cases of allergy to insulin, penicillin and horse serum, as well as sulfonamides, cephalosporins and other commonly used drugs. In patients with a positive history of reaction and with documented skin test reactivity, every effort should be made to avoid the use of these substances. When circumstances require the use of one of these substances, the patient will have to be desensitized. Full-dose therapy should be initiated immediately after reactions (treated and controlled), requiring strict physician monitoring in a setting with continuous monitoring of vital signs and cardio-respiratory status. In most cases, this can be performed in a physician's office if a physician trained to treat anaphylaxis is physically present for the entire duration. In cases where the initial reaction was severe, desensitization should be performed in the ambulatory care department of a hospital.

Desensitization may need to be repeated if future circumstances require an additional course of the offending allergen. Rapid desensitization in the form of rush immunotherapy may also be appropriate for hymenoptera venom (bees, hornets, wasps, fire ants), according to a recent American Academy of Allery, Asthma & Immunology practice parameter.

Treatment Schedules

The starting dose of an allergenic extract and the progression of the dose must be individualized for each patient. The immunotherapy build-up schedule entails administration of gradually increasing doses during a period of approximately 14 to 28 weeks. In conventional schedules a single dose increase is given on each visit, and the visit frequency can vary from 1 to 3 times a week. Accelerated schedules such as rush or cluster immunotherapy entail administration of several injections at increasing doses on a single visit. Accelerated schedules offer the advantage of achieving the therapeutic dose earlier but might be associated with increased risk of systemic reaction in some patients.

Length of Therapy

The duration of all forms of immunotherapy must be individualized. A presumption of failure can be made when, after 12-24 months of therapy, a person does not experience a noticeable decrease of symptoms, an increase in tolerance to the offending allergen and a reduction in

medication usage. Treatment will not be reimbursed after a 2-year period when there is no apparent clinical benefit.

The major risk of allergen immunotherapy is anaphylaxis. Allergen immunotherapy should, therefore, be administered under the supervision of an appropriately trained physician who can recognize early symptoms and signs of anaphylaxis and administer emergency medications where necessary. In addition, immunotherapy should be administered only in facilities equipped to treat anaphylaxis.

Evaluation and management codes are separately reimbursable on the same day as allergen immunotherapy only when a significant, separately identifiable service is performed.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2015, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT Code Table 1: Procedure codes considered medically necessary

CPT* Codes	Description
86003	Allergen specific IgE; quantitative or semiquantitative, each allergen
86005	Allergen specific IgE; qualitative, multiallergen screen (dipstick, paddle, or disk)
95004	Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests
95017	Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with venoms, immediate type reaction, including test interpretation and report, specify number of tests
95018	Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with drugs or biologicals, immediate type reaction, including test interpretation and report, specify number of tests
95024	Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests
95027	Intracutaneous (intradermal) tests, sequential and incremental, with allergenic extracts for airborne allergens, immediate type reaction, including test interpretation and report, specify number of tests
95028	Intracutaneous (intradermal) tests with allergenic extracts, delayed type reaction, including reading, specify number of tests

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Allergy Testing and Immunotherapy

CPT* Codes	Description
95044	Patch or application test(s) (specify number of tests)
95052	Photo patch test(s) (specify number of tests)
95056	Photo tests
95070	Inhalation bronchial challenge testing (not including necessary pulmonary function tests); with histamine, methacholine, or similar compounds
95071	Inhalation bronchial challenge testing (not including necessary pulmonary function tests); with antigens or gases, specify
95076	Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance); initial 120 minutes of testing
95079	Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance); each additional 60 minutes of testing (list separately in addition to code for primary procedure)
95115	Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection
95117	Professional services for allergen immunotherapy not including provision of allergenic extracts; 2 or more injections
95144	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy, single dose vial(s) (specify number of vials)
95145	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); single stinging insect venom
95146	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 2 single stinging insect venoms
95147	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 3 single stinging insect venoms
95148	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 4 single stinging insect venoms
95149	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 5 single stinging insect venoms
95165	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses)
95170	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; whole body extract of biting insect or other arthropod (specify number of doses)
95180	Rapid desensitization procedure, each hour (eg, insulin, penicillin, equine serum)
95199	Unlisted allergy/clinical immunologic service or procedure

CLINICAL POLICY
Allergy Testing and Immunotherapy

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CPT Code Table 2: Procedure codes considered not medically necessary

CPT®* Codes	Description
95060	Ophthalmic mucous membrane tests
95065	Direct nasal mucous membrane test

ICD-10 codes with an * indicate additional digits are needed.

ICD-10-CM Code Table 1: Diagnoses that support medical necessity for CPT codes 86003, 86005, 95004, 95017, 95018, 95024, 95027, 95028

ICD-10-CM Code	Description
H10.01* – H10.45	Conjunctivitis
J30.1 – J30.9	Allergic rhinitis
J31.0*	Chronic rhinitis
J45.2* - J45.998	Asthma
L20.84 – L20.9	Atopic dermatitis
L23.0 – L23.9*	Allergic contact dermatitis
L25.1 – L25.9	Unspecified contact dermatitis
L27.0 – L27.9	Dermatitis due to substances taken internally
L50.0	Allergic urticaria
L50.1	Idiopathic urticaria
L50.6	Contact urticaria
L50.8	Other urticaria
L50.9	Urticaria, unspecified
T36.0X5A – T50.995S	Adverse effect of drugs
T63.001* - T63.94*	Toxic effects of venoms
T78.00X*– T78.1XXS	Anaphylactic reaction due to food
T78.49XA – T78.49XS	Other allergy
T80.52XA – T80.52XS	Anaphylactic reaction due to vaccination
T88.6XXA – T88.6XXS	Anaphylactic reaction due to adverse effect of correct drug or medicament properly administered

ICD-10-CM Code Table 2: Diagnoses that support medical necessity for CPT code 95044

ICD-10-CM Code	Description
L20.84 – L20.9	Intrinsic (allergic) eczema
L23.0 – L23.9	Allergic contact dermatitis, due to other agents
L50.0	Allergic urticaria
L50.1	Idiopathic urticaria
L50.6	Contact urticaria
L50.8	Other urticaria
L50.9	Urticaria, unspecified

ICD-10-CM Code Table 3: Diagnoses that support medical necessity for CPT codes 95052, 95056

ICD-10-CM Code	Description
L56.1	Drug photoallergic response
L56.2	Photocontact dermatitis (berloque dermatitis)
L56.3	Solar urticaria

ICD-10-CM Code Table 4: Diagnoses that support medical necessity for CPT codes 95076, 95079

ICD-10-CM Code	Description
L27.2	Dermatitis due to ingested food
T36.0X5A – T50.995S	Adverse effect of drugs
T78.00X*– T78.1XXS	Anaphylactic reaction due to food
Z88.0 – Z88.9	Allergy status to drugs, medicaments and biological substances

ICD-10-CM Code Table 5: Diagnoses that support medical necessity for CPT codes 95115, 95117, 95144, 95145, 95146, 95147, 95148, 95149, 95165, 95170, and 95199

ICD-10-CM Code	Description
H10.01* – H10.45	Conjunctivitis
J30.1 – J30.9	Allergic rhinitis
J31.0*	Chronic rhinitis
J45.20 – J45.998	Asthma
L20.84 – L20.9	Other atopic dermatitis
L23.0 – L23.9*	Allergic contact dermatitis
L25.1 – L25.9	Unspecified contact dermatitis
L27.0 – L27.9	Dermatitis due to substances taken internally
L50.0	Allergic urticaria
L50.6	Contact urticaria
T36.0X5A – T50.995S	Adverse effects of drugs

ICD-10-CM Code	Description
T63.001* - T63.94*	Toxic effects of venoms
T78.49XA – T78.49XS	Other allergy
T80.52XA – T80.52XS	Anaphylactic reaction due to adverse effect of correct drug or medicament properly administered
Z88.0 – Z88.9	Allergy status to drugs, medicaments, and biological substances
Z91.030 – Z91.038	Insect allergy status

ICD-10-CM Code Table 6: Diagnoses that support medical necessity for CPT code 95180

ICD-10-CM Code	Description
T36.0X5A – T50.995S	Adverse effect of other drugs, medicaments and biological substances
Z91.030 – Z91.038	Insect allergy status

Reviews, Revisions, and Approvals	Date	Approval Date
Policy created, specialist reviewed	01/16	02/16
Added anaphylactic reaction due to vaccinations to ICD-10-CM code list that support medical necessity for CPT Codes 86003, 86005, 95004, 95017, 95018, 95024, 95027, 95028; removed food allergy testing for patients who present with respiratory symptoms from III.C	12/16	01/17
Clarified that rapid desensitization is appropriate only for medication and hymenoptera sensitivities and added ICD-10 codes for insect allergy status to CPT 95180 for rapid desensitization. Combined code ranges in all ICD-10 coding tables including J30.1 – J30.9; J45.2* - J45.998; L25.1 – L25.9; L27.0 – L27.9; T78.00X* - T78.1XXS. Added initial encounters to ICD-10 codes that previously only included subsequent and sequela encounter. Added H10.01* - H10.45; T63.001* - T63.94* to ICD-10-CM code table 1 Added expanded code range for conjunctivitis H10.01* - H10.45; L23.0 – L23.9*; L25.1 – L25.9; L27.0 – L27.9; L50.0, L50.6, T36.0X5A – T50.995S; T78.49XA – T78.49XS; T80.52XA – T80.52XS; Z88.0 – Z88.9 to ICD-10-CM code table 5. Added expanded code range T36.0X5A – T50.995S to ICD-10 code table 6	02/17	
Under Documentation requirements, removed statement about medical necessity for invitro vs invivo testing	04/17	
Frequency limitations for allergy testing and treatment have been removed from this policy as they are based on state specific guidelines (defined in the provider fee schedule). In the absence of state-specific rules, the CMS Medicaid/Medicare NCCI MUE limitations are applied.	6/17	
Added L50.1, L50.8, and L50.9 to ICD-10-CM Code Table 1 and Table 2	07/17	

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4. Lawlor GJ, Fischer TJ, Adelman DC. *Manual of Allergy and Immunology*, 3rd ed. Boston, MA: Little Brown and Company; 1995.

Important reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

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CENTENE Corporation

Clinical Policy: Donor Lymphocyte Infusion

Reference Number: CP.MP.101
Effective Date: 12/15
Last Review Date: 11/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

This policy describes the medical necessity requirements for a donor lymphocyte infusion (DLI). DLI is a treatment for many hematological malignancies that have relapsed following allogenic hematopoietic stem cell transplantation (HSCT) or bone marrow transplant, or to convert a patient's mixed to full donor chimerism in the absence of relapse. In this procedure, donor lymphocytes from the original stem cell donor are infused into the patient to cause an immune-mediated graft vs. tumor response. The hematological malignancies treated by DLIs include chronic myeloid leukemia (CML), acute myeloid leukemia (AML), acute lymphoblastic leukemia (ALL), lymphomas, multiple myeloma, and myelodysplastic syndrome.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that donor lymphocyte infusion is **medically necessary** following an allogenic HSCT or bone marrow transplant for any of the following indications:
- **A.** To treat a relapsed hematological malignancy;
- **B.** To convert a member, who has not relapsed, from mixed to full donor chimerism.

II. It is the policy of health plans affiliated with Centene Corporation that donor lymphocyte infusion for the following are considered **experimental/investigational**:
- **A.** For the treatment of all other conditions than those specified above;
- **B.** Genetic modification or *ex vivo* manipulation of donor lymphocytes;
- **C.** Repeat donor leukocyte infusion when positive health benefit responses are not documented.

Background

In addition to chemotherapy, HSCT has become a mainstream clinical therapy for a variety of hematological malignancies. Even though the anti-tumor effects of HSCT can be durable for some patients, relapse of the original malignancy presents considerable clinical challenges for 40 to 75% of patients who undergo autologous HSCT and 10 to 40% of those who undergo allogenic HSCT.[1] Therefore, salvage therapies to combat the refractory disease are required. DLI is one such post-transplant salvage adoptive immunotherapy.

Donor lymphocyte infusion, otherwise known as buffy coat infusion, was originally described in 1990 by Kolb and colleagues as a treatment protocol for three patients who had relapsed after bone marrow transplantation for CML.[2] In this procedure, mononuclear cells collected by apheresis from the related or unrelated donor who provided the original hematopoietic stem cell graft are infused into the patient to harness the graft vs. tumor effect. While there is some variety in published reports concerning the dose of donor cells infused, Deol and Lum survey several articles and report an effective cellular range of 0.01 to 8.8×10^8 T cells/kg.[3]

The precise mechanism of action, including the tumor-specific antigens as well as the critical effector cells that mediate the anti-tumor immune response, has not yet been fully elucidated. However, recent evidence suggests that both donor T cells and host-derived immune compartments, including antigen presenting cells and B cells, among others, are critical for facilitating the graft vs. tumor effect of DLI.[1,3,4]

In striving to eradicate the tumor cell population from the host, complications may persist in patients treated with DLI. Graft vs. host disease (GvHD), the most common and significant toxicity attributable to DLI, occurs in approximately in 40-60% of patients, according to a range of several published reports.[1,4,5] GvHD ensues when the transplanted donor cells recognize the host as foreign and initiate an immune reaction that usually affects the patient's skin, gastrointestinal tract, and/or liver.[6] However, there is a strong correlation observed with the onset of GvHD and the intended graft vs. tumor effect. The onset of GvHD is independent of the type of hematological malignancy. In a retrospective study, Collins et al. observed that of 140 patients treated with DLI for relapsed disease after stem cell transplant, approximately 60% patients present with GvHD; of these, 42/45 patients in complete response of disease developed acute GvHD and 36/41 patients in complete response of disease displayed chronic GvHD.[7] Nevertheless, Carlens et al. determined that the 3 year leukemia free survival is greater for patients who develop chronic GvHD than for those who do not.[8] Therefore, the ultimate goal of DLI is to maximize the graft vs. tumor response while minimizing the complications that arise from the related GvHD.

In addition to GvHD, bone marrow aplasia is another major complication that can occur in 2-5% of patients following DLI.[9] Infection and bleeding are compounding risks associated with the onset of aplasia following DLI. The infusion of subsequent donor stem cells can reverse marrow aplasia.

Since Kolb's initial study describing the utility of DLI, focus has been placed on evaluating the clinical benefit of DLI in the context of treating relapsed CML. Multiple studies have revealed that DLI can establish complete remissions in 70-80% of patients with relapsed CML, and the response is durable in the majority of these cases.[9]

DLI is less effective for achieving remission in patients with relapsing AML following HSCT. According to Deol and Lum, the ability of DLI to induce remission in relapsed AML is approximately 15-20%.[3] However, unlike the observations made for CML, it is often necessary to combine DLI with a chemotherapy regimen to elicit an anti-tumor effect against AML.

Multiple myeloma is another hematological malignancy with the potential to respond to DLI. Among varying reports, the response rate of relapsed multiple myeloma to DLI is approximately 22-52%.[10,11] The propensity of multiple myeloma patients to receive autologous and not allogenic transplants could have a role in this outcome .[3]

Furthermore, DLI is a treatment possibility for relapsed ALL. However the outcomes for relapsed ALL have been less robust compared to CML and AML. Collins et al analyzed

outcomes in both retrospective and prospective studies in patients with relapsed ALL treated with chemotherapy and DLI, and found that only 3/44 were disease free.[7]

Lastly, chimerism is an important element that develops after the engraftment of a HSCT. Mixed chimerism is defined when < 90% donor cells are detected, whereas full or complete chimerism is defined as 100% donor cells detected, suggesting completed hematopoietic replacement.[12] One such example of the graft vs. tumor effects observed from the conversion to full chimerism was described by Orisini, in which 4 patients with relapsed multiple myeloma received DLI specifically with $CD4^+$ T cells. It was observed that 3/4 patients saw a clinical response in the absence of GvHD with complete hematopoietic conversion.[13]

In summary, donor lymphocyte infusion is an effective clinical treatment for an array of relapsed hematological malignancies. For this adoptive immunotherapy, T lymphocytes from the original stem cell donor are infused into the patient with the intent of inducing a graft vs. tumor response.

Coding Implications

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CPT®* Codes	Description
38215	Transplant preparation of hematopoietic proginitor cells; cell concentration in plasma, mononuclear, or buffy coat layer
38242	Allogeneic lymphocyte infusions
86950	Leukocyte transfusion

HCPCS Codes	Description
S2150	Bone marrow or blood-derived stem-cells (peripheral or umbilical), allogeneic or autologous, harvesting, transplantation, and related complications; including: pheresis and cell preparation/storage; marrow ablative therapy; drugs, supplies, hospitalization with outpatient follow-up; medical/surgical, diagnostic, emergency, and rehabilitative services; and the number of days of pre- and post-transplant care in the global definition

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
C81.00 - C81.99	Hodgkin lymphoma
C85.10 - C85.99	Other specified and unspecified types of non-Hodgkin lymphoma
C90.00 - C90.02	Multiple myeloma

CLINICAL POLICY
Donor Lymphocyte Infusion

ICD-10-CM Code	Description
C91.00 - C91.Z2	Lymphoid leukemia
C92.00 - C92.Z2	Myeloid leukemia
D46.0 - D46.Z	Myelodysplastic syndrome

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed	11/15	11/15
Clarified in I. that DLI is indicated post *allogenic* HSCT; also added post bone marrow transplant. Added II C: Repeat DLI not medically necessary if no documented positive response from the first. Made minor wording changes in the background. Added CPT codes 38215 and 86950. Added HCPCS and ICD-10 codes.	10/16	11/16
References reviewed and updated. Code updates.	10/17	11/17

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22.

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CENTENE Corporation

Clinical Policy: Pancreas Transplantation

Reference Number: CP.MP.102
Effective Date: 04/16
Last Review Date: 03/17

Revision Log
Coding Implications

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

This policy describes the medical necessity requirements for pancreas transplantation procedures. These pancreas transplants are effective therapeutic options to arrest the progression of the complications of diabetes mellitus, and to improve the quality of life for diabetic patients. Multiple iterations of pancreas transplants exist, including: simultaneous pancreas kidney transplant (SPK), pancreas after kidney transplant (PAK), pancreas transplant alone (PTA), and islet cell transplant. The SPK procedure is most commonly performed transplant procedure, and has the highest graft survival post-operative rates.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that a pancreas transplant is **medically necessary** when meeting the all of the following*:*

- **A.** Medical therapy for condition does not exist or has failed;
- **B.** Diagnosis of diabetes mellitus, as demonstrated by one of the following:
  1. Dependent on insulin and C-peptide value ≤ 2 ng/mL,
  2. Dependent on insulin and C-peptide value ≥ 2 ng/mL and BMI ≤ maximal allowable value;
- **C.** Does not have ANY of the following contraindications:
  1. Malignancy in the past two years, except for non-melanoma localized skin cancer that has been treated appropriately;
  2. Malignancy metastasized to or extending beyond the margins of the kidney and/or pancreas;
  3. Untreatable significant dysfunction of another major organ system, unless combined organ transplantation can be performed;
  4. Acute medical instability, including, but not limited to, acute sepsis or myocardial infarction;
  5. Uncorrectable bleeding diathesis;
  6. Chronic infection with highly virulent and/or resistant microbes that are poorly controlled pre-transplant;
  7. Current non-adherence to medical therapy or a history of repeated or prolonged episodes of non-adherence to medical therapy that are perceived to increase the risk of non-adherence after transplantation;
  8. Psychiatric or psychological condition associated with the inability to cooperate or comply with medical therapy;
  9. Absence of an adequate or reliable social support system;
  10. Severely limited functional status with poor rehabilitation potential;
  11. Substance abuse or dependence (including tobacco and alcohol) without convincing evidence of risk reduction behaviors, such as meaningful and/or long-term

participation in therapy for substance abuse and/or dependence. Serial blood and urine testing may be used to verify abstinence from substances that are of concern.

D. Request is for one of the following procedures and meets the corresponding criteria:
1. *PTA*, meets all:
   a. Recurrent, severe, and potentially life-threatening metabolic complications that require medical attention, as documented by chart notes, emergency room visits, or hospitalizations, including any of the following:
      i. Severe hypoglycemia unawareness;
      ii. Marked hyperglycemia;
      iii. Recurring severe ketoacidosis;
   b. Clinical and emotional problems with exogenous insulin therapy that are so severe as to be incapacitating or consistent failure of insulin based management to prevent acute complications.
2. *SPK*, meets all:
   a. End-stage renal disease (ESRD), as defined by both
      i. Presence of uremia;
      ii. Requires dialysis or is expected to require dialysis in the next 12 months;
   b. Glomerular filtrate rate (GFR) < 20mL/min *or* creatinine clearance (CrCl) < 20mL/min
3. *PAK transplant*, meets all:
   a. Underwent successful kidney transplant without significant chronic rejection of kidney transplant;
   b. Stable kidney transplant function, as defined by both:
      i. Stable creatinine clearance ≥ 30 mL/min,
      ii. Absence of significant proteinuria.

II. It is the policy of health plans affiliated with Centene Corporation that *autologous islet cell transplants* are considered **medically necessary** as an adjunct procedure to a total or near total pancreatectomy for severe, refractory pancreatitis.

III. It is the policy of health plans affiliated with Centene Corporation that *pancreas re-transplantation and islet cell transplantation* are considered **medically necessary** after one failed primary pancreas transplant.

IV. It is the policy of health plans affiliated with Centene Corporation that pancreas transplant procedures are considered **experimental/investigational** for any of the following indications:
A. Re-transplantations after two or more failed primary pancreas and/or islet cell transplantation;
B. Allogenic islet cell transplantation or xenotransplantation;
C. SPK transplantation for patients with amputation due to peripheral obstructive vascular disease;
D. For the treatment of all other conditions than those specified above.

Background

The American Diabetes Association defines diabetes mellitus as a group of metabolic diseases, which is characterized by hyperglycemia that results from defects in insulin secretion, insulin

action, or both.[1] According to the Centers for Disease Control and Prevention (CDC)'s estimations in 2012, approximately 29.1 million people or 9.3% of the U.S. population have diabetes, with an approximate 8.1 million undiagnosed cases.[3] The chronic hyperglycemia existing in diabetic patients facilitates long term organ damage, especially to the eyes, kidneys, nerves, and blood vessels.[1]

The prevalent type 2 diabetes is caused by a resistance to insulin action and an inadequate compensatory insulin secretory response.[1] Type 1 diabetes is caused by immune mediated destruction of the insulin secreting pancreatic β cells.[2] Islet cell autoantibodies, insulin autoantibodies, autoantibodies to glutamic acid decarboxylase, zinc transporter 8 (ZnT8A), and autoantibodies to the tyrosine phosphatase IA-2 and IA-2β are serological markers of the pancreatic β cell destruction observed in type 1 diabetes.[1,2,4]

Due to the loss of glucose homeostasis in diabetes mellitus and the dependency of exogenous insulin for glycemic control, pancreatic transplantations presents options to restore glucose regulated endogenous insulin secretion, arrest the progression of the complications of diabetes, and to improve the quality of life for diabetic patients.[5] In fact, pancreas transplantation is the only proven method to restore normoglycemia in type 1 diabetic patients.

There are multiple iterations of pancreas transplantation procedures available to diabetic patients: simultaneous pancreas kidney transplant (SPK), pancreas after kidney transplant (PAK), and pancreas transplant alone (PTA), as well as islet cell transplantation. SPK, performed for patients with type 1 diabetes with end stage renal disease, is the most common pancreas transplant procedure.[6] A comprehensive analysis of the 35,000 pancreas transplantations reported to the International Pancreas Transplant Registry as of 2010, 75% of the procedures are SPK, 18% are PAK transplant, and 9% are PTA.[6]

Patient survival rates were reported at > 95% at 1 year and > 83% at 5 years.[6] The best graft survival rates were observed in SPK transplants at 86% for pancreas and 93% for kidney at one year; PAK procedures displayed graft function at 80%, while PTA had graft function at 78%.[6] Graft survival rate is defined as total freedom from insulin therapy, normal fasting blood glucose concentrations, and normal or only slightly elevated HbA1c values.[8] Patient survival rates were 95 to 98% at one year, 91 to 92 % at 3 years and 78 to 88% at 5 years post operatively.[5] In all three categories, cardio/cerebrovascular problems as well as infections were the leading cause of early and late death.[6]

Patients undergoing the pancreas transplantation, especially the SPK procedure, require extensive immunosuppression regiments; pancreas transplants recipients are believed to require higher levels of immunosuppression than other solid organ transplants, possibly related to the immunogenicity of the pancreas, and or the autoimmune status of the recipients.[7]

Pancreatic islet autotransplantation is performed following a pancreatectomy in patients with severe chronic pancreatitis. Islet β cells transferred into the liver through the portal vein of the recipient.[5] One of the primary symptoms and complications observed in patients with chronic pancreatitis is excessive pain. Therefore control of pain is a primary goal of pancreatectomy and pancreatic islet autotransplantation. Post-operative opiate usage has been reported as an outcome

metric for pain relief, and reductions ranging from approximately 20-80% have been reported due to pancreatic islet autotransplantation.[8]

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Coding Implications

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CPT®* Codes	Description
48160	Pancreatectomy, total or subtotal, with autologous transplantation of pancreas of pancreatic islet cells
48550	Donor pancreatectomy (including cold preservation), with or without duodenal segment for transplantation
48554	Transplantation of pancreatic allograft
48556	Removal of transplanted pancreatic allograft

CPT®* Codes	Description
50300	Donor nephrectomy (including cold preservation) from cadaver donor, unilateral or bilateral
50320	Donor nephrectomy (including cold preservation); open, from living donor
50340	Recipient nephrectomy (separate procedure)
50360	Renal allotransplantation, implantation of graft; without recipient nephrectomy
50365	Renal allotransplantation, implantation of graft; with recipient nephrectomy

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Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed. Reviewed by specialist 4/16.	02/16	04/16
References reviewed and updated	03/17	03/17

Important Reminder

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CLINICAL POLICY
Pancreas Transplantation

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CENTENE Corporation

Clinical Policy: Fractional Exhaled Nitric Oxide

Reference Number: CP.MP.103
Effective Date: 01/16
Last Review Date: 01/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Fractional exhaled nitric oxide (FeNO) measurement is a noninvasive and simple test thought to reflect eosinophilic airway inflammation. While measurement of FeNO is standardized, there are currently no reference guidelines available to aid practitioners in appropriately applying test results in practice.

Policy/Criteria

It is the policy of health plans affiliated with Centene Corporation® that testing for fractionated exhaled nitric oxide (FeNO) is **investigational** for diagnosing and guiding the treatment of asthma, as there is insufficient evidence proving it more than or as effective as existing standards of care**.**

Background

There are multiple methods for diagnosing and assessing control of asthma and, according to the American Thoracic Society (ATS), no single test is an adequate indicator of asthma control.[1] Conventional, objective methods to assess asthma include spirometry/peak flow and degree of airway hyper-responsiveness.[2] These methods are often used as measures of asthma control in addition to patient symptoms, clinical questionnaires, and use of rescue medications.[2,3] Newer methods of diagnosing and assessing control of asthma include the use of biomarkers of airway inflammation such as FeNO and induced sputum analysis.[4]

FeNO describes the levels of exhaled nitric oxide (NO) in the breath and NO is a mediator involved in lung inflammation that is largely formed in the lower airways.[5] Increased levels of FeNO are associated with eosinophilic inflammation, severe asthma, and inhaled glucocorticoid-naïve asthma.[4] Although there are some correlations between FeNO and characteristics related to asthma, there is large variability in FeNO levels between individuals. Other factors that may affect FeNO include atopy, sex, age, and cigarette smoking.[3] However, there are no established guidelines for adjusting FeNO values according to these factors,[3] potentially making the test less accurate for certain populations.

There are currently three types of FeNO tests approved by the FDA[5] and there is a large body of literature on FeNO testing for the diagnosis and management of asthma. Overall, the evidence is mixed for using FeNO as an adjunct to the diagnosis or management of asthma. Multiple studies have shown that FeNO can serve as an indicator of glucocorticoid response.[3,4,6] However, large studies, randomized control trials and a meta-review have found no clinical benefit to the use of FeNO testing over other methods of assessing or managing asthma.[2,4,7-9]

Among the studies that found a benefit to the use of FeNO testing,[6,10-13] there was little agreement regarding FeNO cutoff values which would indicate asthma diagnosis or control.[3,5]

Although the ATS has recommended specific FeNO cutoff values to serve as guidelines for the diagnosis and treatment of asthma,[14] these standardized values have not been consistently used in the research to date on FeNO testing.[3-5] An additional drawback to FeNO testing for the diagnosis or management of asthma is that it is most indicative of inflammation caused by eosinophils, which characterizes only one subtype of asthma.[4]

A 2016 Cochrane Review evaluating the use of FeNO in guiding treatment for adults with asthma concluded that, while management guided by FeNO levels results in reduced exacerbations, it cannot be advocated universally since it does not affect day-to-day clinical symptoms, end-of-study FeNO levels, or inhaled corticosteroid dose.[15] Furthermore, a systematic review and meta-analysis evaluating the diagnostic accuracy of FeNO in asthmatic children found that FeNO has only moderate diagnostic performance.[16]

Given the equivocal results of research on the accuracy and usefulness of FeNO testing for the diagnosis and management of asthma, the lack of standardized cutoff values, and the need for further study, FeNO testing for the diagnosis and/or management of asthma is considered experimental, investigational, or unproven.

Coding Implications

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CPT®* Codes	Description
95012	Nitric Oxide expired gas determination

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ICD-10-CM Diagnosis Codes that Support Coverage Criteria – Not Applicable

ICD-10-CM Code	Description
n/a	

Reviews, Revisions, and Approvals	Date	Approval Date
Policy created	12/15	01/16
Changed FeNO to investigational from not medically necessary. References reviewed and updated, along with background information.	12/16	01/17

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1. Reddel HK, Taylor DR, Bateman ED, et al. An official American Thoracic Society/European Respiratory Society statement: asthma control and exacerbations; standardizing endpoints for clinical asthma trials and clinical practice. *Am J Respir Crit Care* Med. 2009; 180: 602-615. doi: 10.1164/rccm.200801-060ST
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Important reminder

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CLINICAL POLICY
Fractional Exhaled Nitric Oxide

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CENTENE Corporation

Clinical Policy: Digital EEG Spike Analysis

Reference Number: CP.MP.105
Effective Date: 02/16
Last Review Date: 12/16

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Electroencephalography (EEG) is a significant component of epilepsy diagnosis, along with a thorough medical history and neurological workup. Most EEGs today are performed on digital machines which record data and automatically detect spikes that may indicate seizures (ACNS, 2008). For the purpose of this policy, digital EEG spike analysis refers to additional analysis of digitally recorded EEG spikes by a physician and/or technician. Digital EEG spike analysis is also called 3D dipole localization or dipole source imaging.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that digital EEG spike analysis is **medically necessary** for members meeting the following criteria:

A. Intractable epilepsy with a need for presurgical evaluation including topographic voltage and/or dipole analysis in conjunction with any of the following:
   1. Video EEG
   2. Quantitative EEG

II. It is the policy of health plans affiliated with Centene Corporation® that digital EEG spike analysis is **not medically necessary** for any other indication.

Background

According to the American Clinical Neurophysiology Society's (ACNS) Guidelines for Long Term Monitoring of Epilepsy, digital EEG is the industry standard (2008). Ambulatory EEG, video EEG, and routine EEG all use digital technology and usually incorporate automatic spike detection. A report by the American Academy of Neurology (AAN) and the ACNS states that multiple well-designed studies have established automatic spike and seizure detection via digital EEG as highly sensitive, though not very specific (1997, p. 280). This is also true of EEG in general. There are several reasons that an EEG would record a false positive, and most EEG patterns can be caused by a wide variety of neurologic conditions, while many diseases can produce more than one type of EEG pattern (Moeller, Haider & Hirsch, 2015). Nonetheless, the AAN recommends EEG with automatic seizure and spike detection in clinical practice, commenting that "general clinical use in the community has been very positive" (AAN & ACNS, 1997). Automatic spike detection can save a great amount of time as a technician or electroencephalographer does not have to visually review hours or days of data. However, there are some circumstances in which further analysis of the EEG is required, beyond the automatic digital spike analysis.

The ACNS states that in general, 3D dipole localization would require an extra hour of work by a technician, and 20-30 minutes of physician time to review the technician's work and data produced. Moreover, digital EEG analysis by 3D dipole localization is an advanced procedure

that is most commonly used at epilepsy surgery centers, where staff are familiar with how to perform it. The AAN and ACNS recommend further digital analysis, in conjunction with review by a technician or provider, in the noninvasive evaluation of candidates for epilepsy surgery (AAN & ACNS, 1997, p. 281). They note that:

> "The well-designed studies of this specific technique [dipole analysis] are few but consistent and confirmed in follow-up postoperatively. The clinical rationale seems clear. Control testing for evoked potential known cortical generator sites has confirmed the technical accuracy of dipole localization. The use of dipole analysis seems sufficiently demonstrated to warrant its clinical use in patients undergoing evaluation for surgical therapy for epilepsy. In other clinical settings, it has not been demonstrated to be sufficiently clinically useful to warrant general clinical use at this time" (AAN & ACNS, 1997, p. 280).

It is important to note that the ACNS specifically states that ambulatory EEG is not appropriate for "detailed characterization of EEG features as is required in presurgical evaluation" (ACNS, 2008, p. 15).

3D spike dipole source analysis, or digital EEG spike analysis, has been shown to be concordant with other modes of presurgical evaluation of epilepsy, including a thorough neurological workup with video EEG, magnetic resonance imaging (MRI), and multiple other imaging and neuropsychological tests; electrocorticography; and magnetoencephalography (Park et al., 2015). Furthermore, Park and others cite three other studies demonstrating "that dipole source models can be successfully employed to detect the epileptogenic foci of interictal epileptiform discharges" (2015). Park and others agree with the AAN and ACNS that digital EEG spike analysis is "recommended for the presurgical evaluation of intractable epilepsy patients (2015).

Coding Implications

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CPT®* Codes	Procedure codes that support medical necessity criteria
95957	**Digital EEG spike analysis** when performed in conjunction with any of the following:
95830	Insertion by physician or other qualified health care professional of sphenoidal electrodes for electroencephalographic (EEG) recording
95950	Monitoring for identification and lateralization of cerebral seizure focus, electroencephalographic (eg, 8 channel EEG) recording and interpretation, each 24 hours

CPT®* Codes	Procedure codes that support medical necessity criteria
95951	Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, combined electroencephalographic (EEG) and video recording and interpretation (eg, for presurgical localization), each 24 hours
95953	Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG, electroencephalographic (EEG) recording and interpretation, each 24 hours, unattended
95954	Pharmacological or physical activation requiring physician or other qualified health care professional attendance during EEG recording of activation phase (eg, thiopental activation test)
95955	Electroencephalogram (EEG) during nonintracranial surgery (eg, carotid surgery)
95956	Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, electroencephalographic (EEG) recording and interpretation, each 24 hours, attended by a technologist or nurse
95958	Wada activation test for hemispheric function, including electroencephalographic (EEG) monitoring

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ICD-10-CM Diagnosis Codes that Support Coverage Criteria
+ indicates a code requiring an additional character

ICD-10-CM Code	Diagnosis codes that support medical necessity criteria
G40.011	Localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset, intractable, with status epilepticus
G40.019	Localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset, intractable, without status epilepticus
G40.111	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, intractable, with status epilepticus
G40.119	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, intractable, without status epilepticus
G40.211	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, intractable, with status epilepticus
G40.219	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, intractable, without status epilepticus
G40.311	Generalized idiopathic epilepsy and epileptic syndromes, intractable, with status epilepticus

ICD-10-CM Code	Diagnosis codes that support medical necessity criteria
G40.319	Generalized idiopathic epilepsy and epileptic syndromes, intractable, without status epilepticus
G40.411	Other generalized epilepsy and epileptic syndromes, intractable, with status epilepticus
G40.419	Other generalized epilepsy and epileptic syndromes, intractable. without status epilepticus
G40.803	Other epilepsy, intractable, with status epilepticus
G40.804	Other epilepsy, intractable, without status epilepticus
G40.813	Lennox-Gastaut syndrome, intractable, with status epilepticus
G40.814	Lennox-Gastaut syndrome, intractable, without status epilepticus
G40.823	Epileptic spasms, intractable, with status epilepticus
G40.824	Epileptic spasms, intractable, without status epilepticus
G40.911	Epilepsy, unspecified, intractable, with status epilepticus
G40.919	Epilepsy, unspecified, intractable, without status epilepticus
G40.A11	Absence epileptic syndrome, intractable, with status epilepticus
G40.A19	Absence epileptic syndrome, intractable, without status epilepticus
G40.B11	Juvenile myoclonic epilepsy, intractable, with status epilepticus
G40.B19	Juvenile myoclonic epilepsy, intractable without status epilepticus

Reviews, Revisions, and Approvals	Date	Approval Date
Policy Created	1/16	1/16
References reviewed and updated. Added 6th digit to ICD 10 coding to clarify with or without status epilepticus, no codes added	12/16	1/17

References

1. American Academy of Neurology and the American Clinical Neurophysiology Society. Assessment of digital EEG, quantitative EEG, and EEG brain mapping: Report of the American Academy of Neurology and the American Clinical Neurophysiology Society. 1997. Reaffirmed 2013. *Neurology*, 49, 277-292. http://www.neurology.org/content/49/1/277.full.pdf+html
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Important reminder

CLINICAL POLICY
Digital EEG Spike Analysis

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Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and

CLINICAL POLICY
Digital EEG Spike Analysis

Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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CENTENE Corporation

Clinical Policy: Endometrial Ablation

Reference Number: CP.MP.106
Effective Date: 02/16
Last Review Date: 09/17

Revision Log
Coding Implications

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

This policy describes the medical necessity guidelines for an endometrial ablation. Endometrial ablation is a minimally invasive surgical procedure used to treat premenopausal abnormal uterine bleeding. Although this procedure preserves the uterus, endometrial ablation is indicated for those who have no desire for future fertility. The two major classifications of endometrial ablation procedures are first generation resectoscopic techniques and second generation non-resectoscopic methods. Quality of life may improve following endometrial ablation procedures.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that endometrial ablation using an FDA approved device is **medically necessary** when all the following criteria are met:

- **A.** One of the following indications:
  1. Menorrhagia unresponsive to at least 3 months of hormonal or medical therapy (unless contraindicated to such therapy); or
  2. To stop residual menstrual bleeding after at least 6 months of androgen therapy in a female to male transgender person who meets the gender dysphoria and eligibility criteria in CP.MP.95 Gender Reassignment Surgery policy;
- **B.** Cervical cytology and gynecological exam excludes significant cervical disease;
- **C.** No structural anomalies, such as fibroids or polyps that require surgery or represent a contraindication to an ablation procedure, such as classical cesarean incision resulting in a weakened myometrium;
- **D.** Endometrial sampling prior to the procedure has excluded malignancy or hyperplasia;
- **E.** If anatomic or pathologic conditions exist that may result in a weakened myometrium, only a resectoscopic endometrial ablation is appropriate;
- **F.** Does not have any of the following contraindications:
  1. Premenopausal with future desire for fertility;
  2. Untreated disorders of hemostasis;
  3. Pregnancy at time of procedure;
  4. Intrauterine device at time of procedure;
  5. Active pelvic infection.

II. It is the policy of health plans affiliated with Centene Corporation that endometrial ablation is **experimental/investigational** as follows:

- **A.** Photodynamic endometrial ablation procedures;
- **B.** For the treatment of all other conditions than those specified above.

CLINICAL POLICY
Endometrial Ablation

Background
Menstrual disorders are among the most prevalent gynecological health problems in the United States, and abnormal menstrual bleeding affects up to 30% of people at some time during their reproductive years.[5] Endometrial ablation is a minimally invasive surgical procedure used to treat premenopausal, abnormal uterine bleeding.

Endometrial ablation can also be used to treat residual menstrual bleeding in transgender men. Generally, masculinizing hormones cause cessation of menses within 2 – 6 months of initiation. Addition of a progestational agent or endometrial ablation may be considered for those wishing to completely cease menses.

Endometrial ablation encompasses several techniques of targeted destruction of the endothelial surface of the uterine cavity through a vast array of energy sources. While hysterectomies provide permanent relief from abnormal uterine bleeding, they are also associated with longer recovery times, higher rates of postoperative complications, substantial convalescent time and morbidity.[9,10] Although endometrial ablation has a high success rate, there are specific cases of endometrial ablation failures in which the patient will return for repeat care, often for a hysterectomy.[10] Among patients who return for hysterectomy after failure of endometrial ablation, endometriosis is the most common contributing diagnosis.[21]

Pregnancy following endometrial ablation can occur, and premenopausal patients should be counseled that an appropriate contraception method should be used.[1] However endometrial ablation is predominately indicated for patients who have no desire for future fertility.[1] Post-operative complications from endometrial ablation include: (1) pregnancy after endometrial ablation; (2) pain-related to obstructed menses (hematomata, post ablation tubal sterilization syndrome); (3) failure to control menses; (4) risk from preexisting conditions (endometrial neoplasia, cesarean section; and (5) infection.[14]

Table 1: FDA-Approved Techniques Approved For Endometrial Ablation

Procedure[1,2,3]	System[1,2]	Device Size[1] (mm)	Treatment Time[1,] (min)	Amenorrhea Rate[2]
Resectoscopic Ablation				
Laser Vaporization				37%
Electrosurgical Rollerball				25-60%
Transcervical resection of endometrium				26-40%
Radiofrequency Vaporization				N/A
Non-Resectoscopic Ablation				
Cryotherapy	Her Option	4.5	10–18	53%
Heated Free Fluid	Hydro ThermAblator	7.8	~ 14 *	71%
Microwave		8.5	2.5–4.5	61%
Radiofrequency Electricity	NovaSure	7.2	1.5	41%

* 3 minutes to heat the fluid to 90°C, 10 minutes to maintain that temperature to ablate the endometrium, and approximately 1 minute for the fluid to cool down allowing the device to be removed.

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Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2017 American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
58353	Endometrial ablation, thermal, without hysteroscopic guidance
58356	Endometrial cryoablation with ultrasonic guidance, including endometrial curettage, when performed
58563	Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
N92.0	Excessive and frequent menstruation with regular cycle
N92.1	Excessive and frequent menstruation with irregular cycle
N92.4	Excessive bleeding in the premenopausal period

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed, reviewed by specialist	12/15	01/16
Language clarifications d/t confusion in criteria, no specific criteria change: I.C clarified that structural anomalies be limited to those requiring surgery or are otherwise a contraindication to EA I.E language clarified I.F removed anatomic or pathologic conditions affecting the myometrium as this is similar to I.C. I.F.2 added “untreated” for disorders of hemostasis	06/16	
Changed active pelvic inflammatory disease to active pelvic infection Removed postmenopausal women from contraindications as this is a relative, not absolute, contraindication.	08/16	9/16

Reviews, Revisions, and Approvals	Date	Approval Date
Added indication for residual menstrual bleeding in female to male transgender persons after androgen therapy, no codes added as ICD-10 codes would still be applicable for new indication.	09/16	10/16
References reviewed and updated	08/17	09/17

Important reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

CLINICAL POLICY
Endometrial Ablation

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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CENTENE Corporation

Clinical Policy: DME and O&P Criteria

Reference Number: CP.MP.107
Effective Date: 08/09
Last Review Date: 02/17

Coding Implications
Revision Log

See Important Reminder **at the end of this policy for important regulatory and legal information.**

Description

DME is defined as equipment that can stand repeated use, is primarily and customarily used to serve a medical purpose, and is generally not useful to a person in the absence of an illness or injury. Orthotic devices are rigid and semi-rigid devices used for the purpose of supporting a weak or deformed body part or restricting or eliminating motion in a disease or injured body part. Prosthetic devices are custom-made artificial limbs or other assistive devices for people who have lost limbs as a result of traumatic injuries, vascular disease, diabetes, cancer or congenital disorders.

Policy/Criteria

It is the policy of health plans affiliated with Centene Corporation® that durable medical equipment, orthotics, and prosthetics are **medically necessary** when the applicable criteria are met.

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AMBULATORY ASSIST PRODUCTS	CRITERIA	HCPCS
Gait trainers	Medically necessary with therapist evaluation and ongoing treatment when *all* of the following criteria are met: • Member requires moderate to maximum support for walking; • Cleared medically for weight bearing and can physiologically tolerate upright positioning; • The member has been evaluated with the requested gait trainer, can tolerate the positioning in the device, and has successfully demonstrated proper use; • The member and caregivers have been trained on the gait trainer and are motivated to continue ongoing use.	E8000 E8001 E8002

BURN GARMENTS	CRITERIA	HCPCS
Burn garments	Medically necessary with associated physical and/or occupational therapy when *all* of the following criteria are met: • The burn is of documented significance to place the member at risk of a post-burn contracture; • The burn garment and physical and/or occupational therapies are being used with the intent of preventing the need for skin grafting or contractures as a result of hypertrophic scarring; • The burn garment is requested by the primary care physician and/or the treating specialist.	A6501 A6507

CARDIAC EQUIPMENT	CRITERIA	HCPCS
Cardiac event recorder, implantable	Medically necessary for members for evaluation of recurrent unexplained episodes of pre-syncope, syncope, "seizures", palpitations, or dizziness when both of the following criteria are met: A. A cardiac arrhythmia is suspected as the cause of the symptoms; B. Either of the following criteria are met: 1. Members with heart failure, prior myocardial infarction or significant ECG abnormalities (see below): noninvasive ambulatory monitoring, consisting of 30-day pre-symptom external loop recordings or MCT, fails to establish a definitive diagnosis; 2. Members without heart failure, prior myocardial infarction or significant ECG abnormalities (see below) and symptoms occur so infrequently and unpredictably (less frequently than once per month) that noninvasive ambulatory monitoring (MCT or external loop recorders) are unlikely to capture a diagnostic ECG. **Significant ECG Abnormalities** • Syncope during exertion or supine • Palpitations at the time of syncope • Family history of SCD • Non-sustained VT	E0616

CARDIAC EQUIPMENT	CRITERIA	HCPCS
	• Bifascicular-block (LBBB or RBBB combined with left anterior or left posterior fascicular block) or other intraventricular conduction abnormalities with QRS duration ≥120 ms • Inadequate sinus bradycardia (<50 bpm) or sinoatrial block in absence of negative chronotropic medications or physical training • Pre-excited QRS complex • Prolonged or short QT interval • RBBB pattern with ST-elevation in leads V1-V3 (Brugada pattern) • Negative T waves in right precordial leads, epsilon waves, and ventricular late potentials suggestive of ARVC Medically necessary for evaluation of members with suspected atrial fibrillation as a cause of cryptogenic stroke who have had a nondiagnostic Holter monitor or 48 hour telemetry	
External defibrillator with integrated ECG analysis	Considered not medically necessary as it is primarily considered a safety device	E0617

COMPRESSION THERAPY EQUIPMENT	CRITERIA	HCPCS
Pneumatic compression devices	For lymphedema of the abdomen, trunk, chest, genitals, or neck; and for arterial insufficiency, is considered experimental/investigational, thus not medically necessary. Refer to Interqual for requests for extremity lymphedema due to venous insufficiency.	E0670 E0675

DIABETES CARE EQUIPMENT	CRITERIA	HCPCS
Blood glucose monitor with integrated voice synthesizer	Medically necessary for members with diabetes who are legally blind (best corrected visual acuity less than 20/200).	E2100

HEAT, COLD & LIGHT THERAPY EQUIPMENT	CRITERIA	HCPCS
Ultraviolet panel lights	Medically necessary for members who have both: • Refractory psoriasis; • MD must justify treatment at home versus alternate sites (e.g. Outpatient department at hospital). Panel lights should be considered, if several discrete body areas can be treated individually. Cabinet style should be reserved for members with extensive involvement > 54% of body surface area.	E0691 E0692 E0693 E0694

HEAT, COLD & LIGHT THERAPY EQUIPMENT	CRITERIA	HCPCS
Cold pad pump	Medically necessary as a replacement for a water pump cold pad that is no longer functioning from normal wear and tear.	E0236

NEWBORN CARE EQUIPMENT	CRITERIA	HCPCS
Breast pumps	Medically necessary for members for the following: • Breast feeding mother if it is a covered benefit in the State, and • Less than $250.00 as a purchase • If >$250 approve as rental up to purchase price then convert to purchase • Limit one per member.	E0604

ORTHOPEDIC CARE EQUIPMENT	CRITERIA	HCPCS
Traction equipment & fracture frames	Home traction therapy is unproven and considered experimental/investigational, not medically necessary.	E0849, E0947, E0948
Rollabout chair	Medically necessary when used in lieu of a wheelchair for members who would qualify for a wheelchair (except for the ability to self-propel a manual wheelchair).	E1031
Flexion/extension devices	Considered medically necessary for the following: • < 6 months following surgery or intervention to improve motion/stiffness in a joint; • Has been compliant with both therapy and home exercise programs.	E1801, E1810, E1811, E1815, E1818
Halo procedure equipment	Halo placement is generally performed on an emergent or inpatient basis and will be reviewed at the appropriate level of care using nationally recognized decision support tools.	L0810, L0820, L0830, L0859
Cervical collar, custom molded	Requests for custom molded cervical collar will be reviewed by a licensed physical or occupational therapist. Documentation accompanying the request must state reason why pre-fabricated collar not adequate.	L0170, L0190, L0200
Spinal orthotics	Requests for spinal orthotics will be reviewed using relevant nationally recognized decision support tools.	L0700, L0710, L0999, L1000, L1001, L1005
Hip orthotics	Medically necessary when ordered by an orthopedist for treatment of, or postoperatively for, total hip arthroplasty, slipped capital femoral epiphysis, Legg-Calvé-Perthes disease, and hip dysplasia for Charcot-Marie-Tooth disease. Lateral replacements are considered medically necessary in pediatrics due to growth for	L1640, L1680, L1685, L1686, L1690

ORTHOPEDIC CARE EQUIPMENT	CRITERIA	HCPCS
	diagnoses such as hip dysplasia with Charcot-Marie-Tooth disease.	
Legg Perthes orthotics	Medically necessary when ordered by an orthopedist for use in the treatment for Legg-Calvé-Perthes disease in children.	L1700, L1710, L1720, L1730, L1755
Hip-knee-ankle-foot orthotics (KAFO/HKAFO)	Requests for orthotics will be reviewed using relevant nationally recognized decision support tools.	L2050, L2060, L2090,
Orthotic components	Requests for orthotic components listed will be reviewed using relevant nationally recognized decision support tools.	L2570, L2580, L2627, L2628, , L2999
Orthopedic footwear, custom	Requests for custom orthotic components will be reviewed using relevant nationally recognized decision support tools.	L3230
Shoulder, elbow, wrist, hand, finger orthotics	Medically necessary when ordered immediately post-operative for orthopedic surgeries such as rotator cuff repair, tendon repair, or ORIF. Replacement due to normal wear and tear is considered medically necessary when the item is a lateral purchase and the orthotic is still needed; Coverage is based on contract guidelines for replacement DME.	L3720, L3730, L3740, L3760, L3900, L3901, L3904, L3960, L3962, L3981, L3999, L4000, L4010, L4020, L4030, L4130, L4205
Prosthetics and additions	Requests for these prosthetics and additions will be reviewed by a licensed physical or occupational therapist.	L5990, L6000, L6010, L6020, L6026, L6050, L6055, L6100, L6110, L6120, L6130, L6200, L6205, L6250, L6300, L6310, L6320, L6350, L6360, L6370, L6380, L6382, L6384, L6386, L6388, L6400, L6450, L6500, L6550, L6570, L6580, L6582, L6584, L6586, L6588, L6590, L6623, L6624, L6625, L6628, L6638, L6646, L6647, L6648, L6689, L6690, L6692, L6693, L6704, L6707, L6708, L6709, L6711, L6712, L6713, L6714, L6715, L6721, L6722, L6885, L6895, L6900, L6905, L6910, L6915, L6920, L6930, L6940, L6950, L6960, L6965, L6970, L6975, L7040, L7170, L7185, L7186, L7405, L7499

OTHER EQUIPMENT	CRITERIA	HCPCS
Positioning seat	Medically necessary with therapist evaluation and ongoing treatment and *all* of the following criteria are met: • Commercial device must be unable to meet the positioning needs of the member due to height, weight, or disability; • Other positioning devices in the home must be reviewed to ensure a duplication of devices is not already in place;	T5001
Specialized supply or equipment	• Requests for not otherwise specified supplies will have a physician review to determine medical necessity.	T2028 T2029

PUMPS	CRITERIA	HCPCS
Enteral pumps and supplies (food pumps)	Medically necessary for members dependent upon tube feedings for nutritional support as sole source of nutrition and member cannot tolerate gravity or syringe feedings or requires a controlled rate of infusion. • Portable pumps are covered in lieu of stationary pumps if condition requires continuous feeding and/or the member is able to leave the home for prolonged periods such as for physician office visits or medical therapies.	B9000 B9002 B9004 B9006
Parenteral pumps and supplies	Medically necessary for members dependent on parenteral nutrition (TPN) as their source of nutrition and/or requires parenteral administration of medication via pump.	K0455
Gastric suction pump, home model	Medically necessary for members with a medical need for gastric suction in the home.	E2000
Male vacuum erection device	A vacuum erection device (VED) and tension ring are medically necessary for the treatment of erectile dysfunction due to organic impotence when meeting all of the following criteria: • Had an in-person clinical evaluation with the treating physician within six (6) months prior to ordering the VED; • No evidence of symptomatic or untreated hypogonadism or hyperprolactinemia; • Other treatment options have been tried or considered and ruled out, and the result or contraindication must be provided.	L7900

RESPIRATORY EQUIPMENT	CRITERIA	HCPCS
Nebulizer, ultrasonic	Medically necessary for members when used for delivery of pentamidine or aerosolized antibiotics.	E0575
IPPB & supplies	Medically necessary for members with respiratory disease when an incentive spirometer is ineffective.	E0500 E0550
Oximeter	Medically necessary when used as a monitoring and alarm device for any of the following: • To monitor individuals on a home ventilator or with a tracheostomy • To determine appropriate home oxygen requirements • To wean an individual from home oxygen • To monitor an unstable respiratory condition	E0445

RESPIRATORY EQUIPMENT	CRITERIA	HCPCS
	Not medically necessary when used for the following: • Oximetry when used as a diagnostic procedure • Monitoring of a stable respiratory condition • Asthma management • Other conditions not listed above	
Oxygen tent	Medically necessary for members whose ability to breathe is impaired and supplemental oxygen is required. Example diagnosis includes croup.	E0455
Ventilator Second home ventilator	Medically necessary for members with a long-term/chronic condition or disease affecting the ability to effectively maintain adequate respiratory status. Examples of conditions may include neuromuscular disease, thoracic restrictive disease, or chronic respiratory failure following COPD. A second invasive or non-invasive ventilator is considered medically necessary if required for a different purpose from the first ventilator, based on the member's medical needs. Examples include: • Two different types of ventilators are needed for each day, e.g., negative pressure ventilator with chest shell for one indication and a positive pressure ventilator with nasal mask the rest of the day; • Member is confined to a wheelchair and requires a wheel-chair mounted ventilator during the day and another ventilator of the same type for use while in bed. Without both pieces of equipment, member may be prone to medical complications, unable to achieve appropriate medical outcomes, or may not be able to use the equipment effectively. Members residing in remote areas with poor emergency access may also be considered for a second ventilator.	E0465 E0466

STIMULATOR EQUIPMENT	CRITERIA	HCPCS
Neuromuscular stimulator	Medically necessary (E0745) when used as one component of a comprehensive rehab program for the treatment of disuse atrophy when the nerve supply to the atrophied muscle is intact and has any of the following indications for disuse atrophy: • Contractures due to burn scarring; • Previous casting or splinting of a limb; • Major knee surgery with failure to respond to physical therapy; • Recent hip replacement until physical therapy begins. Neuromuscular electrical stimulation for any other indication (e.g., idiopathic scoliosis [E0744], heart failure) is not medically necessary because it is considered experimental/investigational or unproven.	E0745

STIMULATOR EQUIPMENT	CRITERIA	HCPCS
Functional neuromuscular stimulator	Medically necessary for members with a spinal cord injury (SCI) who meet ALL the following criteria: • Member has intact lower motor units (L1 and below (both muscle and peripheral nerve); • Member has muscle and joint stability adequate for weight bearing upper and lower extremities to allow balance and control to maintain an upright support posture independently; • Member has brisk muscle contraction to stimulation and sensory perception electrical stimulation sufficient for muscle contraction; • Member can transfer independently and demonstrates independent standing tolerance for at least 3 minutes; • Member can demonstrate hand and finger function to manipulate controls; • Member has no hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis; • Member is at least 6 months post recovery from SCI and restorative surgery; • Member is highly motivated, committed, and has the cognitive ability to use such devices for walking; • Member has demonstrated a willingness to use the device long-term; • Member has successfully completed a training program consisting of at least 32 physical therapy sessions with the device over a 3-month period. Exclusion criteria includes members with any of the following: • Cardiac pacemaker; • Severe scoliosis or severe osteoporosis; • Skin disease or cancer at area of stimulation; • Irreversible contracture; • Autonomic dysflexia.	E0764
Implantable neurostimulator	Diaphragmatic pacing is medically necessary for the treatment of chronic ventilatory insufficiency due to bilateral paralysis or severe paresis of the diaphragm in members with partial or complete ventilatory insufficiency that retain sufficient function in the phrenic nerves, lungs and diaphragm to accommodate electrical stimulation. See CP.MP.12 Vagus Nerve Stimulation for criteria for implantation of stimulator for epilepsy and depression.	L8681 L8684 L8689

SURGICAL SUPPLIES	CRITERIA	HCPCS
Ambulatory infusion pump	Medically necessary for members when used for one of the following indications:	E0781

SURGICAL SUPPLIES	CRITERIA	HCPCS
	• Iron Poisoning: when used in the administration of deferoxamine for the treatment of acute iron poisoning and iron overload; • Chemotherapy for liver cancer: when used in the treatment of primary hepatocellular carcinoma or colorectal cancer where this disease is unresectable; OR, where the patient refuses surgical excision of the tumor; • With morphine when used in the treatment of intractable pain caused by cancer.	
Implantable infusion pumps	Medically necessary for members when used for one of the following indications: A. Chemotherapy for liver cancer 1. Primary hepatocellular carcinoma or Duke's Class D colorectal cancer, in which the metastases are limited to the liver and where either the disease is unresectable, or the patient refuses excision of the tumor; B. Anti-spasmodic drugs for severe spasticity 1. When administered intrathecal to treat chronic intractable spasticity in patients unresponsive to less invasive medical therapy including both of the following: a. A 6-week trial of noninvasive methods, such as oral anti-spasmodic drugs, that failed to adequately control the spasticity or produced intolerable side effects; b. Prior to pump implantation, member responded favorably to a trial of intrathecal dose of the anti-spasmodic drug; C. Opioid drugs for treatment of chronic intractable pain 1. When administered intrathecal or via epidural for the treatment of severe chronic intractable pain of malignant of nonmalignant origin in patients whose life expectancy is at least 3 months and who have proven unresponsive to less invasive medical therapy as indicated by both of the following: a. Member history indicates inadequate response to noninvasive methods of pain control such as systemic opioids; b. Preliminary trial of intraspinal opioid drug administration provided adequate pain relief with minimal side effects; D. Other uses of implantable infusion pumps when all of the following are met: 1. The drug is reasonable and necessary for the treatment of an individual member; 2. It is medically necessary that the drug be administered by an implanted infusion pump. The infusion pump has been FDA-approved for the drug being administered and the purpose for which it is being administered.	E0782 E0783 E0785 E0786

SURGICAL SUPPLIES	CRITERIA	HCPCS
Other surgical supplies	These items are used as part of a surgical procedure and will be reviewed according to the relevant surgical procedure or level of care.	L8035, L8040, L8041, L8042, L8043, L8044, L8045, L8046, L8047, L8499, L8600, L8609, L8610, L8612, L8615, L8631, L8659

WOUND CARE	CRITERIA	HCPCS
GammaGraft	Experimental/investigational, considered not medically necessary	Q4111
Whirlpool tub	Considered not medically necessary.	E1310

Coding Implications
Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Background
DME items have the following characteristics:

- The equipment is prescribed by a physician;
- The equipment meets the definition of DME;
- The equipment is necessary and reasonable for the treatment of a member's illness or injury;
- The equipment is manufactured primarily for use in the home environment but is not limited to use in the home.

Member's Home
For purposes of rental and purchase of DME, a member's home may be his/her own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution.
However, an institution may not be considered a member's home if the following are met:

- Meets at least the basic requirement in the definition of a hospital, i.e., it is primarily engaged in providing by or under the supervision of physicians, to inpatient, diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, and sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons; or
- Meets at least the basic requirement in the definition of a skilled nursing facility, i.e., it is primarily engaged in providing to inpatients skilled nursing care and related services for members who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

Members who have been permanently admitted to an inpatient skilled nursing facility or inpatient hospice and who have changed their home address to that of the SNF or hospice will have the SNF or hospice defined as their home.

Products
Products is defined as a listing of the most common items, or group of items, that are or may be perceived as home medical equipment. This listing, while reasonably complete, is not intended to quantify the entire spectrum of products that may be considered DME either now or in the future.

Durability
An item is considered durable if it can withstand repeated use, i.e., the type of item that could normally be rented. Medical supplies of an expendable nature, such as incontinence pads, lamb's wool pads, catheters, ace bandages, elastic stockings, surgical facemasks, sheets, and bags are not considered "durable" within the meaning of the definition. There are other items that although durable in nature, may fall into other coverage categories such as supplies and orthotics and prosthetics. Orthotics and Prosthetics items include, but are not limited to, braces, artificial limbs and eyes.

Medical Equipment
Medical equipment is defined as equipment primarily and customarily used for medical purposes and is not generally useful in the absence of illness or injury. In most instances, no documentation will be needed to support whether a specific item of equipment is medical in nature. However, some cases will require documentation to determine whether the item constitutes medical equipment. This documentation would include the advice of local medical organizations and facilities and specialists in the field of physical medicine and rehabilitation. If the equipment is new on the market, it may be necessary, prior to seeking professional advice, to obtain information from the supplier or manufacturer explaining the design, purpose, effectiveness and method of using the equipment in the home as well as the results of any tests or clinical studies that have been conducted.

Personal computers or mobile technology such as iPads, smart phones, iPods, personal digital assistants, etc., may be considered as medical equipment when used for the purpose of speech generating equipment when other non-medical functions are limited or disabled and that device is used as the primary source of communication for those qualifying for a speech generating device.

Reviews, Revisions, and Approvals	Date	Approval Date
Removed all references to previous vendor and referrals to health plan for review	04/13	
Updated HCPCS codes	04/13	
Reviewed and revised to refer to InterQual when InterQual criteria are available. Enteral formula criteria removed to individual policy CP.MP.85 Specialist review (OT)	05/13	06/13

Reviews, Revisions, and Approvals	Date	Approval Date
Updated enteral pump guidelines	07/13	08/13
Updated criteria to only include items on the PA list that do not have existing nationally recognized decision support criteria Removed DME Supply guidelines Specialist review (PT & OT)	11/13	01/14
Updated HCPCS codes for existing criteria to current DME PA list Ventricular assist device replacement parts removed d/t removal from DME PA list Added traction equipment/ fracture frame Removed protective helmet d/t existing InterQual criteria available Removed emergency response system criteria as no longer on the DME PA list Added male vacuum erection device Removed Q4100 & Q4118 skin substitutes as no longer on the DME PA list Added ambulatory infusion pump criteria Added specific criteria for gait trainers and positioning chairs Specialist Review (PT & OT)	01/15	02/15
2015 codes added: L6026 and L7259 to prosthetic section and L3981 added to shoulder orthotic section	03/15	
Updated HCPCS codes per 2016 CMS mandate, removed deleted codes. Changed “lymphedema pumps” to “pneumatic compression devices” for lymphedema or arterial insufficiency. Updated template. Removed oral device criteria and codes which are now covered in Interqual Retitled to CP.MP.107	2/16	2/16
Moved language from Policy/Criteria sections A, B, and C to background and removed definitions of necessary and reasonable. Deleted diagnostic equipment table and moved oximetry to respiratory table, and biofeedback to other equipment table. Clarified that oximetry for diagnostic screening is not a DME use.	07/16	07/16
Removed A6503, E0656, E0657, E0221, E0270, E0840, E0850, E0855, E0856, E0860, E0870, E0880, E0890, E0800, E0930, E0941, E0942, E0945, E0946, L2861, L5969, E0746, E2120, E0457, E0459, E0462, E0744, E0762, L8685, Q4114, Q4130 as they are not on DME or O&P PA list Removed L5782, L6621, L6686, L6687, L6688, L6694, L6695, L6696, L6697, L6698, L6880, L6881, L6682, L7007, L7008, L7009, L7045, L7180, L7181, L7190, L7191, L7366, L7404, L8680, L8682, L8683, L8686, L8687, L8688 because other criteria now exists Added implantable cardiac event recorder as medically necessary in some cases of cryptogenic stroke Added E1801, E1818, L0648, L0650, L0651, L6020, L6026, L6500, Q4111 as they are on PA and no other criteria exists	01/17	02/17
Added background section on use of mobile devices as speech generating devices.	09/17	09/17

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Important Reminder

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The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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CENTENE Corporation

Clinical Policy: Allogenic Hematopoietic Cell Transplants for Sickle Cell Anemia and β-Thalassemia

Reference Number: CP.MP.108
Effective Date: 03/16
Last Review Date: 03/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

This policy describes the medical necessity requirements for allogenic hematopoietic cell transplants for sickle cell anemia and β–thalassemia. Sickle cell anemia and β–thalassemia are two hemoglobinopathies caused by deleterious genetic alterations in hemoglobin. These monogenic diseases present a range of heterogeneous symptoms that stem from damaged red blood cell function. Despite its limitations, allogenic hematopoietic cell transplants are the only curative therapies possible for these hemoglobinopathies.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation that allogenic hematopoietic cell transplants for sickle cell anemia and homozygous β-thalassemia are **medically necessary** for members when all the following criteria are met:

- **A.** *Sickle Cell Anemia*, meets all:
  1. Age ≤ 45 years (children and young adults);
  2. HLA-matched donor is available;
  3. History of stroke or is at risk of stroke or end-organ damage, as shown by at least one of the following: prior stroke, recurrent acute chest syndrome, recurrent vaso-occlusive crises, or red blood cell alloimmunization on chronic transfusion therapy;
- **B.** *Homozygous β-Thalassemia*, meets all:
  1. Age ≤ 45 years (children and young adults);
  2. HLA-matched donor is available;
  3. Transfusion dependent due to thalassemia;
  4. Request is made by, or in consultation with, a thalassemia specialist.

II. It is the policy of health plans affiliated with Centene Corporation that the following are considered **experimental/investigational**:

- **A.** Autologous hematopoietic cell transplant for sickle cell anemia;
- **B.** Autologous hematopoietic cell transplant for β-thalassemia;
- **C.** For the treatment of all other conditions than those two specified above.

Background

Hemoglobinopathies are a group of over 1,000 hematological disorders that result from deleterious molecular alterations to hemoglobin and are broadly classified into two categories based on the phenotypic characteristics of these variations.[1] The first of these categories includes disorders, such as sickle cell anemia, in which there is a structural defect in one of the globin subunits.[1] Thalassemia belongs to the second category of hemoglobinopathies in which there is a quantitative defect in the production of one or more of the globin subunits.[1]

In adults, hemoglobin is a heterotetramer that is comprised of the α-and β-globin subunits.[2] Each globin subunit forms a stable linkage with heme so that oxygen in the cytosol of an erythrocyte can bind reversibly to heme's iron atoms.[2] The hemoglobin tetramer $\alpha_2\beta_2$ binds and unloads oxygen in a cooperative manner, which maximizes the transport of oxygen to cells.[2] Additional gas transport functions of hemoglobin include the transport of carbon dioxide and nitric oxide.[3] Each of these physiological aspects of hemoglobin are deleteriously affected in the hemoglobinopathy disorders.

Sickle Cell Anemia and β-Thalassemia

Sickle cell disease results from a synonymous mutation that exchanges glutamic acid with valine at position 6 in the β-globin subunit.[4] Homozygous inheritance of this mutation results in the disease phenotype, whereas heterozygous carriers do not exhibit clinical disease symptoms; heterozygous carriers are also referred to as sickle cell trait.[4] This amino acid substitution causes deoxygenated hemoglobin to rigid polymers in red blood cells, which ultimately forms the classic sickle-shaped morphology.[2] The sickle red blood cells occlude the microvasculature which leads to tissue hypoxia, infarction, and chronic hemolytic anemia.[4] Thus, sickle cell anemia presents a heterogeneous range of clinical manifestations, including pain, strokes, vaso-occlusive episodes, multi-organ injury, reduced quality of life, and shortened lifespan.[2,4]

Autosomal mutations in the gene encoding the β-globin subunit cause β-thalassemia (also known as thalassemia major or Cooley's anemia).[5] These mutations inhibit the synthesis of β-globin in erythropoietic cells.[2,5] The extent of the molecular basis for these mutations is very heterogeneous because over 200 mutations within the β-globin subunit, ranging from synonymous mutations to deletions.[1] Consequently, α-globin molecules form toxic aggregates which destroy erythroid precursors through a process called ineffective erythropoiesis.[2,5] Also, individuals with β-thalassemia suffer from anemia due to shortened red blood cell survival, hemolysis anemia.[5]

Hematopoietic Cell Transplantation

Hematopoietic cell transplantation (HCT) is recognized as the only cure for sickle cell disease, and the success rate for specific pediatric groups has been shown to be 85 – 90%.[4] In the United States, it is estimated that the number of children with homozygous sickle cell anemia is 70,000 – 100,000, of which 5,000 – 7,000 could be eligible for transplantation.[6] A survey of the European Blood and Marrow Transplant and CIBMTR data files that ~1,200 patients in total have received HCT for sickle cell disease, and the 3 year survival rate is ~90% regardless of the source of hematopoietic stem cells.[6] Furthermore, Lucarelli *et al*. and Angelucci *et al*. both have documented the literature for recent reports on outcomes of HCT from HLA-matched donors in cases of β-thalassemia.[8,9] Although stem cell sources and the risk categories of the patients vary, overall survival and thalassemia free survival range from approximately 65% - 90 % among the numerous reports.[8,9]

The establishment of complete donor-derived erythropoiesis can stabilize function in affected organs, such as the central nervous system and lungs.[7] However, HCT related organ toxicities, graft vs host disease, graft rejection, and donor availability are major limitations of this procedure.[7] Infertility and gonadal failure are two specific morbidities with which HCT is

associated.[4] Also, use of fully matched sibling donors as potentially eligible donors is one of the limitations for HCT implementation.[4] However, siblings are preferable HCT donors due to the lowered risk of graft vs host disease.[6]

Other differences between the considerations for HCT for β-thalassemia and sickle cell anemia include key issues for risk factors for transplant-related complications, transplant outcome, and conditioning regimen.[9] The major risk factors when considering HCT for β-thalassemia include age and organ dysfunction due to iron overload, whereas the major risk factors for HCT due to sickle cell anemia are age and history of cerebral events.[9] Control of iron overload and related tissue damage presents is a significant consideration for HCT for β-thalassemia, while obtaining a cure from chronic inflammation and prevention of sickle cell related organ damage must be considered for sickle cell anemia.[9] Lastly, β-thalassemia patients require an ablative conditioning regimen, whereas a reduced intensity regimen seems to induce stable chimerism and full donor erythropoiesis in sickle cell anemia patients.[9]

Coding Implications

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CPT®* Codes	Description
38205	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogeneic
38240	Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor

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HCPCS Codes	Description
S2150	Bone marrow or blood-derived stem cells (peripheral or umbilical), allogeneic or autologous, harvesting, transplantation, and related complications; including: pheresis and cell preparation/storage; marrow ablative therapy; drugs, supplies, hospitalization with outpatient follow-up; medical/surgical, diagnostic, emergency, and rehabilitative services; and the number of days of pre and post-transplant care in the global definition

ICD-10-CM Code	Description
D56.1	Beta thalassemia
D57	Sickle-cell disorders

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed	03/16	03/16
References reviewed and updated	03/17	03/17
Changed age restriction for sickle cell from ≤25 to ≤45, and changed age for beta thalassemia from ≤30 to ≤45. Revised I.B.3 to require transfusion dependence due to thalassemia and removed "deterioration with conventional treatments…" Added I.B.4 Request is made by, or in consultation with, a thalassemia specialist	11/17	11/17

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Important Reminder

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CLINICAL POLICY
Hematopoietic Cell Transplants for Sickle Cell Anemia and β-Thalassemia

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CENTENE Corporation

Clinical Policy: Panniculectomy

Reference Number: CP.MP.109
Effective Date: 04/16
Last Review Date: 04/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Panniculectomy is the surgical removal of a panniculus or excess skin and adipose tissue that hangs down over the genital and/or thigh area causing difficulty in personal hygiene, walking, and other physical activity.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation that panniculectomy is considered **medically necessary** when meeting all of the following indications:
   A. Panniculus hangs below the level of the pubis, documented by photographs; and
   B. Medical records and photographs document chronic and persistent intertrigo that remains refractory to appropriate therapy for at least 3 months. Appropriate medical therapy includes topical antifungals, topical and/or systemic corticosteroids, and/or local or systemic antibiotics, in addition to good hygiene practices; and
   C. Panniculectomy is expected to restore normal function or improve functional deficit; and
   D. *If* panniculus is due to significant weight loss, there must also be evidence that member has maintained a stable weight for at least 6 months. If weight loss is the result of bariatric surgery, it must be at least 18 months after bariatric surgery and the weight loss has been stable for at least the most recent 6 months.

Background

Panniculectomy is a surgical procedure to remove an abdominal pannus or panniculus. A panniculus is formed secondary to obesity when there is a dense layer of fatty tissue growth on the abdomen that becomes large enough to hang down from the body. Panniculus size varies from grade 1, which reaches the mons pubis, to grade 5, which extends to or reaches past the knees.

Some areas of difficulty associated with a panniculus are personal hygiene, walking, and other physical activities. Sores and infections such as intertrigo, skin ulcers, and panniculitis can form in the folds of the panniculus, leading to painful inflammation of the tissue. This can further hinder physical activity and activities of daily life.

Panniculectomy is very similar to abdominoplasty, a surgical procedure that tightens the lax anterior abdominal wall muscles and trims excess adipose tissue and skin. Panniculectomy differs from abdominoplasty in the sense that abdominoplasty is usually performed as a cosmetic procedure to improve appearance but not function. Panniculectomy can be necessary for restoring normal function or improving functional deficit as well as preventing sores and infections.

CLINICAL POLICY
Panniculectomy

Coding Implications
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CPT® Codes	Description
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
00802	Anesthesia for procedures on lower anterior abdominal wall; panniculectomy

Reviews, Revisions, and Approvals	Date	Approval Date
Criteria separated from CP.MP.31 Cosmetic and Reconstructive Surgery	04/16	04/16
References reviewed and updated.	04/17	04/17

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1. American Society of Plastic Surgeons (ASPS). ASPS Recommended Insurance Coverage Criteria for Third-Party Payers. Abdominoplasty and Panniculectomy Unrelated to Obesity or Massive Weight Loss. 2006 Jul. Last updated 2007 Jan. Accessed March 31, 2016.
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4. Panniculectomy for treatment of symptomatic panniculi. Landsdale, PA: Hayes, Inc. © 2012 Winifred S. Hayes, Inc. May 19, 2016.

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CENTENE Corporation

Clinical Policy: Bronchial Thermoplasty

Reference Number: CP.MP.110
Effective Date: 05/16
Last Review Date: 05/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

This policy describes the medical necessity requirements for bronchial thermoplasty (BT). BT is a bronchoscopic procedure that utilizes radiofrequency ablation to reduce airway smooth muscle cells. It is designed to serve as a therapeutic option to reduce severe bronchoconstriction for severe persistent asthma.

Policy/Criteria

It is the policy of health plans affiliated with Centene Corporation® that bronchial thermoplasty is **not medically necessary** for severe asthma because its long-term safety and effectiveness has not been proven.

Background

Asthma is a common inflammatory syndrome caused by chronic, intermittent obstruction of the lower respiratory tract that affects millions of individuals. This process is mediated by several inflammatory cytokines, chemokines, adhesion molecules, and signal transduction cascades.[1] T helper type 2 (T_H2) and type 17 (T_H17) $CD4^+$, basophils, eosinophils, mast cells, and type 2 innate lymphoid cells are crucial for mediating the asthmatic response.[2]

BT is a bronchoscopic procedure that applies thermal energy to the airway wall and, thereby, reduces the extent of airway smooth muscle cell hypertrophy via radiofrequency ablation.[3] Some studies published on BT have tested its therapeutic potential against severe asthma.[4] However, the literature recently published on BT has been controversial and the studies evaluating the efficacy of BT have not provided consistent results.

A prospective non-randomized study of 16 patients with stable mild to moderate asthma found a significant reduction in airway hyperresponsiveness without a change in FEV_1.[5] The Asthma Intervention Research Trial (AIR), a randomized controlled trial that enrolled 112 patients, showed an improvement in asthma symptoms from BT but no reduction in hyperresponsiveness or FEV_1.[6] The Research in Severe Asthma Trial (RISA), a small randomized study that enrolled only 32 patients, assessed the safety of BT in patients receiving high doses of steroids. Despite several complications, including hospitalizations, a difference was seen in the BT group versus control.[7] Some critics argue that these studies lack the statistical power and blinded placebo control to demonstrate clear conclusions on the efficacy of BT's clinical potential.[8]

In 2010, Castro *et al*. performed a randomized, controlled trial with 288 patients that included a placebo control. This study was called the Asthma Intervention Research Trial 2 (AIR2).[9] AIR2 found a statistically significant improvement in their primary outcome, which was the score from the Asthma Quality of Life Questionnaire (AQLQ).[9] However, these scores fell below a clinically meaningful threshold.[4] There was no difference in peak flow, rescue medication use,

or FEV_1.[9] Moreover, several investigators have criticized the AIR2 study for failing to meet secondary outcome measures such as safety, its patient selection, and its true efficacy.[8,10,11] Thus, this study also remains controversial.

Hayes conducted a review of the available literature on BT, noting that overall the body of evidence is small and of low quality. The findings were that BT may improve quality of life outcomes, however other results including emergency department visits, symptom relief, and medication use were inconsistent across studies. BT was found to not decrease hospitalization following treatment and it actually increased hospitalization during the treatment period. Treatment with BT was associated with a statistically significant increase in complications such as wheezing, chest discomfort, night awakenings, sputum discoloration, and cough. The quality and quantity of evidence was not enough to establish the long-term safety and efficacy of the procedure.[12]

Lastly, a meta-analysis of the aforementioned randomized, controlled trials by Wu, et al, suggests that while BT significantly improves AQLQ scores, there were more respiratory adverse events and hospitalizations for respiratory adverse events with BT than with medications or with placebo.[13]

Coding Implications

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CPT® Codes	Description
31660	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe
31661	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 2 or more lobes

ICD-10-CM Diagnosis Codes

ICD-10-CM Code	Description
J45.X	Asthma

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed	04/16	05/16
References reviewed and updated.	04/17	05/17

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CLINICAL POLICY
Bronchial Thermoplasty

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CENTENE Corporation

Clinical Policy: Diagnostic Testing for Zika Virus

Reference Number: CP.MP.111
Effective Date: 06/16
Last Review Date: 06/17 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Zika virus is a flavivirus whose infection causes Zika virus disease. The virus is primarily transmitted by the bite of infected *Aedes* species mosquitoes. However, Zika virus can be sexually transmitted from an infected man to his sexual partners. While Zika virus infection is usually asymptomatic or causes mild illness, a causal relationship exists between prenatal Zika virus and microcephaly in the infant, as well as other serious brain anomalies. Diagnostic tests to evaluate for Zika virus infection include molecular and serologic testing. This policy describes the medical necessity requirements for these diagnostic tests.

***Note:** All references to travel or residence in the policy/criteria indicate travel within 2 weeks to or residence in an area with ongoing Zika virus transmission (areas with CDC Zika travel notice). References to exposure by sexual contact indicate that the sexual partner has traveled to or lived in an area with ongoing Zika virus transmission, and that a condom was not used.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that real time reverse transcriptase – polymerase chain reaction (rRT-PCR) testing to evaluate Zika virus infection is **medically necessary** for any of the following:

A. Pregnant women with clinical symptoms consistent with Zika virus disease with exposure due to travel, residence, or sexual contact*:[2,4,6]
   1. Serum testing within 7 days of symptom onset, or
   2. Urine testing within 8 – 14 days of symptom onset;

B. Asymptomatic pregnant women within 14 days of exposure due to travel, residence, or sexual contact. Testing at least once per trimester should be considered if living in or frequently traveling to areas with active Zika virus transmission, unless a previous rRT-PCR test has been positive;[15]

C. Asymptomatic pregnant women with a positive or equivocal MAC-ELISA test for Zika IgM, 2-12 weeks following potential exposure due to travel, residence, or sexual contact. Testing should be conducted on all appropriate specimen types available;[13]

D. Amniocentesis specimens if amniocentesis is conducted for reasons other than Zika testing;

E. Men or women within 14 days of onset of symptoms of Zika virus infection, who want to conceive, and one or both partners live in an area of ongoing Zika virus transmission;

F. Neonates with microcephaly or intracranial calcifications born to women with possible exposure to Zika virus through travel, residence, or sexual contact while pregnant, ideally within 2 days of birth*;[9]

G. Neonates without microcephaly or intracranial calcifications born to women with positive or inconclusive Zika virus testing, ideally within 2 days of birth.

II. It is the policy of health plans affiliated with Centene Corporation® that Zika IgM capture enzyme linked immunosorbent assay (MAC-ELISA) and subsequent plaque-reduction neutralization (PRNT)** testing for IgM positive samples is **medically necessary** to evaluate for Zika virus infection for any of the following:

A. Pregnant women with clinical symptoms consistent with Zika virus disease with exposure due to travel, residence, or sexual contact, within 4 days – 12 weeks of symptom onset*;[6, 7]
B. Asymptomatic pregnant women who may have had Zika virus transmission through travel or sexual contact, within 2 – 12 weeks of possible exposure**,** even if rRT-PCR testing conducted within two weeks of exposure was negative;-[2, 4,6, 7, 11]
C. Asymptomatic pregnant women residing in areas with ongoing Zika virus transmission, at the initiation of prenatal care with follow-up testing mid-second trimester;[6]
D. Symptomatic men or women who want to conceive, are within 2-12 weeks of onset of symptoms of Zika virus infection, and one or both partners live in an area of ongoing Zika virus transmission;
E. Neonates with microcephaly or intracranial calcifications born to women with possible exposure to Zika virus through travel, residence, or sexual encounter while pregnant*;[9]
F. Neonates without microcephaly or intracranial calcifications born to women with positive or inconclusive Zika virus testing.[9]

**Note: PRNT is not routinely recommended for testing any specimens in Puerto Rico.

III. It is the policy of health plans affiliated with Centene Corporation® that PRNT testing is medically necessary to evaluate Zika virus infection for any of the following:

A. Infants ≥ 18 months old, whose initial (neonatal) sample was anti-Zika IgM positive, with Zika-specific neutralizing antibodies detected by previous PRNT in either the mother's or infant's sample;[13]
B. Infants ≥ 18 months old, whose initial (neonatal) sample was negative by both MAC-ELISA and rRT-PCR,[13] and both (1 and 2):
   1. Infant's mother had potential exposure to the Zika virus during pregnancy due to travel, residence, or sexual contact;
   2. The infant has clinical findings suggestive of congenital Zika virus, including any of the following:[13]
      a. Microcephaly;
      b. Abnormal neuroimaging findings such as intracranial calcifications, decreased brain parenchymal volume, ventriculomegaly and extra-axial fluid, abnormal gyral patterns, or hypoplasia of brain structures;
      c. Neurologic abnormalities such as hypertonia, hypotonia, spasticity, hyperreflexia, severe irritability, or seizures;
      d. Ocular abnormalities such as chorioretinal atrophy or scarring, pigmentary changes, optic nerve hypoplasia, optic disc pallor, increased optic disc cupping, hemorrhagic retinopathy, and abnormal retinal vasculature.

IV. It is the policy of health plans affiliated with Centene Corporation® that evaluation including rRT-PCR, histopathologic examination, and immunohistochemical staining is **medically necessary** for the evaluation of fetal loss and stillbirth if the woman may have had Zika virus transmission during her pregnancy through travel, residence, or sexual contact.[10]

V. It is the policy of health plans affiliated with Centene Corporation® that the following diagnostic tests to evaluate Zika virus infection are considered **experimental/investigational** under any of the following circumstances:
   A. Testing for men for assessing risk for sexual transmission;[4]
   B. Routine testing for women and men who are attempting conception who have possible exposure to Zika but no clinical illness.[4]

Background

Zika virus is a flavivirus that was originally discovered from a sentinel rhesus monkey in the Zika Forest in Uganda during a study of yellow fever in 1947.[1] Since its discovery, few cases of the infection had been reported until outbreaks in the State of Yap, Federated States of Micronesia, and French Polynesia in 2007 and 2013, respectively.[1] Zika virus was first identified in the Americas in March 2015 in Brazil.[1] As of March 2016, active Zika virus transmission is occurring in 39 countries and territories in the Americas.[2]

Among recent cases, Zika virus is primarily transmitted by the bite of infected *Aedes* species mosquitoes – most commonly through *Ae. aegypti* and possibly through *Ae. albopictus* mosquitoes.[3] Documented sexual transmission of the Zika virus has occurred from infected males to their sexual partners,[4] and from females to male sexual partners.[14] At the present time, testing for risk for sexual transmission of Zika virus is of uncertain value unless either partner is symptomatic, and the couple is wishing to conceive, because of the limited understanding of the shedding of the virus in the male genitourinary tract.[4]

The virus can also be transmitted from mother to fetus during any trimester of pregnancy.[3] Although most persons infected with Zika virus are asymptomatic, the most common symptoms of Zika virus disease are fever, rash, joint pain, and conjunctivitis; these symptoms usually last for up to one week.[2] No antiviral medication is available, and supportive care is recommended. A causal relationship exists between prenatal Zika virus infection and congenital microcephaly, as well as other serious brain and eye anomalies.[5] Preliminary research has found that the risk of congenital birth defects is greatest with Zika virus infection in the first and second trimesters.[12]

Furthermore, a temporal and geographical observation has been made between Zika virus infection and Guillain-Barre syndrome.[1] Continued investigations attempt to understand the link between Zika virus infection and Guillain-Barre syndrome.

The U.S. Food and Drug Administration (FDA) has issued an Emergency Use Authorization to allow the use of CDC's diagnostic tools to assess Zika virus infection. The diagnostic tests for evaluating for Zika virus infection include molecular and serologic testing. Molecular testing is rRT-PCR for the *in vitro* detection of Zika virus nucleic acids. The CDC's Trioplex rRT-PCR assesses Zika, dengue, and chikungunya viruses simultaneously. According to "Revised diagnostic testing for Zika, dengue, and chikungunya viruses in US Public Health Laboratories," viral RNA can be identified in serum during the first 7 days of these illnesses,[7] and additional information from the CDC states that urine samples can be collected less than 14 days after the onset of symptoms for rRT-PCR testing.[8]

CLINICAL POLICY
Diagnostic Testing of Zika Virus

Serologic testing includes the Zika IgM MAC-ELISA and PRNT tests for the respective detection of viral specific IgM and neutralizing antibodies to Zika virus. While virus specific IgM antibodies may be detectable ≥ 4 days after onset of illness, serum collected within 7 days of illness onset may not have detectable levels of these antibodies.[7] IgM antibodies to Zika virus remain present for approximately 2-12 weeks, although there are reports of prolonged IgM responses with Zika virus infection, as with other flaviviruses.[13] Furthermore, Zika antibodies may be detectable in pregnant women months after infection with the virus, making it difficult to determine whether they were infected before or after conception.[13] Importantly, an IgM positive result from the MAC-ELISA cannot differentiate between the presence of Zika and dengue viruses, and thus is indicative of the presence of a flavivirus.[7] Therefore, PRNT assays can be used to discriminate between cross reacting antibodies for in situations that are positive for IgM.[7]

Laboratory evidence of maternal Zika virus infection includes (1) Zika virus RNA detected by RT-PCR in any clinical specimen or (2) positive Zika virus IgM with confirmatory neutralizing antibody tiers that are ≥4 fold higher than dengue virus neutralizing antibody titers in serum by PRNT.[10] Testing is inconclusive if Zika virus neutralizing antibody tiers are < 4 fold higher than dengue virus neutralizing antibody titers.[10]

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed.	05/16	06/16
Defined sexual contact for purposes of this policy. Added the following to indications for section I. rRT-PCR testing: Asymptomatic pregnant women within 14 days of contact with exposure from travel, residence, or sexual contact; asymptomatic pregnant women with a positive or equivocal MAC-ELISA test, 2-12 weeks from exposure; amniocentesis specimens if collected for a purpose other than Zika testing; men or women within 14 days of onset of symptoms of Zika virus infection, who want to conceive, and one or both partners live in an area of ongoing Zika virus transmission. Loosened requirement for neonates to have rRT-PCR testing performed within 2 days of birth. Edited the following indications for section II. MAC-ELISA with subsequent PRNT testing: added "even if rRT-PCR result was negative" to asymptomatic pregnant women with exposure through travel or sexual contact, within 2 – 12 weeks; added "Symptomatic men or women who want to conceive, are within 2-12 weeks of onset of symptoms of Zika virus infection, and one or both partners live in an area of ongoing Zika virus transmission" ; noted that PRNT testing is not currently recommended in Puerto Rico. Added section III. PRNT testing for infants ≥ 18 months old who either: 1) had Zika positive IgM results and positive PRNT results in either mother or infant's sample 2) Were negative for Zika IgM but are symptomatic, and born to mothers with positive IgM or rRT-PCR test for Zika. Edited background to reflect literature and CDC guidance updates.	05/17	06/17

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<u>Important Reminder</u>

CLINICAL POLICY
Diagnostic Testing of Zika Virus

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Diagnostic Testing of Zika Virus

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Clinical Policy: Influenza and Streptococcus Group A Testing

Reference Number: CP.MP.112
Effective Date: 07/16
Last Review Date: 07/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Influenza and streptococcus group A infections generally present with uniquely different signs and symptoms. Because of the improbability of concurrent streptococcus and influenza infection, and the differences in their clinical presentation, these tests should not be performed at the same visit.

Policy

I. It is the policy of health plans affiliated with Centene Corporation® that performing influenza testing and streptococcus group A testing is **not medically necessary** when performed during the same visit because of the improbability of concurrently contracting influenza and streptococcus A.

II. It is the policy of health plans affiliated with Centene Corporation® that performing influenza testing between June 1 and August 31 of each year is **not medically necessary.** Flu season in the United States can happen as early as October and can last as late as May. False-positive influenza test results are more likely to occur when disease prevalence is low (≤ 10%), which is generally at the beginning and end of the season, as well as during summer months.

Background

Clinical research and medical associations consistently suggest that patients with strep throat (streptococcus, group A) present uniquely discrete signs and symptoms inconsistent with influenza. Signs and symptoms of influenza infection can include fever, muscle aches, headache, lack of energy, dry cough, sore throat, nasal congestion, and runny nose. Strep throat symptoms most commonly include sore throat, which usually starts quickly and causes severe pain when swallowing; fever; red and swollen tonsils, possibly with white patches or streaks of pus; tiny red spots on the roof of the mouth; headache; nausea; vomiting; swollen lymph nodes in the front of the neck; and sandpaper-like rash.

The Centers for Disease Control and Prevention (CDC) states that starting antiviral treatment should not wait for laboratory confirmation of influenza. Testing is not needed for all members with signs of influenza prior to making antiviral treatment decisions. Once influenza activity is documented in the geographical area, a clinical diagnosis can be made based on symptoms, especially during peak flu season.

When strep throat is suspected, a positive strep test is needed prior to initiation of antibiotics. If a rapid strep test is negative but strep throat is still suspected, a throat culture swab to confirm a strep infection is required.

CLINICAL POLICY
Influenza and Streptococcus Group A Testing

Coding Implications
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CPT® Codes	Description
87502	Infectious agent detection by nucleic acid (DNA or RNA); influenza virus, for multiple types of subtypes, includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, first 2 types or sub-types
87651	Infectious agent detection by nucleic acid (DNA or RNA); streptococcus, group A, amplified probe technique
87804	Infectious agent antigen detection by immunoassay with direct optical observation; influenza
87880	Infectious agent antigen detection by immunoassay with direct optical observation; streptococcus, group A

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed	07/16	07/16
Added CPT 87502 and 87651. Removed details about the type of flu and strep testing considered not medically necessary in section I, as this is specified in CPT codes.	11/16	12/16
References reviewed and updated	07/17	07/17

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2. Centers for Disease Control and Prevention. CDC Features: Worried your sore throat may be strep? Accessed 7/20/17. Available at: https://www.cdc.gov/Features/StrepThroat/Centers for Disease Control and Prevention. Rapid Influenza Diagnostic Tests. Available at: https://www.cdc.gov/flu/professionals/diagnosis/clinician_guidance_ridt.htm

Important Reminder
This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in

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Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs,

and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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CENTENE Corporation

Clinical Policy: Holter Monitors

Reference Number: CP.MP.113
Effective Date: 08/16
Last Review Date: 08/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Ambulatory electrocardiogram (ECG) monitoring provides a view of cardiac activity over an extended period of time. Holter monitoring, or continuous ambulatory ECG monitoring, for 24 to 48 hours is most practical as the initial monitor for members with daily or near daily symptoms, as well as for assessing the efficacy of medication and other treatments for cardiac arrhythmias.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that Holter monitoring is **medically necessary** for adult members who require 24 to 48 hours of cardiac activity monitoring with any of the following symptoms or indications:

A. Evaluation of any of these unexplained indications: syncope, near-syncope, episodic dizziness, recurrent palpitations, episodic shortness of breath or chest pain;
B. Evaluation of neurological events when transient atrial fibrillation or flutter is suspected;
C. Evaluation of syncope, near-syncope, episodic dizziness, or palpitation in whom a probable cause other than an arrhythmia has been identified but in whom symptoms persist despite treatment of this other cause;
D. Evaluation of patients with cardiomyopathy, or a first-degree relative with arrhythmogenic right ventricular cardiomyopathy;
E. Evaluation of possible or documented prolonged QT syndromes;
F. To screen for asymptomatic arrhythmia in a patient with Brugada syndrome;
G. Assessment of efficacy of medication for arrhythmia treatment when baseline arrhythmia frequency is reproducible and of sufficient frequency to permit analysis;
H. Detection of proarrhythmic responses to antiarrhythmic therapy in patients at high risk;
I. Assessment of the function of pacemakers or implantable cardioverter defibrillators (ICD) with frequent palpitations, syncope, or near-syncope, and to assist in programming of enhanced features;
J. Evaluation of suspected pacemaker or ICD component failure or malfunction when device interrogation is inconclusive;
K. Assessment of efficacy of adjunctive medications in patients receiving frequent ICD therapy;
L. Assessment of suspected variant angina.

II. It is the policy of health plans affiliated with Centene Corporation® that Holter monitoring is **medically necessary** for pediatric members ≤ 18 years old who require 24 to 48 hours of cardiac activity monitoring with any of the following symptoms or indications:

A. Evaluation of syncope, near-syncope, or dizziness in members with identified cardiac disease, previously documented arrhythmia, or pacemaker dependency;
B. Evaluation of syncope or near-syncope associated with exertion when cause is not established;

C. Evaluation of unexplained syncope, near-syncope, or sustained palpitation when there is no overt clinical evidence of heart disease;
D. Assessment of efficacy of medications for arrhythmia following initiation of treatment or during rapid somatic growth;
E. Evaluation of patients with cardiomyopathy, with or a first-degree relative with arrhythmogenic right ventricular cardiomyopathy;
F. Evaluation of possible or documented prolonged QT syndromes;
G. Evaluation of palpitation in a member with prior surgery for congenital heart disease and significant residual hemodynamic abnormalities;
H. Evaluation of asymptomatic congenital complete atrioventricular (AV) block, non-paced;
I. Evaluation of cardiac rhythm after transient AV block associated with heart surgery or catheter ablation;
J. Evaluation of rate-responsive or physiological pacing function in symptomatic patients.

III. It is the policy of health plans affiliated with Centene Corporation® that Holter monitoring for any other indication not included in this policy is **not medically necessary** because efficacy has not been established.

Background

The most common use of ambulatory ECG monitoring is the evaluation and diagnosis of cardiac arrhythmias or conduction abnormalities. The device continuously monitors the heart's electrical activity for a period of 24 to 48 hours. The member has a self-activated event marker which identifies when they are experiencing symptoms such as palpitations, syncope/near-syncope, dizziness, shortness of breath, chest pain, or episodic fatigue. This is especially helpful in members who experience symptoms too infrequent to be caught on a standard ECG.

The recorded data are analyzed with the event markers to determine if the symptoms are related to an arrhythmia. There are four outcomes this analysis could provide. Useful findings include the simultaneous documentation of a cardiac arrhythmia capable of producing the noted symptoms, which can lead to directed therapy for the arrhythmia; and symptoms that occur without arrhythmia, demonstrating symptoms are not related to an arrhythmia. Of equivocal value, the findings may show that a cardiac arrhythmia is present but no symptoms were present during the recording, indicating the arrhythmia may or may not be related to the symptoms. Lastly, if there were no symptoms during the recording and there were no arrhythmias identified, the recording is not useful.

Ambulatory ECG is also helpful in assessing the efficacy of antiarrhythmic therapy. It is noninvasive, provides quantitative data, and permits correlation of symptoms with ECG phenomena. It does have some limitations in regard to its use as a therapeutic guide, which should be taken into consideration. Additionally, ambulatory ECG monitoring is useful in assessing pacemakers and ICDs, as it can evaluate symptoms of palpitations, syncope, or near-syncope to assess device function; assist in the programing of enhanced features; evaluate suspected component failure or a malfunctioning device; and assess concomitant pharmacological therapy for members receiving frequent ICD therapy.

Due to the advancement of technological capabilities in ambulatory ECG assessment, it can provide accurate and clinically meaningful information about myocardial ischemia in patients with coronary disease. The most commonly encountered ambulatory ECG sign of ischemia is ST-segment depression and, while this is an important finding, it is important to note that ST-segment changes and other repolarization abnormalities can occur for reasons other than ischemia. These conditions must be considered when evaluating the predictive value of ST-segment changes in each specific member. Furthermore, ambulatory ECG can be beneficial in members suspected of having variant angina. Periods of ST-segment elevation indicative of transmural ischemia can be identified in those with variant angina or high-grade proximal stenosis.

In the pediatric population, ambulatory ECG can be used for the same indications as for adults, in addition to a number of pediatric-specific concerns. Monitoring in children with heart disease, with or without symptoms, is used to observe the evolution of disease processes, identify medication dose changes required due to growth, and identify the progressive onset of late arrhythmias after surgery for congenital heart defects. Likewise, this monitoring is beneficial in pediatric members with hypertrophic or dilated cardiomyopathies or known or suspected prolonged QT syndromes. Ambulatory ECG can also be used to evaluate asymptomatic pediatric members with congenital complete AV block in order to identify those at increased risk for sudden arrhythmic events who may benefit from prophylactic pacemaker implantation.

Coding Implications

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CPT® Codes	Description
93224	External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; includes recording, scanning analysis with report, physician review and interpretation
93225	External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; recording (includes connection, recording, and disconnection)
93226	External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; scanning analysis with report
93227	External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; review and interpretation by a physician or other qualified health care professional

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
G45.9	Transient cerebral ischemic attack, unspecified
G71.0	Muscular dystrophy
G99.0	Autonomic neuropathy in diseases classified elsewhere
I20.0-I20.9	Angina pectoris
I24.0-I24.9	Other acute ischemic heart diseases
I25.10	Atherosclerotic heart disease of native coronary artery without angina pectoris
I34.0-I34.9	Nonrheumatic mitral valve disorders
I35.0-I35.9	Nonrheumatic aortic valve disorders
I36.0-I36.9	Nonrheumatic tricuspid valve disorders
I37.0-I37.9	Nonrheumatic pulmonary valve disorders
I42.0	Dilated cardiomyopathy
I42.1	Obstructive hypertrophic cardiomyopathy
I42.2	Other hypertrophic cardiomyopathy
I42.8	Other cardiomyopathies
I42.9	Cardiomyopathy, unspecified
I44.0-I44.7	Atrioventricular and left bundle-branch block
I45.0-I45.9	Other conduction disorders
I46.2-I46.9	Cardiac arrest
I47.0-I47.9	Paroxysmal tachycardia
I48.0-I48.92	Atrial fibrillation and flutter
I49.0-I49.9	Other cardiac arrhythmias
I50.1-I50.9	Heart failure
I51.7	Cardiomegaly
I63.00-I63.9	Cerebral infarction
I67.841-I67.848	Cerebral vasospasm and vasoconstriction
Q20.0-Q20.9	Congenital malformations of cardiac chambers and connections
Q21.0-Q21.9	Congenital malformations of cardiac septa
Q22.0-Q22.9	Congenital malformations of pulmonary and tricuspid valves
Q23.0-Q23.9	Congenital malformations of aortic and mitral valves
Q24.0-Q24.9	Other congenital malformations of heart
Q25.0-Q25.9	Congenital malformations of great arteries
R00.0-R00.9	Abnormalities of heart beat
R06.00-R06.09	Shortness of breath
R07.2	Precordial pain
R07.89	Other chest pain
R07.9	Chest pain, unspecified
R42	Dizziness and giddiness
R53.81-R53.83	Malaise and fatigue
R55	Syncope and collapse
R94.31	Abnormal electrocardiogram
Z48.812	Encounter for surgical aftercare following surgery on the circulatory system

ICD-10-CM Code	Description
Z82.41	Family history of sudden cardiac death
Z87.74	Personal history of (corrected) congenital malformations of heart and circulatory systems
Z94.1	Heart transplant status
Z95.0	Presence of cardiac pacemaker
Z95.810	Presence of automatic (implantable) cardiac defibrillator

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed and specialist reviewed	08/16	08/16
ICD-10-CM code table updated	11/16	
Added "Evaluation of patients with cardiomyopathy, or a first-degree relative with arrhythmogenic right ventricular cardiomyopathy" as an indication to the adult criteria, and expanded pediatric criteria for cardiomyopathy- "evaluation of patients with hypertrophic or dilated cardiomyopathy" to the same as the adult cardiomyopathy criteria. Added "Evaluation of possible or documented prolonged QT syndromes" and "To screen for asymptomatic arrhythmia in a patient with Brugada syndrome;" to adult criteria. Added ICD-10-CM Codes I42.8 and Z82.41	08/17	08/17

References

1. Crawford MH, Bernstein SJ, Deedwania PC, DiMarco JP, Ferrick KJ, Garson A Jr, Green LA, Greene HL, Silka MJ, Stone PH, Tracy CM. ACC/AHA guidelines for ambulatory electrocardiography: executive summary and recommendations: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Committee to Revise the Guidelines for Ambulatory Electrocardiography). *Circulation*. 1999;100:886-893
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Important Reminder

CLINICAL POLICY
Holter Monitors

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CENTENE Corporation

Clinical Policy: Disc Decompression Procedures

Reference Number: CP.MP.114
Effective Date: 07/16
Last Review Date: 07/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Microdiscectomy or open discectomy (MD/OD) are the standard procedures for symptomatic lumbar disc herniation and they involve removal of the portion of the intervertebral disc compressing the nerve root or spinal cord (or both) with or without the aid of a headlight loupe or microscope magnification. Potential advantages of newer minimally invasive discectomy (MID) procedures over standard MD/OD include less blood loss, less postoperative pain, shorter hospitalization and earlier return to work.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that open discectomy and microdiscectomy are **medically necessary** when meeting all of the following:
- **A.** Age ≥ 18;
- **B.** Diagnosis of herniated lumbar disc;
- **C.** Nerve root compression confirmed by imaging and one of the following:
  1. Unilateral radiculopathy with motor deficit and one of the following:
     a. Severe weakness in a nerve root distribution, as evidenced by: a score of < 2 on the Medical Research Council 0 to 5 muscle strength scale, or the inability to ambulate;
     b. Mild to moderate weakness in a nerve root distribution, as evidenced by a score of 3 or 4 on the Medical Research Council 0 to 5 muscle strength scale and one of the following:
        i. Worsening weakness or motor deficit;
        ii. Patient has failed to respond to conservative therapy including all of the following:
           a) ≥ 6 weeks physical therapy or prescribed home exercise program;
           b) Nonsteroidal anti-inflammatory drug (NSAID) or acetaminophen ≥ 3 weeks unless contraindicated or not tolerated;
           c) ≥ 6 weeks activity modification;
  2. Unilateral radiculopathy with sensory deficit as evidenced by pain, parasthesias or numbness in a nerve root distribution and patient has failed to respond to conservative therapy including all of the following:
     a. ≥ 6 weeks physical therapy or prescribed home exercise program;
     b. NSAID or acetaminophen ≥ 3 weeks unless contraindicated or not tolerated;
     c. ≥ 6 weeks activity modification.

II. It is the policy of health plans affiliated with Centene Corporation that the following minimally invasive procedures for spinal decompression are **investigational**:
- **A.** Percutaneous Lumbar Discectomy (manual or automated [APLD]);
- **B.** Percutaneous Laser Discectomy (PLD);

- **C.** Laser-assisted Disc Decompression (LADD);
- **D.** Percutaneous laser disc decompression (PLDD);
- **E.** Percutaneous nuclectomy;
- **F.** Percutaneous endoscopic discectomy;
- **G.** Endoscopic laser percutaneous discectomy or LASE;
- **H.** Endoscopic Spinal Surgery System.

Background

A variety of discectomy techniques are available[1]:

- The traditional OD is performed with a standard surgical incision, often with the aid of eyepiece (loupe) magnification. It frequently involves a laminectomy (removal of the vertebral lamina to relieve pressure on nerve roots).
- MD is a refinement of open discectomy and involves a smaller incision in the back, with visualization through an operating microscope; this may include a laminotomy or hemilaminectomy in order to adequately visualize the disc, followed by removal of the disc fragment compressing the affected nerve or nerves.
- MID techniques include percutaneous manual nucleotomy, automated percutaneous lumbar discectomy, laser discectomy, endoscopic discectomy, microendoscopic discectomy, coblation nucleoplasty, and the disc DeKompressor. Tubular or trochar discectomy is a less invasive technique in which a tubular retractor is inserted over a guidewire, gaining access to the disc by muscle splitting rather than muscle incision and detachment.

MID procedures involve smaller incisions and surgery with the aid of indirect visualization; some techniques employ lasers to vaporize parts of the disc or automated techniques for removing portions of the disc. They have the potential advantage of quicker recovery from surgery compared to standard OD or MD.

A systematic review of MID versus MD/OD for symptomatic lumbar disc herniation found MID may be inferior in terms of relief of leg pain, low back pain and re-hospitalization.[2] Additionally, MID may be associated with lower risk of infection and shorter hospital stay, but more research is needed due to inconsistent evidence.[2]

Evaniew and colleagues came to a similar conclusion in their 2014 systematic review of MID versus open surgery for cervical and lumbar discectomy. They state that moderate-quality evidence suggests no advantage of MID in short- and long-term function, and low-quality evidence shows no advantage in short-and long-term pain.[3] At this time the risks due to the more technically complicated MID and potential for inadequate decompression render more conventional spinal decompression procedures the preferred choice.

Chou echoes the findings of the systematic reviews, stating that definitive evidence of advantages of MID techniques is needed before adopting them over OD or MD.[1]

The National Institute for Health and Clinical Excellence (NICE)

Current evidence suggests that there are no major safety concerns associated with automated percutaneous mechanical lumbar discectomy. There is limited evidence of efficacy based on

uncontrolled case series of heterogeneous groups of patients, but evidence from small randomized controlled trials shows conflicting results. In view of the uncertainties about the efficacy of the procedure, it should not be used without special arrangements for consent and for audit or research

Coding Implications

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CPT® Codes	Description
0275T	Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (eg, fluoroscopic, CT), , single or multiple levels, unilateral or bilateral; lumbar
62287*	Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar

***** Important Note: This code encompasses various disc procedures, not all of which are considered medically necessary by Centene. To determine medical necessity, the actual procedure to be performed must be specified.

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
M51.26	Other intervertebral disc displacement, lumbar region
M54.16	Radiculopathy, lumbar region
M54.30-M54.32	Sciatica
M54.40-M54.42	Lumbago with sciatica

Reviews, Revisions, and Approvals	Date	Approval Date
Policy split from CP.MP.63 Pain Management Procedures. Clarified that open discectomy and microdiscectomy are medically necessary, while minimally invasive discectomy procedures are not. Added criteria for open/microdiscectomy per Interqual.	07/16	07/16

Reviews, Revisions, and Approvals	Date	Approval Date
Added background information, CPT, and ICD-10 codes.		
Added NICE guidance regarding automated percutaneous mechanical lumbar discectomy. Updated CPT codes. Reviewed and updated references.	07/17	07/17

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CENTENE Corporation

Clinical Policy: Discography

Reference Number: CP.MP.115
Effective Date: 08/16
Last Review Date: 08/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

In lumbar discography, contrast medium is injected into a lumbar intervertebral disc that is thought to be the cause of low back pain. This procedure is used to reproduce a patient's pain and visualize the disc morphology. Injection pressures are also taken into account when considering whether the test suggests symptomatic disc degeneration.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that lumbar discography is **medically necessary** when meeting the following criteria:

A. The injection is for diagnostic purposes and other diagnostic tests (i.e., CT, MRI) have failed to provide definitive confirmation of the suspect disc as the source of the pain;
B. A detailed psychosocial assessment has been performed with no significant findings of unresolved emotional or psychological problems that abnormally affect perception of chronic pain;
C. The injection is performed at 2 levels, with one level serving as a control;
D. Chronic discogenic back pain (may extend to buttocks) that interferes with ADLs for at least 6 months;
E. Pain is non-radicular;
F. Patient has failed to respond to conservative therapy including all of the following:
   1. ≥ 6 weeks physical therapy or prescribed home exercise program;
   2. Non-steroidal anti-inflammatory drug (NSAID) ≥ 3 weeks or NSAID contraindicated or not tolerated;
   3. ≥ 6 weeks activity modification;
G. A surgical procedure that is not experimental/investigational is being considered and the patient is eligible for the surgery;
H. Member has not had previous surgery on the discs to be injected;
I. MRI has confirmed levels of degenerative disc disease and normal discs to use as potential controls.

II. It is the policy of health plans affiliated with Centene Corporation that cervical and thoracic discography is considered **investigational** because effectiveness has not been established.

Background

Lumbar Discography

Lumbar Discography is a controversial diagnostic test for chronic discogenic low back pain. Proponents argue that recreating the patient's pain makes the test more sensitive and specific than imaging such as radiographs, myelography, and MRI, which identify both symptomatic and asymptomatic abnormalities.[1] However, critics argue that discography lacks reliability, given the absence of a clearly defined gold-standard reference test and the ability of the test to produce

pain in patients without any prior history of back pain.[1,2] Additionally, studies have come to conflicting conclusions regarding the accuracy of lumbar discography in identifying the source of discogenic pain and in guiding treatment decisions.[3-7] Discography after lumbar discectomy in particular has been noted to produce pain in patients who are otherwise asymptomatic.[8]

Recent guidelines upheld prior statements regarding the unsuitability of discography as a stand-alone test.[1,9] Its utility lies in its use as a screening tool in conjunction with imaging. Moreover, there is evidence from a prospective cohort study that discography may lead to accelerated disk degeneration such as occurrence of new herniations, loss of disc height, and loss of disc signal intensity.[10]

Cervical/Thoracic Discography
While evidence is fair for lumbar discography to identify the source of discogenic pain, for cervical or thoracic discography, it is limited by few studies of poor quality.[11-13]

Lumbar discography represents a screening tool for the source of discogenic pain after other sources of lumbar pain have been excluded and when treatment is available.[11] For cervical and thoracic pain, discography is not an appropriate diagnostic or screening tool.

Coding Implications
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CPT® Codes	Description
62290	Injection procedure for discography, each level; lumbar
62291	Injection procedure for discography, each level; cervical or thoracic
62292	Injection procedure for chemonucleolysis, including discography, intervertebral disc, single or multiple levels, lumbar
72285	Discography, cervical or thoracic, radiological supervision and interpretation
72295	Discography, lumbar, radiological supervision and interpretation

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
M54.5	Low back pain
M54.6	Pain in thoracic spine

Reviews, Revisions, and Approvals	Date	Approval Date
Policy split from CP.MP.63 Pain Management Procedures. Added that other imaging must not have confirmed source of discogenic pain. Added that pain must not be radicular, per UpToDate and Manchikanti et al. Added background information.	07/16	
Per specialist review and verification in literature: Added requirement for psychosocial assessment with no major unresolved findings and no previous history of lumbar discectomy. Modified criteria to require that 2 levels must be injected- one for diagnosis and one for control. Added that member must not have had prior surgery on the disks to be injected. Added that patient must be eligible for surgery for which discography is providing confirmation of discogenic pain. II: Changed experimental/investigational to investigational.	08/16	08/16
I.B: changed no “unresolved emotional or chronic pain problems” to “unresolved emotional or psychological problems that abnormally affect perception of chronic pain.” References reviewed and updated.	08/17	08/17

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CENTENE Corporation

Clinical Policy: Lysis of Epidural Lesions

Reference Number: CP.MP.116
Effective Date: 07/16
Last Review Date: 07/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Epidural adhesiolysis, also known as epidural neuroplasty, lysis of epidural adhesions, or caudal neuroplasty, is a minimally invasive surgery for patients with chronic back pain associated with epidural fibrosis or adhesions. Adhesions are commonly caused by scarring after spinal interventions, and are associated with post-laminectomy syndrome or failed back surgery syndrome. Adhesions may also be caused by normal aging of the spine and spinal disorders such as lumbar disc herniation and spinal stenosis.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that lysis of epidural lesions, including percutaneous epidural adhesiolysis and endoscopic epidural adhesiolysis, with or without use of an indwelling epidural Racz catheter, is considered **investigational.** This treatment continues to be evaluated in clinical studies, however current medical literature does not support its efficacy.

Background

Percutaneous lysis of epidural adhesions with epidural injections of hypertonic saline, in conjunction with steroids and analgesics or hyaluronidase, is an interventional pain management technique that has been investigated as a treatment option in managing chronic intractable low back pain caused by extensive peridural scarring. In theory, the use of hypertonic saline results in a mechanical disruption of the adhesions. Adhesions may also be disrupted by the manipulation of the catheter at the time of the injection. The hypertonic saline may also function to reduce edema within previously scarred and/or inflamed nerves. Hyaluronidase may be added to the injectate to further the penetration of the drugs into the scar tissue.

Spinal endoscopy has been used to guide the lysis of adhesions. Prior to use of endoscopy, adhesions can be identified as non-filling lesions on fluoroscopy. Using endoscopy guidance, a flexible fiberoptic catheter is inserted into the sacral hiatus, providing 3-D visualization to steer the catheter toward the adhesions, to more precisely place the injectate in the epidural space and onto the nerve root. Various protocols for lysis have been described; in some situations the catheter may remain in place for several days for serial treatment sessions.

Evidence for percutaneous adhesiolysis

Controlled trials have found short-term positive effects of percutaneous epidural adhesiolysis in patients with chronic, refractory back pain and lower extremity pain.[1-5] However, these studies are limited by methodological limitations including somewhat high attrition rates, insufficient blinding and inadequate statistical power to establish safety. Furthermore, many of the studies were conducted at the same interventional pain management center, which could limit the representativeness of the results obtained by the researchers.[1]

Evidence for endoscopic adhesiolysis
Research conducted on endoscopic epidural adhesiolysis is generally positive, with significant improvements in pain with endoscopic adhesiolysis compared to control groups.[6-9] The studies conducted thus far have been largely observational, however.[6-9] In a 2012 randomized controlled trial (RCT) conducted by Manchikanti et al., endoscopic adhesiolysis was found to significantly improve pain at three, six, and 12 months in patients who had failed conservative treatment for low back pain, compared to endoscopy alone.[10] A systematic review of endoscopic adhesiolysis was conducted by Helm et al. and included three observational studies and one RCT.[11] The systematic review concluded that there is fair quality evidence of positive effects, citing paucity of literature as a limitation.[11]

Guideline Recommendations
A 2013 Guideline Update by the American Society of Interventional Pain Physicians rates the quality of evidence for lumbar percutaneous adhesiolysis as fair for managing chronic low back and lower extremity pain due to post surgery syndrome and spinal stenosis.[12] This is due largely to limited number of high quality RCTs assessing the intervention. The guideline update does not address endoscopic adhesiolysis due to limited evidence.[12] Additionally, the UK National Institute for Clinical Excellence (NICE) has concluded that "current evidence on therapeutic endoscopic division of epidural adhesions is limited to some evidence of short-term efficacy, and there are significant safety concerns. Therefore this procedure should only be used with special arrangements for clinical governance, consent and audit or research."[13]

Given the limited high quality research conducted on percutaneous and endoscopic adhesiolysis, these procedures are considered investigational.

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CPT® Codes	Description
62263	Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (e.g., catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days
62264	Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (e.g., catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day

ICD-10-CM Diagnosis Codes

ICD-10-CM Code	Description
G96.12	Meningeal adhesions (cerebral) (spinal)
G96.19	Other disorders of meninges, not elsewhere classified
M50.00-M50.03	Cervical disc disorder with myelopathy
M50.20	Other cervical disc displacement
M50.30-M50.33	Other cervical disc degeneration
M51.0-M51.06	Thoracic, thoracolumbar, and lumbosacral intervertebral disc disorders with myelopathy
M51.24-M51.27	Other thoracic, thoracolumbar, and lumbosacral intervertebral disc displacement
M51.34-M51.37	Other thoracic, thoracolumbar, and lumbosacral intervertebral disc degeneration
M96.1	Postlaminectomy syndrome, not elsewhere classified

Reviews, Revisions, and Approvals	Date	Approval Date
Policy split from CP.MP.63 Pain Management Procedures. Background information added.	07/16	07/16
References reviewed & updated.	06/17	07/17

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CLINICAL POLICY
Lysis of Epidural Lesions

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CENTENE Corporation

Clinical Policy: Spinal Cord Stimulation

Reference Number: CP.MP.117
Effective Date: 07/16
Last Review Date: 07/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

The dorsal column stimulator (DCS), or spinal column stimulator (SCS) is a device that allows for electrical stimulation of the dorsal aspect of the spinal cord nerves in an effort to relieve pain in patients with a variety of chronic pain disorders. In most cases, neuropathic pain responds poorly to standard pharmacological and surgical therapies and can last indefinitely with increasing severity over time. It may result in severe disability. Stimulation in this area interferes with the conduction of pain impulses through adjacent sensory pathways and may stimulate endorphins. The technique does not alter the underlying pathological process. However, in selective patients with persistent and intractable pain of nerve origin, approximately 50 percent of patients will have pain relief, thereby decreasing the need for analgesic medication and at times obviating the need for further surgical procedures.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that spinal cord stimulation (SCS) is **medically necessary** for the following indications:

A. A *trial of SCS* for *failed back surgery syndrome* when all the following criteria are met:
   1. Prior lumbar surgery;
   2. Neuropathic pain lasting ≥ 6 months, is refractory and interferes with activities of daily living (ADLs);
   3. Patient is not a candidate for additional surgery;
   4. Patient has failed ≥ 6 months of conventional multidisciplinary medical therapy including all of the following:
      a. Chiropractic, physical therapy or prescribed home exercise program;
      b. NSAIDs (non-steroidal anti-inflammatory drugs) unless contraindicated or not tolerated;
      c. Activity modification;
   5. Patient has demonstrated cognitive ability to manage stimulator;
   6. Patient has no inadequately treated major psychiatric disorders;
   7. Patient is willing to cease any inappropriate drug use prior to implantation.

B. A *trial of SCS* for *complex regional pain syndrome* (CRPS) when all the following criteria are met:
   1. Pain is being managed by a pain management specialist with experience treating CRPS and pain/burning has persisted for > 6 months;
   2. The patient has ≥ 2 of the following symptoms limited to one extremity only:
      a. Allodynia (pain sensation in response to a typically non-painful stimulus) or hyperalgesia;
      b. Swelling/tenderness;
      c. Cyanotic/red/pale digit/extremity;

   d. Increased sweating;
   e. Alteration of temperature;
   f. Persistent loss of motion;
   g. Trophic skin changes;
   h. Flexion contractures;
3. Pain is chronic, refractory, and interferes with ADLs;
4. Patient has had ≥ 6 months of failed conventional multidisciplinary therapy including all of the following:
   a. Physical therapy or occupational therapy;
   b. Anticonvulsant or antidepressant medication;
   c. Sympathetic block;
5. Patient has demonstrated cognitive ability to manage stimulator;
6. Patient has no inadequately treated major psychiatric disorders;
7. Patient is willing to cease any inappropriate drug use prior to implantation.

C. *A trial of SCS* for *chronic ischemic leg pain due to peripheral vascular disease* when all of the following criteria are met:
   1. Patient has chronic, ischemic leg pain due to peripheral vascular disease and one of the following:
      a. The patient cannot undergo revascularization;
      b. Revascularization has failed to relieve painful symptoms and the pain has not responded to medical management;
   2. Pain lasting ≥ 6 months, is refractory and interferes with ADLs;
   3. Patient has demonstrated cognitive ability to manage stimulator;
   4. Patient has no inadequately treated major psychiatric disorders;
   5. Patient is willing to cease any inappropriate drug use prior to implantation.

D. *A trial of SCS* for *the following indications* has **limited evidence** to prove effectiveness of treatment and consideration will be made on a case by case basis. Medical necessity will be considered in patients based on the following information:
   1. Patient has chronic, intractable pain due to one of the following:
      a. Lumbosacral adhesive arachnoiditis secondary to multiple myelographies or lumbar surgeries that has not responded to medical management, including physical therapy (the presence of arachnoiditis is usually documented by the presence of high levels of proteins in the cerebro spinal fluid and/or by myelography or magnetic resonance imaging);
      b. Nerve root injuries, post-surgical or post traumatic (e.g., avulsion);
      c. Phantom limb syndrome that has not responded to medical management;
      d. Post-herpetic neuralgia;
      e. Plexopathy;
      f. Polyneuropathy;
      g. Intercostal neuralgia that did not respond to medical management and nerve blocks;
      h. Cauda equina injury/syndrome;
      i. Incomplete spinal cord injury;
      j. Diabetic neuropathy;

2. Pain lasting ≥ 6 months, is refractory and interferes with ADLs;
3. Patient has failed ≥ 6 months of conventional multidisciplinary medical therapy;
4. Patient has demonstrated cognitive ability to manage stimulator;
5. Patient has no inadequately treated major psychiatric disorders;
6. Patient is willing to cease any inappropriate drug use prior to implantation.

E. *A trial of SCS* for *refractory chronic stable angina pectoris* has **limited evidence** to prove effectiveness of treatment and consideration will be made on a case by case basis. It should be reserved only for carefully selected patients, if any. Medical necessity will be considered in patients based on the following information:
   1. Patient has continued angina after percutaneous coronary intervention or coronary artery bypass graft;
   2. Patient is not a candidate for further revascularization;
   3. Patient's angina is NYHA (New York Heart Association) III (less than ordinary physical activity causes symptoms) or IV (symptoms present at rest);
   4. Reversible ischemia documented at least by a symptom-limited treadmill exercise test;
   5. Patient has had optimal pharmacotherapy for at least one month that includes the maximal tolerated dose of at least 2 of the following:
      a. Long-acting nitrates;
      b. Beta-adrenergic blockers;
      c. Calcium channel antagonists;
   6. Pain is chronic, refractory, and interferes with ADLs;
   7. Patient has demonstrated cognitive ability to manage stimulator;
   8. Patient has no inadequately treated major psychiatric disorders;
   9. Patient willing to cease any inappropriate drug use prior to implantation.

F. *Permanent placement of a SCS* is **medically necessary** following a trial of spinal cord stimulation for an indication listed above when all of the following criteria are met:
   1. Disease specific criteria for spinal cord stimulation are met;
   2. Documented trial of ≥ 3 days;
   3. Documented pain reduction of > 50% from the trial associated with functional improvement;
   4. The same device used for the trial is used for permanent placement.

Background

SCS is currently used to treat a wide variety of inoperable and intractable chronic pain syndromes, including failed back surgery syndrome and CRPS. In patients with failed conservative and surgical treatment of lower-limb ischemia, SCS increases skin blood flow, decreases pain, and improves quality of life. Four studies used inferential statistics and found pain reduction to be significant. At least 50% pain reduction at follow-up was found in 78%, 80%, and 85% of patients in the three studies that reported this data. Follow-up ranged from 6 to 35 months.

According to recent systematic reviews, the most favorable results have been observed in patients with peripheral vascular disease, complex regional pain syndrome, and peripheral

neuropathy (e.g., diabetic or causalgic origin). Of interest, the pain relief achieved with SCS in patients with complex regional pain syndrome is possible without vasodilation. The vasodilation found with SCS is attributed to an inhibitory effect on sympathetically maintained vasoconstriction. Diabetic patients with peripheral arterial occlusive disease who present with intractable pain have also been successfully treated with SCS, except those who have severe autonomic neuropathy. Recently, SCS has been successfully used to treat intractable angina pectoris and chronic mesenteric ischemia.

Spinal cord stimulation is proposed as a late or last resort treatment for chronic pain due to stable angina pectoris. Although most of the research reviewed used subjective outcome measures and some studies lacked prospective design, adequate sample size, and control groups, SCS was shown to alleviate pain and reduce myocardial ischemia in many of the study patients for whom pain relief was previously unobtainable. SCS has also been shown to reduce service utilization in aggregate among recipients. Side effects, while not infrequent, are rarely serious and can usually be resolved by the realignment or replacement of the device. Evidence indicates that the analgesic effect of SCS in angina does not mask the warning pain of myocardial infarction. Patients who have been treated with SCS have not been shown to be at increased risk for morbidity or mortality compared with their peers. Although a minority of patients receiving a trial of SCS ultimately experience prolonged pain relief, the significance of the alleviation of pain and suffering among those who do cannot be underestimated. Therefore, spinal cord stimulation for chronic stable angina pectoris secondary to demonstrable myocardial ischemia in patients who are refractory to treatment should be considered.

Slangen et al (2014) performed a multicenter randomized clinical trial in 36 painful diabetic peripheral neuropathy (PDPN) patients with severe lower limb pain not responding to conventional therapy. The authors concluded treatment success was shown in 59% of patients with PDPN who were treated with SCS over a 6-month period, although this treatment is not without risks. Two year outcomes of the same study reported clinically significant improvements in pain and sleep in 53% of patients. Additionally, a randomized controlled trial of 60 patients, conducted by de Vos and colleagues, found that pain due to PDPN was significantly reduced from baseline at 6 months, and quality of life was improved.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2017, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
63650	Percutaneous implantation of neurostimulator electrode array, epidural

CPT® Codes	Description
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural
63685	Incision and subcutaneous placement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
95970	Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (i.e., cranial nerve, peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming
95971	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple spinal cord, or peripheral (i.e., peripheral nerve, sacral nerve, , neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming
95972	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements: complex spinal cord or peripheral (i.e, peripheral nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative subsequent programming.

HCPCS Codes	Description
L8679	Implantable neurostimulator, pulse generator, any type
L8680	Implantable neurostimulator electrode, each
L8681	Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only
L8682	Implantable neurostimulator radiofrequency receiver
L8683	Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver
L8685	Implantable neurostimulator pulse generator, single array, rechargeable includes extension
L8686	Implantable neurostimulator pulse generator, single array, nonrechargeable, includes extension
L8687	Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension
L8688	Implantable neurostimulator pulse generator, dual array, nonrechargeable, includes extension

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
B02.29	Other postherpetic nervous system involvement
E10.40	Type 1 diabetes mellitus with diabetic neuropathy, unspecified
E10.41	Type 1 diabetes mellitus with diabetic mononeuropathy
E10.42	Type 1 diabetes mellitus with diabetic polyneuropathy
E10.43	Type 1 diabetes mellitus with diabetic autonomic (poly) neuropathy
E10.49	Type 1 diabetes mellitus with other diabetic neurological complication
E11.40	Type 2 diabetes mellitus with diabetic neuropathy, unspecified
E11.41	Type 2 diabetes mellitus with diabetic mononeuropathy
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy
E11.43	Type 2 diabetes mellitus with diabetic autonomic (poly) neuropathy
E11.49	Type 2 diabetes mellitus with other diabetic neurological complication
G03.1	Chronic meningitis
G09	Sequelae of inflammatory diseases of central nervous system
G54.0-G54.9	Nerve root and plexus disorders
G56.40-G56.42	Causalgia of upper limb
G56.80-G56.82	Other specified mononeuropathies of upper limb
G56.90-G56.93	Unspecified mononeuropathies of upper limb
G57.70-G57.73	Causalgia of lower limb
G57.80-G57.93	Other specified mononeuropathies of lower limb
G90.50-G90.59	Complex regional pain syndrome I (CRPSI)
I20.1	Angina pectoris with documented spasm
I70.221-I70.229	Atherosclerosis of native arteries of extremities with rest pain
I73.9	Peripheral vascular disease, unspecified
M54.10	Radiculopathy, site unspecified
M54.12	Radiculopathy, cervical region
M54.13	Radiculopathy, cervicothoracic region
M54.14	Radiculopathy, thoracic region
M54.15	Radiculopathy, thoracolumbar region
M54.16	Radiculopathy, lumbar region
M54.17	Radiculopathy, lumbosacral region
M54.30-M54.32	Sciatica
M79.2	Neuralgia and neuritis, unspecified
M96.1	Postlaminectomy syndrome, not elsewhere classified
R20.3	Hyperesthesia
S34.3XX*	Injury of cauda equine

ICD-10-CM Code	Description
S14.2XX*	Injury of nerve root of cervical spine
S24.2XX*	Injury of nerve root of thoracic spine
S34.21X*	Injury of nerve root of lumbar spine
S34.22X*	Injury of nerve root of sacral spine
T87.9	Unspecified complications of amputation stump

*Add 7th digit A-S

Reviews, Revisions, and Approvals	Date	Approval Date
Policy split from CP.MP.63 Pain Management Procedures. Added chronic lower limb ischemia indication in I. C per Cochrane review of effectiveness. I.D. Case by-case indications: Added indications in I.D. per American Association of Neurological Surgeons 2008 information on SCS, and 2010 American Society of Anesthesiologists guidelines; added diabetic neuropathy indication. Added requirement for reversible ischemia documented by treadmill exercise test, per inclusion criteria in study by de Jongste. Added ICD-10 codes for diabetic neuropathy.	07/16	07/16
Took out requirement for more than 1 failed back surgery or failed back surgery at more than 1 level in failed back surgery syndrome (FBSS) indication (I.A.), as this was not supported by literature. Specified that pain in FBSS should be neuropathic. Added hyperalgesia as a symptom of CRPS. Coding updated.	07/17	07/17

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and

regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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CENTENE Corporation

Clinical Policy: Injections and Radiofrequency Neurotomy for Pain Management

Reference Number: CP.MP.118
Effective Date: 08/16
Last Review Date: 09/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Invasive pain management procedures considered in this policy include epidural steroid injections/selective nerve root blocks, facet joint diagnostic and therapeutic blocks and radiofrequency ablation, sacroiliac joint injections and radiofrequency ablation, intradiscal steroid injections, trigger point injections, occipital nerve blocks, peripheral nerve blocks and sympathetic blocks.

Policy/Criteria

It is the policy of health plans affiliated with Centene Corporation® that invasive pain management procedures performed by a physician are medically necessary when *the relevant criteria are met and the patient receives only one procedure per visit, with or without radiographic guidance.*

I. Cervical/thoracic/lumbar/caudal, interlaminar epidural Steroid Injections 1
II. Selective Nerve Root Blocks/Transforaminal Epidural Steroid Injections 2
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XI. Intercostal Nerve Block, Neurolysis 8
XII. All other procedures not specifically addressed in this policy will be considered on a case by case basis.....8

I. Cervical/thoracic/lumbar/caudal, interlaminar epidural Steroid Injections

A. Up to a total of two diagnostic cervical/thoracic/lumbar/caudal, interlaminar epidural steroid injections (ILESI's) given at one level per session, at least 2 weeks apart for chronic pain are considered medically necessary to establish a diagnosis and confirm beneficial response when all of the following are met:
   1. Persistent radicular pain caused by spinal stenosis, disc herniation or degenerative changes in the vertebrae, that interferes with ADLs, that has lasted for at least 3 months;
   2. Patient has failed to respond to conservative therapy including all of the following:
      a. ≥ 6 weeks chiropractic, physical therapy or prescribed home exercise program;
      b. NSAID ≥ 3 weeks or NSAID contraindicated or not tolerated;

c. ≥ 6 weeks activity modification.

3. Patient is not currently being treated with full anticoagulation therapy. For patients on warfarin, INR (international normalized ratio) should be ≤1.4 prior to the procedure.
   Discontinuing anti-platelet therapy is a clinical decision balancing risks and benefits of the procedure on therapy, versus the underlying medical condition if not treated appropriately.

B. If no improvement is seen after the first two injections, *subsequent ILESI's* are considered **not medically necessary** because effectiveness has not been established.

C. If recurrence of symptoms occurs after a favorable response to diagnostic injections, *therapeutic ILESI's* are considered **medically necessary** when all of the following are met:
   1. There is ≥ 50% relief for at least 2 months associated with functional improvement from the initial injection(s);
   2. *ILESI* is given at intervals of no more frequently than every 3 months.
   3. A maximum of 4 therapeutic injections may be given at the same site within 12 months.

D. *Continuation of injections* beyond 12 months or more than 4 therapeutic injections is considered **not medically necessary** because effectiveness and safety has not been established. When more definitive therapies cannot be tolerated or provided, consideration will be made on a case by case basis.

E. *ILESI for **acute** pain management* (pain lasting < 3 months) is considered **medically necessary** when all of the following are met:
   1. There is severe radicular pain that interferes substantially with ADLs;
   2. Severe pain persists after treatment with NSAID and/or opiate (both ≥ 3 days or contraindicated/not tolerated);
   3. The member cannot tolerate chiropractic or physical therapy and the injection is intended as a bridge to therapy.

F. *ILESI for any other indication or location* is considered **not medically necessary** because effectiveness has not been established.

II. Selective Nerve Root Blocks/Transforaminal Epidural Steroid Injections

A. *Diagnostic SNRB/TFESI* performed at either two levels unilaterally, or one level bilaterally, at the exact level of the lesion per session, up to a total of two sessions given at least 2 weeks apart for chronic pain are considered **medically necessary** to establish a diagnosis and confirm beneficial response when all the following criteria are met:
   1. Persistent radicular pain in a defined nerve root level caused by disc herniation or foraminal stenosis at that specific level in the spine, as confirmed by imaging, that interferes with ADLs and has lasted for at least 3 months;
   2. Patient has failed to respond to conservative therapy including all of the following:

a. ≥ 6 weeks chiropractic, physical therapy or prescribed home exercise program;
b. NSAID ≥ 3 weeks or NSAID contraindicated or not tolerated;
c. ≥ 6 weeks activity modification;

3. Patient is not currently being treated with full anticoagulation therapy. For patients on warfarin, international normalized ratio (INR) should be < =1.4 prior to the procedure.
   Discontinuing anti-platelet therapy is a clinical decision balancing risks and benefits of the procedure on therapy, versus the underlying medical condition if not treated appropriately.

C. If no improvement is seen after the first two injections, subsequent *SNRB/TFESI* are considered **not medically necessary** because their effectiveness has not been established

D. If recurrence of symptoms occurs after a favorable response to diagnostic injections, *therapeutic SNRB/TFESI* are considered **medically necessary** when all of the following is met:
   1. There is ≥ 50% relief for at least 2 months associated with functional improvement from the initial injection(s);
   2. SNRB/TFESI is given at intervals of no more frequently than every 3 months;
   3. A maximum of 4 therapeutic injections may be given at the same site within 12 months.

E. Continuation of injections beyond 12 months or more than 4 therapeutic injections is considered **not medically necessary** because effectiveness and safety has not been established. When more definitive therapies cannot be tolerated or provided, consideration will be made on a case by case basis.

F. *SNRB/TFESI* for ***acute*** *pain management* (pain lasting < 3months) is considered **medically necessary** when all of the following are met:
   1. There is severe radicular pain in a specific nerve root distribution that interferes substantially with ADLs;
   2. Severe pain persists after treatment with NSAID and/or opiate (both ≥ 3 days or contraindicated/not tolerated);
   3. The member cannot tolerate chiropractic or physical therapy and the injection is intended as a bridge to therapy.

G. *SNRB/TFESI* for any other indication or location is considered **not medically necessary** because effectiveness has not been established.

III. Facet Joint Interventions

A. Up to two* *controlled medial branch blocks* given at least 2 weeks apart are considered **medically necessary** when all the following criteria are met:
   1. Intermittent or continuous back pain that interferes with ADLs has lasted for ≥ 3 months;
   2. Patient has failed to respond to conservative therapy including all of the following:

   a. ≥ 6 weeks chiropractic, physical therapy or prescribed home exercise program;
   b. NSAID ≥ 3 weeks or NSAID contraindicated or not tolerated;
   c. ≥ 6 weeks activity modification;
3. Clinical findings suggest facet joint syndrome and imaging studies suggest no other obvious cause of the pain (e.g., disc herniation, radiculitis, discogenic or sacroiliac pain). Physical findings of spinal facet joint syndrome can include low back pain exacerbated on extension and rotation; positive response to facet loading maneuvers or pain worse at night;

*Note: If the first *controlled medial branch block/facet joint injection* is negative, a second block is ***not medically necessary***

B. *Facet joint medial branch conventional radiofrequency neurotomy in the lumbar and cervical regions* is considered **medically necessary** in the treatment of chronic back or neck pain when all of the following criteria are met:
   1. Two positive diagnostic controlled facet joint injections/medial branch block(s) (at each region to be treated) as indicated by ≥ 75% pain relief with the ability to perform prior painful movements without significant pain;
   2. All regions being treated will be treated at the same time provided all can be performed safely.

C. *Repeat facet joint medial branch conventional radiofrequency neurotomy of the lumbar and cervical regions* is considered **medically necessary** in the management of chronic back or neck pain when the following criteria are met:
   1. At least 6 months have elapsed since the previous treatment;
   2. ≥ 50% relief is obtained for at least 4 months with associated functional improvement following the previous treatment;
   3. No more than three spinal levels, or two levels bilaterally, are to be treated at the same session.

D. *Conventional radiofrequency neurotomy of the facet joints* of the thoracic region is considered **not medically necessary** because effectiveness has not been established. There is a need for further well-designed, randomized controlled trials to evaluate effectiveness.

E. *Pulsed radiofrequency neurotomy of the facet joints* is considered **not medically necessary.** The available evidence on the effectiveness of pulsed radiofrequency in the treatment of patients with various chronic pain syndromes is largely based on retrospective, case series studies. Its clinical value needs to be examined in well-designed, randomized controlled trials with large sample size and long-term follow-up. Studies on pulsed radiofrequency ablation continue to be done.

F. *Therapeutic facet joint injections* are considered **not medically necessary** because effectiveness has not been established.

IV. Sacroiliac Joint Interventions

A. Up to two *diagnostic sacroiliac joint (SIJ) injections for the diagnosis of SIJ pain* separated by at least 2 weeks are considered **medically necessary** when all of the following criteria are met:
   1. Somatic or nonradicular low back and lower extremity pain below the level of L5 vertebra that interferes with ADLs for at least 3 months;
   2. Tenderness by palpation present over SIJ;
   3. There is a positive response to at least three SIJ pain provocation tests (distraction, compression, thigh thrust, Gaenslen's, and sacral thrust);
   4. Patient has failed to respond to conservative therapy including all of the following:
      a. ≥ 6 weeks chiropractic, physical therapy or prescribed home exercise program;
      b. NSAID ≥ 3 weeks or NSAID contraindicated or not tolerated;
      c. ≥ 6 weeks activity modification;
   5. Clinical findings and imaging studies, when available, lack obvious evidence for disc-related or facet joint pain;
   6. No other possible diagnosis is more likely.

B. If recurrence of symptoms occurs after a favorable response to diagnostic injections, *therapeutic SIJ injections* are considered **medically necessary** when all of the following are met:
   1. There is ≥ 50% relief for at least 2 months associated with functional improvement from the initial injection(s);
   2. Administered for temporary relief of lower back pain in conjunction with other noninvasive treatment methods (e.g., to participate in physical therapy), and not as a stand-alone therapy;
   3. SIJ injection is given at intervals of no more frequently than every 2 months;
   4. A maximum of 4 therapeutic injections may be given at the same site within 12 months.

C. *Continuation of injections* beyond 12 months is considered **not medically necessary** because effectiveness and safety has not been established. When more definitive therapies cannot be tolerated or provided, consideration will be made on a case by case basis.

D. *Radiofrequency neurotomy (conventional, cooled, and pulsed)* of the SIJ is considered **not medically necessary** because effectiveness has not been established. High-quality studies are lacking for conventional and pulsed radiofrequency neurotomy of the SIJ. For cooled radiofrequency neurotomy, additional well-designed studies are needed to evaluate effectiveness.

V. Intradiscal Steroid Injection

Intradiscal steroid injections are considered **not medically necessary** because effectiveness has not been established. The published literature suggests both positive and negative results. Further research is being done to determine the safety and efficacy of injecting steroids directly into the disc.

VI. Trigger Point Injections

A. Trigger point injections of corticosteroids and/or local anesthetics, are considered **medically necessary** for *diagnosis/stabilization* when all of the following are met:
   1. Patient has local pain symptoms in the neck, shoulder and/or back that have persisted for more than 3 months causing tenderness and/or weakness, restricting motion and/or causing referred pain when compressed;
   2. Patient has failed ≥ 3 weeks of conventional multidisciplinary medical therapy including all of the following:
      a. Chiropractic, physical therapy, or prescribed home exercise program or the member is unable to tolerate such therapy and the injection is intended as a bridge to therapy;
      b. NSAID unless contraindicated or not tolerated;
      c. Activity modification;
   3. Trigger points have been identified by palpation;
   4. Trigger points are located in a *few* discrete areas, and are not associated with widespread areas of muscle tenderness (as with fibromyalgia);
   5. Injections are not used in isolation as sole method of treatment. They should facilitate mobilization by providing pain relief and assist in application of non-invasive modalities, e.g., physical therapy, medications, and other alternate therapies that address muscle strengthening, flexibility, and functional restoration.

   Up to 2 sets of injections may be given for diagnosis and stabilization at intervals no more frequently than every 7 days for the same trigger point. When a given body region is injected, it will be considered as one injection service no matter how many injections are given.

B. *Therapeutic trigger point injections* are considered **medically necessary** when all of the following are met:
   1. Prior injections (diagnostic or therapeutic) resulted in ≥ 50% improvement for ≥ 6 weeks;
   2. There was a return of pain and/or deterioration following 6 weeks of improvement;
   3. Injections are given in the neck, shoulder, and/or back;
   4. Injections are given no more frequently than every 2 months for up to 12 months (maximum of 6 sessions);
   5. Injections are not used in isolation as sole method of treatment. They should facilitate mobilization by providing pain relief and assist in application of non-invasive modalities, e.g., physical therapy, medications, and other alternate therapies that address muscle strengthening, flexibility, and functional restoration.

   When a given body region is injected, it will be considered as one injection service no matter how many injections are given.

C. The following types of *trigger point therapies* are considered **not medically necessary**, because although there are ongoing studies, there is little scientifically based data that their use results in improved patient outcomes in the medical literature:
   1. Dry needle stimulation of trigger points;
   2. Trigger point injection with saline or glucose;

3. The use of Botox during trigger point injections.

VII. Interventions for Occipital Neuralgia (Occipital Nerve Block)

A. Local injections of corticosteroids and/or local anesthetics for *occipital neuralgia* are considered **medically necessary** for the diagnosis and treatment of occipital neuralgia when all of the following is met:
   1. Patient has unilateral or bilateral pain located in the distribution of the greater, lesser and/or third occipital nerves;
   2. Pain has two of the following three characteristics:
      a. Recurring in paroxysmal attacks lasting from a few seconds to minutes
      b. Severe intensity
      c. Shooting, stabbing, or sharp in quality
   3. Pain is associated with both of the following:
      a. Dysesthesia and/or allodynia apparent during innocuous stimulation of the scalp and/or hair
      b. Tenderness over the affected nerve branches
   4. Patient has failed 6 weeks of conservative treatment including all of the following:
      a. Heat, rest and/or physical therapy, including massage;
      b. NSAID unless contraindicated or not tolerated;
      c. Oral anticonvulsant medications (e.g., carbamazepine, gabapentin, pregabalin);
      d. Tricyclic antidepressants;
      e. Activity modification to address triggers.

B. Repeat occipital nerve block is considered medically necessary if recurrence of symptoms occurs after a favorable response, when both of the following is met:
   1. There is ≥ 50% relief for at least 2 months associated with functional improvement from the initial injection;
   2. A maximum of 4 injections may be given within 12 months.

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VIII. Genicular Nerve Blocks and Genicular Nerve Radiofrequency Neurotomy

Genicular nerve blocks and *radiofrequency neurotomy of the articular nerve* are considered **not medically necessary** because effectiveness has not been established. There is a paucity of published studies to determine safety and effectiveness.

IX. Peripheral/Ganglion Nerve Blocks for the Treatment of Chronic Nonmalignant Pain

Peripheral/ganglion nerve blocks for any condition not indicated elsewhere in this policy are considered **not medically necessary** as there is ongoing research but insufficient evidence to establish efficacy.

X. Sympathetic Nerve Blocks

A. *Sympathetic nerve blocks* have **limited evidence** to prove effectiveness of treatment and consideration will be made on a case by case basis. The criteria in 1 through 3 below

provide a basis for documenting patient-specific clinical information to help guide clinical decision making.

1. Diagnosis of *complex regional pain syndrome* (CRPS) (also called reflex sympathetic dystrophy) and all of the following:
   a. Pain is being managed by a pain management specialist with experience treating CRPS;
   b. Patient is in an active rehabilitation regimen;
   c. Failed ≥ 3 weeks of conservative therapies such as activity modification, exercises, topical capsaicin cream, and oral medical management such as nonsteroidal anti-inflammatories, antidepressants, anticonvulsants and glucocorticoids;
   d. ≥ 2 of the following findings of the involved digit/extremity:
      i. Allodynia (pain sensation in response to a typically non-painful stimulus);
      ii. Swelling/tenderness;
      iii. Cyanotic/red/pale digit/extremity;
      iv. Increased sweating;
      v. Alteration of temperature;
      vi. Persistent loss of motion;
2. Diagnosis of *ischemic limb pain* and all of the following:
   a. Intractable pain at rest or non-healing ulcer;
   b. Severe peripheral artery disease by angiogram or Doppler;
   c. Patient not a candidate for revascularization (lesion(s) not amenable to reconstruction, lesion(s) not amenable to angioplasty, patient with comorbid condition or previous failed revascularization);
3. Diagnosis of *pancreatic cancer* with severe abdominal/back pain.

B. Celiac nerve block for *acute or chronic pancreatitis* is considered **not medically necessary** as effectiveness has not been established.

XI. Intercostal Nerve Block, Neurolysis

A. *Intercostal nerve block/neurolysis* is considered **medically necessary** for chronic neuralgic pain secondary to an injured intercostal nerve as a result of a rib fracture, a thoracotomy incision or chronic pain due to post herpetic neuralgia, or other neuropathic process when all of the following are met:
   1. Suspected organic problem;
   2. Non-responsiveness to conservative modalities of treatment;
   3. Pain and disability of moderate to severe degree;
   4. No evidence of contraindications such as infection or pain of predominately psychogenic origin.

XII. All other procedures not specifically addressed in this policy will be considered on a case by case basis.

Background

Pain adversely affects the function and wellbeing of an individual. Chronic pain can be persistent or episodic in duration or intensity. Invasive pain management procedures considered in this

policy include facet joint diagnostic and therapeutic blocks and radiofrequency ablation, sacroiliac joint injections, epidural steroid injections/selective nerve root blocks, percutaneous adhesiolysis, trigger point injections, trochanteric bursa injections, sympathetic blocks, lumbar discography and spinal cord stimulation.

Epidural steroid injections/selective nerve root blocks
The debate continues on the efficacy and medical necessity of multiple interventions provided in managing spinal pain. Epidural glucocorticoid injections have been used for pain control in patients with radiculopathy, spinal stenosis, and nonspecific low back pain despite inconsistent results as well as heterogeneous populations and interventions in randomized trials. Epidural injections are performed utilizing 3 approaches in the lumbar spine: caudal, interlaminar, and transforaminal. Generally, candidates for epidural steroid injection are individuals who have acute radicular symptoms or neurogenic claudication unresponsive to traditional analgesics and rest, with significant impairment in activities of daily living. Epidural steroid injections have been used in the treatment of spinal stenosis for many years, and no validated long-term outcomes have been reported to substantiate their use. However, significant improvement in pain scores, have been reported at 3 months.

Zhai et al (2015) conducted a meta-analysis to assess the effects of various surgical and nonsurgical modalities, including epidural injections, used to treat lumbar disc herniation (LDH) or radiculitis. A systematic literature search was conducted to identify RCTs which compared the effect of local anesthetic with or without steroids. The outcomes included pain relief, functional improvement, opioid intake, and therapeutic procedural characteristics. The reviewers concluded the meta-analysis confirms that epidural injections of local anesthetic with or without steroids have beneficial but similar effects in the treatment of patients with chronic low back and lower extremity pain.

Results of a 2 year follow-up of 3 randomized, double-blind, controlled trials, with a total of 360 patients with chronic persistent pain of disc herniation receiving either caudal, lumbar interlaminar or transforaminal epidural injections, showed similar efficacy of the 3 techniques with local anesthetic alone or local anesthetic with steroid. Caudal and interlaminar trials used in the assessment showed some superiority of steroids over local anesthetic, at 3 and 6 month follow-up. Interlaminar with steroids were superior to transforaminal at 12-months.[53]

Facet Joint Interventions
Chronic low back pain is frequently attributed to disorders of the facet joint. Neck pain related to whiplash injury is also thought to be related to the cervical zygapophyseal facet joint. However, the diagnosis of facet joint pain is difficult and often is based on pain relief following a diagnostic pain block of the medial branch of the posterior rami of the spinal nerve supplying the facet joint.

Patients referred for facet injections most often have degenerative disease of the facet joints. However, even if the facet joint appears radiologically normal, facet injections still may be of use as radiologically occult synovitis can cause facet pain, particularly in younger patients. Post laminectomy syndrome, or nonradicular pain occurring after laminectomy, is also an acceptable reason to perform facet injections.

Based on the outcome of a facet joint nerve block, if the patient gets sufficient relief of pain but the pain recurs, one of the options is to denervate the facet joint. Radiofrequency neurotomy, also known as radiofrequency ablation, has been shown to temporarily reduce cervical and lumbar pain. Radiofrequency neurotomy involves delivering radio waves to targeted nerves via needles inserted through the skin. The heat created by the radio waves interferes with the nerves' ability to transmit pain signals.

Sacroiliac Joint Injections
Treatment for sacroiliac joint dysfunction is usually conservative (non-surgical) and focuses on trying to restore normal motion in the joint. In patients who have failed 4 to 6 weeks of a comprehensive exercise program, local icing, mobilization/manipulation and NSAIDs, a SIJ injection can be helpful for both diagnostic and therapeutic purposes. SIJ injections into the synovial sac of the SIJ may provide immediate and significant pain relief. At least 50% resolution of the patient's pain over the ipsilateral SIJ is considered diagnostic of pain emanating from the SIJ. Adding a steroid to the solution injected may help to reduce any inflammation that may exist within the joint(s) and result in a prolonged period of freedom from pain.

Visser et al (2013) assessed which treatment is successful for SIJ-related back and leg pain. Using a single-blinded randomized trial, the authors assessed the short-term therapeutic efficacy of physiotherapy, manual therapy, and intra-articular injection with local corticosteroids in the SIJ in 51 patients with SIJ-related leg pain. The effect of the treatment was evaluated after 6 and 12 weeks. Manual therapy had a significantly better success rate than physiotherapy ($p = 0.003$). The authors concluded in the small single-blinded prospective study, manual therapy appeared to be the choice of treatment for patients with SIJ-related leg pain. A second choice of treatment to be considered is an intra-articular injection.

Intradiscal Steroid Injections
There is no convincing evidence that intradiscal glucocorticoids are effective for low back pain.[6] In patients with MRI evidence of degenerative disc disease and a positive response to discography, two trials found no difference between intradiscal steroid and control injection (saline or local anesthetic).[6] A third trial found that in patients with degenerative disc disease who failed an epidural steroid injection, intradiscal steroid injection was superior to discography alone only in the subgroup of patients with inflammatory endplate changes on MRI. However, outcomes were not well defined in this trial and levels of statistical significance were poorly reported. Based on these trials, the American Pain Society guideline recommends against intradiscal glucocorticoid injection for chronic low back pain.[9]

The use of intradiscal steroid injections is also debated because intradiscal steroid may cause discitis, progression of disc degeneration, and calcification of the intervertebral disc.

Trigger Point Injections
A trigger point is a discrete, hyperirritative focus found in a palpable taut band occurring in any skeletal muscle and/or muscle fascia on the body that is particularly sensitive to touch and, when compressed, gives rise to characteristic referral pain patterns, tenderness and autonomic

phenomena. These trigger points are thought to result from repetitive strain produced by acute or chronic overload or a degenerative and/or inflammatory problem, such as arthritis.

Gerwin et al. (2012) completed a review of literature relevant to the treatment of myofascial pain syndrome by botulinum injections. All identifiable series were reviewed, including open label, single-blinded and double-blinded studies, randomized and controlled, or not. The studies were evaluated according to their design and the selection of outcome measurements, and the interpretation of results. Problems that were common to the studies were robust placebo responders, incomplete treatment of a regional myofascial pain syndrome, inappropriate or confounding control populations or treatments, and inappropriate time periods for assessment of outcomes, or misinterpretation of the time-frame of action of botulinum toxin. The studies of the effect of botulinum toxin treatment of myofascial trigger points have had mixed results. However, few studies have been designed to avoid many of the pitfalls associated with a trial of botulinum toxin treatment of trigger points. Better-designed studies may give results that can be used to guide practice based on reliable evidence. At the present time, the available evidence is insufficient to guide clinical practice.

Local Injections for Cervicogenic and Occipital Neuralgia
Greater occipital nerve blocks have been advocated as a diagnostic test for cervicogenic headache and occipital neuralgia. The effectiveness of greater occipital nerve block in patients with primary headache syndromes is controversial. The International Headache Society (IHS) defines occipital neuralgia as unilateral or bilateral paroxysmal, shooting or stabbing pain in the posterior part of the scalp, in the distribution of the greater, lesser or third occipital nerves, sometimes accompanied by diminished sensation or dysaesthesia in the affected area and commonly associated with tenderness over the involved nerve(s).[54] The IHS includes relief of pain following a local anesthetic block of the affected nerve as part of their diagnostic criteria for occipital neuralgia. Thus, the principal indication for occipital block is diagnosis. Another indication is the treatment of chronic occipital neuralgia, often with a series of therapeutic blocks combining local anesthetic and corticosteroid. Pain relief is typically prompt and may last several weeks or even months. At that time the injection may be repeated.

Genicular Nerve Blocks and Radiofrequency Neurotomy
Genicular nerve blocks and radiofrequency neurotomy are emerging interventions for knee pain. A few small studies suggest that genicular radiofrequency neurotomy based on results of genicular nerve blocks may be effective for relief of pain. However, further research, including RCTs, are needed to establish safety and effectiveness.

Sympathetic Nerve Blocks
Nerve blocks are the temporary interruption of conduction of impulses in peripheral nerves or nerve trunks created by the injection of local anesthetic solutions. Sympathetic nerves may be injected for several reasons:

- Diagnostic - to determine the source of pain, e.g., to identify or pinpoint a nerve that acts as a pathway for pain; to determine the type of nerve that conducts the pain; to distinguish between pain that is central (within the spinal cord) or peripheral (outside the

spinal cord) in origin; or to determine whether a neurolytic block or surgical lysis of the nerve should be performed;
- Therapeutic - to treat painful conditions that respond to nerve blocks (e.g., celiac block for pain of pancreatic cancer); and
- Prognostic - to predict the outcome of long-lasting interventions (e.g., lumbar sympathectomy).

The response to sympathetic blockade is the best diagnostic test for CRPS. If the patient has had a technically successful sympathetic block and does not obtain significant relief, then the patient probably does not have CRPS. Over two thirds of patients will obtain significant relief with minimal effect on motor and sensory function because the sympathetic fibers are the least myelinated (as compared to motor and sensory nerve fibers) these fibers are the first to be affected by the local anesthetic.

Intercostal Nerve Blocks
Intermittent intercostal nerve blocks can be used to control pain in the chest and upper abdomen, such as pain associated with rib fractures or chronic pain due to post herpetic neuralgia. Intercostal nerve blocks can be performed using anatomic landmarks or with ultrasound guidance, which can be used to minimize the chance of intravascular injection and pneumothorax and to increase reliable dermatomal coverage. [41 45]

For isolated injuries, such as single rib fracture, nonsteroidal anti-inflammatory drugs with or without opioids would be the initial treatment. For more severe injuries, particularly if ventilation is compromised, intercostal nerve blocks may be needed. For patients with multiple rib fractures, there is a need to perform the procedure at multiple intercostal levels. Repeated blockade may be needed for prolonged relief upon return of pain and/or deterioration in functional status. For repeat blocks or other interventions, patient must have been responsive to prior interventions with improvement in physical and functional status. [42 45]

Regional anesthesia plays an important role in thoracic surgery, particularly with regard to post-operative pain control. The first choice of regional anesthesia for thoracic surgery is epidural analgesia or thoracic paravertebral block. In general, the analgesic efficiencies of both these types of anesthesia are equivalent; however, thoracic paravertebral block has some advantages over epidural analgesia, including fewer complications. When these two blocks are contraindicated, intercostal nerve block or interpleural block should be considered. [43 44]

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Coding Implications

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CPT®* Codes	Description
20552	Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)
20553	Injection(s); single or multiple trigger point(s), 3 or more muscle(s)
27096	Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed
62323	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)
64405	Injection, anesthetic agent, greater occipital nerve
64420	Injection, anesthetic agent, intercostal nerve, single
64421	Injection, anesthetic agent, intercostal nerves, multiple, regional block
64450	Injection, anesthetic agent, other peripheral nerve or branch
64479	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level
64480	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional level (List separately in addition to code for primary procedure)
64483	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level
64484	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional level (List separately in addition to code for primary procedure
64490	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level
64491	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)
64492	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure)

64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level
64494	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure)
64495	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure)
64505	Sympathetic nerve block: sphenopalatine ganglion
64508	Sympathetic nerve block, carotid sinus
64510	Sympathetic nerve block, stellate ganglion (cervical sympathetic)
64517	Sympathetic nerve block, superior hypogastric plexus
64520	Sympathetic nerve block, lumbar or thoracic (paravertebral sympathetic)
64530	Sympathetic nerve block, celiac plexus
64620	Destruction by neurolytic agent, intercostal nerve
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint
64634	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure)
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint
64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)
64640	Destruction by neurolytic agent; other peripheral nerve or branch
77003	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, subarachnoid, or sacroiliac joint), including neurolytic agent destruction

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ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
B02.23	Postherpetic polyneuropathy
B02.29	Other Postherpetic nervous system involvement
C25.0-C25.9	Malignant neoplasm of pancreas
C56.42	Causalgia of upper limb
D49.9	Neoplasm of unspecified behavior of unspecified site
G56.40	Causalgia of unspecified upper limb
G54-G54.9	Nerve root and plexus disorders
G54.0	Brachial plexus disorders

CLINICAL POLICY
Injections for Pain Management

ICD-10-CM Code	Description
G60.9	Hereditary and idiopathic neuropathy
G89.21	Chronic pain due to trauma
G89.22	Chronic post thoracotomy pain
G89.28	Other chronic post procedural pain
G89.29	Other chronic pain
G89.4	Chronic pain syndrome
G90.5-G90.59	Complex regional pain syndrome
M25.579	Pain in joint
M43.00	Spondylolysis, site unspecified
M43.10-M43.19	Spondylolisthesis, site unspecified
M46.00-M46.99	Other inflammatory spondylopathies
M46.1	Sacroiliitis, not elsewhere classified
M47	Spondylosis
M47.1	Other Spondylosis with myelopathy
M47.12	Other Spondylosis with myelopathy, cervical region
M47.13	Other Spondylosis with myelopathy, cervicothoracic region
M47.14	Other Spondylosis with myelopathy, thoracic region
M47.15	Other Spondylosis with myelopathy, thoracolumbar region
M47.16	Other Spondylosis with myelopathy, lumbar region
M47.17	Other Spondylosis with myelopathy, lumbosacral region
M47.812	Spondylosis without myelopathy or radiculopathy, cervical region
M47.813	Spondylosis without myelopathy or radiculopathy, cervicothoracic region
M47.814	Spondylosis without myelopathy or radiculopathy, thoracic region
M47.815	Spondylosis without myelopathy or radiculopathy, thoracolumbar region
M47.816	Spondylosis without myelopathy or radiculopathy, lumbar region
M47.817	Spondylosis without myelopathy or radiculopathy, lumbosacral region
M47.819	Spondylosis without myelopathy or radiculopathy, site unspecified
M48.00 - M48.9	Other Spondylopathies
M49.8 - M49.89	Spondylopathy in diseases classified elsewhere
M50.00 - M50.03	Cervical disc disorder with myelopathy
M50.1 - M54.9	Other Dorsopathies
M75.0	Adhesive capsulitis of shoulder
M76.9	Entesopathies, lower limb, excluding foot
M77.00-M77.9	Other entestopathies
M79.0-M79.9	Other and unspecified soft tissue disorders, not elsewhere classified
M96.1	Postlaminectomy syndrome, not elsewhere classified

CLINICAL POLICY
Injections for Pain Management

ICD-10-CM Code	Description
Q76.2	Congenital spondylolisthesis
S22.41	Multiple fractures of ribs, right side
S22.42	Multiple fractures of ribs, left side
S22.43	Multiple fractures of ribs, bilateral
S33.6	Sprain of sacroiliac joint
S33.8	Sprain of other parts of lumbar spine and pelvis
S33.9	Sprain of unspecified parts of lumbar spine and pelvis

Reviews, Revisions, and Approvals	Date	Approval Date
Physical Med & Rehab specialist review	06/13	08/13
Therapeutic facet joint injections changed to experimental Trochanteric bursa injection criteria removed as it does not require PA Removed one year limit for 2.D Removed pain scale criteria from II.A Physical Med & Rehab and Anesthesiology PM specialist review	08/14	08/14
Clarified language in ESI section, criteria remained the same	09/14	N/A
Added neurostimulator CPT codes	02/15	N/A
Updated formatting and bullets In I.A added “given at least 2 weeks apart” In I.D added “or more than 4 injections” for continuation of injections In I.E removed “sustained” and added “or” for NSAIDs/opiates failure In II.A added max of 2 diagnostic injections and at least 2 weeks apart II.C. Removed no prior spinal fusion surgery IX. A. Removed pain persistent for 3 months and changed failure of therapy to 3 weeks and added unless provided as a bridge to therapy IX.B. Clarified all language and removed bullet point that injections beyond 12 months are experimental X.A. Clarified language Therapeutic SIJ injections added per Specialist recommendation Specialist reviewed	08/15	08/15
Policy split from CP.MP.63 Pain Management Procedures. Policy converted to new template. Changed “experimental/investigational” to “investigational for the following indications: Continued ESI/SNRB after no improvement with diagnostic injection; ESI/SNRB beyond 12 months; therapeutic facet joint injections and SIJ injections beyond 12 months; thoracic radiofrequency neurotomy; occipital nerve block; SIJ radiofrequency neurotomy; intradiscal steroid injection; celiac nerve block; peripheral nerve blocks not otherwise listed in policy. Facet Joint interventions: Added pulsed radiofrequency neurotomy of facet joints indication as investigational; changed diagnostic facet joint blocks to “controlled medial branch blocks;” requirement removed to wait one week	08/16	08/16

Reviews, Revisions, and Approvals	Date	Approval Date
after successful diagnostic injection to administer facet joint medial branch conventional radiofrequency. SIJ interventions: Added types of radiofrequency neurotomy, added rationale for investigational status. Therapeutic SIJ: added requirement that injections be administered with other noninvasive treatment. Added requirement for positive response to at least three SIJ pain provocation tests (distraction, compression, thigh thrust, Gaenslen's and sacral thrust). Added rationale for intradiscal steroid injection investigational status. Trigger point Injections: Added criteria for pain duration, location and quality; added that it should not be used as sole method of treatment; changed number of diagnostic injections allowed from 4 to 2; added types of trigger point therapies that are investigational: dry needling, saline/glucose, and botox. Added genicular nerve block/radiofrequency ablation as investigational procedures. Added description of interventions and supporting evidence to background.		
Added intercostal nerve blocks as medically necessary with specific criteria. Added intercostal nerve block information to background. Moved therapeutic facet joint injections to II.F. from II.B. Modified Facet Joint intervention background to contain more information on radiofrequency neurotomy vs. facet joint injections.	12/16	12/16
CPT codes updated per 2017 changes	01/17	
Added transforaminal epidural steroid injection performed at more than two levels during the same session/procedure as not medically necessary. Added interlaminar or caudal epidural steroid injection performed at more than a single level during the same session/procedure as not medically necessary Code table updated with retired and added codes	07/17	
Removed criteria addressing SNRB from section I. Renamed section I, ". Cervical/Thoracic/Lumbar/Caudal, Interlaminar ESI" Added section II, "Selective Nerve Root Blocks/Transforaminal Epidural Steroid Injections" that includes criteria for SNRB/TFESI. All subsequent sections have been renumbered accordingly. Under section IIIB, removed #2 and #3, as the criteria are already addressed in section III C	8/17	
Moved number of ESI sessions & levels to be treated per session to sections IA and IIB. Added recommendations regarding anticoagulation therapy to sections on interlaminar and transforaminal ESI. Under section III facet joint injections added criteria that if first controlled medial branch block/facet joint injection is negative, a second block is not medically necessary. Revised IIIB Facet joint medial branch conventional radiofrequency neurotomy to require 2 positive facet joint injections prior to RFA.	09/17	09/17

Reviews, Revisions, and Approvals	Date	Approval Date
Changed positive response from 80% to 75% pain relief as per ASIPP recommendations. Revised section VII to consider occipital nerve block as medically necessary when criteria is met. Modified Local Injections for Cervicogenic and Occipital Neuralgia intervention background to contain more information on occipital neuralgia. Code updates. Specialist reviewed.		
Removed the following text from Selective Nerve Root Block Criteria as it is strictly informational, and not to be used as criteria "The effectiveness of *selective nerve root blocks/transforaminal epidural steroid injections (SNRB/TFESI)* versus *ILESI* has not been established."	10/17	

Important Reminder

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This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible

for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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CENTENE Corporation

Clinical Policy: Balloon Sinus Ostial Dilation for Treatment of Chronic Sinusitis

Reference Number: CP.MP.119
Effective Date: 11/16
Last Review Date: 11/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Sinuplasty, also known as balloon catheter sinusotomy and balloon sinus ostial dilation, is a minimally invasive technique intended to dilate the sinus ostia in patients with chronic sinusitis. The Relieva Balloon Sinuplasty System by Acclarant Inc. received FDA approval in April of 2005. It is a set of single-use, endoscopic, catheter-based instruments intended to provide a means to dilate the sinus ostia and spaces within the paranasal sinus cavities for diagnostic and therapeutic procedures to open passages and to restore normal drainage. Balloon sinuplasty is proposed to treat patients with chronic sinusitis who have exhausted less aggressive treatment options.

Policy/Criteria

1. It is the policy of health plans affiliated with Centene Corporation® that balloon sinuplasty is **medically necessary** in order to relieve obstruction of the maxillary, sphenoid, and frontal sinus ostia, either alone or in combination with standard endoscopic sinus surgery techniques, when all of the following are met:

- **A.** Diagnosis of one of the following (1 or 2):
  - 1. Chronic rhinosinusitis (CRS) has persisted for ≥ 12 weeks and all of the following:
    - a. If > 18 years of age, meets both of the following (i and ii):
      - i. Has at least one of the following symptoms:
        - a) Anterior or posterior mucopurulent nasal discharge;
        - b) Nasal obstruction;
        - c) Facial pain/pressure/fullness;
        - d) Decreased or lost sense of smell;
      - ii. Has at least one of the following findings (a or b):
        - a) Computed tomography (CT) scan showing either of the following:
          - 1) Polyps in nasal cavity or the middle meatus, and/or opacification;
          - 2) Radiographic imaging showing inflammation of the paranasal sinuses;
        - b) Nasal endoscopy showing either of the following:
          - 1) Purulent mucous or edema in the middle meatus or ethmoid region;
          - 2) Polyps in the nasal cavity or middle meatus;
    - b. If ≤ 18 years of age, meets both of the following (i and ii):
      - i. Has at least two of the following symptoms:
        - a) Purulent rhinorrhea;
        - b) Nasal obstruction;
        - c) Facial pressure/pain;
        - d) Cough;
      - ii. Has at least one of the following findings:
        - a) Endoscopic signs of mucosal edema, purulent drainage, or nasal polyposis;

b) Mucosal changes within the ostiomeatal complex and/or sinuses, by CT scan;

2. Recurrent acute rhinosinusitis (RARS), both of the following:
   a. Documented ≥ 4 episodes of acute bacterial rhinosinusitis in the past year without signs or symptoms of rhinosinusitis between episodes;
   b. Anterior or posterior purulent nasal discharge and at least one of the following:
      i. Nasal obstruction;
      ii. Facial pain/pressure/fullness;

B. Continued symptoms after medical therapy consisting of both of the following (1 and 2):
1. Antibiotic therapy meeting one of the following (a or b):
   a. Therapy guided by culture and sensitivity for ≥ 3 weeks;
   b. Beta-lactamase resistant antibiotic for ≥ 3 weeks (e.g., amoxicillin [recommended], amoxicillin-clavulanate, trimethoprim-sulfisoxazole, cefuroxime);
2. Intranasal corticosteroids for ≥ 4 weeks;

C. Allergic or immune etiologies of symptoms have been ruled out or treated appropriately.

II. It is the policy of health plans affiliated with Centene Corporation that balloon sinuplasty is **not medically necessary** in any of the following situations:
A. For the treatment of ethmoid disease;
B. Extensive previous surgery with significant osteoneogenesis.

Background

CRS is defined as an inflammatory condition involving the paranasal sinuses and linings of the nasal passages, which persists for 12 weeks or longer. Symptoms of CRS include anterior and/or posterior mucopurulent drainage, nasal obstruction, facial pain, pressure, and/or fullness and decreased sense of smell. RARS is defined as 4 or more episodes of ABRS within a year, without persistent symptoms between episodes. The goal of medical therapy (e.g., antibiotics, nasal irrigation, topical corticosteroids) is directed toward facilitating the drainage of sinus secretions and treatment to eradicate the offending pathogens. Surgical intervention may be indicated when the patient requires more than three courses of antibiotics for sinusitis within a 12-month period along with evidence of abnormalities of the sinuses or ostiomeatal complex on nasal endoscopy or CT imaging. The goal of functional endoscopic sinus surgery is to restore physiologic sinus ventilation and drainage, which allows for the gradual resolution of mucosal disease. Balloon dilation is a less invasive alternative to endoscopic sinus surgery in the management of CRS or RARS.

The goal of balloon sinuplasty is to restore normal sinus drainage by enlarging passages of the sinus ostia and spaces within the paranasal sinus cavities, without cutting bone or removing tissue. Per the manufacturer of the Relieva Sinus Balloon Dilation Catheter, the procedure is performed under fluoroscopic guidance using endoscopic technique, by an otolaryngologist trained in the use of the Balloon Sinuplasty System. Fiber optics can also be used to illuminate the sinus cavity, without radiation exposure. The initial sinus access is achieved by the introduction of a guide catheter into the target sinus. A flexible guidewire is then introduced through the guide catheter and gently advanced into the target sinus. The balloon catheter tracks smoothly over the guide wire and positioned across the blocked ostium. After the position of the

balloon catheter is confirmed, it is gradually inflated to gently restructure the blocked ostium. The system is removed, leaving the ostium open and allowing the return of normal sinus drainage and function with little to no disruption to the mucosal lining. Balloon sinuplasty may be performed in conjunction with endoscopic sinus surgery and used as an assistive procedure for sinus tissue biopsy or culturing, sinus lavage, drainage, or antibiotic irrigation.

Studies evaluating balloon sinuplasty are limited and include a prospective randomized trial, cohort studies, case series, observational and retrospective studies. Most studies were small and long term studies are lacking. However, the available studies suggest that balloon sinuplasty for CRS or RARS refractory to medical therapy is safe and efficacious. The data show that balloon sinuplasty can successfully dilate the sinus ostia and relieve symptoms of CRS and RARS. In addition, the use of balloon sinuplasty is supported as a treatment option by the professional societies noted below.

There is limited evidence regarding balloon sinuplasty in the pediatric population. However, two small studies have found positive effects of balloon sinuplasty in pediatric patients with CRS failing to respond to medical therapy.[16,18] Additionally, one study found that balloon sinuplasty led to improved outcomes after failure to respond adequately to adenoidectomy.[14]

Guideline Recommendations
American Academy of Otolaryngology (AAO)-Head and Neck Surgery and the American Rhinologic Society (ARS)
Both the AAO Head and the ARS position statements on dilation of sinuses, any method (e.g., balloon, etc.), state “sinus ostial dilation (e.g., balloon ostial dilation) is a therapeutic option for selected patients with chronic rhinosinusitis (CRS) and recurrent acute rhinosinusitis (RARS) who have failed appropriate medical therapy. Clinical diagnosis of CRS and RARS should be based on symptoms of sinusitis and supported by nasal endoscopy documenting sinonasal abnormality or mucosal thickening on computed tomography of the paranasal sinuses. This approach may be used alone to dilate an obstructed sinus ostium (frontal, maxillary, or sphenoid) or in conjunction with other instruments (eg, microdebrider, forceps). The final decision regarding use of techniques or instrumentation for sinus surgery is the responsibility of the attending surgeon. For pediatric patients, the AAO did not reach consensus on whether balloon sinuplasty should be recommended for the treatment of CRS; however, near consensus was reached regarding the safety of balloon sinuplasty.

American Academy of Allergy Asthma and Immunology (AAAAI), the American College of Allergy Asthma and Immunology (ACAAI), and the Joint Council of Allergy Asthma and Immunology (JCAAI)
In 2014, the AAAI, ACAAI, and JCAAI made a recommendation that balloon ostial dilation should be considered in a small subset of patients with medically unresponsive acute rhinosinusitis, primarily those with early or localized disease. They note that symptomatic improvement is primarily documented among patients with mild disease that could potentially be relieved with medical therapy alone. For CRS, the AAAI, ACAAI, and JCAAI list balloon sinus dilation as one of the most commonly used modalities for patients that have failed maximal medical therapy.

Coding Implications

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CPT® Codes	Description
31295	Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (e.g., balloon dilation), transnasal or via canine fossa
31296	Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (e.g., balloon dilation)
31297	Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium (e.g., balloon dilation)

HCPCS Codes	Description
N/A	

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
J01.01	Acute recurrent maxillary sinusitis
J01.11	Acute recurrent frontal sinusitis
J01.31	Acute recurrent sphenoidal sinusitis
J32.0	Chronic maxillary sinusitis
J32.1	Chronic frontal sinusitis
J32.3	Chronic sphenoidal sinusitis

Reviews, Revisions, and Approvals	Date	Approval Date
Policy adopted from Health Net NMP307 Balloon Sinuplasty for Treatment of Chronic Sinusitis.	07/16	
Differentiated criteria by age-≤ 18 and >18. For ≥ 18, replaced headache with lost or decreased smell per AAO guidelines. Edited objective findings (via CT) for > 18 to reflect AAO guidelines. Added criteria for pediatric CRS diagnosis. Added a required trial of intranasal corticosteroids per pediatric and adult AAO guidelines. Added supporting background information for pediatric indication. Removed nasal polyps from not medically necessary list.	11/16	11/16
Changed 2nd listing of CPT code 31296 to 31297 in order to correctly match the code description.	07/17	

Reviews, Revisions, and Approvals	Date	Approval Date
Changed criteria to apply to RARS as well as CRS, and allowed endoscopic diagnosis of CRS/RARS. Modified AAO statement in background. Added that allergic or immune etiologies should be ruled out or treated appropriately. Included AAAI guideline statements in background. Updated ICD-10 CM codes to include acute recurrent sinusitis. Removed "other" and "unspecified" ICD-CM codes.	11/17	11/17

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CLINICAL POLICY
Balloon Sinuplasty

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CENTENE Corporation

Clinical Policy: Homocysteine Testing

Reference Number: CP.MP.121
Effective Date: 08/16
Last Review Date: 08/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Homocysteine is a nonproteinogenic amino acid that is generated during the conversion of methionine to cysteine. Mutations of the enzymes within the biochemical pathways that regulate homeostatic homocysteine levels are associated with risk factors for various diseases, including venous thromboembolism. Supplementation of folic acid, vitamin B6, and vitamin B12 are known to modulate homocysteine levels, given the interplay between the folate cycle and metabolism. This policy describes the medical necessity requirements for testing levels of homocysteine.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that homocysteine testing is **medically necessary** for the following indications:
   A. Borderline vitamin B12 deficiency;
   B. Homocystinuria caused by cystathionine beta-synthase deficiency;
   C. Idiopathic venous thromboembolism, recurrent venous thromboembolism, thrombosis occurring at < 45 years of age, or thrombosis at an unusual site.

II. It is the policy of health plans affiliated with Centene Corporation® that homocysteine testing is considered **investigational** for the following indications:
   A. Cardiovascular risk testing;
   B. For the testing of all other conditions.

Background

Homocysteine is a naturally occurring intermediary amino acid that is generated during the conversion of methionine to cysteine. While homoeostatic plasma levels of homocysteine typically range at low micro molar concentrations, epistatic mutations and other aberrant modifications of the metabolic pathways modulate homocysteine levels.[1] The metabolic pathway of homocysteine consists of upstream remethylation pathways and a downstream transsulfuration pathway. Notably, mutations in cystathionine-β-synthase, a key enzyme of the transsulfuration pathway, are associated with excess levels of homocysteine and premature thrombotic events.[1] Furthermore, a common mutation at a single nucleotide (677C→T) in the gene encoding 5,10-methenetetrahydrolate reductase, an enzyme in the folate cycle whose byproducts are necessary cofactors in the metabolism of homocysteine, affects homoeostatic levels of homocysteine. This mutation predisposes the individual to low folate plasma levels, and consequently a status of hyperhomocysteine.[2]

Changes in the plasma homocysteine levels can result from alterations in folate or vitamin B6 or vitamin B12.[7] A meta-analysis of 25 randomized clinical trials demonstrated that daily supplementation of ≥ 0.8 mg folic acid is sufficient to achieve the maximal reduction in plasma

homocysteine levels. [8] Moreover, basal levels of homocysteine range between 5-15 µmol/L, while moderate hyperhomocysteine concentrations are 15-30 µmol/L, intermediate levels are 30-100 µmol/L and severe hyperhomocysteine concentrations are >100 µmol/L.[7]

Hyperhomocysteine was identified as an independent risk factor for ischemic heart disease and vascular disease.[3,4] Initial reports hypothesized that heterozygosity of cystathionine-β-synthase contributed to the accumulation of homocysteine, and these reports were corroborated by later meta-analyses.[3,4] However, this rationale has not been corroborated, as two randomized controlled trials, the Heart Outcomes Prevention Evaluation 2 (Hope-2) and the Norwegian Vitamin (NORVIT) trials simultaneously demonstrated no effect from lowering homocysteine levels, by way of folic acid or vitamin B6 supplementation, on cardiovascular outcomes.[5,6]

Furthermore, hyperhomocysteine is a risk factor for venous thromboembolic disease. Ray et al performed a meta-analysis of 9 case control studies measuring fasting plasma homocystine, as well as 5 studies measured after methionine loading. All 9 studies demonstrated a similar trend in the levels and the associated risk for venous thromboembolism; following methionine loading, the trend increased toward the risk of venous thromboembolism.[9,10]

Coding Implications

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CPT® Codes	Description
83090	Homocysteine

HCPCS Codes	Description
N/A	

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
D51.0-D51.9	Vitamin B12 deficiency anemia
E53.8	Deficiency of other unspecified B group vitamins
E72.10	Disorders of sulfur-bearing amino-acid metabolism, unspecified
E72.11	Homocystinuria
E72.19	Other disorders of sulphur-bearing amino-acid metabolism
I26.01-I26.99	Pulmonary embolism
I81	Portal vein thrombosis

ICD-10-CM Code	Description
I82.0-I82.91	Other venous embolism and thrombosis
Z86.711	Personal history of pulmonary embolism
Z86.718	Personal history of other venous thrombosis or embolism

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed	07/16	08/16
References reviewed and updated	07/17	08/17

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CLINICAL POLICY
Homocysteine Testing

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CENTENE Corporation

Clinical Policy: Laser Therapy for Skin Conditions

Reference Number: CP.MP.123
Effective Date: 08/16
Last Review Date: 08/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Targeted phototherapy utilizes non-ionizing ultraviolet radiation with therapeutic benefit. Phototherapy is an efficacious local therapy that provides several advantages to traditional and biologic systemic therapies. Excimer lasers are monochromatic 308 nm xenon chloride lasers that are approved to treat certain inflammatory skin diseases. This policy describes the medical necessity requirements for excimer laser based targeted phototherapy.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that excimer laser based targeted phototherapy is **medically necessary** for the following indications after the failure of topical treatments:
   A. Mild, moderate, or severe psoriasis with < 10% body surface area (BSA) involvement;
   B. Vitiligo.

II. It is the policy of health plans affiliated with Centene Corporation that excimer laser targeted phototherapy is considered **experimental/investigational** for the following indications:
   A. Patients with photosensitivity disorders;
   B. Acute dermatitis;
   C. For the treatment of all other conditions than those specified above.

Background

Targeted phototherapy uses a localized delivery of ultraviolet light to facilitate therapeutic relief of some conditions. Ultraviolet light is predominantly absorbed by skin DNA, leading to the generation of pyrimidine dimers, pyrimidine, and (6-4)-photoproducts which are either repaired or marked for arrest or cell death through the cell's checkpoint machinery.[5] Various spectra of ultraviolet A (UVA) and ultraviolet B (UVB) wavelengths are utilized to treat a varying array of inflammatory skin disorders, including narrowband, broadband, and excimer lasers, as well as combinations of UVA and UVB with topical, systemic, biologic, and chemotherapeutic regimens.[1] Additionally, phototherapy is cost effective and avoids the immunosuppressive effects that often accompany traditional and biologic based systemic therapies.

Excimer lasers are monochromatic 308nm xenon chloride lasers that provide a safe and selective approach to treating dermatological conditions. Excimer lasers are associated with significant T-cell depletion, alterations in apoptosis-related molecules, reductions in proliferation indices, and immunomodulatory mechanisms.[6] An early study by Feldman *et al* assessed the efficacy of excimer lasers for the treatment of mild to moderate psoriasis in a multicenter study. The authors noted that 84% of the patients reached the primary outcome of at least 75% improvement of their plaques within 1 month.[7] Another study by Rodewald *et al* compared the excimer laser to a non-intervention, placebo cohort, as well as other standard topical treatments for psoriasis.[8]

The laser and topical calcipotriene had similar efficacies but both were more effective than topical tazarotene or fluocinonide and the time to achieve 75% improvement favored the excimer laser.[8] Therefore, laser was comparable to or more effective than other standard treatments for psoriasis.[8]

According to the American Academy of Dermatologists, the excimer laser is indicated for both adult and pediatric patients with mild, moderate, and severe psoriasis who have less than 10% BSA involvement.[1] The initial treatment dose of the excimer laser depends on the individual's skin type, plaque characteristics, and thickness, with subsequent doses adjusted in accordance to the patient's clinical response and side effects.[1] Treatment takes place 2-3 times per week until a patient is clear of symptoms and lasts an average of 10-12 treatments. Initial response is noted within 8-10 treatments, which depends on the protocol used, lesion characteristics, and site, and the mean remission time is 3.5-6 months.[1]

The European Dermatology Forum and the British Association of Dermatologists provide guidelines for the management of vitiligo.[3-4] The consensus of the European Dermatology Forum is that targeting phototherapy should be indicated for localized vitiligo and for small lesion of recent onset and childhood vitiligo.[3] Notably, Alhowaish *et al* documented the effectiveness of excimer laser treatments in vitiligo in 23 separate articles that included case studies, randomized controlled studies, retrospective analyses, randomized blinded studies, and controlled comparative studies.[9] Although the response time and the duration of response varied, the excimer laser therapy was generally effective across all of the studies.[9]

Coding Implications

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CPT® Codes	Description
96920	Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq. cm
96921	Laser treatment for inflammatory skin disease (psoriasis); 250 sq. cm to 500 sq. cm
96922	Laser treatment for inflammatory skin disease (psoriasis); over 500 sq. cm

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
L40.0	Psoriasis vulgaris (plaque psoriasis)
L80	Vitiligo

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed	07/16	08/16
References reviewed and updated.	07/17	08/17

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CENTENE Corporation

Clinical Policy: DNA Analysis of Stool to Screen for Colorectal Cancer

Reference Number: CP.MP.125
Effective Date: 09/16
Last Review Date: 09/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Cologuard is a noninvasive screening test for colon cancer. This test comprises a multi-target screen for several aberrant DNA markers of colon cancer, as well as a hemoglobin immunoassay. This policy describes the medical necessity requirements for DNA analysis of stool with Cologuard.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that screening for colorectal cancer by DNA analysis of stool (i.e., Cologuard) is **medically necessary** every three years when meeting the following:
   A. Age 50-85 years;
   B. Asymptomatic and at average risk for colon cancer;
   C. Is not within the standard interval of another screening test for colon cancer.

II. It is the policy of health plans affiliated with Centene Corporation that DNA analysis of stool (i.e., Cologuard) is **experimental/investigational** for any circumstances other than those specified above.

Background

Colorectal cancer has become the second leading cause of cancer-related deaths in the United States, according to the latest statistics.[3] Multi-target stool testing for colorectal cancer is a noninvasive DNA test that screens for multiple lesions, including those related to *Kras* mutations, *NDRG4* and *BMP3* methylations, *β-actin*, and hemoglobin immunoassay.[1] The FDA approved Cologuard (Exact Sciences) based on this multi-target stool testing.[2] The sensitivity for detecting colorectal cancer from the multi-target DNA testing was 92.3% (60 of 65) and 73.8% (48 of 65) with fecal immunohistochemical tests (FIT), which look for intact human hemoglobin. Multi-target DNA testing is not a replacement for diagnostic colonoscopy testing in patients at high risk for colorectal cancer.

The United States Preventative Services Task Force recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years. According to this recommendation, the specificity of FIT-DNA is lower than that of FIT alone, and has a higher number of false-positive results, as well as a higher likelihood of follow-up colonoscopy and associated adverse events per screening test.[3] While no longitudinal follow-up data exists, with an abnormal FIT-DNA test result followed by a negative colonoscopy, there is potential for overly intensive surveillance due to clinician and patient concerns about the implications of the genetic component of the test.[3]

Coding Implications

CLINICAL POLICY
DNA Analysis of Stool

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CPT® Codes	Description
81528	Oncology (colorectal) screening, quantitative real time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result

HCPCS Codes	Description
G0464	Colorectal cancer screening; screening; stool based DNA and fecal occult hemoglobin (e.g. KRAS, NDRG4 and BPM3)

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
Z12.11	Encounter for screening for malignant neoplasm of colon

Reviews, Revisions, and Approvals	Date	Approval Date
Policy converted from Health Net policy	08/16	09/16
Added that request is not within the standard interval of another normal screen for colon cancer.	10/16	
Removed parenthetical example of appropriate intervals for colon cancer screening in I.C.	06/17	
References reviewed and updated.	09/17	09/17

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4. National Comprehensive Cancer Network. NCCN clinical practice guidelines in oncology: Colorectal cancer screening. Version 1.2017.

CLINICAL POLICY
DNA Analysis of Stool

Important Reminder

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CLINICAL POLICY
DNA Analysis of Stool

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CENTENE Corporation

Clinical Policy: Sacroiliac Joint Fusion

Reference Number: CP.MP.126
Effective Date: 09/16
Last Review Date: 09/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Sacroiliac joint fusion, or arthrodesis, is a surgical technique that fuses the iliac bone to the sacrum for stabilization. This procedure may be performed in a minimally invasive manner or as an open surgical procedure requiring a larger incision and subsequent increased recovery time.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that sacroiliac joint fusion is **medically necessary** for any of the following indications:
- A. Stabilization of a traumatic, severe disruption, or fracture of the pelvic ring; or
- B. As an adjunct to sacrectomy or partial sacrectomy for the treatment of sacral tumors; or
- C. As an adjunct to the medical treatment of sacroiliac joint infection or sepsis (e.g., osteomyelitis, pyogenic sacroiliitis); or
- D. During multisegment spinal constructs (e.g., correction of deformity in scoliosis or kyphosis surgery, extending to the ilium).

II. It is the policy of health plans affiliated with Centene Corporation that sacroiliac joint fusion procedures, either open or minimally invasive (e.g., iFuse), are investigational for treating mechanical low back pain due to sacroiliac joint syndrome, radicular pain syndromes, degenerative sacroiliac joint, sacral insufficiency fractures, and pelvic girdle pain, because long-term safety and effectiveness has not been established.

Background

Low back pain may become chronic and disabling for about 5-10% of the adults in the United States. When the sacroiliac joint is the source of this pain, and all appropriate conservative measures fail to relieve symptoms of trauma associated with fracture, infection/sepsis, tumors involving the sacrum, cancer, or spinal instability, options may include fusion of this joint or implantation of devices that stabilize this joint with minimally invasive surgery. To stabilize the sacroiliac joint, the iliac crest bone and the sacrum are held together by plates and/or screws or an interbody fusion cage, until the two bones fuse.

There are a number of FDA-approved implants that have been proposed for sacroiliac joint disorders, but the majority of clinical trials and studies have been done on the iFuse implant system. This was initially called the SI Joint Fusion and received the original 510(k) clearance from the Food and Drug Administration in November 2008, for fracture fixation of long bones, large bone fragments of the pelvis and for conditions including sacroiliac joint disruptions and degenerative sacroiliitis. Additional FDA clearances were given on April 21, 2011 and on April 17, 2015. The iFuse system involves the fluoroscopically guided insertion of titanium implants across the sacroiliac joint. Under general anesthesia, a 2 to 3 centimeter incision is created, and after determining the appropriate size of the implant, a cannulated delivery system is used to

insert the implants into the proper position. While the number varies, most patients receive 3 implants to stabilize the joint.[13] [14]

Wang and Polly completed two randomized controlled trials with a six month and one year follow up, respectively, on sacroiliac joint fusion using iFuse verses non-surgical management. The iFuse led to better outcomes and similar safety compared with nonsurgical management, and to better operative outcomes and at least comparable efficacy compared with open surgery. However, uncertainty remains due to the lack of longer-term efficacy and safety follow-up with radiologic confirmation, and to the lack of comparisons with other minimally invasive approaches. [15, 10]

The sacroiliac joint remains a controversial source of primary low back pain, and surgery is rarely performed for sacroiliac joint dysfunction. Although there are ongoing published peer-reviewed studies, there is a paucity of long-term, scientific literature to support sacroiliac joint fusion for low back pain. Additional randomized, controlled trials or comparison studies are needed to compare sacroiliac joint fusion for low back pain to non-surgical treatments to determine the impact on health outcomes and long-term efficacy and safety. [17]

State of Colorado, Department of Labor and Employment, Division of Workers' Compensation, recommends: sacroiliac (SI) joint fusion may be indicated for stabilization of a traumatic severe disruption of the pelvic ring. This procedure has limited use in minor trauma and would be considered only on an individual, case-by-case basis. In patients with typical, mechanical low back pain, this procedure is considered to be investigational. Until the efficacy of this procedure for mechanical low back pain is determined by an independent, valid, prospective outcome study, this procedure is not recommended for mechanical low back pain. [12]

American Association of Neurological Surgeons (AANS)
At the Current Procedural Terminology (CPT®) Editorial Panel meeting, the American Association of Neurological Surgeons and Congress of Neurological Surgeons presented the following proposal: for a new Category I CPT code for minimally invasive sacroiliac joint fusion. The new code was approved and went into effect on January 1, 2015, replacing the previous Category III code 0334T. CPT code 27280 was revised to clarify that it is for open procedures only. [2]

International Society for the Advancement of Spine Surgery (ISASS)
ISASS published a policy statement on minimally invasive sacroiliac joint fusion, with criteria for determining a patient's eligibility regarding minimally invasive SI joint fusion. Several limitations of their recommendations include, but are not limited to: the literature review method, lack of formal assessment of the quality of the evidence, and no clear link between the recommendations for fusion with supporting evidence.[8,21]

North American Spine Society (NASS)
NASS recommends percutaneous sacroiliac joint (SIJ) fusion for the treatment of sacroiliac joint pain for patients with low back/buttock pain who meet specific criteria. [9]

Coding Implications

CLINICAL POLICY
Sacroiliac Joint Fusion

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CPT® Codes	Description
27279	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device
27280	Arthrodesis, open, sacroiliac joint, including obtaining bone graft, including instrumentation, when performed

HCPCS Codes	Description
N/A	

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
M43.27-M43.28	Fusion of spine, lumbosacral to sacral and sacrococcygeal region
M46.1	Sacroiliitis, not elsewhere classified
M53.2X7-M53.2X8	Spinal instabilities, lumbar – sacral and sacrococcygeal region
M53.3	Sacrococcygeal disorders, not elsewhere classified

Reviews, Revisions, and Approvals	Date	Approval Date
New policy developed based off of Health Net policy NMP536 Sacroiliac Joint Fusion.	09/16	09/16
References reviewed and updated. Codes reviewed and updated.	09/17	09/17

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Important Reminder

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approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence.

CLINICAL POLICY
Sacroiliac Joint Fusion

Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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CENTENE Corporation

Clinical Policy: Total Artificial Heart

Reference Number: CP.MP.127
Effective Date: 12/16
Last Review Date: 12/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

The SynCardia temporary Total Artificial Heart (TAH-t) (SynCardia Systems Inc.), formerly known as the CardioWest Total Artificial Heart, is a biventricular pulsatile pump that replaces the patient's native ventricles and valves. This policy describes the medical necessity requirements for the total artificial heart.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that the TAH-t is **medically necessary** as a bridge to heart transplantation when all of the following criteria are met:
- **A.** Patient is approved for cardiac transplant and is currently on transplant list;
- **B.** New York Heart Association (NYHA) Functional Class IV;
- **C.** Presence of non-reversible biventricular failure unresponsive to all other treatments;
- **D.** Ineligible for other ventricular support devices;
- **E.** Compatible donor heart is currently unavailable;
- **F.** Imminent risk of death;
- **G.** Sufficient space in the chest area vacated by the natural ventricles (generally body surface areas greater than 1.7 m^2 and a distance between the sternum and the 10th anterior vertebral body measured by computed tomography imaging greater than or equal to 10cm) to support the total artificial heart;
- **H.** Patient is able to receive adequate anti-coagulation while on the total artificial heart.

II. It is the policy of health plans affiliated with Centene Corporation that the TAH-t is **experimental/investigational** for use as destination therapy (permanent replacement of the failing heart).

III. It is the policy of health plans affiliated with Centene Corporation that hospital discharge of patients implanted with the TAH-t who are supported by portable drivers (e.g., the Freedom portable driver) is **experimental/investigational**.

Background

Heart transplantation has become the standard treatment for eligible patients with irreversible biventricular failure unresponsive to medical and surgical treatment. The SynCardia temporary Total Artificial Heart (TAH-t) system is indicated as a bridge to transplantation in cardiac transplant eligible candidates at risk of imminent death from biventricular heart failure. The TAH-t is a biventricular pulsatile pump that replaces the patient's native ventricles and valves and pumps blood to both the pulmonary and systemic circulations. The system consists of the implantable TAH-t and an external console connected by drivelines.

There is limited evidence on the use of TAH-t as a bridge to transplantation as compared with the use of left ventricular assist devices. However, the available evidence demonstrates that the TAH-t improves survival in transplant-eligible patients with biventricular heart failure at imminent risk of death.[1] There is insufficient evidence on the use of TAH-t as destination therapy.

The TAH-t was originally approved by the Food and Drug Administration (FDA) for in-hospital use. On June 26, 2014, the FDA approved the SynCardia Freedom portable driver for use in patients who have been implanted with the TAH-t and are clinically stable. The portable driver allows patients to be discharged from the hospital while waiting for a donor heart. There is a paucity of data evaluating the SynCardia Freedom portable driver. A retrospective review of 30 patients who underwent TAH-t implantation, 11 of whom successfully transferred to portable driver, reported that 90% of the 11 were bridged to transplantation. Five (45.5%) of 11 patients were discharged home and 5 (45.5%) remained in-patient on the portable driver before transplantation. Six patients (55%) transferred to the portable driver required a return to a main driver console. Two patients were temporarily maintained on the main driver then returned to the Freedom Driver for bridge to transplantation.[2] At this time, there is insufficient evidence on the safety and efficacy of the SynCardia Freedom portable driver.

Coding Implications

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CPT® Codes	Description
0051T	Implantation of a total replacement heart system (artificial heart) with recipient cardiectomy
0052T	Replacement or repair of thoracic unit of a total replacement heart system (artificial heart)
0053T	Replacement or repair of implantable component or components of total replacement heart system (artificial heart) excluding thoracic unit

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
I50.20-I50.23	Systolic (congestive) heart failure
I50.30-I50.33	Diastolic (congestive) heart failure
I50.40-I50.43	Combined systolic (congestive) and diastolic (congestive) heart failure
I50.9	Heart failure, unspecified

Reviews, Revisions, and Approvals	Date	Approval Date
Policy adopted from Health Net NMP188.	9/16	12/16
References reviewed and updated.	11/17	12/17

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Important Reminder

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CLINICAL POLICY
Total Artificial Heart

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CENTENE Corporation

Clinical Policy: Optic Nerve Decompression Surgery

Reference Number: CP.MP.128
Effective Date: 09/16
Last Review Date: 09/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Optic nerve (ON) sheath decompression involves direct decompression (fenestration) of the ON sheaths just behind the globe. The approach and technique for an ON sheath fenestration varies. This policy describes the medical necessity requirements for ON decompression surgery.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that ON sheath decompression surgery is **medically necessary** for treatment of the following indications:
- A. Papilledema accompanying idiopathic intracranial hypertension (IIH) for either of the following:
  1. Visual function that is severely impaired or continues to deteriorate, despite aggressive medical management (e.g., Diamox [acetazolamide], furosemide, and corticosteroids); or
  2. Incapacitating headaches;
- B. Traumatic optic neuropathy (TON) with radiologic evidence of any of the following:
  1. Optic canal fracture with impingement of the ON by a fracture fragment;
  2. Intraneural edema;
  3. Sheath hematoma;
- C. Facial fibrous dysplasia, and either of the following:
  1. Cystic degenerations and optic canal narrowing:
     a. If intent is prophylactic, risk of ON damage is clearly explained;
  2. Vision loss.

II. It is the policy of health plans affiliated with Centene Corporation® that ON sheath decompression surgery is **investigational** for the treatment of non-arteritic anterior ischemic optic neuropathy (NAION).

Background

ON sheath decompression surgery is typically performed in instances of papilledema due to idiopathic intracranial hypertension (IIH), in which the main symptom is rapid and/or progressive vision loss rather than headache. The effect is normally limited to the ipsilateral ON, although occasionally the procedure appears to have a filtration effect, resulting in improvements in headaches and contralateral disc edema, as well.

Idiopathic intracranial hypertension

IIH, also known as pseudotumor cerebri, is a disorder defined by clinical criteria which include symptoms and signs isolated to those produced by increased intracranial pressure (e.g., headache, papilledema, vision loss), elevated intracranial pressure with normal cerebrospinal fluid composition, and no other cause of intracranial hypertension evident on neuroimaging or other

evaluations. The incidence of IIH in the general population is thought to be about 1 per 100,000. In obese, young females the incidence of IIH is about 20 per 100,000. IIH occurs in men and children as well, but with substantially lower frequency. Weight is not usually a factor in men and in children under 10 years of age. Many individuals suffer from intractable, disabling headaches, and there is a risk of severe, permanent vision loss. Individuals with mild vision loss have an associated reduction in quality of life. Recommendations for the treatment of IIH are limited due to a lack of randomized controlled trials. In addition, the natural history of untreated IIH is uncertain.

The goals of treatment are to detect and prevent vision loss, to reduce the intracranial pressure, and to relieve headache. Medical treatment consists of first line treatment with Diamox (acetazolamide), which inhibits choroid plexus carbonic anhydrase and reduces cerebrospinal fluid production by 50 to 60%. Furosemide (Lasix®) and corticosteroids can be added. Surgery is reserved for patients whose visual function is severely impaired or continues to deteriorate despite aggressive medical management. Those who suffer incapacitating headaches may also be candidates for surgery.

Surgical options include ON sheath decompression and lumboperitoneal shunting. However, prevailing opinion seems to favor the former. This procedure has been found to be highly effective for relief of papilledema. In fact, following a unilateral procedure, most patients have improvement in bilateral disc swelling and in severity of headache. Stabilization or improvement of vision occurs in an estimated 85 to 100% of patients. Visual function is greatly improved in patients with acute rather than chronic papilledema. Thus, in patients with significant visual loss, waiting a prolonged period for a response to medical therapy may not be warranted. ON sheath decompression also may improve visual function in patients with progressive visual loss despite functioning lumboperitoneal shunts.

Traumatic optic neuropathy
TON is an important cause of severe visual loss following blunt or penetrating head trauma. Following the initial insult, ON swelling within the ON canal or compression by bone fragments are thought to result in secondary retinal ganglion cell loss. ON decompression with steroids or surgical interventions, or both, have been advocated to improve visual prognosis in TON.

A 2013 Cochrane Review of surgical treatment for TON concluded there is not enough evidence that surgical decompression of the ON provides any additional benefit beyond conservative management, citing a lack of randomized controlled trials (RCTs), and a wide range of surgical techniques that make comparisons difficult.[11] Given that it would be quite difficult to conduct an adequately powered RCT of surgical ON decompression for TON, the authors state ON decompression for TON should be assessed on a case by case basis, taking risks of surgery into consideration.[11] A 2015 review of TON investigation and management included 14 articles regarding treatment for TON.[1] The authors noted that studies investigating ON decompression for TON are largely small and retrospective, with one larger study- the International Optic Nerve Trauma Study- comprised of 133 patients. Across the studies reviewed, improvement after ON decompression ranged from 27 to 82%, potentially reflecting the poorly defined indications for surgery. The authors argue that surgery should be reserved for instances in which “there is

radiological evidence of optic canal fracture (and impingement of ON by fracture fragment), intraneural edema or an ON sheath hematoma." [1]

Facial Fibrous Dypslasia
Fibrous dysplasia (FD) is a rare condition involving non-malignant overgrowth of bone; approximately 20% of FD cases involve craniofacial bones. Surgery has been the primary form of management of compression of the optic nerve due to FD, although there is no clear agreement on timing of surgery, or in which circumstances the surgery is most beneficial. [7] McCune-Albright syndrome (MAS) is a very rare condition that accounts for about 3% of all FD cases, and presents as polyostotic FD (involving multiple bones/foci of disease), café-au-lait skin macules, and precocious puberty.[3] Studies have shown that narrowing of the optic canal in MAS is not directly correlated with vision loss, and that acute visual loss is related to aneurysmal bone cysts and mucoceles.[3] However, ideal operative management of craniofacial dysplasia in MAS has not been established due to its rarity. Due to the risks of postoperative complications, which occur in 50% of patients, prophylactic surgery to prevent vision loss is only indicated in cases with aneurysmal bone cysts and mucoceles.[3] Otherwise, surgery to decompress the ON is reserved for cases of FD with established vision loss.[3]

Nonarteritic anterior ischemic optic neuropathy
NAION is the most common form of ischemic optic neuropathy. It is an idiopathic, ischemic insult of the ON head characterized by acute, monocular, painless visual loss with optic disc swelling. Visual function can be impaired through decreased central visual acuity or peripheral field loss, or both. The typical presentation is sudden onset of painless monocular vision loss, often upon awakening

ON sheath decompression surgery was reported in 1989 to be of benefit to patients with NAION. The presumed mechanism of action in ON decompression surgery revolved around restoration of impaired blood flow to the ON through reduction of the pressure around the nerve. Initial results of uncontrolled studies suggested that ON sheath decompression was a promising treatment of progressive visual loss in patients with NAION. Other investigators who evaluated this surgical procedure reported varying degrees of success. To resolve the controversy over the effectiveness of ON decompression for NAION, the National Eye Institute sponsored the Ischemic Optic Neuropathy Decompression Trial, a multicenter, randomized controlled clinical trial of ON decompression surgery for patients with NAION. The study found no benefit from surgery in NAION patients with progressive visual loss; in fact, significantly more patients in the surgery group had progressive loss of vision than patients who received only careful follow-up. The investigators concluded that ON decompression surgery is not an effective treatment for NAION and, in fact, may increase the risk of progressive visual loss in NAION patients. The trial was stopped early because the surgery was not helping the participants more than careful follow-up alone. Pain and double vision were harms experienced by some participants in the surgery group at one week after the surgery. The trial investigators reported that continued enrollment would be unlikely to produce results in favor of surgery.

Coding Implications
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CPT® Codes	Description
67570	Decompression ON (e.g., incision or fenestration of optic nerve sheath.

HCPCS Codes	Description
N/A	

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
G93.2	Benign intracranial hypertension
H47.021	Hemorrhage in ON sheath, right eye
H47.022	Hemorrhage in ON sheath, left eye
H47.11	Papilledema associated with increased intracranial pressure
M85.08	Fibrous dysplasia (monostotic), other site
M85.09	Fibrous dysplasia (monostotic), multiple sites
Q78.1	Polyostotic fibrous dysplasia
S04.011+-S04.019+	Injury of ON

Reviews, Revisions, and Approvals	Date	Approval Date
Policy adopted from Health Net NMP353 ON Decompression Surgery	08/16	09/16
Reclassified TON as medically necessary with certain criteria; added facial fibrous dysplasia as a medically necessary indication, and updated related background information and codes.	09/17	09/17

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CLINICAL POLICY
Optic Nerve Decompression Surgery

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CENTENE Corporation

Clinical Policy: Fetal Surgery in Utero for Prenatally Diagnosed Malformations

Reference Number: CP.MP.129
Effective Date: 10/16
Last Review Date: 10/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

This policy describes the medical necessity requirements for performing fetal surgery. This becomes an option when it is predicted that the fetus will not live long enough to survive delivery or after birth. Therefore, surgical intervention during pregnancy on the fetus is meant to correct problems that would be too advanced to correct after birth.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that in-utero fetal surgery (IUFS) is **medically necessary** when meeting the following criteria (A and B):

A. Treatment is for one of the following indications (1-8):

1. In-utero removal of sacrococcygeal teratoma (SCT) associated with fetal hydrops related to high output heart failure secondary to arteriovenous shunting through the tumor; or
2. Vesico-amniotic shunting as a treatment of lower urinary tract obstruction when there are no other lethal abnormalities or lethal chromosomal abnormalities; or
3. Open or in-utero resection of malformed pulmonary tissue, or placement of a thoraco-amniotic shunt as a treatment of either a congenital pulmonary airway malformation (previously referred to as congenital cystic adenomatoid malformation or bronchopulmonary sequestration) when fetus has evidence of fetal hydrops (hydrops fetalis); or
4. Amnioreduction alone as a treatment of twin-twin transfusion syndrome (TTTS); or
5. Fetoscopic or open laser ablation of anastomotic vessels, with or without amnioreduction, as a treatment for TTTS, when both of the following are met:
   a. Severe TTTS is confirmed clinically and by ultrasound between 16 and 26 weeks' gestation; and
   b. The benefits of laser surgery outweigh the risks to a pre-viable fetus who is not a candidate for delivery and for whom the mortality rate is otherwise high; or
6. Ablation of anastomotic vessels in acardiac twins with twin-reversed-arterial-perfusion (TRAP); or
7. The ex utero intrapartum treatment (EXIT) procedure for congenital pulmonary airway malformation/congenital cystic adenomatoid malformation or bronchopulmonary sequestration; or
8. Myelomeningocele repair when all of the following criteria are met:
   a. Singleton pregnancy;
   b. Upper boundary of myelomeningocele located between T1 and S1;
   c. Evidence of hindbrain herniation;
   d. Gestational age 19.0 to 25.9 weeks;
   e. Normal fetal karyotype; and

f. None of the following:
   i. Severe kyphosis;
   ii. Risk of preterm birth(e.g., short cervix or previous preterm birth);
   iii. Placental abruption;
   iv. Maternal body mass index of ≥ 35;
   v. No previous hysterotomy in the active uterine segment.

B. Member does not have placentomegaly or severe pre-eclampsia.

II. It is the policy of health plans affiliated with Centene Corporation that in utero fetal surgery is **investigational** for any of the following indications:

A. Open or endoscopic fetal surgery for congenital diaphragmatic hernia (CDH), including temporary tracheal occlusion;
B. Surgery for heart block, pulmonary valve, or aortic obstruction;
C. Tracheal atresia or stenosis;
D. Cleft lip and palate;
E. In-utero stem cell transplantation;
F. In-utero gene therapy;
G. Amnioexchange procedure for gastroschisis.

Background

Maternal–Fetal Surgery

Maternal–fetal surgery is a major procedure for the mother and her fetus, and it has significant implications and complications that could occur acutely, postoperatively, for the duration of the pregnancy, and in subsequent pregnancies. For the fetus, safety and effectiveness are variable, and depend on the specific procedure, the reasons for the procedure, and the gestational age and condition of the fetus. Often babies who have been operated on in this manner are born pre-term. Therefore, it should only be offered at facilities with the expertise, multidisciplinary teams, services, and facilities to provide the intensive care required for these patients.

Fetal surgery approaches can be divided into two categories:

- Open fetal surgery is considered when the fetal condition is life threatening, and the intervention is felt to be the only option for fetal survival. A hysterotomy is performed, the fetus is partially removed to expose the area that needs surgery, the fetal abnormality is corrected, and the fetus is returned to the uterus where it continues to develop until delivery.
- Fetoscopic surgery employs minimally invasive techniques and uses small fiberoptic telescopes and instruments to enter the uterus through small surgical openings to correct congenital malformations without major incisions or removing the fetus from the womb. This interim procedure is less traumatic, reduces the chances of preterm labor, and is intended to allow the fetus to remain in utero until it has matured enough to survive delivery and neonatal surgical procedures.

In some cases, surgery on the fetus is scheduled to coincide with delivery. The planned surgery is done on the fetus after Cesarean section, but before the cord is cut, so that the fetus continues to be sustained by the mother's placenta and doesn't have to breathe on his or her own. This method, known as an EXIT (ex utero intrapartum treatment) is usually employed when the fetus suffers from a congenital defect that blocks the airway, such as a cervical teratoma. EXIT gives

surgeons time to perform multiple procedures to secure the baby's airway, so that by the time the cord is cut and the baby has to breathe; he or she has an unblocked airway.

Twin reversed-arterial-perfusion
Twin reversed-arterial-perfusion (TRAP) sequence is a serious complication of monozygotic twin pregnancies, affecting 1% of monozygotic twins. Inadequate perfusion of the recipient twin is responsible for the development of a characteristic and invariably lethal set of anomalies, including the acardius fetal malformation (acardiac twins) and acephalus. Typically, the pump twin is structurally normal, but it is at risk for in utero cardiac failure and without treatment dies in 50 to 75% of cases, particularly if the recipient twin weighs more than half as much as the pump twin.

Guideline Recommendations
The American College of Obstetricians and Gynecologists and the Society for Maternal–Fetal Medicine make the following recommendations:
•Open maternal–fetal surgery for myelomeningocele repair has been demonstrated to improve a number of important pediatric outcomes at the expense of procedure-associated maternal and fetal risks.
•Women with pregnancies complicated by fetal myelomeningocele who meet established criteria for in utero repair should be counseled in nondirective fashion regarding all management options, including the possibility of open maternal–fetal surgery.
•Interested candidates for fetal myelomeningocele repair should be referred for further assessment and consultation to a fetal therapy center that offers this intervention and possesses the expertise, multi-disciplinary team, services, and facilities to provide detailed information regarding maternal–fetal surgery and the intensive care required for patients who choose to undergo open maternal–fetal surgery.[9]

Coding Implications
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CPT® Codes	Description
59076	Fetal shunt placement, including ultrasound guidance
59897	Unlisted fetal invasive procedure, including ultrasound guidance

HCPCS Codes	Description
S2401	Repair, urinary tract obstruction in the fetus, procedure performed in utero

HCPCS Codes	Description
S2402	Repair, congenital cystic adenomatoid malformation in the fetus, procedure performed in utero
S2403	Repair, extralobar pulmonary sequestration in the fetus, procedure performed in utero
S2404	Repair, myelomeningocele in the fetus, procedure performed in utero
S2405	Repair of sacrococcygeal teratoma in the fetus, procedure performed in utero
S2409	Repair congenital malformation of fetus, procedure performed in utero, not otherwise classified
S2411	Fetoscopic laser therapy for treatment of twin-to-twin transfusion

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
D43.4	Neoplasm of uncertain behavior of spinal cord
O30.021-O30.029	Conjoined twin pregnancy [twin reversed arterial perfusion (TRAP)]
O35.0XX0-O35.9XX9	Maternal care for known or suspected fetal abnormality and damage
O36.20X0-O36.23X9	Maternal care for hydrops fetalis
O43.021 - O43.023	Fetus-to-fetus placental transfusion syndrome
Q05.0-Q05.9	Spina Bifida
Q33.0	Congenital cystic lung
Q33.2	Sequestration of lung
Q33.3	Agenesis of lung
Q33.6	Congenital hypoplasia and dysplasia of lung
Q34.0-Q34.9	Other Congenital malformations of respiratory system
Q62.31-Q62.39	Other obstructive defects of renal pelvis and ureter
Q64.2	Congenital posterior urethral valves
Q64.31-Q64.39	Other atresia and stenosis of urethra and bladder neck
Q89.4	Conjoined twins
Q89.8	Other specified congenital malformations

Reviews, Revisions, and Approvals	Date	Approval Date
Policy adopted from HN NMP344 Fetal Surgery in Utero for Prenatally Diagnosed Malformations.	09/16	10/16
Removed gestational age requirements from sections: IA.1, treatment of sacrococcygeal teratoma and IA.3 congenital pulmonary airway malformation or bronchopulmonary sequestration.	09/17	10/17

Reviews, Revisions, and Approvals	Date	Approval Date
Removed specific criteria from IA.2, Vesico-amniotic shunting as a treatment of lower urinary tract obstruction to allow procedure per the discretion of the treating surgeon. Updated background with more recent recommendations from ACOG committee opinion. Code updates.		

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CENTENE Corporation

Clinical Policy: Fertility Preservation

Reference Number: CP.MP.130
Effective Date: 10/16
Last Review Date: 10/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Male and female fertility may be transiently or permanently affected by medical treatments such as gonadotoxic therapy, cytotoxic chemotherapy, or radiation therapy, as well as by other iatrogenic causes. Rates of permanent infertility and compromised fertility after medical treatment vary and depend on many factors, including the drug, size and location of the radiation field if applicable, dose, dose-intensity, method of administration (oral versus intravenous), disease, age, treatment type and dosages, and pretreatment fertility.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that, when a covered benefit under the member's benefit plan contract, any of the following procedures are **medically necessary** for women and adolescent girls prior to commencing treatment that is likely to cause infertility (excluding voluntary sterilization):
- A. Embryo cryopreservation;
- B. Cryopreservation of unfertilized oocytes;
- C. Ovarian transposition (oophoropexy);
- D. Radiation (gonadal) shielding;
- E. Conservative gynecologic surgery including but not limited to the following:
  1. Radical trachelectomy in early stage cervical cancer (i.e., stage IA2 to IB cervical cancer with diameter <2 cm and invasion <10 mm);
  2. Ovarian cystectomy for early-stage ovarian cancer.

II. It is the policy of health plans affiliated with Centene Corporation that, when a covered benefit under the member's benefit plan contract, the following procedures are **medically necessary** for men and adolescent boys prior to commencing treatment that is likely to cause infertility (excluding voluntary sterilization):
- A. Cryopreservation of sperm;
- B. Radiation (gonadal) shielding.

III. It is the policy of health plans affiliated with Centene Corporation that the following procedures for women and adolescent girls prior to commencing treatment that is likely to affect fertility are considered **investigational**:
- A. Ovarian tissue cryopreservation and transplantation procedures;
- B. Ovarian suppression with gonadotropin releasing hormone (GnRH) analogs or antagonists.

IV. It is the policy of health plans affiliated with Centene Corporation that the following procedures for men and adolescent boys prior to commencing treatment that is likely to affect fertility are considered **investigational**:

A. Testicular suppression with gonadotropin-releasing hormone (GnRH) analogs or antagonists;
B. Testicular tissue or spermatogonial cryopreservation;
C. Reimplantation or grafting of human testicular tissue.

Background
The most frequent cause of impaired fertility in male cancer survivors is chemotherapy or radiation-induced damage to sperm. The fertility of female survivors may be impaired by any treatment that damages immature eggs, affects the body's hormonal balance, or injures the reproductive organs. Fertility preservation is an essential part of the management of adolescents and young adults who are at risk for infertility due to cancer treatments, or bilateral ovary or testicular removal for treatment of disease.

Embryo cryopreservation is an established fertility preservation method, and it has routinely been used for storing surplus embryos after in vitro fertilization. Cryopreservation of unfertilized oocytes is an option, particularly for patients who do not have a male partner, do not wish to use donor sperm, or have religious or ethical objections to embryo freezing. Success rates for this procedure have improved significantly, with some reproductive specialty centers reporting success rates comparable to those obtained using unfrozen eggs, especially in younger women. Like embryo cryopreservation, this technique also requires ovarian stimulation and ultrasound-guided oocyte retrieval.

The effectiveness of ovarian suppression with gonadotropin releasing hormone (GnRH) analogs or antagonists is inconclusive. Studies to date have not provided definitive data demonstrating that GnRHa preserves fertility, and it remains the subject of ongoing research.

American Society of Clinical Oncology (ASCO)
ASCO's recommends discussing fertility preservation with all patients of reproductive age (and with parents or guardians of children and adolescents) if infertility is a potential risk of therapy, as early as possible, before treatment starts.

For males who express an interest in fertility preservation, sperm cryopreservation is the only established fertility preservation method. ASCO notes that hormonal therapy in men has not shown to be successful in preserving fertility. Per ASCO, other methods, including testicular tissue cryopreservation for the purpose of future reimplantation or grafting of human testicular tissue are experimental.

For females who express an interest in fertility preservation, both embryo and oocyte cryopreservation are established fertility preservation methods. Other options for women include ovarian transposition (oophoroexy) when pelvic radiation therapy for cancer treatment is performed or conservative gynecological surgery and radiation options. ASCO notes that ovarian tissue cryopreservation for the purpose of future transplantation is experimental. They note also, there is insufficient evidence regarding the effectiveness of ovarian suppression (gonadotropin-releasing hormone analogs) to preserve fertility.

For children, ASCO recommends using established methods of fertility preservation (semen cryopreservation and oocyte cryopreservation) for postpubertal minor children, with patient assent, if appropriate, and parent or guardian consent.[1]

National Comprehensive Care Network (NCCN)
NCCN guidelines on Adolescent and Young Adult Oncology are similar to that of ASCO. NCCN notes that mature oocyte cryopreservation is no longer considered investigational, however, embryo cryopreservation is preferred if there is an identified sperm donor.[2]

Coding Implications
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CPT® Codes	Description
00840	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified
57531	Radical trachelectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling biopsy, with or without removal of tube(s), with or without removal of ovary(s)
58825	Transposition, ovary(s)
58970	Follicle Puncture for oocyte retrieval, any method
76856	Ultrasound, pelvic (nonobstetric), real time with image documentation; complete
76948	Ultrasonic guidance for aspiration of ova, imaging supervision and interpretation
77334	Treatment devices, design and construction, complex (irregular blocks, special shields, compensators, wedges, molds or casts)
82670	Estradiol
83001	Gonadotropin; follicle stimulating hormone (FSH)
83002	Gonadotropin; luteinizing hormone (LH)
84144	Progesterone
84702	Gonadotropin; chorionic (hCG); quantitative
89250	Culture of oocyte(s)/embryo(s), less than 4 days
89251	Culture of oocyte(s)/embryo(s), less than 4 days; with co-culture of oocyte(s)/embryos
89254	Oocyte identification from follicular fluid
89258	Cryopreservation, embryo(s) (freezing services, not storage)
89259	Cryopreservation; sperm
89268	Insemination of oocytes
89272	Extended culture of oocytes/embryo(s), 4-7 days
89280	Assisted oocyte fertilization, microtechnique; less than or equal to 10 oocytes
89281	Assisted oocyte fertilization, microtechnique; greater than 10 oocytes

CPT® Codes	Description
89320	Semen analysis; volume, count motility and differential
89337	Cryopreservation, mature oocyte(s)
89352	Thawing of cryopreserved; embryo(s)
89353	Thawing of cryopreserved; sperm/semen, each aliquot
99000	Handling and/or conveyance of specimen for transfer from office to a laboratory
99001	Handling and/or conveyance of specimen for transfer from the patient in other than an office to a laboratory (distance may be indicated)
99070	Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)
99078	Physician or other qualified health care professional qualified by education, training, licensure/regulation (when applicable) educational services in a group setting (eg, prenatal, obesity, or diabetic instructions)
99199	Unlisted special service, procedure or report

HCPCS Codes	Description
S4030	Sperm procurement and cryopreservation services; initial visit
S4031	Sperm procurement and cryopreservation services; subsequent visit

CPT Codes Considered Investigational

CPT® Codes	Description
0357T	Cryopreservation; immature oocyte(s)
89335	Cryopreservation, reproductive tissue, testicular
0058T	Cryopreservation; reproductive tissue, ovarian

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
C00-D49	Neoplasms
D27.0	Benign neoplasm of right ovary
D27.1	Benign neoplasm of left ovary
D39.10-D39.12	Neoplasm of uncertain behavior of ovary
D40.10-D40.12	Neoplasm of uncertain behavior of testis
N70.01-N70.03	Acute salpingitis and oophorits
N70.11-N70.13	Chronic salpingitis and oophoritis
N83.511-N83.519	Torsion of ovary and ovarian pedicle
Z31.84	Encounter for fertility preservation procedure

Reviews, Revisions, and Approvals	Date	Approval Date
Policy adopted from Health Net NMP512, Fertility Preservation in Cancer Patients. Expanded criteria to include iatrogenic causes of infertility. Added the following ICD-10 codes: D27.0, D27.1, N70.03, N70.13, N83.51.	9/16	10/16
Added the following to medical necessity statements in I. and II: "when a covered benefit under the member's benefit plan contract." References reviewed and updated. Codes updates	09/17	10/17

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Important Reminder

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practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs,

and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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CENTENE Corporation

Clinical Policy: Essure Removal

Reference Number: CP.MP.131
Effective Date: 11/16
Last Review Date: 11/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

This policy describes the medical necessity requirements for the removal of Essure®, a permanent birth control method that involves the bilateral placement of coils into the fallopian tubes which results in the development of scar tissue and occlusion of the fallopian tubes.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that the removal of Essure is **medically necessary** when meeting all of the following:
- A. Member is having symptoms related to the device such as abdominal/pelvic pain or heavy/irregular menses not related to other gynecologic pathologies, device migration, or nickel allergy/hypersensitivity;
- B. Performed by a gynecologist or surgeon experienced in removing the device;
- C. Radiologic evaluation to determine the device location;
- D. One of the following procedures:
  1. Hysteroscopy if ≤ 7 weeks post-placement;
  2. Laparoscopy or laparotomy for one of the following:
     - a. Linear salpingotomy, salpingostomy, or salpingo-oophorectomy;
     - b. Cornual resection and repair;
     - c. Removal of devices that have migrated from the fallopian tubes.

Background

Essure is a form of permanent birth control that can be performed in an office setting and does not require incisions or general anesthesia. It involves the placement of spring-like devices into the proximal section of each fallopian tube via hysteroscopy. Over the next three months, scar tissue forms around the Essure coils facilitating insert retention and pregnancy prevention. The build-up of tissue creates a barrier to block sperm from reaching the eggs, preventing pregnancy.

Over the past several years, a growing number of adverse events have been report to the FDA (Food and Drug Administration) associated with the use of Essure. Frequently reported adverse events include pain/abdominal pain, menstrual irregularities, headache, fatigue, device migration, allergy/hypersensitivity reaction, and weight fluctuations. Because of these reported adverse events, there has been an increase in the number of women seeking removal of the Essure device.

On November 15, 2016, the U.S. Food and Drug Administration approved important labeling changes for the Essure permanent birth control device. Essure labeling now includes the addition of a boxed warning and a Patient Decision Checklist, both intended to support patient counseling and understanding of benefits and risks associated with Essure, as well as what to expect during and after the Essure procedure. The boxed warning includes safety statements to

clearly communicate significant side effects or adverse outcomes associated with this device and information about the potential need for removal.

Coding Implications

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CPT® Codes	Description
58555	Hysteroscopy, diagnostic (separate procedure)
58562	Hysteroscopy, surgical; with removal of impacted foreign body
58579	Unlisted hysteroscopy procedure, uterus
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58673	Laparoscopy, surgical; with salpingostomy (salpingoneostomy)
58700	Salpingectomy, complete or partial, unilateral or bilateral (separate procedure)
58770	Salpingostomy (salpingoneostomy)

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
N92.0-N92.6	Excessive, frequent and irregular menstruation
R10.0-R10.84	Abdominal and pelvic pain
R21	Rash and other nonspecific skin eruption
T56.891*	Toxic effect of other metals, accidental (unintentional)
T83.428*	Displacement of other prosthetic devices, implants and grafts of genital tract

*7th digit required

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed. Specialist reviewed	11/16	11/16
Reworded criteria in I.D. per specialist suggestion to include laparoscopy or laparotomy for one of the following: salpingotomy, salpingostomy or salingo-oophorectomy, as well as corneal resection and repair, and removal of devices that have migrated from the fallopian tubes.	12/16	
References reviewed and updated	11/17	11/17

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Important Reminder

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CLINICAL POLICY
Essure Removal

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CENTENE Corporation

Clinical Policy: Heart-Lung Transplant

Reference Number: CP.MP.132
Effective Date: 06/17
Last Review Date: 06/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Heart-lung transplantation is treatment of choice for patients with both end-stage heart and end-stage lung disease. This policy establishes the medical necessity requirements heart-lung transplants.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that heart-lung transplant is **medically necessary** for members who meet all of the following guidelines:

A. End-stage heart and end-stage lung disease due to one of the following:
   1. Age > 18 years and any of the following:
      a. Irreversible primary pulmonary hypertension with heart failure;
      b. Nonspecific severe pulmonary fibrosis;
      c. Eisenmenger complex with irreversible pulmonary hypertension and heart failure;
      d. Cystic fibrosis with severe heart failure;
      e. Chronic obstructive pulmonary disease with heart failure;
      f. Emphysema with severe heart failure;
      g. Pulmonary fibrosis with uncontrollable pulmonary hypertension or heart failure;
      h. Non-complex congenital heart disease associated with pulmonary hypertension that is not amenable to lung transplantation and repair by standard surgery;
      i. Severe coronary artery disease or cardiomyopathy with irreversible pulmonary hypertension;
   2. Age ≤ 18 years and any of the following:
      a. Eisenmenger syndrome;
      b. Heart re-transplant;
      c. Alpha 1 antitrypsin deficiency;
      d. Lung re-transplant;
      e. Alveolar proteinosis;
      f. Primary pulmonary hypertension;
      g. Pulmonary vascular disease;
      h. Restrictive cardiomyopathy;
      i. Congenital heart disease;
      j. Cystic fibrosis;
      k. Dilated cardiomyopathy;

B. Meets the following disease severity criteria:
   1. Meets one of the following staging criteria:
      a. Age > 18 years: New York Heart Association classification of heart failure III or IV (Table 1); or

   b. Age ≤ 18 years: American Heart Association Stage C or Stage D heart disease, (Table 2);
2. Adequate functional status with the ability for rehabilitation;
3. Life expectancy in the absence of cardiopulmonary disease ≥ 2 years;

C. Does not have any of the following contraindications:
1. HIV and any of the following:
   a. Active or prior opportunistic infections (progressive multifocal leukoencephalopathy or chronic intestinal cryptosporidiosis > 1 month);
   b. Has not been clinically stable and compliant on combination antiretroviral therapy for > 3 months;
   c. Detectable HIV RNA;
   d. Has not had CD4 counts > 200 cells/µl for >3 months;
2. History of psychological, behavioral, or cognitive disorders, poor family support structures, or documented noncompliance with previous therapies that could interfere with successful performance of care regimens after transplantation;
3. Severe, irreversible disease in other organ systems or when it is part of a severe, irreversible, multisystemic disease process;
4. Severe, irreversible, fixed elevation of pulmonary vascular resistance;
5. Severe hypoplasia of the central branch pulmonary arteries or pulmonary veins;
6. Any specific congenital heart lesion;
7. Retransplantation should not be performed during an episode of ongoing acute; allograft rejection, even in the presence of graft vasculopathy;
8. Retransplantation when performed during the first 6 months after primary transplantation;
9. Malignancy in the past two years, except for non-melanoma localized skin cancer that has been treated appropriately;
10. Uncorrected atherosclerotic disease with suspected or confirmed end-organ ischemia or dysfunction and/or coronary artery disease not amenable to revascularization;
11. Acute medical instability, including, but not limited to, acute sepsis, myocardial infarction, and liver failure;
12. Uncorrectable bleeding diathesis;
13. Chronic infection with highly virulent and/or resistant microbes that are poorly controlled pre-transplant;
14. Evidence of active Mycobacterium tuberculosis infection;
15. Significant chest wall/spinal deformity expected to cause severe restriction after transplantation;
16. Class II or III obesity (body mass index ≥35.0 kg/m$^{2)}$;
17. Current non-adherence to medical therapy or a history of repeated or prolonged episodes of non-adherence to medical therapy that are perceived to increase the risk of non-adherence after transplantation;
18. Substance abuse or dependence (including tobacco and alcohol) without convincing evidence of risk reduction behaviors, such as meaningful and/or long-term participation in therapy for substance abuse and/or dependence. Serial blood and urine testing may be used to verify abstinence from substances that are of concern.

Table 1: NYHA Classifications of Heart Failure	
Classification	**Characteristics**
Class I	Patients with cardiac disease but without the resulting limitations in physical activity. Ordinary activity does not cause undue fatigue, palpitation, dyspnea, or anginal pain
Class II	Patients with heart disease resulting in slight limitations of physical activity. They are comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea or anginal pain
Class III	Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary physical activity causes fatigue, palpitation, dyspnea, or anginal pain.
Class IV	Patients with cardiac disease resulting in inability to carry on any physical activity without discomfort. They symptoms of cardiac insufficiency or of the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort increases.

Table 2: Heart Failure Stages in Pediatric Heart Disease	
Classification	**Characteristics**
A	At high risk for developing heart failure
B	Abnormal cardiac structure and/or function; no symptoms of heart failure
C	Abnormal cardiac structure and/or function; Past or present symptoms of heart failure
D	Abnormal structure and/or function; continuous infusion of intravenous inotropes or prostaglandin E_1 to maintain of a ductus arteriosus; mechanical ventilatory and/or mechanical circulatory support

*Note: Heart lung transplantations may be considered medically necessary for other congenital cardiopulmonary anomalies as determined upon individual case review.

Background

Heart-lung transplantation is a strong surgical option for selected patients with simultaneous end-stage heart failure and end-stage lung disease. However, due to a shortage of suitable donors, it is a rare procedure. Only about one hundred such transplants are performed each year in the USA. The 2016 International Society for Heart Lung Transplantation provides listing criteria and best practice recommendations for heart-lung transplants.[1]

The one and five-year survival rates are reported, respectively, at 59.1% and 88.2% for patients with hypertension, 26.8% and 70.4% for patients with hyperlipidemia, and 18% and 28.9% for patients with diabetes.[2]

Spahr et al discusses the pediatric indications and outcomes for heart-lung transplantations and reports that primary pulmonary hypertension, congenital heart disease, and Eisenmenger's syndrome, with a penetrance at 29%, 20% and 16%, respectively, are most common indications for heart lung transplants in children.[5] Since 1988, 188 pediatric heart lung transplants have been reported. Of these procedures, 16 have been performed at < 1 year of age, 52 procedures for

patients 1-5 years of age, 28 procedures for patients 6-10 years of age, 92 procedures for patients 11-17 years of age.[5] Of note, outcomes for heart lung transplants are largely dependent on the success on the lung graft.[5]

Coding Implications

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CPT® Codes	Description
33930	Donor cardiectomy-pneumonectomy, with preparation and maintenance of allograft
33933	Backbench standard preparation of cadaver donor heart/lung allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare aorta, superior vena cava, inferior vena cava, and trachea for implantation
33935	Heart-lung transplant with recipient cardiectomy-pneumonectomy

HCPCS Codes	Description
S2152	Solid organ(s), complete or segmental, single organ or combination of organs; deceased or living donor(s), procurement, transplantation, and related complications including: drugs; supplies; hospitalization with outpatient follow-up; medical/surgical, diagnostic, emergency, and rehabilitative services; and the number of days of pre- and post-transplant care in the global definition

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
D86.0-D86.89	Sarcoidosis
E84.0-E84.9	Cystic fibrosis
I27.0-I27.9	Other pulmonary heart diseases
I42.0-I43	Cardiomyopathy
J47.9 J44.0-	Bronchiectasis
J44.0-J44.9	Other chronic obstructive pulmonary disease
J84.1Ø	Pulmonary fibrosis, unspecified
M32.9	Systemic lupus erythematosus (SLE)
Q33.0-Q33.9	Congenital malformations of lung
Q34.9	Congenital malformations of respiratory system

Reviews, Revisions, and Approvals	Date	Approval Date
New policy.	06/17	06/17

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Important Reminder

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CLINICAL POLICY
Heart-Lung Transplant

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Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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CENTENE Corporation

Clinical Policy: Posterior Tibial Nerve Stimulation for Voiding Dysfunction

Reference Number: CP.MP.133
Effective Date: 10/16
Last Review Date: 10/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Posterior tibial nerve stimulation (PTNS), also known as peripheral tibial nerve stimulation, is a minimally invasive form of electrical neuromodulation used to treat overactive bladder (OAB) syndrome and associated symptoms of urinary urgency, urinary frequency, and urge urinary incontinence. This policy describes the medical necessity requirements for posterior tibial nerve stimulation.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that PTNS is **medically necessary** for the treatment of moderate to severe urinary dysfunction and OAB symptoms when all of the following criteria are met:
- **A.** Urinary dysfunction has persisted for at least 12 months and the condition has resulted in significant disability (i.e., the urinary urgency, frequency, and/or severity of symptoms are limiting the member's ability to participate in activities of daily living); and
- **B.** There has been a failure of, contraindications to, or intolerance to conservative medical management (e.g. pharmacotherapy with alpha blockers and cholinergics and/or antibiotics for urinary tract infections); and
- **C.** Service is provided in accordance with the standard treatment regimen of 30-minute weekly sessions for 12 weeks.

II. It is the policy of health plans affiliated with Centene Corporation that once a month maintenance treatments with PTNS are **medically necessary** for patients who experience significant improvement in their OAB symptoms after the 12 initial treatments. Treatment frequency may vary depending on return of symptoms.

III. It is the policy of health plans affiliated with Centene Corporation that PTNS beyond 12 months or when there is no improvement in urinary dysfunction is **investigational.**

Background

The term “voiding dysfunction" has been used to refer to urinary incontinence, urinary retention, and symptoms of frequency and urgency. OAB is a specific type of voiding dysfunction that includes any of the following symptoms: urinary frequency, urinary urgency, urge incontinence, and nocturia. OAB can significantly impact quality of life; including physical function, sexual function, and social interactions. Treatments for OAB include lifestyle changes, bladder training, pelvic floor muscle training and anticholinergic (anti-muscarinic) drugs.

PTNS involves indirect modulation of the specific nerve that controls bladder function (i.e., the sacral nerve plexus) via stimulation of the posterior tibial nerve accessed just above the ankle.

This minimally invasive form of neuromodulation consists of insertion of a 34-gauge needle electrode approximately 5 centimeters (cm) cephalad to the medial malleolus and 2 cm posterior to the tibia near the tibial nerve. A surface electrode is placed on the medial aspect of the foot. The needle electrode is connected via a lead wire to a low-voltage electrical stimulator. Stimulation is administered at a current level of 0.5 to 9 milliamperes (mA) at 20 hertz (Hz) and continues for 30 minutes. Initial treatment regimens typically consist of 12 weekly sessions, with responders exhibiting some symptom improvement after 6 to 8 sessions. Maintenance treatment sessions may be required to sustain the response to treatment.[1]

National Institute for Health and Care Excellence
Current evidence on PTNS for OAB syndrome shows that it is efficacious in reducing symptoms in the short and medium term. There are no major safety concerns, therefore the procedure may be used provided that normal arrangements are in place for clinical governance, consent and audit.[2]

American Urological Association
Clinicians may offer PTNS as third-line treatment in a carefully selected patient population, characterized by moderately severe baseline incontinence and frequency and willingness to comply with the PTNS protocol. Patients must also have the resources to make frequent office visits both during the initial treatment phase and to obtain maintenance treatments in order to achieve and maintain treatment effects because treatment effects dissipate once treatment ceases. The most common protocol is the application of 30 min of stimulation once a week for 12 weeks (the trial duration; for continued benefit, weekly stimulation would have to continue).[3]

Studies to date evaluating PTNS for the treatment of OAB conclude there is evidence of benefit, although most studies have been small and report short-term outcomes after 12 weeks of treatment. A small study of 33 PTNS responders who continued therapy for 6-12 months reported excellent durability through 12 months.[4] Another small study reported sustained safety and efficacy of PTNS for the treatment of OAB symptom control over 24 months with initial success after 12 weekly treatments, followed by a 14-week prescribed tapering protocol and a personalized treatment plan with an average of 1.3 treatments per month.[5]

Coding Implications
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CPT® Codes	Description
64566	Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming

HCPCS Codes	Description
N/A	

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
N39.41-N39.9	Other specified urinary incontinence
R32	Unspecified urinary incontinence
R35.0-R35.8	Polyuria
R39.81	Functional urinary incontinence

Reviews, Revisions, and Approvals	Date	Approval Date
Policy adopted from Health Net NMP368 Posterior Tibial Nerve Stimulation for Voiding Dysfunction	10/16	10/16
References reviewed and updated.	09/17	10/17

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CLINICAL POLICY

Posterior Tibial Nerve Stimulation for Voiding Dysfunction

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CENTENE Corporation

Clinical Policy: Evoked Potential Testing

Reference Number: CP.MP.134
Effective Date: 01/17
Last Review Date: 11/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information

Description

Evoked potentials evaluate electrical activity in the nervous system in response to stimulation of specific nerve pathways. Types of evoked potentials include somatosensory, brainstem auditory, visual and motor. Monitoring of neurophysiologic evoked potentials intraoperatively helps prevent neurologic injury during neurological, orthopedic, and other types of surgeries. This policy describes the medically necessary indications for neurophysiologic evoked potentials.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that evoked potential testing is **medically necessary** for the following indications:

A. Somatosensory Evoked Potentials Testing
1. Evaluation of acute anoxic encephalopathy;
2. Assessment of a decline in status which may warrant emergent surgery in unconscious spinal cord injury patients who show specific structural damage to the somatosensory system, and who are candidates for emergency spinal cord surgery;
3. Aid in the diagnosis of multiple sclerosis;
4. Evaluation of suspected brain death;
5. Assessment of coma following traumatic, hypoxic-ischemic, and other diffuse brain injuries;
6. Assessment of central nervous system deficiency identified on clinical exam when not explained by appropriate imaging studies;
7. Assessment of unexplained myelopathy;
8. Localization of the cause of neurologic deficits seen on exam that are not explained by lesions on CT or MRI;
9. Management of conditions causing spinocerebral degeneration, such as Fredreichs ataxia;
10. Intraoperative monitoring during surgeries which may impact neural structures.

B. Brainstem Auditory Evoked Potential Testing
1. Assessment of brainstem function in acquired metabolic disorders;
2. Assessment of brainstem function after a lesion compressing the brainstem has been surgically removed;
3. Diagnosis and monitoring of demyelinating and degenerative diseases affecting the brain stem such as multiple sclerosis, central pontine myelinolysis, and olivopontocerebellar degeneration;
4. Diagnosis of lesions in the auditory system;
5. Evaluation of irreversibility of a coma or brain death in combination with EEG;
6. Screening of children < 5 years for hearing loss;
7. Intraoperative monitoring during surgeries which may impact neural structures.

C. Visual Evoked Potential Testing
   1. Diagnosis and monitoring of demyelinating disorders of the optic nerve such as multiple sclerosis or neuromyelitis optic;
   2. Assessment of suspected disorder of the optic nerve, optic chiasm or optic radiations not explained by lesions seen on a CT or MRI, metabolic disorder or infectious disease;
   3. Evaluation of visual loss in those unable to communicate.

II. It is the policy of health plans affiliated with Centene Corporation® that somatosensory evoked potentials, motor evoked potentials using transcranial electrical stimulation, and brainstem auditory evoked potentials are **medically necessary** during intracranial, orthopedic, spinal, and vascular surgeries.

III. It is the policy of health plans affiliated with Centene Corporation® that evoked potential testing is **experimental/investigational** for the following indications:
A. Intraoperative monitoring of visual evoked potentials;
B. Motor evoked potentials from transcranial magnetic stimulation.

IV. It is the policy of health plans affiliated with Centene Corporation® that evoked potential testing is **not medically necessary** for the following indications:
A. Motor evoked potentials for non-operative monitoring;
B. For the treatment of all other conditions than those specified above.

Background

Evoked potentials provide electrical recordings of afferent and efferent networks within the central and peripheral nervous systems in response to specific stimulation. These sophisticated tests facilitate the diagnosis nerve damage, or locate the specific site of nerve damage. There are several types of evoked potentials including sensory evoked potentials and motor evoked. Examples of sensory evoked potentials include somatosensory, brainstem auditory, and visual evoked potentials. Somatosensory evoked potentials generate sensory information from peripheral nerve stimulation.[2] Brainstem auditory evoked potentials are created in response to aural cues and are evaluated at the brainstem and posterior fossa.[2] Visual evoked potentials provide information regarding conduction within the visual pathway, including the retino-striate conduction time.[2] Motor evoked potentials are elicited by electrical or magnetic stimulation of the motor cortex or spinal cord.

Intraoperative monitoring of neurophysiologic responses involves the electrophysiologic measurement of myogenic and neural responses during the course of surgeries. These measurements and testing are in response to controlled and modality specific stimulation. According to the American Speech Langue Hearing Association's Position Statement on Intraoperative Monitoring, the primary objectives of intraoperative monitoring include: (1) to avoid intraoperative injury to neural structures; (2) to facilitate specific stages of the surgical procedure; (3) to reduce the risk of permanent postoperative neurological injury; and (4) to assist the surgeon in identifying specific neural structures.[1]

The American Academy of Neurology published an assessment of intraoperative neurophysiologic monitoring with an evidence based guideline update in 2012.[3] This guideline specifically addressed whether spinal cord intraoperative monitoring with somatosensory and motor evoked potentials predict adverse surgical outcomes. All studies that met inclusion criteria were consistent in showing all of the occurrences of paraparesis, paraplegia, and quadriplegia in the intraoperative monitoring of patients with evoked potential changes, and showed no occurrences of paraparesis, paraplegia, and quadriplegia in patients without evoked potential changes.[3] Thus, intraoperative neurophysioloic monitoring provides operating teams with information regarding increased risk of severe adverse neurologic outcomes. Furthermore, the American Society Clinical Neurophysiology has published specific guidelines on an array of specifications, including the amplifier, safety, filtering, calibration, replication, and interpretation of results.[4]

Coding Implications

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CPT® Codes	Description
92585	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive
95925	Short–latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs
95926	Short–latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in lower limbs
95927	Short–latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in the trunk or head
95928	Central motor evoked potential study (transcranial motor stimulation); upper limbs
95929	Central motor evoked potential study (transcranial motor stimulation); lower limbs
95930	Visual evoked potential (VEP) testing central nervous system, checkerboard or flash
95938	Short–latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs
95939	Central motor evoked potential study (transcranial motor stimulation), in upper and lower limbs

CPT® Codes	Description
95940	Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes (List separately in addition to code for primary procedure)
95941	Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour (List separately in addition to code for primary procedure)
0333T	Visual evoked potential, screening of visual acuity, automated

HCPCS Codes	Description
G0453	Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby), per patient, (attention directed exclusively to one patient) each 15 minutes (list in addition to primary procedure)

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
A17.0-A17.89	Tuberculosis of nervous system
C30.1	Malignant neoplasm of middle ear
C41.0	Malignant neoplasm of bones of skull and face
C41.2	Malignant neoplasm of vertebral column
C70.0-C70.9	Malignant neoplasm of meninges
C71.0-C71.9	Malignant neoplasm of brain
C72.0-C72.9	Malignant neoplasm of spinal cord, cranial nerves and other parts of the central nervous system
C79.31-C79.32	Secondary malignant neoplasm of brain and cerebral meninges
C79.49	Secondary malignant neoplasm of other parts of nervous system
D02.3	Carcinoma in situ of other parts of respiratory system
D14.0	Benign neoplasm of middle ear and respiratory system
D16.6	Benign neoplasm of vertebral column
D18.02	Hemangioma of intracranial structures
D32.0-D32.9	Benign neoplasm of meninges
D33.0-D33.9	Benign neoplasm of brain and other parts of central nervous system
D38.5	Neoplasm of uncertain behavior of other respiratory organs
D42.0-D42.9	Neoplasm of uncertain behavior of meninges
D43.0-D43.9	Neoplasm of uncertain behavior of brain and central nervous system
D44.3	Neoplasm of uncertain behavior of pituitary gland
D44.4	Neoplasm of uncertain behavior of craniopharyngeal duct
D44.5	Neoplasm of uncertain behavior of pineal gland
D49.1	Neoplasm of unspecified behavior of respiratory system
D49.6	Neoplasm of unspecified behavior of brain

ICD-10-CM Code	Description
G06.0-G06.2	Intracranial and intraspinal abscess and granuloma
G11.1	Early-onset cerebellar ataxia
G23.8	Other specified degenerative diseases of basal ganglia
G35	Multiple sclerosis
G36.0-G36.9	Other acute disseminated demyelination
G37.0-G37.9	Other demyelinating diseases of central nervous system
G50.0-G50.9	Disorders of trigeminal nerve
G52.0-G52.9	Disorders of other cranial nerves
G54.0	Brachial plexus disorders
G54.1	Lumbosacral plexus disorders
G54.2	Cervical root disorders, not elsewhere classified
G54.3	Thoracic root disorders, not elsewhere classified
G54.4	Lumbosacral root disorders, not elsewhere classified
G93.0	Cerebral cysts
G93.1	Anoxic brain damage, not elsewhere classified
G93.5	Compression of the brain
G93.6	Cerebral edema
G93.82	Brain death
G95.9	Disease of spinal cord, unspecified
G96.8	Other specified disorders of central nervous system
H47.011-H47.649	Other disorders of optic (2nd) nerve and visual pathways
H53.001 – H53.9	Visual disturbances
H81.01 – H81.09	Meniere's disease
H81.391 – H81.399	Other peripheral vertigo
H81.41 – H81.49	Vertigo of central origin
H90.0-H90.72	Conductive and sensorineural hearing loss
H91.01-H91.93	Other and unspecified hearing loss
H93.3x1 – H93.3x9	Disorders of acoustic nerve
I60.00-I60.8	Nontraumatic subarachnoid hemorrhage
I61.0-I61.8	Nontraumatic intracerebral hemorrhage
I62.00-I62.1	Other and unspecified nontraumatic intracranial hemorrhage
I63.00-I63.9	Cerebral infarction
I65.01-I65.9	Occlusion and stenosis of precerebral arteries, not resulting in cerebral infarction
I66.01-I66.9	Occlusion and stenosis of cerebral arteries, not resulting in cerebral infarction

ICD-10-CM Code	Description
I67.0-I67.7	Other cerebral vascular diseases
I71.00-I71.9	Aortic aneurysm and dissection
I72.0	Aneurysm of carotid artery
I77.71	Dissection of carotid artery
I77.74	Dissection of vertebral artery
M40.00-M40.57	Kyphosis and lordosis
M41.00-M41.9	Scoliosis
M43.00-M43.09	Spondylolysis
M43.10-M43.19	Spondylolisthesis
M47.011-M47.9	Spondylosis
M48.00-M48.08	Spinal stenosis
M50.00-M50.93	Cervical disc disorders
M51.04-M51.9	Thoracic, thoracolumbar, and lumbosacral intervertebral disc disorders
P10.0-P10.9	Intracranial laceration and hemorrhage due to birth injury
P11.0-P11.9	Other birth injuries to central nervous system
P14.0-P14,9	Birth injury to peripheral nervous system
Q01.0-Q01.9	Encephalocele
Q04.0-Q04.9	Other congentital malformations of brain
Q05.0-Q05.9	Spina bifida
Q07.00-Q07.03	Arnold –Chiari syndrome
Q28.0-Q28.9	Other congenital malformations of circulatory systems
Q76.2	Congenital spondylolisthesis
Q85.00-Q85.09	Phakomatoses, not elsewhere classified
R40.20-R40.4	Coma
R40.3	Persistent vegetative state
R42	Dizziness and giddiness
R47.01	Aphasia
R94.110 – R94.138	Abnormal results of function studies of peripheral nervous system and special senses
S02.0XX-S02.42X (add 7th digit A-S)	Fracture of skull and facial bones

ICD-10-CM Code	Description
S04.011-S04.9XX (add 7th digit A-S)	Injury of optic nerve and pathways
S06.0X0-S06.898 (add 7th digit A-S)	Intracranial injury
S07.0XX - S07.9XX (add 7th digit A-S)	Crushing injury of head
S12.000 - S12.9XX (add 7th digit A-S)	Fracture of cervical vertebrae and other parts of the neck
S14.0XX-S14.9XX (add 7th digit A-S)	Injury of nerves and spinal cord at neck level
S22.000 - S22.089 (add 7th digit A-S)	Fracture of thoracic vertebrae
S24.101-S24.9XX(add 7th digit A-S)	Other and unspecified injuries of thoracic spinal cord
S34.01X - S34.9XX (add 7th digit A-S)	Injury of lumbar and sacral spinal cord and nerves at abdomen, lower back and pelvis level
Z01.110	Encounter for hearing examination following failed hearing screening
Z08	Encounter for follow-up examination after completed treatment for malignant neoplasm
Z87.710-Z87.798	Personal history of (corrected) congenital malformations

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed, Neurological surgery specialist reviewed.	11/16	11/16
References reviewed and updated. 2018 ICD-10 CM coding clarifications.	11/17	11/17

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Important Reminder

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Clinical Policy: Fecal Calprotectin Assay

Reference Number: CP.MP.135
Effective Date: 11/16
Last Review Date: 11/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Calprotectin is a calcium binding protein that is excreted in stool in patients with inflammatory bowel disease (IBD) and other gastrointestinal conditions. Fecal calprotectin (FC), used as a noninvasive marker of intestinal inflammation, has been proposed to aid in the diagnosis and as a predictor of relapse in IBD including Crohn's disease (CD) and ulcerative colitis (UC), rather than relying solely on clinical symptoms. The policy provides a statement of medical necessity for FC assay testing.

Policy/Criteria

It is the policy of health plans affiliated with Centene Corporation® that the FC assay is **investigational** for both the diagnosis and screening of IBD. Although there are many ongoing studies on FC assays, there is conflicting and inconsistent evidence regarding the optimal calprotectin cutoff level.

Background

Noninvasive diagnose of IBD is difficult because the clinical manifestations of intestinal disorders and colon cancer are relatively non-specific. One of the primary biological functions of calprotectin seems to be inhibition of bacterial growth. It is released by immune system cells that trigger and maintain the inflammation involved in IBD. FC is a biochemical measurement of the protein calprotectin in the stool that is usually measured with an enzyme-linked immunosorbent assay (ELISA). Elevated FC indicates the migration of neutrophils to the intestinal mucosa, which occurs during intestinal inflammation, including inflammation caused by IBD.

Per the existing research, FC assay testing seems to be safe; however, the studies do not provide enough information to support its clinical use. The use of this testing for detection of IBD activity or prediction of relapse requires clearly defined cutoffs for determining which patients have active disease and which patients are predicted to undergo relapse. These cutoffs do not have to be exactly the same since they are used for detection in different patient populations. The issue is that the studies provided cutoffs that were scattered over wide ranges, from 120 to 340 mg/g, and have overestimated the apparent sensitivity and specificity of this test by using its interpretation for several small subpopulations of patients. These studies do not provide reliable evidence of the accuracy of FC versus other available tests due to lack of comparative analysis and failure to agree upon cutoffs for interpreting the FC testing results. Additional peer-reviewed, randomized controlled or comparative studies are needed to define uniform cutoffs for FC testing, as well as to evaluate and compare with other tests that have been used for the management of IBD. [2, 5, 7, 8]

American College of Gastroenterology

There is no mention on this site of fecal calprotectin assay for IBD. [10]

American Gastroenterological Association
The AGA mentions FC in their laboratory criteria to assess inflammatory status for the identification, assessment and initial medical treatment in CD. [12]

Crohn's and Colitis Foundation of America
There is no mention of the fecal calprotectin assay for IBD on the site. [4]

North American Society of Pediatric Gastroenterology, Hepatology, and Nutrition
There is no mention on this site of fecal calprotectin assay for IBD. [11]

National Institute for Health and Care Excellence
Faecal calprotectin testing is recommended by NICE as an option to help doctors distinguish between IBD, such as CD and UC, and non-inflammatory bowel diseases, such as irritable bowel syndrome. Specific criteria must be met. [9]

World Gastroenterology Organization
Calprotectin, a simple, reliable, and readily available test for measuring IBD activity, may be better for UC than CD; the rapid fecal calprotectin tests could be very helpful in developing countries. [3]

Coding Implications
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CPT® Codes	Description
83993	Calprotectin, fecal

HCPCS Codes	Description
N/A	

Related ICD-10-CM Diagnosis Codes

ICD-10-CM Code	Description
K50.90	Crohn's disease, unspecified without complications
K50.911-K50.919	Crohn's disease with complications
K51.00	Ulcerative (chronic) pancolitis without complications

ICD-10-CM Code	Description
K51.011-K51.019	Ulcerative (chronic) pancolitis with complications
K51.20	Ulcerative (chronic) proctitis without complications
K51.211-K51.219	Ulcerative (chronic) proctitis with complications
K51.50	Left sided colitis without complications
K51.511-K51.519	Left sided colitis with complications
K51.80	Other ulcerative colitis without complications
K51.811-K51.819	Other ulcerative colitis with complications
K52.0-K52.2	Other and unspecified noninfective gastroenteritis and colitis
Z13.811	Encounter for screening for lower gastrointestinal disorder

Reviews, Revisions, and Approvals	Date	Approval Date
Policy Adopted from Health Net NMP#205 Fecal Calprotectin Assay	11/16	11/16
References reviewed and updated.	10/17	11/17

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CENTENE Corporation

Clinical Policy: Home Births

Reference Number: CP.MP.136
Effective Date: 12/16
Last Review Date: 12/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

A planned home birth is an elective alternative to delivery in a birthing center or hospital setting. Women are encouraged to make medically informed decisions about home delivery, and provision of home births will be considered when coverage is mandated by law or member's benefit language.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that home births are **medically necessary** only for low-risk pregnancies when a qualified health care professional is present and the following criteria are met:

A. The birth is overseen by a participating and credentialed provider of the Plan who meets one of the following criteria:
   1. If home birth services are being managed by a midwife, all of the following criteria must be met:
      a. The availability of a certified nurse–midwife, certified midwife, or midwife whose education and licensure meet International Confederation of Midwives Global Standards for Midwifery Education;
      b. Certified nurse midwife's written plan for emergency care includes documentation that emergency transportation to the nearest appropriate hospital can be accomplished within 15 minutes from the onset of an emergency condition;
   2. If home birth services are being managed by a doctor, all of the following must be met:
      a. Physician practices obstetrics within an integrated and regulated health system;
      b. If the physician is not an obstetrician, there is documentation of proof of back-up supervision and coverage by a Board Certified or Board Eligible obstetrician;
      c. Emergency care is planned at a facility where the supervising obstetrician has admitting privileges;
      d. The facility for emergency care is within 15 minutes by emergency transportation from the site of delivery;

B. No preexisting medical condition(s);
C. No prior cesarean delivery;
D. Absence of significant disease during pregnancy;
E. A singleton pregnancy;
F. Cephalic presentation;
G. Pregnancy has lasted at least 38 weeks but no more than 41 weeks;
H. There is a preexisting arrangement for emergency transportation to a nearby hospital, should it be needed.

II. It is the policy of health plans affiliated with Centene Corporation that home births are considered **not medically necessary** for any circumstances other than those specified above.

Background

Home birth remains a controversial issue, with safety as the primary focus. Although many countries have established lists based on specific patient characteristics and risks that might compromise the safety of out of hospital births, no specific list exists for the United States. Planned home birth must include a system that allows for collaboration, and referral and transfer to hospital care if problems arise. Appropriate risk screening is paramount in evaluating which home births may lead to positive outcomes. [3, 7]

American College of Obstetricians and Gynecologists (ACOG)

ACOG does not support planned home births given the published medical data and believes that hospitals and birthing centers are the safest settings for birth. However, ACOG respects the right of a woman to make a medically informed decision about delivery. Women inquiring about planned home birth should be informed of its risks and benefits based on recent evidence. This includes the appropriate selection of candidates for home birth; the appropriate certification for midwifes, as noted in the policy statement; practicing obstetrics within an integrated and regulated health system; ready access to consultation; and access to safe and timely transport to nearby hospitals. Specifically, women should be informed that although the absolute risk may be low, planned home birth is associated with a twofold to threefold increased risk of neonatal death when compared with planned hospital birth. [3]

American Academy of Pediatrics (AAP)

The most recent policy statement concurs with ACOG, affirming that hospitals and birthing centers are the safest settings for birth in the United States while respecting the right of women to make a medically informed decision about delivery. In addition, in the United States, the AAP recommends that the delivery be attended by at least two individuals, one who has primary responsibility for the mother and one who has primary responsibility for the infant.[1]

American College of Nurse Midwives & American Public Health Association

These two organizations have policy statements supporting the practice of planned out-of-hospital birth in select populations of women.[2, 4]

World Health Organization

A recent policy statement indicates that women can choose to deliver at home if they have low-risk pregnancies, receive the appropriate level of care, and formulate contingency plans for transfer to a properly-staffed/equipped delivery unit if problems arise. [9]

A meta-analysis was completed comparing maternal and newborn outcomes in planned home birth versus planned hospital births. Planned home births were associated with fewer maternal interventions including labor induction or augmentation, regional analgesia, electronic fetal heart rate monitoring, episiotomy, operative vaginal delivery, and cesarean delivery. These women were less likely to experience lacerations, and infections. Neonatal outcomes of planned home

births revealed less frequent prematurity, low birthweight, and assisted newborn ventilation. Although planned home and hospital births exhibited similar perinatal mortality rates, planned home births were associated with significantly elevated neonatal mortality rates. [3, 12]

In the Netherlands and the United Kingdom, some large observational studies suggest that elevated neonatal mortality rates were associated with first time births in the home versus other birth settings, and that multiparous, low-risk births at home did not have an increased risk of maternal or neonatal complications.[13, 14] In contrast, a retrospective cohort study of Canadian patients found no risk of increased adverse neonatal outcomes for infants of primiparous or multiparous women with planned home births, and for both primiparous and multiparous women, rates of intrapartum interventions were lower.[15] A prospective study in the Netherlands similarly found no increased risk of perinatal complications for infants of primiparous women planning to deliver at home, and for infants of multiparous women, planned home delivery resulted in significantly better perinatal outcomes.[16]

There is a paucity of randomized, controlled trials of planned home birth. Most information on planned home births comes from observational studies, which are often limited by methodological problems, including small sample sizes, lack of an appropriate control group, reliance on voluntary submission of data or self-reporting, limited ability to distinguish accurately between planned and unplanned home births, variation in the skill, training, and certification of the birth attendant, and an inability to account for and accurately attribute adverse outcomes associated with antepartum or intrapartum transfers.[6, 10]

Coding Implications

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CPT® Codes	Description
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and / or forceps) and postpartum care
59409	Vaginal delivery only (with or without episiotomy and/or forceps)
59410	Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care
54914	Delivery of placenta

HCPCS Codes	Description
N/A	

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
O80	Encounter for full-term uncomplicated delivery

Reviews, Revisions, and Approvals	Date	Approval Date
Policy Adopted from Health Net NMP#216 Home Births	12/16	12/16
Minor wording change in I.A.2.c. for clarity. Added criteria that women planning home birth should not have had a previous cesarean, per ACOG committee opinion updated 2017. Minor wording changes in background per ACOG update. Reworded I.F. from head down to cephalic presentation. Removed CPT code 54192, external cephalic version	11/17	12/17

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CENTENE Corporation

Clinical Policy: Fecal Incontinence Treatments

Reference Number: CP.MP.137
Effective Date: 12/16
Last Review Date: 12/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Fecal incontinence defined as the uncontrolled passage of feces or gas over at least 1 month's duration, in an individual of at least four years of age, who had previously achieved control. It has a negative impact on self-esteem and quality of life.[1] The choice of therapy depends upon the etiology of incontinence, the anatomy of the sphincters, and also on the effect of incontinence on the quality of life.

Note: For biofeedback treatment for fecal incontinence, please refer to CP.MP.168 Biofeedback.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that any of the following procedures are **medically necessary** for treatment of severe, chronic fecal incontinence when there has been an inadequate response to conservative treatments (e.g. pharmacotherapy, dietary management, strengthening exercises) and the treatment-specific criteria have been met:
- **A.** Sacral nerve stimulation for a weak but structurally intact anal sphincter;
- **B.** Sphincter repair (sphincteroplasty) when there is a defined defect of the external anal sphincter;
- **C.** Artificial bowel sphincter (Acticon Neosphincter) when all of the following criteria is met:
  1. Age 18 or older;
  2. Failure of or not a candidate for medical or surgical interventions;
  3. Incontinence is not complicated by an irreversibly or obstructed proximal segment of bowel;
  4. Absence of any physical or mental illness that would increase surgical risk;
- **D.** Colostomy, as last resort, when all other treatments have failed.

II. It is the policy of health plans affiliated with Centene Corporation that any the following procedures are considered **investigational** for the treatment of fecal incontinence. Although they continue to be evaluated in clinical studies, current medical literature does not support their efficacy:
- **A.** Transanal radiofrequency therapy (Secca procedure);
- **B.** Injectable bulking agents [e.g., dextranomer/hyaluronic acid (Solesta)];
- **C.** Anal electrical stimulation;
- **D.** Posterior tibial nerve stimulation;
- **E.** Vaginal bowel control (e.g, Eclipse system).

Background

Treatment of fecal incontinence is challenging. The goal of treatment is to restore continence and to improve the quality of life. Dietary and medical management are recommended as first-line therapy for patients with fecal incontinence. If fecal incontinence is a result of or in conjunction with anatomic defects (e.g., rectovaginal fistula, rectal or hemorrhoidal prolapse etc.), the defects should be corrected first as this often improves or eliminates the incontinence.

Sacral neuromodulation is thought to modulate rectal sensation by activating or deactivating chemical mediating receptors, stimulating the afferent pathway, and changing brain activity relevant to the continence. Sacral neuromodulation has consistently shown to result in a reduction in frequency of fecal incontinence episodes and may be considered for incontinent patients with and without sphincter defects. Sphincter repair (sphincteroplasty) may be offered to symptomatic patients with a defined defect of the external anal sphincter. Implantation of an artificial bowel sphincter remains an effective tool for select patients with severe fecal incontinence; however, its use is limited by complications including explanation in up to one-third of patients.[2]

Injectable bulking agents [e.g., dextranomer/hyaluronic acid (Solesta)] have been investigated for the treatment of fecal incontinence. However, evidence in the peer review literature evaluating this treatment is limited. There is a paucity of randomized, controlled trials and studies are limited by their small study sizes. A prospective multicenter trial of 136 patients with fecal incontinence who received non-animal stabilized hyaluronic acid/dextranomer (NASHA Dx) bulking agent reported it provided a significant improvement of fecal incontinence symptoms in a majority of patients and this effect was stable during the course of the follow-up and maintained for 3 years.[3] Long-term data is lacking, however, regarding the durability of this treatment.

Transanal radiofrequency therapy (e.g., Secca procedure) is another procedure proposed for the treatment of fecal incontinence). This procedure uses thermo-controlled delivery of radiofrequency energy to the anal canal. The reported evidence is relatively sparse and has relevant limitations. Most studies have been small single-center series with short to mid-term follow-up.

The Eclipse System (Pelvalon Inc) is a nonsurgical vaginal bowel-control system for the treatment of fecal incontinence in women 18 to 75 years old who have had four or more FI episodes in a two-week period. The device includes an inflatable balloon, which is placed in the vagina. Upon inflation, the balloon exerts pressure through the vaginal wall onto the rectal area, thereby reducing the number of FI episodes. The device is initially fitted and inflated by a clinician (with the use of a pump) and after proper fitting, the patient can inflate and deflate the device at home as needed. The device was granted FDA approval through the de novo classification process based on non-clinical testing as well as a clinical trial of 61 women with FI treated with the device. The trial showed that after one month almost 80 percent of women in the study experienced a 50 percent decrease in the number of FI episodes while using the device, as compared to baseline. Studies to date are limited by size and lack of long term evidence.

American Society of Colon and Rectal Surgeons (ASCRS)

In their most recent guidelines on the treatment of fecal incontinence, the ASCRS assigns strong recommendations in favor of sacral neuromodulation, and sphincteroplasty based upon moderate quality of evidence. The ASCRS reports that injection of biocompatible bulking agents into the anal canal may help to decrease episodes of passive fecal incontinence. However, based upon moderate-quality evidence, this is a weak recommendation. The ASCRS notes that although modest improvements have been reported in short-term outcomes, long-term follow-up with regard to safety and efficacy awaits further experience.

The ASCRS guideline states the application of temperature-controlled radiofrequency energy to the sphincter complex may be used to treat fecal incontinence. However, this is also a weak recommendation based on moderate-quality of evidence. The ASCRS reports that most studies have been small single-center series with short-term follow-up. Per the ASCRS, "Because of the limitations in the available data, alternative treatments should be pursued before considering radiofrequency energy delivery."[1]

American College of Gastroenterology (ACG)
Regarding minimally invasive procedures for the treatment of fecal incontinence, the ACG concluded that minimally invasive procedures such as injectable anal bulking agents may have a role in patients with fecal incontinence who do not respond to conservative therapy. However, they note this is a weak recommendation based on moderate-quality of evidence. The ACG reported that there is insufficient evidence to recommend radiofrequency ablation treatment to the anal sphincter (SECCA) at this time.[4]

National Institute for Health and Clinical Excellence
An interventional procedure guidance on injectable bulking agents for fecal incontinence concluded the current evidence on the safety and efficacy of injectable bulking agents for fecal incontinence does not appear adequate for this procedure to be used without special arrangements for consent and for audit or research, which should take place in the context of a clinical trial or formal audit protocol that includes information on well-defined patient groups.[5]

Coding Implications
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CPT® Codes	Description
46750	Sphincteroplasty, anal, for incontinence or prolapse; adult
46751	Sphincteroplasty, anal, for incontinence or prolapse; child
46760	Sphincteroplasty, anal, for incontinence or prolapse, adult; muscle transplant

CPT® Codes	Description
46761	Sphincteroplasty, anal, for incontinence or prolapse, adult; levator muscle imbrication (Park posterior anal repair)
46762	Sphincteroplasty, anal, for incontinence or prolapse, adult; implantation artificial sphincter
46999	Unlisted procedure, anus
64561	Percutaneous implantation of neurostimulator electrodes; sacral nerve (transforaminal placement) including image guidance, if performed
64581	Incision for implantation of neurostimulator electrodes; sacral nerve (transforaminal placement)
64585	Revision or removal of peripheral neurostimulator electrodes
64590	Insertion and replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling
64595	Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver
95970	Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (i.e. cranial nerve, peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming
95971	Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude. Pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (i.e., cranial nerve, peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming
95972	Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude. pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord or peripheral (i.e., peripheral nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse/generator/transmitter, with intraoperative or subsequent programming

HCPCS Codes	Description
A4290	Sacral nerve stimulation test lead, each
A4335	Incontinence supply; miscellaneous
E0745	Neuromuscular stimulator, electronic shock unit
L8680	Implantable neurostimulator electrode, each
L8681	Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only

HCPCS Codes	Description
L8682	Implantable neurostimulator radiofrequency receiver
L8683	Radiofrequency transmitter (internal) for use with implantable neurostimulator radiofrequency receiver
L8684	Radiofrequency transmitter (external) for use with implantable sacral root neurostimulator receiver for bowel and bladder management, replacement
L8685	Implantable neurostimulator pulse generator, single array, rechargeable, includes extension
L8686	Implantable neurostimulator pulse generator, single array, nonrechargeable, includes extension
L8687	Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension
L8688	Implantable neurostimulator pulse generator, dual array, nonrechargeable, includes extension
L8689	External recharging system for battery (internal) for use with implantable neurostimulator, replacement only.

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
R15-R15.9	Fecal incontinence

Reviews, Revisions, and Approvals	Date	Approval Date
Policy adopted from Health Net NMP325 Fecal Incontinence Treatments	11/16	12/16
Removed criteria and related background for biofeedback treatment, as this was incorporated into CP.MP.168 Biofeedback.	06/17	
Added II.E. Vaginal bowel control (e.g, Eclipse system) as investigational. References and codes reviewed and updated.	11/17	12/17

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Important Reminder

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recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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CENTENE Corporation

Clinical Policy: Pediatric Heart Transplant

Reference Number: CP.MP.138
Effective Date: 01/17
Last Review Date: 12/16

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Pediatric heart disease may be a progressive disease which affects cardiac structure and function in infants and children. Heart transplantation is treatment of choice for pediatric patients with end-stage heart disease. This policy establishes the medical necessity requirements for pediatric heart transplants and re-transplants.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that heart transplant for pediatric members (age < 18) with end-stage heart disease is **medically necessary** when all of the following conditions are met:

A. End-stage heart disease due to any of the following indications[1]:

1. *For heart transplantation*
   a. Systemic ventricular dysfunction with cardiomyopathies or previously repaired/palliated congenital heart disease;
   b. Heart failure associated with severe limitation of exercise and activity evidenced by peak maximum oxygen consumption < 50% predicted for age and sex;
   c. Heart failure associated with systemic ventricular dysfunction in patients with cardiomyopathies or previously repaired/palliated congenital heart disease (CHD) when heart failure is associated with significant growth failure attributable to the heart disease;
   d. Heart failure with associated near sudden death and/or life-threatening arrhythmias untreatable with medications or an implantable defibrillator;
   e. Restrictive cardiomyopathy disease associated with reactive pulmonary hypertension;
   f. Pulmonary hypertension and a potential risk of developing fixed, irreversible elevation of pulmonary vascular resistance that could preclude orthotopic heart transplantation in the future;
   g. Certain anatomic and physiological conditions likely to worsen the natural history of CHD in infant patients with a functional single ventricle, which can lead to use of heart transplantation as primary therapy, including any of the following:
      i. Severe stenosis (stenoses) or atresia in proximal coronary arteries;
      ii. Moderate to severe stenosis and/or insufficiency of the AV and/or systemic semilunar valve(s);
      iii. Severe ventricular dysfunction;
   h. Several anatomic and physiological conditions likely to worsen the natural history of previously repaired or palliated CHD that may lead to consideration for heart

transplantation without severe systemic ventricular dysfunction, including any of the following:
i. Severe aortic or systemic AV valve insufficiency that is not considered amenable to surgical correction;
ii. Severe arterial oxygen desaturation (cyanosis) that is not considered amenable to surgical correction;
iii. Persistent protein-losing enteropathy despite optimal medical/surgical therapy;

2. *For heart re-transplantation*
   a. Moderate to severe graft vasculopathy;

B. American Heart Association Stage C or Stage D heart disease, as per Table 1;
C. Adequate functional status with the ability for rehabilitation;
D. Life expectancy in the absence of cardiopulmonary disease ≥ 2 years;
E. Does not have any of the following contraindications:
1. Severe, irreversible, fixed elevation of pulmonary vascular resistance;
2. Severe hypoplasia of the central branch pulmonary arteries or pulmonary veins;
3. Any specific congenital heart lesion;
4. Retransplantation should not be performed during an episode of ongoing acute; allograft rejection, even in the presence of graft vasculopathy;
5. Retransplantation when performed during the first 6 months after primary transplantation;
6. Malignancy in the past two years, except for non-melanoma localized skin cancer that has been treated appropriately;
7. Untreatable significant dysfunction of another major organ system unless combined organ transplantation can be performed;
8. Uncorrected atherosclerotic disease with suspected or confirmed end-organ ischemia or dysfunction and/or coronary artery disease not amenable to revascularization;
9. Acute medical instability, including, but not limited to, acute sepsis, myocardial infarction, and liver failure;
10. Uncorrectable bleeding diathesis;
11. Chronic infection with highly virulent and/or resistant microbes that are poorly controlled pre-transplant;
12. Evidence of active *Mycobacterium tuberculosis* infection;
13. Significant chest wall/spinal deformity expected to cause severe restriction after transplantation;
14. Class II or III obesity (body mass index ≥35.0 kg/m^2);
15. Current non-adherence to medical therapy or a history of repeated or prolonged episodes of non-adherence to medical therapy that are perceived to increase the risk of non-adherence after transplantation;
16. Psychiatric or psychological condition associated with the inability to cooperate or comply with medical therapy;
17. Absence of an adequate or reliable social support system;
18. Severely limited functional status with poor rehabilitation potential;
19. Substance abuse or dependence (including tobacco and alcohol) without convincing evidence of risk reduction behaviors, such as meaningful and/or long-term participation in therapy for substance abuse and/or dependence. Serial blood and urine testing may be used to verify abstinence from substances that are of concern.

Background

Pediatric heart disease incorporates a wide range of diseases and includes a variety of age ranges. Heart transplantation is recommended for end-stage pediatric heart disease. Cardiomyopathy is the most common indication for heart transplant in children and dilated cardiomyopathy is the most common form of cardiomyopathy in the pediatric population, followed by hypertrophic and restrictive diseases.[1]

The American Heart Association has published a scientific statement specifically to address the requirements for heart transplantation and re-transplantations in pediatric heart disease.[1] Canter, *et al*, addresses the indications for heart transplants, as well as defines the staging of heart failure as illustrated in Table 1.

The current survival in pediatric recipients 1, 5, and 10 years after transplantation is approximately 90, 80, and 60%, respectively.[2] The median survival is 19.7 years for infants, 16.8 years for children ages 1-5, 14.5 years for children ages 6-10, and 12.4 years for children ages 11-17 at the time of trasnplanation.[3] Several risk factors contribute to the decreasing survival in older ages groups, including immature immune system in infants, the absence of preformed antibodies in infants, sensitization in the older children due to surgical repair for congestive heart disease, and medication non-compliance in older children.[3]

Dipchand, *et al*, analyzed the Registry of the International Society for Heart and Lung Transplantation and reported that the proportion of transplant recipients by age remains similar with 24% infants, 25% aged between 1 and 5 years, 16% aged between 6 and 10 years, and 35% aged between 11 and 17 years.[5]

Table 1: Heart Failure Stages in Pediatric Heart Disease

Classification	Characteristics
A	At high risk for developing heart failure
B	Abnormal cardiac structure and/or function; no symptoms of heart failure
C	Abnormal cardiac structure and/or function; past or present symptoms of heart failure
D	Abnormal structure and/or function; continuous infusion of intravenous inotropes or prostaglandin E_1 to maintain of a ductus arteriosus; mechanical ventilatory and/or mechanical circulatory support

Coding Implications

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CLINICAL POLICY
Pediatric Heart Transplant

Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
33944	Backbench standard preparation of cadaver donor heart allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare aorta, superior vena cava, inferior vena cava, pulmonary artery, and left atrium for implantation
33945	Heart transplant, with or without recipient cardiectomy

HCPCS Codes	Description
N/A	

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
I25.1 – I25.9	Chronic ischemic heart disease
I42.0 – I42.9	Cardiomyopathy
I50.1 – I50.9	Heart failure
Q20.0 – Q28.9	Congenital malformations of circulatory system

Reviews, Revisions, and Approvals	Date	Approval Date
New policy developed, specialist reviewed	12/16	1/17

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Important Reminder

CLINICAL POLICY
Pediatric Heart Transplant

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CLINICAL POLICY
Pediatric Heart Transplant

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CENTENE Corporation

Clinical Policy: Low-Frequency Ultrasound Therapy for Wound Management

Reference Number: CP.MP.139
Effective Date: 02/17
Last Review Date: 02/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Low-frequency ultrasound debridement is a noncontact debridement method that provides simultaneous cleansing and debridement of wounds. It is generally performed at a 5 mm - 15 mm distance from the wound surface. A device uses ultrasound technology to atomize saline, delivering a continuous mist to the treatment site. Multiple passes over the wound are made with the treatment head of the device for a predetermined treatment session. This can accelerate the wound healing process by removing the necrotic tissue, fibrosis, exudate, and bacteria with minimum bleeding and pain.

Policy/Criteria

It is the policy of health plans affiliated with Centene Corporation® that low-frequency ultrasound wound therapy is considered **investigational**. This treatment continues to be evaluated in clinical studies. However, current peer reviewed literature is inconclusive at this time.

Background

The treatment of chronic and difficult to heal wounds presents many clinical challenges. To ensure proper healing, the wound bed needs to be well vascularized, free of devitalized tissue, clear of infection, and moist. Surgical debridement is the most appropriate choice for removing large areas of necrotic tissue and is indicated whenever there is any evidence of infection (cellulitis, sepsis). Surgical debridement is also indicated in the management of chronic non-healing wounds to remove infection, handle undermined wound edges, or obtain deep tissue for culture and pathology.[1]

Noncontact, low-frequency ultrasound debridement devices have been proposed as adjunctive treatment of a variety of wounds including, but not limited to, acute, traumatic, chronic, and dehisced wounds. Several devices have received FDA approval, including but not limited to, The Mist Therapy System (Alliqua Biomedical), Qoustic Wound Therapy System (Arobella Medical, LLC), SonicOne Ultrasonic Wound Debridement System (Misonix Inc.) and Sonoca TM 180/1 96 Wound Care System. Evidence for the use of these devices to treat wounds is limited and consist of studies that lack adequate sample sizes. Results at this time are inconclusive.

A Cochrane database review of randomized control trials (RCTs) comparing ultrasound with no ultrasound in wound care identified two trials evaluating low frequency ultrasound. The trials reported healing at different time points. Both trials reported no evidence of a difference in the proportion of ulcers healed with ultrasound compared with no ultrasound. Both trials were significantly underpowered. The reviewers concluded there is no evidence of a benefit associated

with low frequency ultrasound.[2] Several other small randomized controlled trials that compared patients treated with non-contact low-frequency ultrasound therapy in addition to standard wound care reported that outcome measures favored non-contact low-frequency ultrasound therapy in addition to standard wound care over standard wound care alone. However, the differences were not statistically significant.[3,4] A small RCT of 35 patients who received MIST Therapy plus the standard of wound care (treatment group) compared to 35 patients who received the standard of wound care alone (control group) for 12 weeks or until fully healed reported that a significantly higher percentage of patients treated with the standard of care plus MIST Therapy achieved greater than 50% wound healing at 12 weeks than those treated with the standard of care alone (63% vs 29%).[5] Additional research with larger randomized trials is necessary in order to demonstrate that low frequency ultrasound is beneficial for health outcomes in patients with wounds.

Society for Vascular Surgery and the American Venous Forum.
The Committee suggests against ultrasonic debridement over surgical debridement in the treatment of venous leg ulcers. (Grade 2, Level of Evidence C) [6]

National Institute of Health Care Excellence (NICE)
The National Institute of Health Care Excellence (NICE) concluded, "The MIST Therapy system shows potential to enhance the healing of chronic, "hard-to-heal," complex wounds, compared with standard methods of wound management. However, the amount and quality of published evidence on the relative effectiveness of the MIST Therapy system is not sufficient to support the case for routine adoption of the MIST Therapy system. Comparative research is recommended to reduce uncertainty about the outcomes of patients with chronic, "hard-to-heal," complex wounds treated by the MIST Therapy system compared with those treated by standard methods of wound care."[7] In June 2016, NICE reviewed the guidance again and decided not to update it, noting new relevant evidence has been published but it is inconclusive.

Coding Implications
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CPT® Codes	Description
97610	Low frequency, non-contact, non-thermal ultrasound, including topical application(s) when performed, wound assessment, and instruction(s) for ongoing care; per day

HCPCS Codes	Description
N/A	

ICD-10-CM Diagnosis Codes that do NOT Support Coverage Criteria

ICD-10-CM Code	Description
ALL	

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed	1/17	02/17

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

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recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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CENTENE Corporation

Clinical Policy: EpiFix Wound Treatment

Reference Number: CP.MP.140
Effective Date: 04/17
Last Review Date: 04/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

EpiFix® (MiMedx Group) is dehydrated human amniotic tissue that is used as an allograft material (or tissue graft) to treat nonhealing wounds. It is prepared using a proprietary process by which placental tissues are gently separated, cleaned of viable cells, reassembled, and dehydrated, preserving factors important in healing. EpiFix is processed from human tissue according to the American Association of Tissue Banks (AATB) standards, and is regulated as a human cell, tissue, or cellular or tissue-based product.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that Epifix is **medically necessary** for the treatment of chronic foot ulcers when all of following criteria are met:

A. Age ≥ 18 years;
B. Type I or Type II diabetes;
C. Foot ulcer surface area* > $1cm^2$ and < $25cm^2$;
D. Ulcer duration of ≥ 4 weeks, unresponsive to standard wound care;
E. No clinical signs of infection;
F. Ulcer does not probe to tendon, muscle, capsule or bone;
G. Serum creatinine < 3.0 mg/dl;
H. HbA1c < 12%;
I. Adequate circulation to the affected extremity as demonstrated by dorsum transcutaneous oxygen test (TcPO2) > 30mmHg, or ankle-brachial index (ABI) between 0.7 and 1.2 or triphasic or biphasic Doppler arterial waveforms at the ankle of affected leg.
**Surface area can be calculated by multiplying width in cm by length in cm.*

II. It is the policy of health plans affiliated with Centene Corporation that continued treatment with EpiFix is **not medically necessary** when the ulcer fails to heal by ≥ 50% within the first 6 weeks of treatment. Treatment beyond 12 weeks is considered **not medically necessary** regardless of wound status.

III. It is the policy of health plans affiliated with Centene Corporation that treatment with EpiFix for any other types of nonhealing wounds is considered **investigational.**

Background

Lower extremity ulceration is a common complication for patients with diabetes. Diabetic foot ulcers lead to some form of amputation in 20% of patients and are associated with higher morbidity and mortality. The presence of peripheral vascular disease, neuropathy and poor blood glucose control contribute to the development of lower extremity wounds, their slow rate of healing and their propensity to recur. Evidence-based guidelines for the management of lower extremity diabetic ulcers include moist dressings, debridement, wound offloading, infection

control and implementation of advanced wound therapies if the ulcer does not decrease in size by 40% or more after 4 weeks of standard therapy. [1]

EpiFix is proposed to promote cellular migration to enhance soft tissue repair in acute and chronic wounds free of necrotic tissue and infection; partial- and full-thickness wounds; venous, diabetic, pressure, and chronic vascular ulcers; trauma wounds, including burns; and surgical wounds. EpiFix is not indicated for wounds that probe to bone or are infected. EpiFix is typically ordered and applied by wound care specialists in an outpatient setting.

The general steps involved in using EpiFix include:

- Surgical debridement of infected or decaying tissue until the wound base is visible and has good blood flow.
- If necessary, trimming of the EpiFix membrane to produce a 1-millimeter (mm) overlap with the wound margin. The product may be applied either dry or moistened with saline.
- Confirmation of the correct orientation of the EpiFix membrane, which is then placed over the wound and secured with adhesive strips.
- Application of a nonadherent contact layer followed by a moist dressing.

The membrane typically incorporates into the wound bed within 2 weeks of application.

The overall quality of evidence evaluating EpiFix is low, however, among diabetic patients with chronic foot ulcers, studies although limited, reported a greater reduction in mean wound size and higher proportion of wound healing among patients treated with EpiFix compared with those treated with standard care.[2] A systematic review of randomized clinical trials (RCTs) of skin grafts or tissue replacements for treating foot ulcers in people with diabetes, concluded the incidence of completed closure of diabetic foot ulcers was significantly improved for the skin grafts or substitutes compared with standard care. No specific type of skin graft or tissue replacement showed a superior effect on ulcer healing over another type of skin graft or tissue replacement.[3]

A prospective, randomized, controlled, parallel group, multi-center clinical trial of 60 patients reported that dehydrated human amnion/chorion membrane (i.e., EpiFix) is superior to standard wound care (SWC) and bioengineered skin substitutes (i.e., Apligraf) in achieving complete wound closure within 4–6 weeks.[4] Rates and time to closure at a longer time interval and factors influencing outcomes remained unassessed; therefore, the study was continued in order to achieve at least 100 patients. With the larger cohort, the authors compared clinical outcomes at 12 weeks in 100 patients with chronic lower extremity diabetic ulcers treated with weekly applications of Apligraf (n = 33), EpiFix (n = 32) or standard wound care (SWC) (n = 35) with collagen-alginate dressing as controls. The proportion of wounds achieving complete closure within the 12-week study period were 73% (24/33), 97% (31/32), and 51% (18/35) for Apligraf, EpiFix and SWC, respectively (adjusted P = 0·00019). Subjects treated with EpiFix had a very significant higher probability of their wounds healing compared to SWC alone. Mean time-to-heal within 12 weeks was 47·9 days with Apligraf, 23·6 days with EpiFix group and 57·4 days with the SWC alone group.[1]

The evidence to assess the effectiveness and safety of EpiFix for the treatment of other types of nonhealing wounds, including venous leg ulcers is very limited. A multicenter, randomized, controlled study of 84 patients evaluating the safety and efficacy of one or two applications of dehydrated human amnion/chorion membrane allograft and multilayer compression therapy vs. multilayer compression therapy alone in the treatment of venous leg ulcers reported at 4 weeks, 62% in the allograft group and 32% in the control group showed a greater than 40% wound closure. After 4 weeks, wounds treated with allograft had reduced in size a mean of 48.1% compared with 19.0% for controls. Venous leg ulcers treated with allograft had a significant improvement in healing at 4 weeks compared with multilayer compression therapy alone.[5]

Coding Implications

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CPT codes considered medically necessary per policy criteria when billed with Q4131

CPT® Codes	Description
15275	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area
15276	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)

HCPCS codes considered medically necessary per policy criteria

HCPCS Codes	Description
Q4131	EpiFix or Epicord, per sq cm

ICD-10-CM diagnosis codes that support medical necessity

ICD-10-CM Code	Description
E08.621	Diabetes mellitus due to underlying condition with foot ulcer
E09.621	Drug or chemical induced diabetes mellitus with foot ulcer
E10.621	Type 1 diabetes mellitus with foot ulcer
E11.621	Type 2 diabetes mellitus with foot ulcer
E13.621	Other specified diabetes mellitus with foot ulcer

CPT codes NOT medically necessary when billed with Q4131

CLINICAL POLICY
EpiFix Wound Treatment

CPT® Codes	Description
15277	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children
15278	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed	04/17	04/17

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Important Reminder

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CLINICAL POLICY
EpiFix Wound Treatment

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CENTENE Corporation

Clinical Policy: Non-Myeloablative Allogeneic Stem Cell Transplants

Reference Number: CP.MP.141
Effective Date: 04/17
Last Review Date: 04/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Non-myeloablative allogeneic stem cell transplants (also known as "mini-transplants", "mini-allograft", "transplant lite" or "reduced intensity conditioning transplant") is a therapeutic option for an array of malignant and nonmalignant hematologic diseases. This approach can circumvent the need for high dose conditioning regimens that are associated with organ toxicity and mortality. Non-myeloablative allogeneic stem cell transplants use a reduced intensity protocol and is considered an established alternative. This policy describes the medical necessity requirements for these transplants.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that non-myeloablative allogeneic transplants is **medically necessary** for members who meet all of the following criteria:

- **A.** Candidate for conventional high dose chemotherapy (myeloablative) and allogeneic stem cell transplantation for any of the following diagnoses:
  1. Acute lymphoblastic leukemia
  2. Acute myelogenous leukemia
  3. Aplastic anemia
  4. Chronic lymphoblastic leukemia
  5. Chronic myelogenous leukemia
  6. Congenital immunodeficiency syndromes: molecular remissions induced by Gleevec
  7. Hodgkin's disease: primary refractory or relapsed, including those who have relapsed having an autologous bone marrow transplant
  8. Non-Hodgkin's disease, any of the following:
     - a. Primary refractory or relapsed, including those who have relapsed having an autologous bone marrow transplant
     - b. Follicular lymphomas
     - c. Mantle cell lymphoma
     - d. Diffuse large cell lymphoma
  9. Multiple myeloma
  10. Myelodysplastic syndromes
  11. Neuroblastoma, High Risk
  12. Sickle Cell Anemia
  13. Thalassemia Major
- **B.** Unsuitable for conventional high-dose allografting because of untreatable significant dysfunction of another major organ system and/or severe comorbidities, including any of the following :
  1. Bilirubin > 2 mg/dL
  2. Hemostasis: international normalized ratio (INR) > 1.6 (unless on oral anticoagulants)

3. Cardiac function: multigated acquisition scan (MUGA) or echocardiogram with ejection fraction (EF) < 45%
4. Pulmonary function
   a. Forced expiratory volume in 1 second (FEV1) ≤ 50% of predicted value; or
   b. Diffusing capacity of the lung for carbon monoxide (DLCO) ≤ 50% of predicted value
5. Performance Scale Index
   a. Karnofsky or Lansky score < 70%; or
   b. Eastern Cooperative Oncology Group (ECOG) performance score ≤ 2

C. Does not have ANY of the following absolute contraindications:
1. Chronic infection with highly virulent and/or resistant microbes that are poorly controlled pre-transplant;
2. Current non-adherence to medical therapy or a history of repeated or prolonged episodes of non-adherence to medical therapy that are perceived to increase the risk of non-adherence after transplantation;
3. Psychiatric or psychological condition associated with the inability to cooperate or comply with medical therapy;
4. Absence of an adequate or reliable social support system;
5. Substance abuse or dependence (including tobacco and alcohol) without convincing evidence of risk reduction behaviors, such as meaningful and/or long-term participation in therapy for substance abuse and/or dependence. Serial blood and urine testing may be used to verify abstinence from substances that are of concern.

II. It is the policy of health plans affiliated with Centene Corporation® that non-myeloablative allogeneic transplants are **experimental / investigational** for the following indications:

A. Non-myeloablative allogeneic transplants in patients who do not meet the criteria for high dose chemotherapy and allogeneic stem cell transplants:
1. Less than three years of age;
2. Severe co-morbidities.

B. Treatment for other conditions, including but not limited to the following:
1. Astrocytomas and gliomas
2. Breast cancer
3. Dermatomyositis
4. Diffuse large cell B-cell Non-Hodgkin's disease
5. Ewing sarcoma
6. Germ cell Tumors
7. Idiopathic thrombocytopenic purpura
8. Juvenile rheumatoid arthritis
9. Lupus erythematosus
10. Medulloblastoma
11. Melanoma
12. Multiple sclerosis
13. Osteosarcoma
14. Ovarian epithelia and mixed epitheilia/germ cell cancers
15. Polycythemia vera
16. Polymyositis

17. Ovarian germ cell Tumors
18. Primitive Neuroectodermal Tumors (PNET), including medulloblastoma and ependymoma
19. Renal cell carcinoma
20. Retinoblastoma
21. Rhabdomyosarcoma
22. Severe systemic rheumatoid arthritis, Adult and Juvenile
23. Sarcoma
24. Systemic lupus erythematosus
25. Systemic sclerosis
26. Testicular Cancer
27. Wilms tumor

Background

Allogeneic stem cell transplant (AlloBMT) has been used as a treatment for cancer and diseases of the blood system for many years. For this treatment, stem cells are collected from either related or unrelated donors. During the conditioning phase, high doses of chemotherapy (HDC), with or without radiation therapy, are used to eradicate the disease and this is followed by infusion of an allogeneic stem cell transplantation to rescue bone marrow and restore normal immune function. Major limitations of this technique are the associations with serious side effects and high mortality. All stem cell transplants (SCTs) preparative regimens have the potential for extensive toxicity. Loss of appetite and energy, alopecia, and nausea/vomiting are very frequent and add to poor physical and emotional tolerance of the transplant procedure. In addition, mucositis, diarrhea, and transient pancytopenia are inevitable side effects of most preparative regimens, and these complications are synergistic in dramatically increasing the risk of bacterial and fungal infections. Any decrease in toxicity, without concomitant loss of efficacy, would be desirable.

Myeloablative means that the treatment kills (ablates) the myeloid stem cells in the bone marrow, the cells that produce new blood cells. Several less intense conditioning regimens have been developed recently and rely more on immuno-suppression than cytotoxic effects to permit engraftment of donor cells. These regimens are collectively termed non-myeloablative. Studies have shown that donor allogeneic stem cells can engraft in recipients using less-intensive conditioning regimens that are sufficiently immunosuppressive to permit graft-host tolerance. This manifests as a stable mixed donor-host hematopoietic chimerism, a term which means the coexistence of donor and recipient cells. Once chimerism has developed, a further infusion of donor leukocytes may be given to eradicate malignant cells by inducing a graft vs. tumor effect. Non-myeloablative allogeneic transplants, also referred to as “mini-transplant” or “transplant lite”, are thought to be potentially as effective as conventional HDC followed by an allogeneic stem cell transplantation, but with decreased morbidity and mortality related to the less intense non-myeloablative chemotherapy conditioning regimen. Consequently, for patients with malignancies who are eligible for conventional HDC/AlloBMT, conditioning with milder, non-myeloablative regimens represents a variation of an established procedure.

Coding Implications

CLINICAL POLICY
Non-Myeloablative Allogeneic Stem Cell Transplants

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CPT® Codes	Description
38204	Management of recipient hematopoietic progenitor cell donor search and cell acquisition
38205	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogeneic
38206	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous
38207	Transplant preparation of hematopoietic progenitor cells; cryopreservation and storage
38208	Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, without washing, per donor
38209	Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, with washing, per donor
38210	Transplant preparation of hematopoietic progenitor cells; specific cell deletion within harvest. T-cell depletion
38211	Transplant preparation of hematopoietic progenitor cells; tumor depletion
38212	Transplant preparation of hematopoietic progenitor cells; red blood cell removal
38213	Transplant preparation of hematopoietic progenitor cells; platelet depletion
38214	Transplant preparation of hematopoietic progenitor cells; plasma (volume) depletion
38215	Transplant preparation of hematopoietic progenitor cells; cell concentration in plasma, mononuclear, or buffy coat layer
38230	Bone marrow harvesting for transplantation; allogeneic
38240	Hematopoietic progenitor cell (HPC), allogeneic transplantation per donor

HCPCS Codes	Description
S2142	Cord blood-derived stem cell transplantation, allogeneic
S2150	Bone marrow or blood-derived peripheral stem cells (peripheral orumbilical), allogeneic or autologous, harvesting, transplantation, and related complications; including pheresis and cell preparation/storage, marrow ablative therapy, drugs, supplies, hospitalization with outpatient follow-up, medical/surgical, diagnostic, emergency, and rehabilitative services, and the number of days of pre- and post-transplant care in the global definition

CLINICAL POLICY
Non-Myeloablative Allogeneic Stem Cell Transplants

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
C74.00-C74.02	Malignant neoplasm of adrenal gland
C81.0-C96.9	Malignant neoplasm of lymphoid, hematpoietic and related tissue
D46.0-D46.9	Myeloplastic syndromes
D56.0D56.9	Thalassemia
D57.00-D57.819	Sickle-cell disorders
D61.01-D61.09	Constitutional aplastic anemia
Z51.11	Encounter for antineoplastic chemotherapy
Z94.84	Stem cells transplant status

Reviews, Revisions, and Approvals	Date	Approval Date
Policy adopted from HN version	03/17	4/17

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Important Reminder

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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CENTENE Corporation

Clinical Policy: Urinary Incontinence Devices and Treatments

Reference Number: CP.MP.142
Effective Date: 04/17
Last Review Date: 04/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Sacral neuromodulation (SNM) or sacral nerve stimulation (SNS) refers to stimulation of nerves that innervate the bladder and pelvic floor to treat lower urinary tract dysfunction. SNS involves both a temporary test stimulation to determine if an implantable stimulator would be effective, and a permanent implantation in appropriate candidates.

Urethral bulking agents (UBAs) are injectable substances used to increase tissue bulk, which can be injected periurethrally to treat urinary incontinence. The U.S. Food and Drug Administration (FDA) has approved several bulking agent products for treating urinary incontinence.

Note: For biofeedback treatment for urinary incontinence, please refer to CP.MP.168 Biofeedback.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that SNM is **medically necessary** to treat lower urinary tract dysfunction when all of the following criteria are met:
- **A.** Symptoms of incontinence have been present for at least 12 months and have resulted in significant disability, such as the limited ability to work or participate in activities outside of the home;
- **B.** Diagnosis is non-obstructive urinary retention;
- **C.** Incontinence is not related to a neurologic condition;
- **D.** Conservative measures such as bladder training, pelvic floor physical therapy with biofeedback, and pharmacologic treatment have failed;
- **E.** A percutaneous stimulation test has provided a 50% reduction in incontinence symptoms prior to permanent device implantation.

II. It is the policy of health plans affiliated with Centene Corporation that injection of U.S. FDA approved UBAs is **medically necessary** when all of the following criteria are met:
- **A.** Diagnosis of persistent or recurrent stress urinary incontinence due to intrinsic sphincter deficiency, or post traumatic or surgical injury;
- **B.** Conservative management such as Kegel exercises, biofeedback, electrical stimulation, and pharmacotherapies have failed;
- **C.** Patient is unable to tolerate surgery.

*A recurrence of incontinence following a successful treatment series (i.e., 6-12 months previously, may benefit from additional treatments). [10]

III. It is the policy of health plans affiliated with Centene Corporation that UBA is considered **investigational** for autologous fat injection, procedures that are not FDA approved, and for any other circumstances than those specified above.

Background

The three major categories of treatment for urinary incontinence are behavioral, pharmacologic and surgical. The first choice should be the least invasive treatment with the fewest potential adverse complications for the patient. Before treatment begins, a complete evaluation and appropriate urodynamic testing should be completed.

Sacral neuromodulation

SNM, a minimally invasive form of electrical stimulation, is delivered via the InterStim system. This implantable system involves chronic modulation of the S3 and, less frequently, the S4 nerve via a transforaminal route. A wire lead in the foramen is connected to a stimulation device. Modulation implies that the therapy is thought to act indirectly, via a central afferent mechanism, targeting reflex centers in the spinal cord and pons, influencing reflexes between the bladder, urethral sphincter, and pelvic floor. Stimulation implies a more direct effect on efferent nerves, as in functional electrical stimulation.

A distinct advantage of sacral neuromodulation is that it is tested for potential success prior to moving on to long-term therapy. The evaluation gives patients and physicians an opportunity to find out in as few as 3 to 7 days whether adequate symptom reduction is achieved. The most common adverse events experienced during clinical studies of patients with SNM included pain at implant sites, new pain, lead migration, infection, technical or device problems, adverse change in bowel or voiding function, and undesirable stimulation or sensations. Any of these may require additional surgery or cause return of symptoms.

In the United States, SNM is approved for the treatment of nonobstructive urinary retention. Success rates in general are not as promising as for urgency urinary incontinence and overactive bladder, but it is reasonable to try prior to more invasive and permanent solutions.

A prospective study has demonstrated that sacral nerve stimulation for refractory urinary urge incontinence had a positive benefit of 30.8 months.[8] A meta-analysis noted that sacral neuromodulation is an effective therapy for the treatment of nonobstructive urinary retention.[12] A prospective, randomized, multicenter trial demonstrated that SNM has shown to be a safe and effective treatment for overactive bladder (OAB) patients with mild to moderate symptoms. In studies comparing patients who received SNM with patients who delayed implantation and continued standard management, those with SNM experienced significant improvements in quality of life.[5,6]

American Urologic Association

Clinicians may offer SNM as third-line treatment in a carefully selected patient population characterized by severe refractory OAB symptoms or patients who are not candidates for second-line therapy and are willing to undergo a surgical procedure. Recommendation (Grade C; benefits outweigh risk/burdens).[5]

National Institute for Clinical Excellence
SNS can be recommended for those with urge incontinence and urgency-frequency when the patient understands what is involved and agrees to the treatment. SNS should only be tried when other treatments for incontinence have been unsuccessful, changes in daily lives have been made, or learning techniques to help control the bladder, have been put in place. [11]

Periurethral Bulking Agents
UBA therapy, also known as periurethral injection therapy, is rarely used as a primary treatment for stress urge incontinence (SUI) but remains an option for women with persistent/recurrent SUI who are unable to tolerate surgical procedure. Although UBA is an option for this type of incontinence, it can be more invasive and usually requires repeat injections. The most common complications associated with UBA are urinary retention and urinary tract infection, but these are easily managed.[3 4 9 10]

Candidates for periurethral bulking agents also include women with intrinsic sphincter deficiency and men who are incontinent after prostate surgery. UBA used to treat intrinsic sphincteric deficiency is being performed less frequently in current practice. Surgical interventions are generally more efficacious in both, whereas injectable therapy can be considered in cases in which surgery is contraindicated or as an adjunct to surgery if symptoms persist. In women with severe intrinsic sphincter deficiency or urethral hypermobility, the best long-term results are obtained with a pubovaginal sling or retropubic bladder neck suspension procedure.[3 4 9 10]

U.S. FDA approved products for periurethral injection therapy include:
- Carbon-coated zirconium oxide beads suspended in a water-based gel (Durasphere EXP, FDA approved 1999)
- Crosslinked polydimethylsiloxane (Macroplastique, FDA approved 10/30/2006)
- Calcium hydroxylapatite suspended in a water and glycerin gel (Coaptite, 11/10, 2005)

Evidence in major reviews shows low efficacy rates compared with surgical incontinence therapies, a need for repeat treatments because of symptom recurrence, and problems with the injection of some synthetic agents.

Currently, there has been increased interest in autologous skeletal muscle derived stem cell injections for the treatment of SUI specifically due to intrinsic urinary incontinence. This therapy involves obtaining a biopsy of the patient's skeletal muscle, which is then processed ex vivo to ensure a large quantity of myogenic cells in the product. The product is then injected into the urethral sphincter, transurethrally or periurethrally. Additional peer-reviewed studies are necessary to confirm the efficacy of this treatment. [3]

Coding Implications
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CPT® Codes	Description
51715	Endoscopic injection of implant material into the submucosal tissue of the
64561	Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including image guidance, if performed
64581	Incision for implantation of neurostimulator electrode array; sacral nerve (transforaminal placement)

HCPCS Codes	Description
L8603	Injectable bulking agent, collagen implant, urinary tract, 2.5 ml syringe, includes shipping and necessary supplies
L8606	Injectable bulking agent, synthetic implant, urinary tract, 1 ml syringe, includes shipping and necessary supplies

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
N32.81	Overactive bladder
N36,42	Intrinsic sphincter deficiency (ISD)
N39.3	Stress incontinence (female) (male)
N39.41	Urge incontinence
R33.8	Other retention of urine

Reviews, Revisions, and Approvals	Date	Approval Date
Policy adopted from Health Net NMP#215, Urinary Incontinence Devices and Treatments. Formerly, up to 5 UBA treatments were noted as covered, and beyond that would be considered a treatment failure. However, since this specific information could not be found in references, it was removed.	04/17	04/17
Added note to refer to CP.MP.168 Biofeedback for criteria related to biofeedback for urinary incontinence.	06/17	

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Important Reminder

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CENTENE Corporation

Clinical Policy: Wireless Motility Capsule

Reference Number: CP.MP.143
Effective Date: 04/17
Last Review Date: 04/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

The wireless motility capsule (WMC) assesses gastroparesis or delayed gastric emptying. The WMC is an orally ingested, nondigestible, data recording device that enables the simultaneous assessment of regional and whole gut transit.

Policy/Criteria

It is the policy of health plans affiliated with Centene Corporation® that WMC is **not medically necessary** for the evaluation of suspected gastric and intestinal motility disorders, as well as all other indications. There is a paucity of peer-reviewed, evidence-based literature to determine that the diagnostic performance and clinical utility surpass conventional means of measuring gastric emptying.

Background

The U.S. Food and Drug Administration approved WMC for the evaluation of patients with suspected gastroparesis, even though there is no sign of a blockage. The WMC, which is a 26 x 13 mm size capsule with a battery life of five days, is also proposed to evaluate colonic transit time in patients with chronic idiopathic constipation; in addition, it is noted to continuously measure the temperature, pH, and pressure of its surrounding environment while traveling through the gastrointestinal tract, via gut peristalsis, until exiting the body through the anus.[6]

After eating a standard meal, the member swallows the capsule and wears a small monitor that makes telemetry recordings. The established cutoff point for gastric emptying time is 300 minutes. Gastric emptying of the WMC seems to occur with the Phase III migrating motor complex, signifying completion of postprandial phase and return of the fasting state. It assesses small bowel transit time by a sharp increase in pH on entry into duodenum and by a fall in pH at the ileocecal junction. However, in 15% of patients, this pH drop is not observed and this may be related to the ileocecal valve incompetence.[6] An example of a wireless GI motility monitoring system is the SmartPill GI monitoring system 2.0.

Advantages of the WMC include that it is wireless and painless and contains no radiation. Disadvantages of the capsule include failure to capture data which would require repeat testing; and delay or total failure to pass the capsule, requiring serial x-rays to document passage or endoscopic or surgical removal. Another disadvantage is that it should not be used in patients with a possible stricture, altered anatomy, or severe pyloric stenosis.[9] Patients ideally should be able to tolerate not using proton pump inhibitors and histamine 2 blockers before testing.[8]

Agency for Healthcare Research and Quality

Based on current literature, the WMC appears to be accurate in detection of gastroparesis and slow-transit constipation and may provide increased diagnostic gain as compared with standard

motility testing. However, evidence is insufficient to determine whether use of the WMC will improve outcomes of care. One goal would be to define the populations who would benefit most from motility testing, including WMC testing.[9]

American College of Gastroenterology
Guideline for management of gastroparesis indicates that WMC requires further validation before it can be considered as an alternative to scintigraphy for diagnosis of gastroparesis.[3]

American Journal of Gastroenterology
Alternative approaches for assessment of gastric emptying include wireless capsule motility testing and 13 C breath testing using octanoate or spirulina incorporated into a solid meal; they require further validation before they can be considered as alternates to scintigraphy for diagnosis of gastroparesis.[2] (Conditional recommendation, moderate level of evidence)

BlueCross BlueShield Association Technology Evaluation Center
This society concluded that the WMC does not meet the TEC criteria, but that the limited body of evidence on the diagnostic characteristics of SmartPill does reveal correlations between SmartPill and other tests that indicate some capability to distinguish diseased from non-diseased persons.[2]

American and European Neurogastroenterology and Motility Societies
Tests of gastrointestinal transit are available and useful in the evaluation of patients with symptoms suggestive of gastrointestinal dysmotility, since they can provide objective diagnosis and a rational approach to patient management.[4]

Studies note that WMC is comparable in accuracy to current modalities in use for detection of slow-transit constipation and gastric emptying delay, and is therefore another viable diagnostic modality. However, little data are available to determine the optimal timing of this device for diagnostic algorithms.[12]

Other studies have noted that the sensitivity and specificity of the WMC is comparable to radiopaque marker test and scintographic gastric emptying. WMC is well tolerated, has good compliance, and avoids the risk of radiation exposure. However, it is not clear that it provides added clinical value in most patients. [6, 8, 10]

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CLINICAL POLICY
Wireless Motility Capsule

CPT® Codes	Description
91112	Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report

HCPCS Codes	Description
N/A	

ICD-10-CM Diagnosis Codes Related to Procedure

ICD-10-CM Code	Description
K31.84	Gastroparesis
K59.01	Slow transit constipation
K59.04	Chronic idiopathic constipation

Reviews, Revisions, and Approvals	Date	Approval Date
New payment policy developed.	04/17	04/17

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CENTENE Corporation

Clinical Policy: Mechanical Stretching Devices for Joint Stiffness and Contracture

Reference Number: CP.MP.144
Effective Date: 04/17
Last Review Date: 04/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Mechanical stretching devices are used for the prevention and treatment of joint contractures of the extremities, with the goal to maintain or restore range of motion (ROM) to the joint. A variety of mechanical stretching devices are available for extension or flexion of the shoulder, elbow, wrist, fingers, knee, ankle, and toes. These devices are generally used as adjunct treatment to physical therapy and/or exercise.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that the low-load prolonged-duration stretch (LLPS) device /dynamic stretch device is **medically necessary** for rehabilitation of extensor tendon injury of the finger.

II. It is the policy of health plans affiliated with Centene Corporation that the LLPS device for any other indication or any other joint is considered not medically necessary.

III. It is the policy of health plans affiliated with Centene Corporation that static progressive (SP) stretch devices and the patient-actuated serial stretch (PASS) device for any indication are considered not medically necessary.

Background

A joint contracture is characterized by a chronically reduced ROM secondary to structural changes in non-bony tissues, including muscle, tendons, ligaments, and skin. Prolonged immobilization of joints following surgery or trauma is the most common cause of joint contractures. A number of different modalities are used to treat or prevent joint contractures.

Mechanical stretching devices have been investigated for the treatment of joint contractures. The use of these devices is based on the theory that passive motion early in the healing process can promote movement of the synovial fluid, and thus promote lubrication of the joint; stimulate the healing of articular tissues; prevent adhesions and joint stiffnes; and reduce edema without interfering with the healing of incisions or wounds over the moving joint.

Several types of devices exist, including low-load prolonged duration stretch devices (also referred to as dynamic splinting), static progressive stretch devices, and patient-actuated serial stretch (PASS) (also known as patient-directed serial stretch) devices. LLPS devices permit resisted active and passive motion (elastic traction) within a limited range. LLPS devices maintain a set level of tension by means of incorporated springs. PASS devices permit resisted active and passive motion within a limited range utilizing pneumatic or hydraulic systems that can be adjusted by the patient. The extensionaters use pneumatic systems while the flexionaters

use hydraulic systems. These devices require custom fitting. SP stretch devices hold the joint in a set position but allow for manual modification of the joint angle and may allow for active motion without resistance (inelastic traction). This type of device itself does not exert a stress on the tissue unless the joint angle is set at the maximum ROM.

Dynamic splinting is commonly used in the post-operative period for the prevention or treatment of motion stiffness/loss in the knee, elbow, wrist or finger. Peer reviewed studies investigating dynamic splinting are limited. The best evidence is available in studies evaluating LLPS following extensor injury. Results from a small, prospective, randomized trial comparing dynamic splinting to static splinting suggest that dynamic splinting of complex lacerations of the extensor tendons in zones V-VII provides improved functional outcomes at 4 and 12 weeks and 6 months when compared with static splinting.[1] Another small, prospective, randomized, controlled study comparing postoperative dynamic- versus static- splinting outcomes of patients following extensor tendon repair reported dynamic splinting of simple, complete lacerations of the extensor tendons in zones V and VI. Dynamic splinting provided improved functional outcomes at 4, 6, and 8 weeks but not by 6 months when compared with static splinting.[2]

Limited evidence suggests that LLPS following surgical extensor injury repair may increase range of motion faster than static splinting. However, the treatment benefit is small and the final outcome is similar to that achieved with static splinting.

There is insufficient evidence in the published medical literature to demonstrate the safety, efficacy, and long-term outcomes on the use of static progressive stretch and patient-actuated serial stretch devices, as well as low-load prolonged stretch devices for other joints, including but not limited to, the hand, wrist, elbow, shoulder, toes, and knee.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes considered medically necessary when meeting policy criteria

HCPCS Codes	Description
E1825	Dynamic adjustable finger extension/flexion device, includes soft interface material

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
M24.541 – M24.549	Contracture, hand
M25.641 - M25.649	Stiffness of hand, not elsewhere classified
M84.441S	Pathological fracture, right hand, sequela

ICD-10-CM Code	Description
M84.442S	Pathological fracture, left hand
M84.443S	Pathological fracture, unspecified hand, sequela
M84.444S	Pathological fracture, right finger(s), sequela
M84.445S	Pathological fracture, left finger(s), sequela
M84.446S	Pathological fracture, unspecified finger(s), sequela
S61.001A - S61.459S	Open wound of fingers and hands
S62.201A - S62.92XS	Fracture of hand
S63.101A - S63.106S	Unspecified subluxation and dislocation of thumb
S63.111A - S63.116S	Subluxation and dislocation of metacarpophalangeal joint of thumb
S63.121A - S63.126S	Subluxation and dislocation of unspecified interphalangeal joint of thumb
S63.131A - S63.136S	Subluxation and dislocation of proximal interphalangeal joint of thumb
S63.141A - S63.146S	Subluxation and dislocation of distal interphalangeal joint of thumb
S63.200A- S63.209S	Unspecified subluxation of other finger
S63.210A - S63.219S	Subluxation of metacarpophalangeal joint of finger
S63.220A - S63.229S	Subluxation of unspecified interphalangeal joint of finger
S63.230A - S63.239S	Subluxation of proximal interphalangeal joint of finger
S63.240A - S63.249S	Subluxation of distal interphalangeal joint of finger
S63.250A - S63.259S	Unspecified dislocation of other finger
S63.260A - S63.269S	Dislocation of metacarpophalangeal joint of finger
S63.270A - S63.279S	Dislocation of unspecified interphalangeal joint of finger
S63.280A - S63.289S	Dislocation of proximal interphalangeal joint of finger
S63.290A - S63.299S	Dislocation of distal interphalangeal joint of finger
S66.011A - S66.019S	Strain of long flexor muscle, fascia, and tendon of thumb at wrist and hand level
S66.021A – S66.029S	Laceration of long flexor muscle, fascia, and tendon of thumb at wrist and hand level

ICD-10-CM Code	Description
S66.091A - S66.099S	Other specified injury of long flexor muscle, fascia, and tendon of thumb at wrist and hand level
S66.110A - S66.119S	Strain of flexor muscle, fascia, and tendon of other and unspecified finger at wrist and hand level
S66.120A - S66.129S	Laceration of flexor muscle, fascia, and tendon of other and unspecified finger at wrist and hand level
S66.190A – S66.199S	Other injury of flexor muscle, fascia, and tendon of other and unspecified finger at wrist and hand level
S66.211A - S66.219S	Strain of extensor muscle, fascia and tendon of thumb at wrist and hand level
S66.221A - S66.229S	Laceration of extensor muscle, fascia and tendon of thumb at wrist and hand level
S66.291A - S66.299S	Other specified injury of extensor muscle, fascia and tendon of thumb at wrist and hand level
S66.300A - S66.309S	Unspecified injury of extensor muscle, fascia and tendon of other and unspecified finger at wrist and hand level
S66.310A - S66.319S	Strain of extensor muscle, fascia and tendon of other and unspecified finger at wrist and hand level
S66.320A - S66.329S	Laceration of extensor muscle, fascia and tendon of other and unspecified finger at wrist and hand level
S66.390A - S66.399S	Other injury of extensor muscle, fascia and tendon of other and unspecified finger at wrist and hand level
S66.401A - S66.499S	Injury of intrinsic muscle, fascia and tendon of thumb at wrist and hand level
S66.500A - S66.599S	Injury of intrinsic muscle, fascia and tendon of other and unspecified finger at wrist and hand level
S67.00XA-S67.92XS	Crushing injury of wrist, hand and fingers

HCPCS Codes considered NOT medically necessary per this policy

HCPCS Codes	Description
E1800	Dynamic adjustable elbow extension/flexion device, includes soft interface material
E1801	Static progressive stretch elbow device, extension and/or flexion, with or without range of motion adjustment, includes all components and accessories
E1802	Dynamic adjustable forearm pronation/supination device, includes soft interface material
E1805	Dynamic adjustable wrist extension/flexion device, includes soft interface material
E1806	Static progressive stretch wrist device, flexion and/or extension, with or without range of motion adjustment, includes all components and accessories
E1810	Dynamic adjustable knee extension/flexion device, includes soft interface material

CLINICAL POLICY
Mechanical Stretching Devices for Joint Stiffness and Contracture

HCPCS Codes	Description
E1811	Static progressive stretch knee device, extension and/or flexion, with or without range of motion adjustment, includes all components and accessories
E1812	Dynamic knee, extension/flexion device with active resistance control
E1815	Dynamic adjustable ankle extension/flexion device, includes soft interface material
E1816	Static progressive stretch ankle device, flexion and/or extension, with or without range of motion adjustment, includes all components and accessories
E1818	Static progressive stretch forearm pronation/supination device, with or without range of motion adjustment, includes all components and accessories
E1830	Dynamic adjustable toe extension/flexion device, includes soft interface material
E1831	Static progressive stretch toe device, extension and/or flexion, with or without range of motion adjustment, includes all components and accessories
E1840	Dynamic adjustable shoulder flexion/abduction/rotation device, includes soft interface material
E1841	Static progressive stretch shoulder device, with or without range of motion adjustment, includes all components and accessories

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed	04/17	04/17

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CENTENE Corporation

Clinical Policy: Electric Tumor Treating Fields (Optune)

Reference Number: CP.MP.145
Effective Date: 05/17
Last Review Date: 06/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Electric tumor treating fields (TTF), also known as alternating electric field therapy, are used for the treatment of glioblastoma, and are delivered by Optune® (NovoCure™), a portable medical device that generates low-intensity electric fields termed Tumor Treating Fields. TTF are believed to disrupt the rapid cell division exhibited by cancer cells, with the alternating electrical fields applied to the brain through electrodes placed on the scalp. The device is worn by the patient throughout the day and attached to the head by electrodes which creates a low intensity, alternating electric field within the tumor that exerts physical forces on electrically charged cellular components, preventing the normal mitotic process and causing cancer cell death prior to division.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that TTF therapy is **medically necessary** for the following indication:
- A. New diagnosis of glioblastoma, histologically confirmed, and all of the following:
  1. Glioblastoma is in the supratentorial region;
  2. Member has good performance status, as defined by a Karnofsky Performance Status rating of ≥ 60;
  3. Alternating electric field therapy will be delivered in conjunction with temozolomide after standard surgical and radiation therapies have been completed.
- B. Recurrent glioblastoma, histologically- or radiologically- confirmed and all of the following:
  1. Glioblastoma is in the supratentorial region;
  2. Alternating electric field therapy will be used as a monotherapy, after standard treatment with surgery, radiation, and chemotherapy.

II. It is the policy of health plans affiliated with Centene Corporation® that TTF therapy is **investigational and not medically necessary** for all other indications.

III. It is the policy of health plans affiliated with Centene Corporation® that computer mapping software (NovoTal™) for planning TTF therapy is **investigational and not medically necessary** for all indications, as there is insufficient evidence to establish the efficacy of these products in the long-term outcomes of patients receiving TTF therapy.

Background

Optune Product Description[1]

Optunformerly NovoTTF-100A) produces alternating electrical fields within the human body that disrupt the rapid cell division exhibited by cancer cells, with the alternating electrical fields applied to the brain through transducer arrays placed on the scalp. Electric TTF alter the tumor

cell polarity at an intermediate frequency (on the order of 100-300 kHz). The frequency used for a particular treatment is specific to the cell type being treated (e.g., 200kHz for GBM). In contrast, the TTF have not been shown to have an effect on cells that are not undergoing division. Since most normal adult brain cells proliferate very slowly, if at all, they are hypothesized to be little affected by the TTF. Testing demonstrates no differences between treated and control animals in histology of the major internal organs (including the brain), blood examination, cardiac rhythm, body temperature, or in animal behavior. In addition, because the fields alternate so rapidly, they have no effect on normal quiescent cells nor do they stimulate nerves and muscles. It is noted that, because TTF are only applied to the brain, they have no effect on rapidly proliferating cells in the rest of the body. The intensities of the electric fields within the tissues are very small and do not result in any meaningful increase in tissue temperature. Thus, TTF application has the advantage of being highly selective and is not expected to be associated with significant toxicity.

Position Statement
In its 2016 Update of guidelines for central nervous system cancers, the National Comprehensive Cancer Network (NCCN) added alternating electrical fields therapy as a recommended (2A-uniform consensus, based on low-quality evidence) treatment option for newly diagnosed glioblastoma. The NCCN guidelines state TTF is recommended "for patients with good performance status and either methylated or unmethylated/indeterminate MGMT promoter status," in conjunction with standard brain radiation therapy plus concurrent temozolomide and adjuvant temozolomide.[2] For recurrent glioblastoma, NCCN gives alternating electrical field therapy a 2B rating (consensus based on low-quality evidence).[2]

Evidence for Optune
Initial FDA approval for recurrent glioblastoma was based on Stupp et al.'s 2012[3] phase III clinical trial that randomized 237 patients to chemotherapy-free treatment of NovoTTF (20-24h/day) versus active chemotherapy in the treatment of patients with recurrent glioblastoma[5]. Primary end-point was improvement of overall survival. Patients were randomized to TTF alone or active chemotherapy control. Responses were more common in the TTF arm (14% versus 9.6%, p=0.19) and TTF-related adverse events were mild. Quality of life analyses favored TTF therapy in most domains. The investigators concluded that no improvement in overall survival was demonstrated. However, efficacy and activity with this chemotherapy-free treatment device appears comparable to chemotherapy regimens that are commonly used for recurrent glioblastoma. Toxicity and quality of life measures favored TTF.

The FDA based its approval[4] of the newly diagnosed glioblastoma indication of the Optune device on results from a 2015 clinical trial by Stupp et al.[5]. The EF-14 trial included 695 patients newly diagnosed with GB, and compared those who used Optune with temozolomide to those receiving temozolomide alone. Patients who used the device along with temozolomide lived, on average, about seven months with no disease progression compared to four months for those who had the drug alone. The Optune plus temozolomide group survived for an average of 19.4 months after starting treatment compared to 16.6 months for those who were treated with only temozolomide[5]. One critique of this study is that the study was terminated at the pre-planned intermediate analysis due to success of the TTF treatment, With the newly diagnosed glioblastoma indication, Optune can be used for GBM before the disease progresses. For newly

diagnosed GBM, Optune is not intended to be used as a substitute for standard treatments, but rather as an adjunct therapy, and should not be used without a physician's supervision.

Hayes conducted a review of the available literature on TTF, noting that overall the body of evidence was of fair to very poor quality, although it was consistently positive.[6] Hayes found the evidence to be stronger for the use of TTF for recurrent disease as opposed to newly diagnosed disease, as there were more supportive studies for recurrent disease at the time of publication (2 vs. 6). Out of the 10 studies they reviewed, pertaining to the use of TTF in patients with GBM and select other cancers, two were of fair quality, and the other eight ranged from poor quality to very poor quality. The two fair quality trials were those conducted by Stupp et al. in 2012[5] and 2015[4], although these were noted to have limitations such as lack of a sham intervention and significant loss to follow up (22% and 20%, respectively)[6].

A post-hoc analysis of Stupp et al.'s E-14 trial of TTF plus temozolomide versus temozolomide alone in newly diagnosed glioblastoma compared the efficacy of TTF plus physician's choice of chemotherapy versus chemotherapy alone after first recurrence[7]. Median overall survival in the TTF plus chemotherapy was 11.8 months versus 9.2 months for the chemotherapy only group ($p=.049$)[7]. TTF demonstrated low toxicity, consistent with previous studies. Limitations of this analysis are its post-hoc nature, as well as the crossover of 13 patients from the temozolomide only group to the TTF plus chemo group after approval and commercial availability of TTF for recurrent GBM[7].

Vymazal et al.[8] analyzed the response patterns in individuals who exhibited an objective response to TTF in two previous studies in order to evaluate the baseline characteristics of those individuals who responded and to evaluate the relationship between compliance with use and efficacy outcomes. The analysis was completed on one pilot study (n=10) and a phase III trial (n=237) in which TTF was compared to standard chemotherapy. Between both studies, TTF was administered as monotherapy in 130 individuals. Across both trials, there was a 15% response rate (16/110 with a 4% complete response rate)[8]. There were no significant differences in baseline characteristics between the responder and nonresponder groups. In those in which a response was noted, there was frequently a delayed response; the tumor would initially continue to grow before responding to treatment. Analysis supported that an increase in compliance was associated with better treatment response and longer OS. The extent of treatment response in those who exhibited a response was dependent on compliance ($p<0.001$)[8].

Although Optune is promising for the treatment of newly diagnosed glioblastoma, there is insufficient evidence to promote it as standard of care at this time. Evidence is stronger for recurrent glioblastoma which has been previously treated with radiation, surgery and chemotherapy.

NovoTal
The NovoTal system (Novocure) is a computer software planning tool that helps direct placement of transducer arrays for TTF therapy. Few studies have evaluated outcomes of TTF planned by physicians with and without the use of NovoTal, and these are limited to a case series, physician use study, and two review articles. Additionally, many of the authors reported ties to Novocure.

Coding Implications
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HCPCS Codes	Description
A4555	Electrode/transducer for use with electrical stimulation device used for cancer treatment, replacement only
E0766	Electrical stimulation device used for cancer treatment, includes all accessories, any type

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
C71.0 - C71.9	Malignant neoplasm of brain [supratentorial glioblastomas (WHO grade IV astrocytomas)]

Reviews, Revisions, and Approvals	Date	Approval Date
Policy adopted from Health Net Electric Tumor Treating fields policy.	04/17	05/17
Added new diagnosis of glioblastoma as medically necessary.	06/17	06/17

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Important Reminder

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CLINICAL POLICY
Electric Tumor Treating fields

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Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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CENTENE Corporation

Clinical Policy: Sclerotherapy for Varicose Veins

Reference Number: CP.MP.146
Effective Date: 06/17
Last Review Date: 05/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Sclerotherapy is a minimally invasive procedure to diminish abnormally dilated and symptomatic veins. In this procedure, liquid or foam irritants are injected into unwanted veins, causing their eventual reduction. This policy describes the medical necessity requirements for sclerotherapy.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that sclerotherapy is **medically necessary** for the following indications:

A. Symptomatic varicose veins, including all of the following criteria:
   1. Ultrasound-documented saphenous varicosities at the saphenofemoral junction or saphenopopliteal junction, including both of the following:
      a. Junctional reflux ≥ 500 milliseconds;
      b. Vein size ≥ 2.5 mm;
   2. Complications attributed to the varicosities, including any of the following:
      a. Intractable ulceration;
      b. Hemorrhage or recurrent bleeding episodes from a ruptured varicosity;
      c. Recurrent superficial thrombophlebitis;
      d. Severe and persistent pain and swelling, including both of the following:
         i. Duration ≥ 6 months;
         ii. Failure of ≥ 3 weeks prescription dose analgesic medications for pain;
   3. Does NOT include any of the following contraindications:
      a. Allergy to sclerotherapy agent;
      b. During pregnancy and for 3 months after delivery;
      c. Acute febrile illness;
      d. Local or general infection;
      e. Severe distal arterial occlusive disease (ankle-brachial index 0.4 or less);
      f. Critical limb ischemia, arterial ulcer(s), gangrene;
      g. Obliteration of deep venous system;
      h. Recent deep venous thrombosis;
      i. Acute deep venous thrombophlebitis or acute superficial thrombophlebitis;
      j. Inability to ambulate;
      k. Tortuosity of the great saphenous vein severe enough to impede catheter placement.

II. It is the policy of health plans affiliated with Centene Corporation® that sclerotherapy is **not medically necessary** for any of the following indications:

A. Asymptomatic varicose veins
   1. Superficial reticular veins and/or telangiectasias;

B. For the treatment of all other conditions than those specified above.

Background

Varicose veins can cause significant pain and discomfort, superficial thrombophlebitis, bleeding, and ulceration. As such, the management of chronic venous insufficiency, including symptomatic varicosities, can have a substantial negative impact on quality of life.[1] The pathophysiology that leads to these varicosities include inadequate muscle pump function, incompetent venous valves (reflux), and venous obstruction.[2]

According to clinical practice guidelines by the Society for Vascular Surgery and the American Venous Form, sclerotherapy is a recommended treatment option for varicose veins.[4] Sclerotherapy is a minimally invasive and cost effective procedure used to treat varicose veins. To perform this procedure, chemical irritants are injected into the unwanted vein to close varicosities. Destruction of venous endothelial cells and the formation of a fibrotic obstruction facilitate the venous closure due to injection of sclerosing agents. Liquid and foam sclerotherapy are the two predominant modalities for the introduction of sclerosing agents; examples of such sclerosing agents include osmotic, alcohol and detergent agents.[3,4] A systemic review by Tisi *et al* evaluated 17 randomized controlled trials, and concluded that choice of sclerosing agents, dose, formulation (foam versus liquid), among other factors lack a significant effect on the efficacy of sclerotherapy for varicose veins.[7]

Coding Implications

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CPT® Codes	Description
36470	Inj sclerosing solution; sngl vein
36471	Inj sclerosing solution; mx veins same leg

Reviews, Revisions, and Approvals	Date	Approval Date
New policy	05/17	06/17

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CENTENE Corporation

Policy: Percutaneous Left Atrial Appendage Closure Device for Stroke Prevention

Reference Number: CP.MP.147
Effective Date: 07/17
Last Review Date: 07/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Atrial fibrillation (AF) is the most commonly encountered sustained tachyarrhythmia and is associated with a 5-fold increased risk of stroke, and stroke risk increases with age.[1] Among patients with non-valvular AF, the vast majority of thrombus material is located within or involves the left atrial appendage (LAA). Most patients with atrial fibrillation should receive anticoagulant therapy to reduce the risk of systemic embolization. However, not all individuals are candidates for this therapy. LAA occlusion devices have been investigated as an alternative to pharmacological therapy to reduce the risk of stroke in these individuals.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that the WATCHMAN™ LAA Closure Technology for occlusion of the LAA is **medically necessary** to reduce the risk of stroke in adults with non-valvular AF when both of the following criteria are met:
- **A.** There is an increased risk for stroke and systemic embolism based on CHADS2 or CHA2DS2-VASc scores and anticoagulation therapy is recommended; and
- **B.** Failure and/or contraindications to oral anticoagulants such as warfarin, factor Xa inhibitors, and direct thrombin inhibitors (e.g., allergic reactions, severe liver disease, recent trauma or surgery, severe high blood pressure, active bleeding, inability to obtain regular INR, etc.)

II. It is the policy of health plans affiliated with Centene Corporation that all other percutaneous devices for occlusion of the LAA to reduce the risk of stroke in adults with non-valvular atrial fibrillation (other than the WATCHMAN LAA Closure Technology noted above), are considered **investigational.** There is a paucity of evidence regarding the long-term safety and efficacy of these devices and at this time, no other percutaneous device is FDA approved for this indication.

Background

The individualized assessment of the risk-benefit balance is central to decision making around pharmacotherapy for stroke reduction in AF. To estimate stroke risk, the ACC/American Heart Association/HRS Guideline for the Management of Patients with Atrial Fibrillation recommends the use of the CHA2DS2-VASc point score [Congestive heart failure, Hypertension, Age $\geq$75 years (doubled), Diabetes mellitus, prior Stroke, transient ischemic attack, or thromboembolism (doubled), Vascular disease, Age 65 to74 years, Sex category), which provides an estimate of the potential benefits of therapy. Per the guideline, oral anticoagulation is a class I recommendation for patients with prior stroke, transient ischemic attack (TIA), or a CHA2DS2-VASc score $\geq$ 2 (estimated annual stroke risk of 2.2%) in the context of shared decision making, including a discussion of risks of stroke and bleeding, and the patient's preferences.[2]

Some patients with AF, whose stroke risk profiles would favor anticoagulation, have relative or absolute contraindications to anticoagulation. Others are unable or unwilling to adhere to long-term anticoagulation therapy. As a result, a number of percutaneous techniques that mechanically prevent embolization of LAA thrombi, often referred to as LAA exclusion procedures, have been investigated as an alternative to pharmacological therapy to reduce the risk of stroke. The percutaneous devices include two broad categories: endocardial plug devices to occlude the ostium of the LAA and epicardial LAA ligation procedures to exclude the LAA.

At this time, only the WATCHMAN LAA Closure Technology (Boston Scientific Corporation) has been evaluated in randomized controlled trials compared with the current standard of care. This device has received approval by the Food and Drug Administration (FDA) as an alternative to warfarin for stroke prevention. The WATCHMAN device is deployed percutaneously via transseptal puncture and has a polyethylene membrane that covers a self-expanding nitinol cage with barbs to anchor the device in the LAA. The early findings for the WATCHMAN device suggest noninferiority to warfarin for the composite endpoint of stroke, systemic embolism, and cardiovascular death; however, early adverse events occur in approximately 10% of patients, including pericardial bleeding. Longer-term follow-up of the WATCHMAN device at 1588 patient-years suggests noninferiority of this device to warfarin.[3] A subsequent registry study demonstrated that the WATCHMAN device achieved noninferiority in patients who could not receive warfarin.[4] Quality of life was assessed in a subset of patients (361device and 186 warfarin patients) enrolled in the PROTECT AF (Percutaneous Closure of the Left Atrial Appendage Versus Warfarin Therapy for Prevention of Stroke in Patients With Atrial Fibrillation) trial at baseline and 12 months. It was reported that patients with nonvalvular AF at risk for stroke, treated with left atrial appendage closure, have favorable QOL changes at 12 months versus patients treated with warfarin. [5]

The LARIAT device (SentreHEART) has FDA approval to facilitate suture placement and knot tying in surgical applications where soft tissues are being approximated or ligated with a pretied polyester suture. The FDA has not evaluated the use of the LARIAT Suture Delivery Device for LAA closure to reduce the risk of stroke in atrial fibrillation patients. In fact, the FDA has alerted health care providers and patients of reports of patient deaths and other serious adverse events associated with the use of the LARIAT Suture Delivery Device for this off label indication.

The FDA-approved AtriClip LAA Exclusion System is indicated for the occlusion of the heart's LAA, performed under direct visualization and in conjunction with other cardiac surgical procedures. Direct visualization, in this context, requires that the surgeon is able to see the heart directly, with or without assistance from a camera, endoscope, etc., or other appropriate viewing technologies. The American Heart Association/American College of Cardiology/ Heart Rhythm Society (AHA/ACC/HRS) concludes the current data on LA occlusion at the time of concomitant cardiac surgery reveal a lack of clear consensus because of the inconsistency of techniques used for surgical excision, the highly variable rates of successful LAA occlusion, and the unknown impact of LAA occlusion on future thromboembolic events.[1] Per the AHA/ACC/HRS, surgical excision of the LAA may be considered in patients undergoing cardiac surgery. (IIb recommendation- usefulness/efficacy is less well established.)

Various other devices continue to be investigated and some have European Conformity (CE) approval in Europe for LAA closure but they do not have FDA approval in the US. Some examples include Amplatzer cardiac plug, redesigned as the Amplatzer Amulet (St. Jude Medical), WaveCrest (Coherex Medical), LAmbre (Lifetech Scientific Corp), Occlutech LAA Occluder (Occlutech International AB), and the Cardia Ultrasept LAA Occluder (Cardia).

National Institute for Health and Clinical Excellence (NICE)
Current evidence suggests that percutaneous occlusion of the LAA is efficacious in reducing the risk of thromboembolic complications associated with nonvalvular AF. With regard to safety, there is a risk of life-threatening complications from the procedure, but the incidence of these is low. Therefore, this procedure may be used, provided that normal arrangements are in place for clinical governance, consent and audit.[7]

European Society of Cardiology
Guidelines for the Management of Atrial Fibrillation states LAA occlusion may be considered for stroke prevention in patients with AF and contraindications for long-term anticoagulant treatment. (Class IIb recommendation-usefulness/efficacy is less well established by evidence/opinion.) [9]

American Heart Association/American College of Cardiology/ Heart Rhythm Society
The latest guideline on the management of patients with atrial fibrillation (2014) does not include recommendations for the use of LAA occlusion devices due to the lack of adequate data and the absence of an FDA-approved LAA closure device labeled for the indication of stroke prevention at the time of the development of the guideline.[1]

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CPT® Codes	Description
33340	Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation

HCPCS Codes	Description
N/A	

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
I47.1	Persistent atrial fibrillation
I47.2	Chronic atrial fibrillation
I48.91	Unspecified atrial fibrillation

Reviews, Revisions, and Approvals	Date	Approval Date
Policy adopted from Health Net NMP 376, Left Atrial Appendage Devices	06/17	07/17

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CENTENE Corporation

Clinical Policy: Radial Head Implant

Reference Number: CP.MP.148
Effective Date: 08/17
Last Review Date: 08/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Radial head implant, or arthroplasty, was developed for the treatment of complex radial head fractures, and severe arthritic conditions causing radial head joint destruction.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that radial head implants are **medically necessary** for a select subset of individuals who meet either of the following indications:
   A. Type III comminuted fractures of the radial head; or
   B. Radiographic evidence of radial head joint destruction, too far advanced to benefit from radial head excision and synovectomy with demonstrated resistance or failure of conservative medical treatment.

II. It is the policy of health plans affiliated with Centene Corporation that radial head implants are **not medically necessary** for any other circumstances than those specified above, as well as any of the following:
   A. History of previous elbow sepsis;
   B. Previous fascial or other interpositional arthroplasty and previous hinged arthroplasty with the use of a capitellocondylar implant;
   C. Excessive bone loss on either side of the joint and poorly functioning flexor and extensor mechanism.

Background

Radial Head Fractures

Radial-head and -neck fractures are common and occur in about 30% of elbow fractures. The following modified Mason classification is frequently used to describe the fractures:

- Mason Type I – nondisplaced fractures (displacement $\leq$ 2 mm);
- Mason Type II – displaced fractures > 2 mm;
- Mason Type III – comminuted fractures in which bone is broken, splintered or crushed into a number of pieces. Treatment includes excision, operative fixation and replacement arthroplasty;
- Mason Type IV – radial head fracture associated with elbow fracture/dislocation. [8]

Immediate orthopedic evaluation is necessary for any individual with an open fracture, neurovascular compromise, or fracture dislocation. Immediate reduction is critical in patients who present with a radial-head or -neck fracture and elbow dislocation. The longer the joint is allowed to remain dislocated, the more difficult the reduction and the greater the risk of avascular necrosis. [8]

Studies
The peer-reviewed evidence for optimal management of Mason type III radial head fractures is unclear, since there is difficulty performing randomized controlled trials due to the small numbers of these types of fractures. Type III comminuted fractures often do poorly with open reduction internal fixation, especially when there are more than three fragments; in addition, there is a risk of posterior interosseous nerve injury with the procedure. Although many of the studies related to radial head implants are small, these types of prostheses are noted as an acceptable option in cases of Type III comminuted fractures. Many of these fractures will have a ligamentous injury between the radius and ulna shaft in the forearm, which are termed Essex-Lopresti injuries. Excision of a radial head fracture that has an associated Essex Lopresti injury will cause very significant shortening and wrist morbity. [3, 4, 5, 9]

The radial head implant is also beneficial in patients with rheumatoid arthritis with radiographic evidence of joint destruction, which is too far advanced to benefit from radial head excision and synovectomy. In patients with rheumatoid arthritis, arthroplasty should be considered only after conservative medical treatment has failed; this would include pharmacologic therapy consisting of combinations of salicylates, nonsteroidal anti-inflammatory drugs, disease modifying antirheumatic drugs, and/or glucocorticoids for 3-6 months. [7]

In summary, multicenter, long-term, evidence-based, peer-reviewed studies or clinical trials would be helpful to assess the benefits and/or problems associated with radial head implants.

Coding Implications
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CPT® Codes	Description
24366	Arthroplasty, radial head; with implant

HCPCS Codes	Description
N/A	

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
M06.821	Other specified rheumatoid arthritis , right elbow
M06.822	Other specified rheumatoid arthritis, left elbow

ICD-10-CM Code	Description
S52.121 (A-S)	Displaced fracture of head of right radius
S52.122(A-S)	Displaced fracture of head of left radius

Reviews, Revisions, and Approvals	Date	Approval Date
Policy Adopted from Health Net NMP#429 Radial Head Implant	07/17	08/17

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Important Reminder

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CENTENE Corporation

Clinical Policy: Testing for Rupture of Fetal Membranes

Reference Number: CP.MP.149
Effective Date: 08/17
Last Review Date: 08/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Premature rupture of membranes is a complication in pregnancy that can lead to preterm delivery. The purpose of this policy is to define medical necessity criteria for testing for rupture of fetal membranes using AmniSure®, Actim® PROM and the ROM Plus Fetal Membranes Rupture Test for the diagnostic evaluation for premature rupture of membranes.

Policy/Criteria

It is the policy of health plans affiliated with Centene Corporation that AmniSure, Actim PROM and the ROM Plus Fetal Membranes Rupture Test (tests billed with CPT® code 84112) are considered **not medically necessary** for members as they have not been shown to improve clinical outcomes over standard methods of diagnosis.

Background

Preterm delivery is a major contributing factor to perinatal morbidity and mortality. According to the American College of Obstetricians and Gynecologists (ACOG) Practice Bulletin: Premature Rupture of Membranes, premature rupture of membranes (PROM) complicates approximately 3% of all pregnancies in the United States.[1] Membrane rupture prior to 37 weeks of gestation is referred to as preterm PROM. There are many pathologies that can influence PROM, although intraamniotic infection is commonly related to preterm PROM.[1]

The ACOG Practice Bulletin states that test kits should be considered ancillary to standard methods of diagnosis.[1] PROM is diagnosed through several methods, including: (1) the visualization of amniotic fluid pooling in the vagina from the cervical canal; (2) a pH test of the vaginal fluid; (3) ferning of dried vaginal fluid through microscopic evaluation.[1] The pH of normal vaginal secretions is 4.5 – 6.0, whereas the pH of amniotic fluid is 7.1 – 7.3.[1]

The AmniSure test measures the presence of placental alpha macroglobulin-1 (PAMG-1) protein in the amniotic fluid using an immunochromotographic assay from a vaginal swab. This test has been reported to have a high sensitivity for detecting the PAMG-1 protein.[2] However, the clinical significance of the positive outcomes reported in other studies (evaluating women with term labor and women with preterm labor) should be measured against the small sample sizes (n= 125 and n=90), as well as high false positive rates of 19-30%.[1,3-4]

Actim PROM rapid test detects insulin-like growth factor binding protein-1 (IGFBP-1) present in amniotic fluid as a marker of the presence of amniotic fluid in a cervicogenic sample. IGFBP-2 is synthesized in the fetal liver and detected in the amniotic fluid throughout pregnancy and the rupture of membranes would cause its displacement. Recent studies utilizing this test have reported a sensitivity and a specificity to as low as 89.3 and 82.7%.[5] Moreover, the positive

predictive value of the Actim test was determined to be less than that of the AmniSure test in a recent meta-analysis study.[6]

ROM Plus Fetal Membranes Rupture Test detects the presence of insulin-like growth factor binding protein-1 (IGFBP-1) and alpha fetoprotein (AFP) as markers of membrane rupture. To date, no published studies have established the clinical effectiveness of this test.

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CPT Codes considered Not Medically Necessary

CPT® Codes	Description
84112	Evaluation of cervicovaginal fluid for specific amniotic fluid protein(s) (eg, placental alpha microglobulin-1 [PAMG-1], placental protein 12 [PP12], alpha-fetoprotein), qualitative, each specimen

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
N/A	

Reviews, Revisions, and Approvals	Date	Approval Date
Policy created	08/17	08/17

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CLINICAL POLICY
Rupture of Fetal Membranes Testing

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CENTENE Corporation

Clinical Policy: Transcatheter Closure of Patent Foramen Ovale

Reference Number: CP.MP.151
Effective Date: 12/17
Last Review Date: 12/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Patent foramen ovale (PFO) is a congenital cardiac lesion which is generally asymptomatic that affects up to a quarter of the population. PFO can present an array of significant clinical complications, including cryptogenic stroke. This policy describes the medical necessity requirements for the percutaneous transcatheter closure of a patent foramen ovale with the Amplatzer™ PFO Occluder.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that the percutaneous transcatheter closure of PFO with the Amplatzer PFO Occluder is **medically necessary** to reduce the risk of recurrent ischemic stroke for the following indications:
- A. Age ≥ 18 and ≤ 60;
- B. Both a neurologist and a cardiologist confirm all of the following:
  1. PFO with a right-to-left interatrial shunt detected by bubble study;
  2. Cryptogenic stroke caused by a presumed paradoxical embolism;
  3. Absence of other risk factors of ischemic stroke, including any of the following:
     - a. Atherosclerosis;
     - b. Small vessel occlusion.

II. It is the policy of health plans affiliated with Centene Corporation® that the percutaneous transcatheter closure of PFO is **experimental/investigational** to reduce the risk of ischemic stroke for the following indications:
- A. Devices not currently FDA-approved for PFO, including any of the following:
  1. CardioSEAL STARFlex Septal Closure System;
  2. Buttoned Device;
  3. Atrial Septal Defect Occluding System;
  4. Helex Septal Occluder;
- B. Migraine prophylaxis;
- C. Stroke prevention;
- D. Unexplained oxygen desaturation.

Background

The foramen ovale is a particular structure of the fetal circulation that fails to close in 25% of the adult population, forming a PFO.[1,2] The biological significance of PFOs have been widely debated in the literature for the last decade. Case control studies have established an association between an increased risk of ischemic stroke and the PFO.[1] Three initial randomized controlled trials (*e.g.* the CLOSURE I study, the PC study, and the RESPECT study), as well as a meta-analysis of 14 trials, collectively demonstrate that that there is no significant advantage for surgical PFO closure to improve ischemic stroke prevention over medical therapy.[7-10]

Consequently, the 2014 American Heart Association / American Stroke Association, as well as the 2016 Practice Advisory Board of the American Academy of Neurology, do not recommend percutaneous transcatheter closure of PFO outside of research settings.[11-12]

However, four more recently published articles in *The New England Journal of Medicine* expand the body of work and extend analyses.[2-6] Mas *et al.* for the CLOSE investigators assessed 663 patients and demonstrated reduced recurrent stroke rates after PFO closure compared to oral anticoagulation with antiplatelet medical therapy in patients with cryptogenic stroke.[2] This finding was also validated by Søndergaard for the Gore REDUCE investigators in their analysis of 664 patients[4.] Furthermore, Saver *et al.* for the RESPECT investigators recapitulate earlier results in a multicenter trial, noting that closure of PFO was associated with a lower rate of recurrent ischemic stroke, after having followed 980 patients for a median of 5.9 years.[3]

Coding Implications

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CPT® Codes	Description
93580	Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant

HCPCS Codes	Description
C1817	Septal defect implant system, intracardiac

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
Q21.1	Atrial septal defect

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed	11/17	12/17

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CENTENE Corporation

Clinical Policy: Biofeedback

Reference Number: CP.MP.168
Effective Date: 07/17
Last Review Date: 07/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Biofeedback therapy provides visual, auditory or other evidence of the status of certain body functions so that a person can exert voluntary control over the functions, and thereby alleviate an abnormal bodily condition. Biofeedback therapy often uses electrical devices to transform bodily signals indicative of such functions as heart rate, blood pressure, skin temperature, salivation, peripheral vasomotor activity, and gross muscle tone into a tone or light, the loudness or brightness of which shows the extent of activity in the function being measured.[1]

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that biofeedback is **medically necessary** for the following indications when the basic and treatment-specific criteria in A and B are met.

Reconsideration of medical necessity should be made if more than 14 biofeedback treatments sessions in a 12 month period are necessary. For treatment of fecal and/or urinary incontinence, objective improvement is usually noted within 4 sessions.

A. Basic Criteria- meets all of the following:
1. The individual is motivated to actively participate in the treatment plan, including being responsive to the care plan requirements (e.g., practice and follow-through at home);
2. The individual is capable of participating in the treatment plan (physically as well as intellectually);
3. The condition can be appropriately treated with biofeedback (e.g., existing pathology does not prevent success of the treatment);
4. There is a readily identifiable and measurable response;
5. Biofeedback training is performed by a physician or qualified non-physician practitioner which can include physical and occupational therapists, nurse practitioners, physician assistants, and clinical nurse specialists.

B. Treatment-Specific Criteria - meets any of the following:
1. Stress, urge, or mixed urinary incontinence in cognitively intact adult females who have failed a documented four week trial of Kegel pelvic muscle exercise training;
2. Dysfunctional voiding in children, when other alternative options have been unsuccessful (e.g., timed voiding, prophylactic antibacterial therapy for recurrent urinary tract infections, short term anticholinergic medications to assist developing a normal voiding pattern);
3. Fecal incontinence when either of the following criteria have been met:
   a. Anorectal manometry demonstrates weakness of the external anal sphincter;

   b. Decreased ability to perceive rectal distension because of nerve injury;
4. Chronic constipation in patients with organic neuromuscular impairment who have difficulty with outlet obstruction;
5. Anal muscle abnormalities of spasticity, incapacitating muscle spasm, and/or muscle weakness;
6. Thermal biofeedback combined with relaxation training or electromyography (EMG) biofeedback as treatment options in management of tension and migraine headaches;
7. Chronic pain as part of a rehabilitation program;
8. Muscle re-education of specific muscle groups or for treating pathological muscle abnormalities of spasticity, incapacitating muscle spasm (including pain due to spasm), or weakness when more conventional treatments (heat, cold, massage, exercise, support) have not been successful.

II. It is the policy of health plans affiliated with Centene Corporation that biofeedback (including neurofeedback) is **experimental/investigational** for any other circumstances than those specified above.

Background

The three most commonly used forms of biofeedback therapy are: (1) electromyography (EMG), which measures muscle tension; (2) thermal biofeedback, which measures skin temperature; and (3) neurofeedback or electroencephalography (EEG), which measures brain wave activity. Various forms of biofeedback appear to be effective for a narrow range of health problems.

First line treatment of urinary incontinence (stress, urgency, mixed) consists of behavioral treatments with an emphasis on improving quality of life. Initial treatment includes lifestyle modifications and pelvic floor muscle exercise (Kegel exercises). Biofeedback is used as an adjunct to pelvic floor muscle exercises. By providing individuals with concurrent feedback on muscle tone, biofeedback is intended to improve the patient's ability to perform pelvic muscle exercises. Augmented versions also use abdominal and perineal EMG recordings to demonstrate improper contraction of abdominal and gluteal muscles. A systematic review and meta-analysis of 17 randomized or quasi-randomized trials found that compared with women who received pelvic floor muscle exercises alone, those that also received biofeedback were more likely to report improvement or cure of urinary incontinence.[1]

Dysfunctional voiding in children is a learned behavior of abnormal urination, which often evolves from attempts to suppress impending or active bladder contractions by inappropriately contracting the pelvic floor muscles, thereby tightening the urinary sphincter complex. Symptoms vary but daytime wetness and urinary tract infections are common. Other urinary symptoms include urgency, frequency, infrequency, and constipation. Usual care of dysfunctional voiding includes voiding on a schedule and keeping voiding diaries. Kegel or pelvic floor exercises may help children gain conscious control of pelvic floor musculature and urination.[2] Biofeedback teaches children how to identify and control the muscle groups involved in voiding. It is reserved for children with dysfunctional voiding despite an adequate trial of conservative therapy and/or pharmacotherapy. Available studies suggest that biofeedback-directed pelvic floor exercises can improve urinary function in dysfunctional voiding, including

those who have previously failed conservative treatment. Biofeedback therapy may result in a faster resolution of symptoms than traditional pelvic floor training without biofeedback.

Biofeedback therapy improves symptoms in more than 70% of patients with defecatory disorders. Biofeedback can be useful in the treatment of constipation to train patients to relax their pelvic floor muscles during straining and to correlate relaxation and pushing to achieve defecation. By the relearning process, the non-relaxing pelvic floor is gradually suppressed and normal coordination restored. Biofeedback has been shown to improve rectoanal coordination during defecation and symptoms of constipation despite reduced laxative use. Biofeedback is also used in the treatment of fecal incontinence.[3]

American Gastroenterological Association
Pelvic floor retraining by biofeedback therapy rather than laxatives is recommended for defecatory disorders (strong recommendation, high-quality evidence).[3]

American Society of Colon and Rectal Surgeons
Biofeedback may be considered as an initial treatment for patients with fecal incontinence and some preserved voluntary sphincter contraction when there is no response to simple dietary modification, medications, and other supportive measures. In their most recent guidelines on the treatment of fecal incontinence, the American Society of Colon and Rectal Surgeons assign a strong recommendations in favor of biofeedback.[4]

American Academy of Neurology
The American Academy of Neurology recommends relaxation training, thermal biofeedback combined with relaxation training, EMG biofeedback, and cognitive-behavioral therapy as treatment options for prevention of migraine (Grade A). Specific recommendations regarding which of these to use for specific patients cannot be made.[5]

Coding Implications
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CPT® Codes	Description
90901	Biofeedback training by any modality
90911	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry

HCPCS Codes	Description
N/A	

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
G43.001 - G43.719	Migraine headache
G44.201 - G44.209	Tension-type headache
K59.00 - K59.09	Constipation
K59.4	Anal spasm
M62.40 - M62.49	Contracture of muscle
M62.50 - M62.59	Muscle wasting and atrophy, not elsewhere classified
N39.3 - N39.498	Stress incontinence
R15.0 - R15.9	Fecal incontinence

Reviews, Revisions, and Approvals	Date	Approval Date
Policy adopted from Health Net NMP168 Biofeedback	06/17	07/17

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postmenopausal women with stress urinary incontinence: A randomized controlled trial. Neurourol Urodyn. 2017 May 16.
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Important Reminder

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CLINICAL POLICY
Biofeedback

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Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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envolve

Clinical Policy: Applied Behavioral Analysis

Reference Number: ENY.MP.104
Effective Date: 08/09
Last Review Date: 01/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Applied Behavioral Analysis (ABA) is the application of behavioral principles to everyday situations, intended to increase or decrease targeted behaviors. ABA has been used to improve areas such as language, self-help, and play skills, as well as decrease behaviors such as aggression, self-stimulatory behaviors, and self-injury. For children with Autism Spectrum Disorder (ASD), therapy can range from 25 to 40 hours per week and requires active parent/guardian involvement to increase the potential for behavior improvement. ABA can also be referred to as Lovaas therapy and intensive behavioral intervention (IBI).

Policy/Criteria

I. When ABA is a **covered benefit**, the *initiation of services* is considered **medically necessary** for members meeting all of the following criteria:

A. Age < 21 years;

B. Diagnosis by age eight confirmed by one of the following diagnosis specific tests/screening tools:
   1. Checklist for Autism in Toddlers (CHAT);
   2. Modified Checklist for Autism in Toddlers (M-CHAT);
   3. Screening Tool for Autism in Two-Year Olds (STAT);
   4. Social Communication Questionnaire (SCQ) (recommended for children ≥ four-years);
   5. Autism Spectrum Screening Questionnaire (ASSQ);
   6. Childhood Asperger's Syndrome Test (CAST);
   7. Krug Asperger's Disorder Index (KADI);
   8. Autism Diagnostic Observation Schedule (ADOS);
   9. Autism Diagnostic Interview (ADI);
   10. Childhood Autism Rating Scale (CARS);
   11. Gilliam Autism Rating Scale (GARS);

C. An appropriate diagnostician has ruled out all of the following as a sole explanation for symptoms of ASD:
   1. Neurological disorder (by an MD);
   2. Heavy metal poisoning (by an MD);
   3. Primary speech disorder;
   4. Primary hearing disorder;

D. A licensed Psychologist has evaluated the member within the last 6 months for current validation of the ASD diagnosis using one of the following:
   1. Autism Diagnostic Observation Schedule (ADOS);
   2. Autism Diagnostic Interview (ADI-R);
   3. Childhood Autism Rating Scale (CARS);

4. A DSM-IV or DSM-V Diagnostic Criteria result which validates one of the three ASD diagnoses;

E. Member exhibits severe behavior that presents a clinically significant health or safety risk to self or others (such as self-injury, aggression toward others, destruction of property, elopement, severe disruptive behavior or significant interference with basic home or community activities of daily living);
F. Less-intensive behavior treatment or other therapy of 60 – 90 days in duration has not been sufficient to reduce interfering behaviors, to increase pro-social behaviors, or to maintain desired behaviors;
G. The member is medically stable and does not require 24-hour medical/nursing monitoring or procedures provided in a hospital level of care;
H. A qualified, treating health care professional who has completed an initial evaluation of the member has a reasonable expectation that the individual's behavior will improve significantly with ABA therapy provided by, or supervised by, a participating ABA provider;
I. The treatment plan is built upon individualized goals and projected time to achieve those goals. Objectives are measurable and tailored to the patient;
J. Parent or caregiver training and support is incorporated into the treatment plan and takes place on a regular basis;
K. Interventions emphasize generalization of skills and focus on the development of spontaneous social communication, adaptive skills, and appropriate behaviors.
L. Interventions are consistent with ABA techniques;
M. The number of service hours necessary to effectively address the challenging behaviors is listed in the treatment plan.

II. The *continuation of ABA services* is considered **medically necessary** when all of the following criteria are met. Requests for continuation of therapy must be accompanied by documentation maintained by the provider that outlines actual services received and a graphic representation documenting the progress made by the member.

A. Continues to meet the criteria in section I.E through I.M.;
B. There is reasonable expectation that the member will benefit from the continuation of ABA therapy as evidenced by mastery of skills defined in initial plan or a change of treatment approach from the initial plan;
C. The treatment plan is updated on a monthly basis;
D. The treatment plan is submitted for review every 12 months or as state-mandated;
E. Measurable progress is documented and submitted every 12 months with the treatment plan. Continued progress is determined based on improvement in goals as outlined in the provider treatment plan and will focus on improvements in verbal skills, social functioning, and IQ (for children under 4 years);
F. Treatment is not making the symptoms worse;
G. There is a reasonable expectation, based on the member's clinical history that withdrawal of treatment will result in decompensation/loss of progress made or recurrence of signs and symptoms.

III. Exclusion criteria: ABA treatment will not be authorized for any of the following purposes:

A. Speech therapy;

B. Occupational therapy;
C. Vocational rehabilitation;
D. Supportive respite care;
E. Recreational therapy;
F. Orientation and mobility;
G. ABA services provided in the school setting.

Background

A number of scientific studies have been conducted evaluating the effectiveness of ABA. The original and long-term follow-up study conducted by O. Ivar Lovaas included 38 children who were non-randomly assigned to ABA therapy or minimal therapy. Outcomes were compared to data from 21 children in another facility that had similar characteristics. Lovaas reported improvements in cognitive function and behavior that were sustained for at least 5 years. Almost half of the ABA group passed normal first grade and had an IQ score that was at least average. The flaws in this study included: small sample size, non-randomization of patients to treatment groups, potential selection bias, and endpoints that may not meet current standards (Hayes Medical Directory). More recent studies have reported effectiveness in some autistic children, especially in relatively high-functioning children, but none have replicated the results from the Lovaas study.

Multiple systematic reviews with meta-analyses have been conducted on ABA studies for ASD, with conflicting results. Ospina and colleagues (2008) systematically reviewed studies comparing behavioral and developmental interventions for ASD. The four randomized control trials (RCTs) reviewed that compared ABA to Developmental Individual-difference relationship-based intervention (DIR) or Integrative/Discrete trial combined with Treatment and Education of Autistic and related Communication Handicapped Children (TEACCH) found no significant difference in outcomes (Ospina et al., p. 4). Seven out of eight studies that reported significant improvements were not RCTs and have significant methodological limitations (Ospina et al., 2008, p. 5). Results from a meta-analysis of controlled clinical trials demonstrated that Lovaas is superior to special education for a variety of outcomes; however, there is no definitive evidence suggesting superiority of Lovaas over other active interventions (Ospina et al. 2008, p. 26). Additionally, five other systematic reviews found that ABA was an effective intervention for ASD, but still noted the substantial limitations of included studies, which could affect meta-analysis results and the expected efficacy of ABA (Eldevik 2009; Reichow 2009; Makrygianni 2010; Virues-Ortega 2010; Warren et al. 2011).

Furthermore, Reichow and others (2014) conducted a systematic review of the RCTs, quasi-RCTs, and controlled clinical trials in the ABA literature, commenting that these were not of optimal design. Reichow and others (2014) concluded that the evidence suggests ABA can lead to improvements in IQ, adaptive behavior, socialization, communication and daily living skills. However, they strongly caution that given the limited amount of reliable evidence, decisions about using ABA as an intervention for ASD should be made on a case by case basis (Reichow et al. 2014, p. 33). In contrast, Spreckley and Boyd (2009) state in their systematic review that children receiving high intensity ABA did not show significant improvement in cognitive functioning (IQ), receptive and expressive language, and adaptive behavior compared to lesser

interventions including parenting training, parent- applied behavior intervention supervised weekly by a therapist, or interventions in the kindergarten.

Further research needs to be done to determine the effectiveness of ABA at improving IQ, language skills, social skills, and adaptive behaviors, especially compared to other interventions. In addition, rigorous studies should examine which subgroups of children or adolescents with ASD benefit the most from ABA.

Coding Implications

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ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
F84.0	Autistic disorder
F84.2	Rett's syndrome
F84.3	Other childhood disintegrative disorder
F84.5	Asperger's syndrome
F84.8	Other pervasive developmental disorders
F84.9	Pervasive developmental disorder, unspecified

Reviews, Revisions, and Approvals	Date	Approval Date
Added ICD-9 codes	11/12	12/12
Removed State Specific Coverage table	05/13	
References reviewed and updated, sent to external specialist for review.	12/13	01/14
Updated policy to "Applied Behavioral Analysis" and description Split criteria into initial and continuation and removed authorization protocols Combined diagnostic specific screening tools into one section and removed Confirmation of diagnosis by specialist type in II.B Add DSM-V to list in II.D Added length of failure for less intensive treatments Changed treatment provided by requirements to a credentialed provider In continuation criteria, added reasonable expectations of therapy points	12/14	01/15
Updated template Updated background with recent studies Changed policy reference number from CP.BH.02 to CP.MP.103 Specialist reviewed	01/16	01/16

Reviews, Revisions, and Approvals	Date	Approval Date
Reviewed and updated references. Added ICD-10 codes.	12/16	01/17

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CLINICAL POLICY
Applied Behavioral Analysis

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REFERENCES:
CP.MP.104 Applied Behavioral Analysis for Autism, Corporate Policy

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5.9 Quality Assessment and Performance Improvement

5.9. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

SUNFLOWER DEMONSTRATED SUCCESS

Dedication to continuous quality improvement is a Sunflower Health Plan (Sunflower) core business strategy that is manifested in our plan-wide quality culture and overseen and monitored through our effective and mature Quality Assessment and Performance Improvement (QAPI) Program. Our many quality improvement (QI) accomplishments benefiting our members, providers and the State of Kansas include, in part, the following:

- First KanCare managed care organization (MCO) to achieve National Committee for Quality Assurance (NCQA) "Commendable" status
- Cited as an "exemplar program" demonstrating successful long term services and supports (LTSS) integration by the Long-Term Care Alliance in September 2016
- Achieved consistent year-over-year (YOY) improvement in both Member Experience and Provider Satisfaction
- Improved HEDIS® quality outcomes in our home and community-based services (HCBS) population and exceptional member satisfaction with LTSS Service Coordination. For example in our 2017 LTSS member satisfaction survey, over 95% of members receiving HCBS reported satisfaction with the help they receive from their Sunflower Service Coordinator and 99% indicated their Service Coordinator respects their beliefs and preferences
- YOY improvement in NCQA accreditation HEDIS measures (15.6% increase in 2016 compared to 2015)
- Improved member experience with YOY improvement in NCQA accreditation score in both Adult and Child-CCC CAHPS® surveys
- Exceeded the NCQA Quality Compass 90th percentile in Follow Up After Hospitalization for Mental Illness and 75th percentile in BH services and screening in our pediatric population
- Reduced psychotropic medication utilization from 33.5% in 2013 to 28.9% in 2016; decreased 60+ day psychotropic medication utilization from 13.4% in 2013 to 11.6% in 2016 through our Psychotropic Medication Utilization Review (PMUR) program for foster care members

Our experienced quality professionals work closely with the State to consistently safeguard member and provider rights while ensuring member safety and a high-quality provider network.

COMPLIANCE WITH SCOPE OF WORK

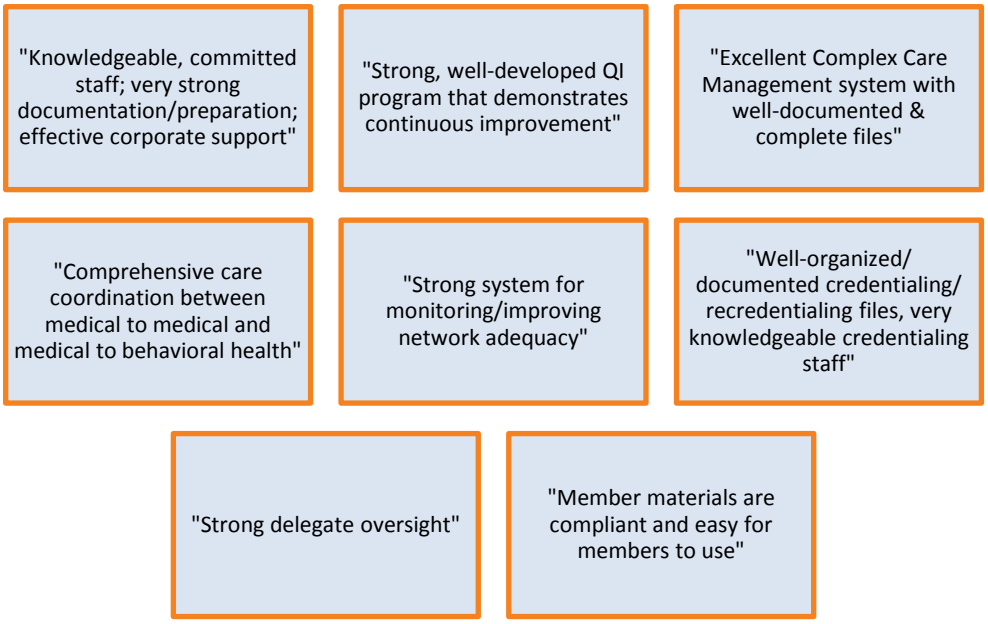
Our QAPI Program meets or exceeds, and will continue to meet or exceed, all Contract, State, federal, and NCQA requirements. Sunflower's QAPI Program supports and complies with KDHE's Quality Management Strategy (QMS) and incorporates values consistent with the RFP goals. Below we describe in detail our overall QAPI program and processes, including accountability, oversight, and evaluation, for complying with each element of the Scope of Work (SOW). For ease of review we have included SOW references in headers and in the narrative.

5.9.1. GENERAL REQUIREMENTS

QUALITY CULTURE (5.9.1.N.7)

The entire Sunflower staff is committed to quality improvement, and quality management processes are fully integrated into all plan functional areas. This integration is evidenced by our "excellent" NCQA onsite review of the quality and efficiency of our fundamental management processes completed in April 2017, including the key Sunflower strengths noted by NCQA auditors described in ***Figure 5.9.1.A Sunflower Strengths Noted by NCQA Auditors*** below. Sunflower scored 49.44 out of a possible 50 points on the NCQA standards, including 100% on all file review domains (Utilization Management (UM) Appeals, UM Denials, Care Management, Credentialing/Recredentialing, and Pharmacy).

Figure 5.9.1.A Sunflower Strengths Noted by NCQA Auditors



COMMITMENT TO THE QUADRUPLE AIM

Our entire Sunflower leadership team, starting with our Chief Executive Officer, is committed to focusing our clinical, network and operational processes towards achieving the Triple Aim: simultaneously improving the health of our members (including all demographic groups and those with special needs), enhancing each member's experience of care and service, and lowering the per capita cost of their health care. We are also committed to the fourth leg of a Quadruple Aim: improving the work life of our network providers and their staff, as well as their experience and satisfaction with KanCare and Sunflower. As illustrated in ***Table 5.9.1.A Sunflower***

Figure 5.9.1.B
Values of the "Quadruple" Aim

Selected Performance Results Supporting the Quadruple Aim below, our commitment to the Quadruple Aim is evidenced by our performance and statistically significant improvements on member satisfaction surveys, HEDIS measures, and provider satisfaction surveys, and our success in achieving cost savings.

Table 5.9.1.A_Sunflower Selected Performance Results Supporting the Quadruple Aim

Element	Sunflower Performance Result
Member Experience	• Adult CAHPS®. Exceeded Quality Compass 75th percentile in 5 out of 6 Composite Score Adult Medicaid Survey Domains (Getting Care Quickly, How Well Doctors Communicate, Care Coordination, Getting Needed Care, Customer Service) and 3 out of 4 Overall Rating Scores (Health Care, Personal Doctor and Specialist) • Child-CCC CAHPS®. Exceeded Quality Compass 75th Percentile in 6 out of 8 Accreditation Domains (Customer Service, Getting Needed Care, Rating of All Health Care, Rating of Health Plan, Rating of Personal Doctor, Rating of Specialist Seen Most Often) o *Also, exceeded the 90th percentile for Rating of Health Plan*

Population Health	• Attained "Commendable" accreditation status level based on our 2016 HEDIS results and then again in 2017
	• Achieved YOY improvements in many HEDIS rates between measurement years 2014 and 2016, and met or exceeded the NCQA Quality Compass 50th percentile for 18 out of 34 NCQA scored measures in 2017. Most notably:
	  o Exceeded the 75th percentile in Access to Primary Care and Annual Dental Visits with consistent YOY increase in Well-Child Visits and preventive visits
	  o Exceeded the 75th percentile in chronic disease management in metrics related to diabetes and asthma management
	  o Exceeded the 90th percentile in Follow Up After Hospitalization for Mental Illness and 75th percentile in BH services and screening in our pediatric population

Cost Savings	• Using our Integrated Care Model, we reduced total expenditures in a high cost cohort of 450 members with inappropriate utilization or poorly controlled chronic conditions by 30.2%, saving over $5.1 million • Implementation of a revised multidisciplinary approach using a new member entry assessment, risk stratification, and transition program resulted in a 6% reduction in overall spending for foster care youth in 2016 • Sunflower is one of three KanCare MCOs that has contributed to a significant reduction in Average Monthly KanCare expenditures per enrollee, dropping from $625 in 2013 to $563 in 2016, a 10% reduction over that time period
Provider Work-Life Balance	• Sunflower has achieved significant YOY improvement in overall provider satisfaction, increasing from 53.2% in 2015 to 61.2% in 2017, a 15% increase over that time period • Due to Sunflower initiatives to respond to provider feedback and educate and outreach to providers on claims, prior authorization and other issues (revealed through trend analyses of administrative data), the number of provider appeals dropped by 29% in 2016 compared to 2015

LOCAL EXPERIENCE BACKED BY NATIONAL BEST PRACTICES

Sunflower benefits from the resources and expertise of our parent company, Centene Corporation (Centene), in support of our quality improvement (QI) activities. Examples of Centene's support include research, design, production and printing of member and provider materials for national quality improvement interventions, such as diabetes and sickle cell anemia initiatives. In addition, QI staff frequently exchange best practices with peers at our

affiliate plans via regular conference calls. This allows us to continually refine and improve our approaches based on collective lessons learned.

In line with Sunflower's unwavering commitment to quality, Centene is always looking for new ways to improve care, quality, services, and, ultimately, member health outcomes. To this end, in 2017 through 2018, Centene is making a $41 million investment in supporting a modular, cloud-based and enterprise-wide quality analytics platform. With improved integration and enhanced performance management, this quality platform will allow for weekly, instead of monthly, data updates, and integrated risk gap visualization. Using the most current NCQA HEDIS technical specifications, and consistent with Sunflower's Rapid Cycle Plan Do Study Act (PDSA) improvement methodologies, our quality analytics enhancements will also enable Sunflower to use more real-time data to track HEDIS rates, evaluate intervention effectiveness, and make evidence-informed decisions about whether to modify or discontinue interventions, where necessary.

ALIGNMENT WITH QUALITY MANAGEMENT STRATEGY (5.9.1.A)

Sunflower currently complies with, and will continue to comply with and support, KDHE's Quality Management Strategy (QMS), including any revisions and updates, through direct alignment and integration with our QAPI Program goals and objectives. Sunflower will continue to develop our programs, policies, procedures, processes, and committee structures to support the needs of KDHE and requirements of the QMS.

Sunflower complies with all reporting requirements including quality of care, access standards, satisfaction surveys, utilization, and encounter data reporting; external quality review; clinical standards/guidelines; onsite operational reviews; performance improvement projects; and provider credentialing/re-credentialing. We incorporate the QMS content into our quality training, ensuring that all QI staff and members of the QI Committee and subcommittees have access to the QMS and understand how it integrates into our QAPI Program and processes. Sunflower actively participates in annual meetings of KDHE's QI Committee, including the review of data and information used to develop the QMS; review of the QMS; recommendations for improving the QMS; and recommendations to improve members' quality of care, access, utilization, and satisfaction; and review and recommendations of KDHE's QMS.

During 2017, Sunflower fully complied with all KanCare reporting requirements. On average, all quality reports were submitted 4 days prior to the State due date.

Scope of the Quality Assessment and Performance Improvement (QAPI) Program

The scope of Sunflower's QAPI Program is comprehensive, addressing both the quality of clinical care and the quality of services provided to members and providers. Sunflower takes seriously our accountability for improving quality outcomes and our QAPI Program incorporates ongoing review of all major clinical programs and operational areas. Sunflower's quality improvement activities encompass all demographic groups, benefits and care settings; and address all services, including physical health (PH), behavioral health (BH) and LTSS; preventive,

emergency, primary, and specialty care; acute care, short-term care, home and community-based care, and long-term care facility; and home care, pharmacy, and ancillary services. Areas subject to quality oversight are included in ***Table 5.9.1.B Areas of Quality Oversight*** below.

Table 5.9.1.B_ Areas of Quality Oversight

Areas of Quality Oversight	
• Acute and chronic care management • Adoption and compliance with preventive health and clinical practice guidelines • Behavioral health care management and coordination with medical practitioners • Compliance with member confidentiality laws and regulation • Continuity and coordination of care in all settings including home and community based settings and residential and long-term care facilities • Delegated entity oversight • Department performance and service • Employee and provider cultural competency • Monitoring for disparities in care • Member choice, including least restrictive setting and self-direction • Member grievances and appeals	• Member enrollment and disenrollment • Member experience/satisfaction • Health education and promotion • Network accessibility and appointment availability, including specialty practitioners, with a focus on accessible providers for members with special needs • Patient safety including appropriateness, quality of health and direct care services, fraud, abuse and neglect • Primary Care Provider changes • Pharmacy • Provider experience/satisfaction • Selection and retention of skilled, quality-oriented practitioners, facilities, and non-traditional service providers (credentialing and recredentialing) • Utilization Management, including under- and over-utilization and fraud, waste and abuse

Performance Improvement Projects (5.9.1.B and 5.9.1.C) Sunflower's QAPI Program includes Performance Improvement Projects (PIPs) (described further in Section 5.9.5 below) that will focus on clinical and non-clinical areas as required by the Contract, comply with all State, federal and NCQA requirements, incorporate Rapid Cycle process improvements, and include at least annual reporting to the State (or the State's External Quality Review Organization (EQRO)) on status and results (at the frequency requested by the State or EQRO). Our QAPI Program also addresses how specific interventions will better manage the care and impact healthier patient outcomes to achieve the goal of providing comprehensive, coordinated, high quality, accessible, cost effective, and efficient health care to members, including those with BH, LTSS, and other special health care needs.

LTSS QUALITY MONITORING (5.9.1.D, G, J, K, L)

Sunflower embraces a holistic approach to evaluate and improve member outcomes and quality of services. We use a person-centered planning approach with a focus on identifying and achieving member goals, including least restrictive setting, independence, and quality of life. We also focus on integration of PH and BH needs and addressing social determinants of health. The Sunflower Integrated Care Team is the critical link connecting members with access to high quality, comprehensive, care and services in all care settings, and our Centelligence®

LTSS Key Performance Indicator Dashboard (LTSS KPI Dashboard), described further below, provides actionable reports that enable Sunflower staff to review and monitor LTSS-related metrics across service coordination, quality, operations, member satisfaction, enrollment and financial performance.

Our Kansas and Texas plans were named "exemplar" managed LTSS plans by Long Term Quality Alliance (LTQA). We take our position as the industry leader seriously and have focused on enhancing LTSS nationally. Sunflower affiliates have collaborated with Mathematica and NCQA on behalf of CMS to test new HCBS measures. We also benefit from Centene's LTSS quality experience, which includes participation in numerous national LTSS quality initiatives. For example, Centene co-chaired the National Quality Forum Measure Application Partnership (MAP) Dual Eligible Beneficiaries Workgroup (which provides recommendations to CMS on quality and performance measures for dual eligibles, including for LTSS). Centene also serves on the LTQA Board, and on a Medicaid Innovation Accelerator Project Technical Expert Panel. Centene LTSS experts participated as advisors during development of the Institute for Healthcare Improvement's 2016 *The Playbook: Better Care for People with Complex Needs*, a digital resource to help improve care for people with complex medical and social needs. Centene is also an Early Adopter in pursuing NCQA's new MLTSS Distinction.

Sunflower was cited as an "exemplar program" demonstrating successful LTSS integration by the Long-Term Care Alliance in September 2016.

Incorporating National Best Practices

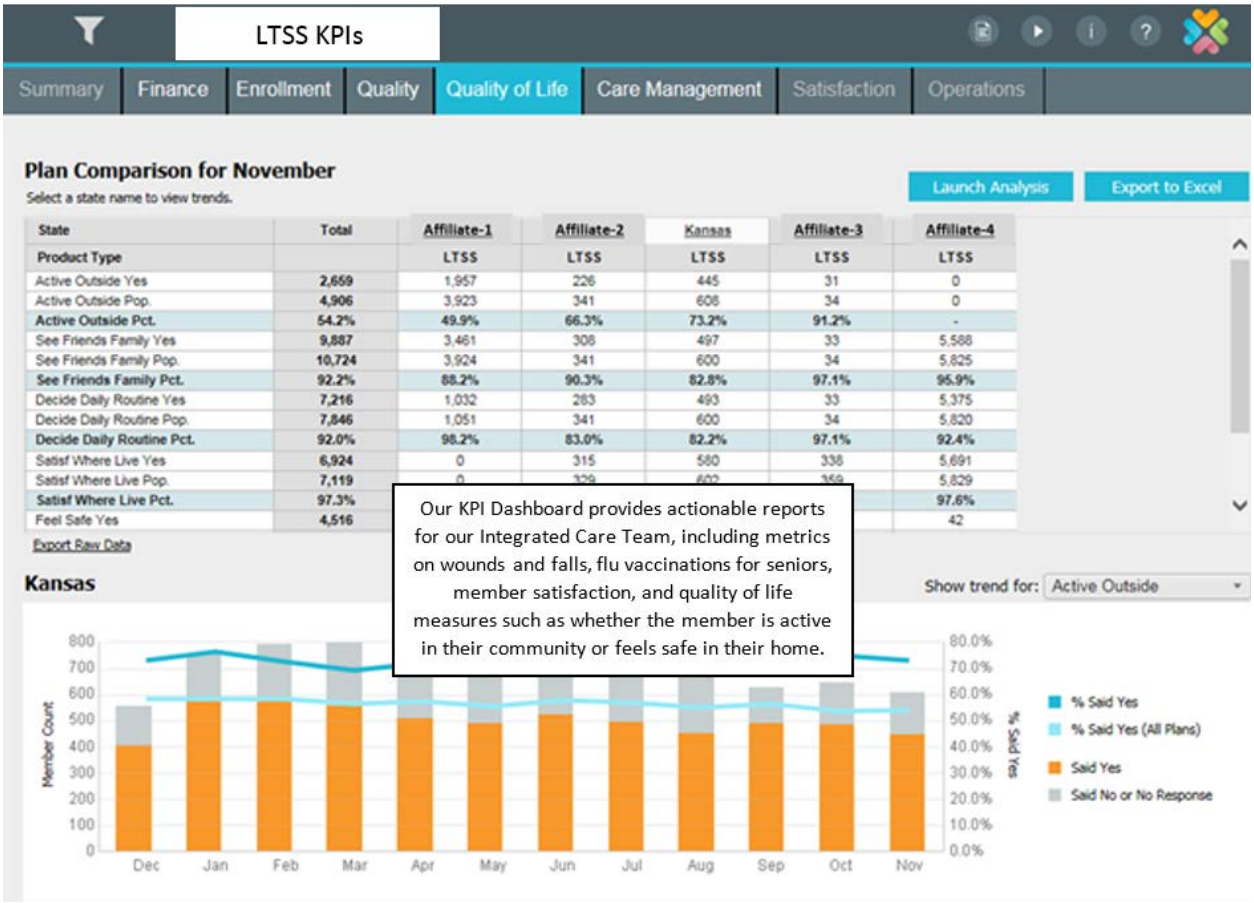
As a leader in the LTSS field, Centene is at the forefront of meaningful member measurement, and continues to engage in a variety of activities to inform this effort. For example, with Centene and our affiliated State health plans, Sunflower is actively collaborating with the National MLTSS Health Plan Association to develop standard MLTSS quality measures, which will be integrated into our LTSS Dashboard. Our measures are derived, where possible, from recognized and validated national assessment tools such as the Home and Community-Based Services Consumer Assessment of Health Care Providers and Systems (HCBS CAHPS) surveys and National Core Indicators-Aging and Disabilities (NCI-AD).

LTSS KPI Dashboard (5.9.1.D)

Sunflower's approach recognizes the importance of performance measures specific to the LTSS population. The LTSS KPI Dashboard, shown in ***Figure 5.9.1.C LTSS KPI Dashboard Screenshot*** below, includes metrics on quality of life, such as member satisfaction with living arrangement, employment status, member participation in the community, and control over daily routine. It also includes clinical quality metrics on risk factors that can lead to institutionalization (such as wounds, falls, incidences of urinary tract infection, and flu vaccinations), and other data (such as enrollment, financial/utilization, and satisfaction). Sunflower leaders can review trends in their own performance, benchmark against other Centene plans, and download data to drill down by Service Coordinator or provider. Centene is currently building the capability to connect

metric performance with each member's key providers, and will make performance reports available to providers who serve a significant number of Sunflower LTSS members.

Figure 5.9.1.C_LTSS KPI Dashboard Screenshot



State	Total	Affiliate-1	Affiliate-2	Kansas	Affiliate-3	Affiliate-4
Product Type		LTSS	LTSS	LTSS	LTSS	LTSS
Active Outside Yes	2,659	1,957	226	445	31	0
Active Outside Pop.	4,906	3,923	341	608	34	0
Active Outside Pct.	**54.2%**	**49.9%**	**66.3%**	**73.2%**	**91.2%**	-
See Friends Family Yes	9,887	3,461	308	497	33	5,588
See Friends Family Pop.	10,724	3,924	341	600	34	5,825
See Friends Family Pct.	**92.2%**	**88.2%**	**90.3%**	**82.8%**	**97.1%**	**95.9%**
Decide Daily Routine Yes	7,216	1,032	283	493	33	5,375
Decide Daily Routine Pop.	7,846	1,051	341	600	34	5,820
Decide Daily Routine Pct.	**92.0%**	**98.2%**	**83.0%**	**82.2%**	**97.1%**	**92.4%**
Satisf Where Live Yes	6,924	0	315	580	338	5,691
Satisf Where Live Pop.	7,119	0	[illegible]	[illegible]	[illegible]	5,829
Satisf Where Live Pct.	**97.3%**	[illegible]	[illegible]	[illegible]	[illegible]	**97.6%**
Feel Safe Yes	4,516	[illegible]	[illegible]	[illegible]	[illegible]	42

One way we measure the efficacy of our person-centered planning process is through our quality of life (QoL) assessment metrics which are self-reported by the members as part of the annual assessment/reassessment process. We use the findings of this assessment at both an individual member level to inform or make modifications to the member's Person-Centered Service Plan (PCSP) as well as at the aggregate population level to assess the efficacy of our PCSP process. The QoL metrics are part of our overall LTSS Dashboard. Below are some highlights of our 2017 results.

- Over 98% of Sunflower's members receiving HCBS services have stated they feel safe in their home
- Over 96% of Sunflower's members receiving HCBS services have stated they are satisfied where they live, including 100% of children (and parents) participating in the Technology Assisted waiver
- Over 90% of our members on the Physical Disability (PD) waiver stated they get to see family and friends when they want and over 90% stated they decide on their daily routine

Using the LTSS Dashboard, Sunflower also collects, tracks and reports performance measures related to rebalancing and community integration activities. For example, engagement and partnership with LTSS-related agencies, such as Centers for Independent Living, Area Agencies on Aging, and Intellectual/Developmental Disability (I/DD) providers has allowed Sunflower to successfully transition 513 LTSS members from nursing facility services to HCBS since 2014. Sunflower continues to expand and evolve community partnerships to support optimal community integration and independence for members.

As described further in our response to ***Section 5.9.10*** below, Sunflower also launched our first LTSS member satisfaction survey in 2017. As noted above, over 95% of surveyed members receiving HCBS reported satisfaction with the help they receive from their Sunflower Service Coordinator and 99% indicated their Service Coordinator respects their beliefs and preferences.

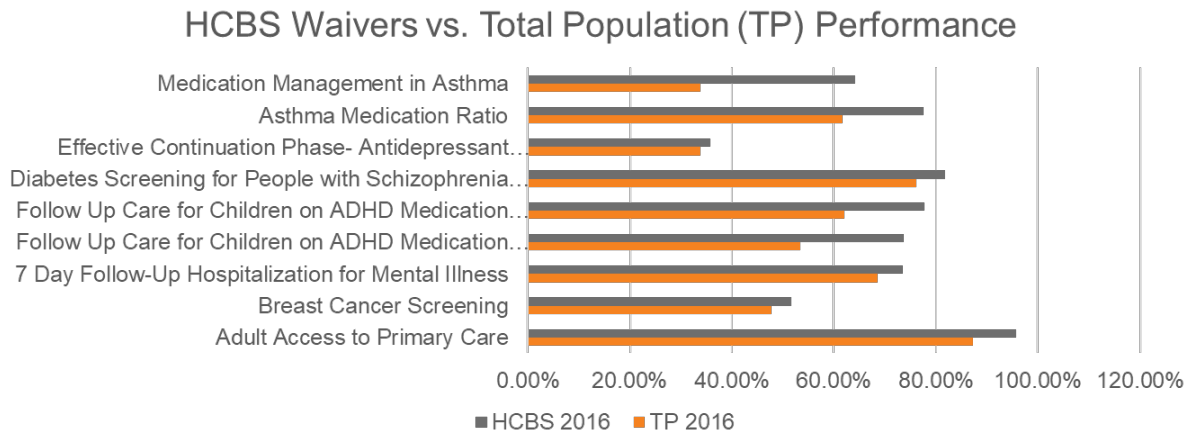
HCBS Waiver Utilization (5.9.1.F, 5.9.1.G)

Sunflower monitors HCBS waiver service utilization through monthly reports that compare monthly HCBS waiver claims data to approved service levels. Through this approach, we also identify HCBS waiver enrollees who are not receiving HCBS waiver services. Once identified, the member's Service Coordinator investigates why the member is not receiving HCBS waiver services to determine whether there are service barriers that need to be addressed and assists the member to utilize services as appropriate. If the Service Coordinator finds that the member is no longer in need of HCBS, or is voluntarily stopping HCBS services, Sunflower will notify the State through the 3161 process, recommending closure of HCBS services for the member.

Assessing the Quality and Appropriateness of LTSS (5.9.1.J)

Early identification of quality-of-care and/or service issues is essential to identifying concerns before they become significant or result in poor patient care or outcomes. Through the LTSS Dashboard and other quality reports, we routinely and continuously monitor performance data to identify, track and review critical incidents and identify trends and aberrant events in the following areas: member safety; member rights; quality of care and services (including an assessment of care between care settings); utilization patterns; provider performance; service access and availability; care planning and implementation; coordination and continuity of care; member and provider satisfaction; and complaints, grievances and appeals. For example, ***Figure 5.9.1.D Selected MY 2016 HEDIS Measures, HCBS Enrollees and Total Plan Results*** below provides a few examples of 2016 HEDIS measure result where members served by HCBS Waivers outperformed the total population of Sunflower membership.

Figure 5.9.1.D_Selected MY 2016 HEDIS Measures, HCBS Enrollees and Total Plan Results



Prevention, Detection and Remediation of Critical Incidents (5.9.1.K)

As described further in Section 5.9.9 below, Sunflower has processes and procedures in place to report, investigate, and address Adverse Incidents that harm or bring potential harm to a member receiving LTSS or BH services, as well as other Quality of Care events (QOCs) that impact member safety. In 2016, Sunflower was notified by the State's Adverse Incident Reporting and Management System of 1,169 individual Adverse Incidents for investigation and potential action: hospital/ER visits was the most frequently reported type of Adverse Incident (577 reports), followed by threatening behavior/threatening suicide (201 reports) and abuse (sexual, emotional, physical and financial) (140 reports). Sunflower also investigated and, when appropriate, addressed 257 QOCs: "Safety/Risk Management" was the most frequent type of QOC referral, followed by "Adverse Medical Events" and "Medical Care Below Standard." All Adverse Incident and QOCs assigned a severity level of medium, high or critical by the Medical Director are referred to the Peer Review Committee for evaluation and action. Issues are tracked and trended for patterns and any applicable corrective action plans (CAPs) put into place when issues warrant further action.

Community Integration Reports (5.9.1.L)

Sunflower currently submits a monthly Money Follows the Person report to the State providing information on persons that have transitioned from care in an institutional setting to HCBS services. Under the new Contract, in compliance with Attachment H to the SOW, Sunflower will submit to the State a monthly Community Transitions report that includes information on members transitioning from an institutional setting, including nursing facilities, nursing facilities for mental health, State and private intermediate care facilities, State hospitals, psychiatric residential treatment facilities and other psychiatric impatient settings.

Sunflower has successfully transitioned 513 LTSS members from nursing facility setting to HCBS since 2014.

DETECTING OVER AND UNDER UTILIZATION (5.9.1.E)

Sunflower's UM Committee 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. This analysis is reported to the QI Committee and referrals are made to the appropriate Sunflower team for performance improvement or corrective action. For example, Sunflower analyzed members with high utilization patterns from the prior 12 rolling months, assessing raw data regarding utilization, participation in Service Coordination, social determinants, and diagnosis to determine which members had the highest likelihood of benefiting from Service Coordination. Based on this review, and using our Integrated Care Model, we reduced total expenditures by 30.2%, saving over $5 million, for 450 high-cost members with inappropriate utilization or poorly controlled chronic conditions. Our Sickle Cell program is an example of our efforts to detect under-utilization. Hydroxyurea is a treatment that has been shown to decrease pain crises and complications in members with Sickle Cell disease and also improves survival. However, based on data review, we know that not all members with this condition are taking this medication. We regularly identify those members who are under-utilizing this important treatment and target outreach to them and their providers to encourage appropriate utilization.

BH QUALITY MONITORING (5.9.1.H)

Sunflower has developed and implemented mechanisms to identify, address, and monitor the BH needs of our members to ensure that they receive all State approved services for unmet needs. We take a comprehensive "no wrong door" approach to identify members with unmet BH needs. We review a wide variety of member data including: claims data; utilization information; admission, discharge and transfer (ADT) hospital data received electronically; pharmacy data; lab results if available; health screening, Health Risk Assessment, and needs assessment data and results; and predictive modeling risk scores. We stratify our entire population to identify both new and existing members who would benefit from Service Coordination and target our resources effectively to meet their needs. Our Customer Service staff is also trained to listen for indicators of BH needs and make referrals to the Service Coordination team as appropriate.

For persons identified with BH service needs that would benefit from Service Coordination, our Service Coordinators and Community Service Coordination providers employ a person-centered planning approach to develop, implement, and monitor a Plan of Service (PoS) and Person Centered Service Plan (PCSP) in conjunction with the member, the member's authorized representative or guardian, family members, support circle, Primary Care Provider and other health care team members. The PoS and PCSP address the member's holistic care needs, including all State approved BH services appropriate for the member. Through TruCare and the CareLink daily dashboard, Service Coordinators can view member ED utilization and inpatient admission alerts, upcoming member contacts and visits, care gaps, and a caseload planner displaying members coming on and off the caseload and members with upcoming Medicaid recertification, all updated in near real-time. These tools empower our Service Coordinators to

engage with members, the Integrated Care Team, and other providers and proactively address the member's complex, unique needs as they come up. Through this process (as further described in our response to ***Section 5.4***), Sunflower assures that members receive the appropriate delivery of services at the right time, in the right setting, by the right provider.

Sunflower exceeded the NCQA 2016 Quality Compass 90th percentile for Follow Up After Hospitalization for a Mental Illness (FUH) in 30 days and also exceeded the 95th percentile for FUH in 7 days.

Sunflower analyzes and tracks our BH outcomes in a variety of ways. For example:

- We complete and track all HEDIS measures designated by NCQA as relevant to Medicaid across all populations, including persons with BH needs, including BH-specific HEDIS measures such as Follow Up after Hospitalization for Mental Illness (FUH) and Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD).
- In addition to annual CAHPS surveys assessing member satisfaction, Sunflower conducts an annual care management/service coordination member satisfaction survey for Sunflower members in active PH or BH complex care management to measure satisfaction with care management services including whether the member feels that the Service Coordinator is helping the member to get needed health care services.
- Sunflower has implemented Performance Improvement Projects (PIPs) targeting BH services, described further in our response to ***Section 5.9.5***, including a PIP related to the HEDIS SSD measure. The goal of this PIP is to increase diabetes screening rates for persons using antipsychotics through interventions such as provider education, member education and care management, internal staff training, and community mental health center (CMHC) outreach and collaboration.

Sunflower has also initiated a project with Horizons Mental Health to use the Level of Care guidelines that were produced by the CMHCs to discern whether a member is offered and accessing services that are at the correct level based on their functioning. We have compared Horizon's assessment, using the DLA-20 functional assessment tool, with claims and will continue to use this methodology and expand it to other CMHCs with the implementation of our expanded web portal. The DLA 20 is a researched based tool developed through MTM Services that measures 20 domains of functioning, including social determinants of health.

QUALITY MONITORING FOR MEMBERS WITH SPECIAL HEALTH CARE NEEDS (5.9.1.I)

Sunflower recognizes that every member has different needs that require varying levels of service and interventions that can change over time. Our Service Coordination model is designed to address these individual member needs across the entire continuum of care including PH, BH, LTSS and social needs. In addition to the quality monitoring processes and procedures for LTSS and BH services described above, Sunflower has also implemented mechanisms to assess the quality and appropriateness of care furnished to members with other special health care needs, including children, youth and adults served by KDHE's Special Health Care Needs (SHCN) Program.

Sunflower recognizes that our SHCN members may require regular, ongoing therapeutic intervention, and evaluation by appropriately trained health care personnel and need for health, and/or, health-related services at a level significantly above the usual for the child's or youth's age. While KDHE is responsible for developing assessments and plans of care, Sunflower assesses each SHCN member to identify any ongoing special conditions that require a course of treatment or regular care monitoring. A Sunflower Service Coordinator also outreaches to each SHCN member to discuss the member's needs and develop a written, individualized care plan incorporating the SHCN program recommendations based upon member's current health status, family support systems and level of understanding of care management.

Sunflower has also developed and implemented a number of initiatives to monitor and improve health outcomes for children and youth in foster care including the following:

- Sunflower uses predictive modeling software to assess our highest-risk foster care members, including those who are likely to disrupt placement. We conduct interdisciplinary team reviews on these members and submit appropriate referrals based on identified need.
- Through our Psychotropic Medication Utilization Review (PMUR) Program, Sunflower actively supports best practices in prescribing psychotropic medications for children in foster care. This program uses a retrospective claims review process to compare a child's medication regimen to a set of prescribing parameters. When medications are outside of parameters, a review of medical records is conducted, and in some cases a peer to peer discussion occurs between a Sunflower BH Medical Director and the prescriber. Recommendations of the review are shared with the prescriber and the assigned Foster Care Contractor. Sunflower's diligence has resulted in an overall reduction in psychotropic medications utilized by members in foster care from 33.5% in 2013 to 28.9% in 2016. 60+ day psychotropic medication utilization among Sunflower's foster care membership decreased from 13.4% in 2013 to 11.6% in 2016.
- In July 2017, Sunflower launched a Foster Care Transitioning Youth Program, designed to identify those youth who are approaching their 18th birthday and who would benefit from support as they age out of foster care eligibility. Sunflower's goal is to improve outcomes for youth as they transition into adulthood by providing education about our health plan and the youth's benefits under Medicaid.
- Sunflower's Online Member Health Record, our secure, web-based clinical data home, will be expanded to further support our foster care population and children through features such as contact information of the member's integrated care team (e.g., caregiver, caseworker, PCP), completed EPSDT assessments, immunization schedules, and growth charts among other information to assist providers in their practice of coordinated care delivery.

EVALUATING THE IMPACT AND EFFECTIVENESS OF THE QAPI PROGRAM (5.9.1.M)

As further described in our response to ***Section 5.9.1.N.6***, Sunflower conducts an Annual Program Evaluation to evaluate the impact and effectiveness of its QAPI.

STRUCTURE, GOVERNANCE, AND ACCOUNTABILITY ACROSS THE ORGANIZATION (5.9.1.N)

QI Department (5.9.1.N.1)

Sunflower's QI Department is a separate and distinct operational unit. QI processes, however, such as tracking and trending of issues, are integrated across all departments throughout Sunflower and are overseen by the Sunflower Board of Directors and the Quality Improvement (QI) Committee.

Dedicated QAPI Program Staff Resources (5.9.1.N.2)

Sunflower's QAPI Program is infused throughout all operations across the organization; however, key positions are accountable for leading and supporting these efforts. These positions are described in the ***Table 5.9.1.D Sunflower Quality Improvement Staff*** below.

Table 5.9.1.D_Sunflower Quality Improvement Staff

Position Title	Responsibilities
Chief Medical Director	The Chief Medical Director (CMD) is the senior physician on our staff with overall accountability for Sunflower's clinical activities and has direct responsibility for our Quality Improvement department. The CMD is a Kansas-licensed physician in good standing. As Senior Executive for Quality Improvement, the CMD is responsible for the successful operation of our QAPI Program. Sunflower also employs supporting Medical Director(s) who report to the CMD and conduct medical necessity reviews and review potential quality of care concerns.
Director of Quality Improvement	The Director of Quality Improvement (QI Director) is a Kansas licensed registered nurse or other qualified person with experience in quality improvement, population health management/improvement, data analysis, barrier analysis, and project management as it relates to improving clinical quality of care and quality of service provided to health plan members. The QI Director reports to the CMD and is responsible for overseeing the QAPI program, ensuring compliance with quality management requirements and quality improvements, directing the activities of Sunflower's QI staff in monitoring and auditing the health care delivery system, including, but not limited to, internal processes and procedures, provider network(s), service quality and clinical quality. The QI Director assists Sunflower's senior executive staff, both clinical and non-clinical, in overseeing operational activities to meet the goal of providing health care services that improve the health outcomes and quality of life of its members. Additionally, the QI Director coordinates Sunflower's QI Committee proceedings in conjunction with the CMD; supports corporate initiatives through participation on committees and projects as requested; reviews statistical analysis of clinical, service and utilization data; and recommends performance improvement initiatives while incorporating best practices as applicable; and oversees accreditation processes and activities.
Manager of Accreditation and Reporting	The Manager of Accreditation and Reporting is a registered nurse or other qualified person with experience in quality improvement, population health

Position Title	Responsibilities
	management/improvement, data analysis, and project management. This manager directly oversees the daily operations of the Quality Improvement department team members and ensures all Contract, HEDIS, NCQA, and CAHPS requirements and deadlines are completed, action plans developed and executed to achieve optimal plan, provider and member outcomes. The QI Accreditation and Reporting Manager is responsible for maintaining departmental documentation to support State Contract requirements and NCQA standards including, but not limited to applicable policies and procedures, QI focus studies and quality improvement activities, routine control monitoring reports, meeting minutes, access and availability analysis, member satisfaction analysis, continuity and coordination of care, subcontractor oversight and drafting and maintaining the QAPI and annual evaluation of effectiveness of the QAPI program. This QI Manager collaborates with other departments as needed to implement corrective action or improvement initiatives as identified through Sunflower's quality improvement activities.
Manager of Appeals, Grievances and Quality of Care	The Manager of Appeals, Grievances and Quality of Care is a registered nurse or other qualified person with experience in quality improvement, population health management/improvement, and data analysis and project management. This manager directly oversees the daily operations of the QI department team members while ensuring that all Contractual requirements, NCQA, State and federal policies are being followed, deadlines are met, action plans developed and executed to achieve optimal plan, member and provider outcomes. The Manager of Appeals, Grievances and Quality of care is responsible for maintaining documentation to support State Contract requirements and NCQA standards, including but not limited to applicable policies/procedures, QI focus studies, quality improvement activities, routine control monitoring repots, meeting minutes, member satisfaction analysis, continuity and coordination of care, subcontractor oversight, drafting and maintaining the QAPI and annual evaluation of the QAPI program. This manager collaborates with other departments as needed to implement corrective action or improvement initiatives as identified through Sunflower's quality improvement activities and quality of care reviews.
HEDIS Coordinator	The HEDIS Coordinator reports to the Accreditation and Reporting Manager and is responsible for coordinating the documentation, collection and reporting and intervention planning of HEDIS measures to both NCQA and the State. The HEDIS coordinator also assists with coordination measures that are Pay-for-Performance (P4P) measures and implementation of the Quality Strategy.
EPSDT Coordinator	The EPSDT Coordinator conducts enrollee outreach and education on preventive care and early diagnosis of disease and coordinates with physician offices to organize population-based initiatives to improve adherence to recommended preventive health guidelines for examinations, screenings, and immunizations.
Grievance Coordinators	The Grievance Coordinators (GCs) coordinate the tracking, trending, and improvement of all member grievances. The GCs work with departments within Sunflower to coordinate resolution, identify opportunities for improvement, and recommend actions for implementation to improve member satisfaction with services provided by the Plan and its subcontractors. GCs evaluate complaints and grievances by type, location, and region to identify trends indicating potential areas in need of further analysis and

Position Title	Responsibilities
	intervention. GCs also track and resolve all administrative member grievances and provider complaints and serve as Member Advocates to assist members as needed to complete forms for initiating processes with Sunflower or other agencies which may include appeals, grievances and State fair hearings.
Lead Clinical Appeals Coordinator	The Lead Clinical Appeals Coordinator (LAC) is a nurse with experience in managed care in utilization review, specifically medical necessity review process. The LAC is directly responsible for monitoring the volume of appeals and State Fair Hearing (SFH) cases, triaging and delegation of those cases as appropriate to the Appeals Coordinators. The LAC is a resource to the Appeals Coordinator to ensure that Contract requirements for turnaround times are met, reports trends with cases to the QI leadership as appropriate, and works to coordinate all internal processes related to member and provider appeals. The LAC collaborates directly with Medical Directors and QI Leadership to process documentation, ensure processes follow federal, State and plan requirements. Additionally, the LAC works appeals and SFH cases as appropriate to ensure member and provider cases are addressed appropriately.
Appeals Coordinator	The Appeals Coordinator (AC) is a nurse with experience in utilization review, specifically medical necessity review, that coordinates all internal processes related to member and provider appeals. The AC works with members, providers, subcontractors and departments to gather data, complete medical necessity review, coordinate review activities with the Medical Director, and State authorities governing the appeals process. The AC processes all documentation, following all federal, State, and plan requirements. The AC also facilities all responses to SFH activities under the direction of the CMD. Additionally, the AC also provides education to members and providers to help resolve appeals and to assist in future situations to ensure efficiency in care or services for members.
Quality Improvement Auditors	Quality Improvement Auditors are highly trained clinical and non-clinical staff (including at least one registered nurse) with significant experience in a health care setting, and experience with data analysis and/or project management. The QI Auditors' scope of work may include medical record audits, data collection for various quality improvement studies and activities, data analysis and implementation of improvement activities and complaint response with follow up review of risk management and sentinel/adverse event issues. A QI Auditor may specialize in one area of the quality process or may be cross trained across several areas. The QI Auditors collaborate with other departments as needed to implement corrective action or improvement initiatives as identified through Plan's quality improvement activities and quality of care reviews.
QI Project Manager	The QI project Manager is a qualified person with experience in quality improvement, population health management/improvement, and data analysis and project management and is responsible for oversight of initiatives aimed at improving population health for members served. The QI Project Manager may also assist with initiatives that provide data for audits to demonstrate the efforts of Sunflower with regard to State contractual requirements, federal and accreditation standards. The QI Project Manager works in collaboration with other departments as well to implement quality improvement initiatives, corrective actions, and other target activities as identified through the plan's quality improvement activities and quality of care reviews.

QAPI Program Authority and Accountability (5.9.1.N.3)

The Sunflower Board of Directors oversees development, implementation and evaluation of the QAPI Program. The Board has ultimate authority and accountability for oversight of the quality of clinical and non-clinical care and services provided to members. The Board supports the QAPI Program by:

- Providing input and direction on QI strategies
- Establishing mechanisms for monitoring and evaluating quality, utilization, and risk
- Supporting QI Committee recommendations for proposed quality studies and other QI initiatives
- Providing the resources, support and systems necessary for optimum performance of QI functions
- 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 QI Committee which is chaired by Sunflower's Chief Medical Director. Sunflower senior management staff, clinical staff, and network providers, who may include primary, specialty, behavioral, dental, vision, and LTSS providers are involved in the implementation, monitoring and directing of the relative aspects of the quality improvement program through the QI Committee, which is directly accountable to the Board. We have developed relationships with many providers, advocates and associations and have created an 11–member Board of Directors, with at least 5 positions held by local Kansas health care leaders representing physical health, behavioral health and LTSS.

The Chief Medical Director serves as the Senior Executive for Quality Improvement (SEQI) and is responsible for:

- Ensuring compliance with State, federal, and NCQA accreditation requirements and regulations
- Chairing the QI Committee, or designating an appropriate alternate chair, and participating as appropriate
- Monitoring and directing QI activities among Sunflower personnel and among the various subcommittees reporting to the QI Committee
- Coordinating the resolution of outstanding issues with the appropriate leadership staff, pertaining to QI Committee recommendations, subcommittee recommendations, and/or other stakeholder recommendations
- Being actively involved in Sunflower's QAPI Program to include: (1) recommending QI study methodology; (2) formulating topics for QI studies as they relate to accreditation and regulatory agencies and State and federal law; (3) promoting participating providers' compliance with utilization management (UM) criteria and clinical practice guidelines; (4) assisting in the development of guidelines for on-going patient care monitoring as it relates to preventive health/sponsored wellness programs, pharmacy, diagnostic-specific case

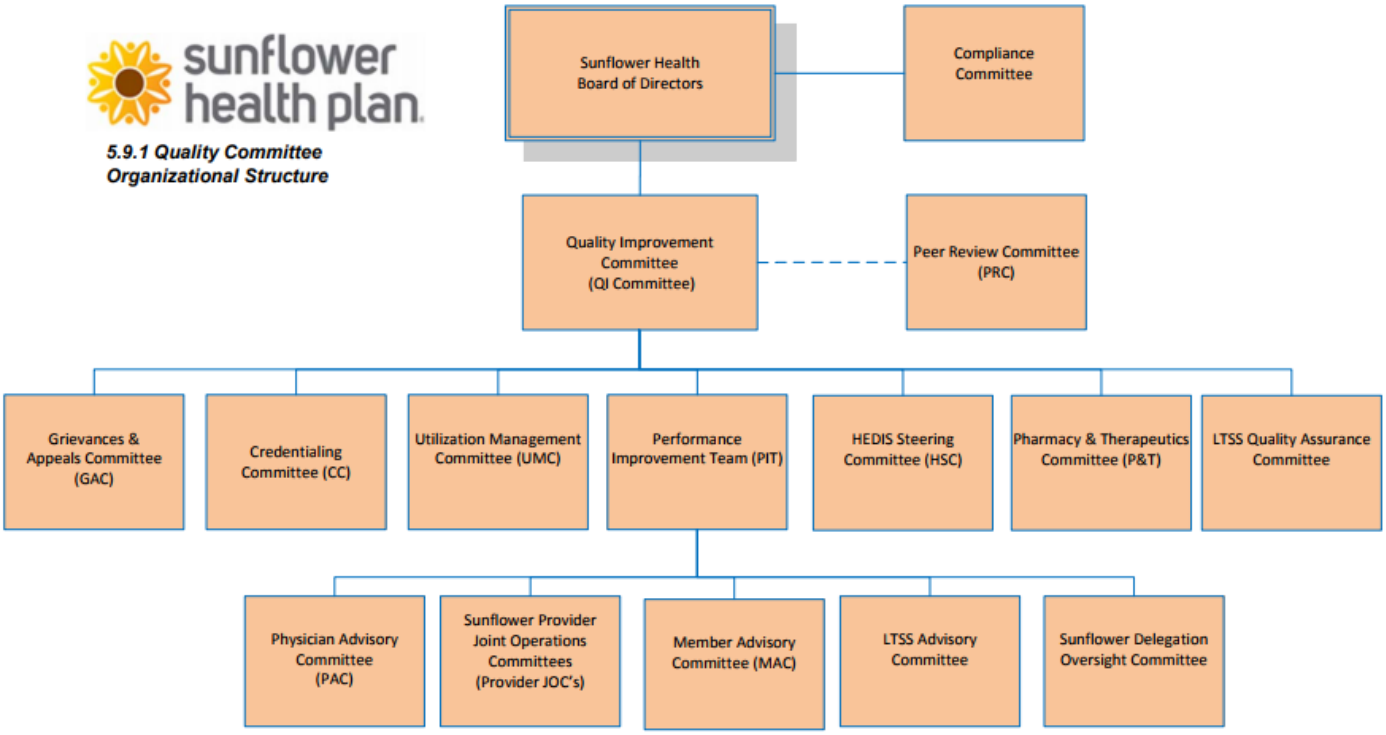
reviews and other focused studies; and (5) directing credentialing and recredentialing activities in accordance with the Sunflower's policies and procedures

- Reporting the QAPI Program activities and outcomes to the Board of Directors at least annually

QAPI Program Committee Structure (5.9.1.N.4)

Quality is integrated throughout Sunflower, and represents the strong commitment to the quality of care and services for our members. To this end, Sunflower has established various committees, subcommittees, and ad-hoc work groups to monitor and support its QAPI Program. As noted above, the QI Committee reports directly to Sunflower's Board of Directors (BOD). The QI Committee is supported by the Credentialing, Pharmacy and Therapeutics and Utilization Management Committees, Peer Review, Grievance and Appeals Committee, Performance Improvement Team, LTSS Quality Assurance Committee (to be established in 2018), Member Advisory Committee and Delegation Oversight Committee (called the "Joint Oversight Committee"). Ad-hoc committees may include regional level committees for the Member Advisory Committee based on distribution of membership. Our QAPI Program committee structure is portrayed in ***Figure 5.9.1.E Sunflower's QAPI Program Committee Structure*** below. Detailed information about each committee follows.

Figure 5.9.1.E: Sunflower's QAPI Program Committee Structure



Compliance Committee. Sunflower's Compliance Committee is a senior leadership committee, accountable to the Board of Directors (BOD), which meets at least quarterly or more frequently

as needed. It reviews as well as monitors the activities and performance of Sunflower's Compliance Program including the Fraud, Waste and Abuse Plan. The Compliance Committee consists of a standing, internal cross-functional team of individuals from the Compliance Department, within the organization, its subcontractors, as applicable, and other ad hoc members, as needed, who have the authority to implement corrective actions. The goals of the Sunflower Compliance Program are to reinforce and maintain a culture of compliance; provide evidence of an effective compliance program and to be a strategic and trusted resource. The goals of the Fraud, Waste and Abuse (FWA) Plan are to prevent potential health risks to Sunflower members and minimizes exposure to erroneous, wasteful or fraudulent activities.

Quality Improvement Committee (QI Committee). The purpose of the QI Committee is to promote a system-wide approach to quality assurance, provide oversight and direction in assessing the appropriateness of care and service delivered, encourage provider participation, and to continuously enhance and improve the quality of care and services provided to members. The QI Committee also has the responsibility for developing and implementing the QAPI Program. This is accomplished through a comprehensive, plan-wide system of:

- Ongoing, objective, and systematic monitoring
- Identification, evaluation, and resolution of process problems
- Identification of opportunities to improve member outcomes
- Analysis and evaluation of QAPI activities
- Recommendations for policy decisions
- Annual review and approval of the QAPI Annual Evaluation, QAPI Program Description and QAPI Work plan
- Education of members, providers and staff regarding the QI, UM, and Credentialing programs

The QI Committee is chaired by the Chief Medical Director (CMD). Other members include the CEO/President, Associate Medical Director and QI senior leadership, along with other Sunflower executive staff representing Utilization Management, Service Coordination, Network Development, Customer Service, Compliance, and Pharmacy departments with other ad hoc members as necessary. Other QI Committee attendees include staff responsible for clinical appeals and Fraud, Waste and Abuse. The QI Committee also includes at least two network physicians representing the range of practitioners within the network and across the regions in which it operates (i.e. Family Practice, Internal Medicine, OB/GYN, Pediatrics, Behavioral Health, LTSS providers, Vision/Dental care providers, and other high-volume specialists as appropriate), to the extent there is not a conflict of interest. Sunflower also ensures that at least one physician on the committee is a Behavioral Health Care provider.

The QI Committee meets no less than quarterly, but may have ad hoc meetings as needed (for example, to assure timely review and approval of NCQA reports). The QI Committee receives regular reports from the following subcommittees that report directly to the QI Committee:

- Credentialing Committee

- Pharmacy and Therapeutics Committee (P&T)
- Utilization Management
- Peer Review Committee (Ad Hoc Committee)
- Performance Improvement Team (PIT)
- HEDIS Steering Committee
- Grievances and Appeals
- LTSS Quality Assurance Committee

Examples of topics addressed by the QI Committee include: PIP updates, requests for feedback and recommendations regarding QI interventions and Provider Profile updates, and review of HEDIS results, CAHPS member satisfaction data, Provider Satisfaction survey data and pay for performance updates.

Credentialing Committee (CC). The Credentialing Committee (CC) is a standing subcommittee that meets monthly to oversee and exercise operating authority over the Credentialing Program. The CC is responsible for development and annual review of the Credentialing Program Description and associated policies and procedures. The CC has final authority for review and appropriate approval of licensed physicians, other licensed health care professionals, and certain facilities who have an independent relationship with Sunflower. Credentialing activities are performed in compliance with NCQA standards as well as State and federal guidelines, as applicable. The CC is chaired by the CMD or designee. Other members include the Sunflower Credentialing designee and network physicians from the following specialties: Family Practice/Internal Medicine, OB/GYN, high-volume specialists, mid-level practitioners, and BH practitioners. The Director of Credentialing maintains detailed records and minutes of all CC meetings, activities, program statistics and recommendations made by the committee. The CC routinely submits meeting minutes as well as written reports regarding analysis of the above tracking and monitoring processes and status of corrective action plans (as applicable) to the QI Committee.

Pharmacy and Therapeutics (P&T) Committee. The Pharmacy and Therapeutics (P&T) Committee is a standing subcommittee of the QI Committee, chaired by the CMD or designee, that meets no less than quarterly to oversee and exercise operating authority over the Pharmacy Program. The P&T Committee is a multidisciplinary team that includes representation from a range of network physicians, participating network pharmacist(s) and clinical pharmacist(s). Sunflower ensures that at least one physician on the committee is a Behavioral Health Care provider. Plan representatives from Pharmacy, UM, Service Coordination, Network Development, Quality, and Compliance are also standing members. The P&T Committee is responsible for development and annual review of the Pharmacy Program Description and associated policies and procedures, as well as activities such as reviewing pharmacy utilization data; evaluating and recommending drugs for inclusion in or removal from the State of Kansas Preferred Drug List; and reviewing and recommending clinical management activities to the State of Kansas Drug Utilization Review Board and health plan for

consideration. The P&T Committee also makes recommendations regarding drug utilization review activities such as targeted prescriber and/or member education initiatives and may assist with review of complaints/grievances regarding pharmacy issues and oversight of Sunflower's affiliated Pharmacy Benefit Manager (PBM). The Sunflower Pharmacy Department maintains detailed records and minutes of all P&T Committee meetings, activities, program statistics and recommendations made by the committee. The P&T routinely submits meeting minutes as well as written reports regarding committee activities and the status of corrective action plans (as applicable) to the QI Committee to allow for its review, feedback and recommendations.

Utilization Management Committee (UMC). The UMC, also a standing subcommittee of the QI Committee, meets at least quarterly to oversee and exercise operating authority over the Utilization Management (UM) Program, including 24-hr nurse triage, referrals, second opinions and peer to peer reviews, prior authorization, pre-certification, concurrent review, ambulatory review, retrospective review, discharge planning and service coordination. The UMC, chaired by the CMD or designee, 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 provider satisfaction with the UM process. The UMC includes network physicians representing the range of practitioners within the Sunflower network (i.e., Family Practice, Internal Medicine, OB/GYN, Pediatrics, Behavioral Health, LTSS providers, Vision/Dental care providers, and other high-volume specialists as appropriate) and across the regions in which we operate, and we ensure that at least one member is a behavioral health provider. Additional members include senior management staff from the following departments: Medical Affairs, Service Coordination, Quality, Network Development, Compliance, and Pharmacy. The UMC coordinates annual review and revision of the Utilization Management Program Description, Work Plan and Annual UM Program Evaluation, and subsequent approval by the QI Committee.

HEDIS Steering Committee (HSC). The HEDIS Steering Committee (HSC) meets no less than quarterly to oversee Sunflower's HEDIS process and performance measures and reports directly to the QI Committee. The HSC reviews trending and stratified data, identifies performance priorities and concerns, develops action plans and communicates corporate initiatives to Sunflower senior leadership. HSC also directs both clinical and non-clinical, and member and provider initiatives to improve HEDIS scores. The HSC is responsible for reviewing HEDIS scores on an ongoing basis, identifying areas in need of improvement, and developing an annual HEDIS work plan with prioritized measures and related interventions. The HSC also reviews, approves and implements both Sunflower and its parent organization, Centene, led initiatives to improve selected HEDIS measures. The HSC will also review or establish benchmarks or performance goals for HEDIS and oversee subcontractor roles in improving HEDIS scores. The HSC is chaired by the QI Manager and other HSC members include the HEDIS Coordinator and representation from Medical Affairs, Quality Improvement, UM, Services Coordination, Network Development,

Customer Services, Compliance, Pharmacy, and other plan staff as needed to develop appropriate interventions.

Peer Review Committee (PRC). The Peer Review Committee (PRC) is an ad-hoc committee chaired by the CMD or Associate Medical Director. The PRC is responsible for reviewing services where the plan or others may have identified potential quality of care concerns, adverse events, and sentinel events and an initial investigation indicates a significant potential or a significant, severe adverse outcome has occurred. Other cases may be reviewed at the discretion of the CMD. The PRC is expected to use their clinical judgment in assessing the appropriateness of clinical care and recommending a Corrective Action Plan (CAP) that will best suit the individual provider's situation and mitigate potential events from recurring in the future. Each PRC includes three or more network physicians who represent a range of specialties including at least one physician with the same or similar specialty as the provider and/or issue under review. Network physician members are not standing members of the committee and their attendance may change based on the type of case being reviewed. Reporting of Quality of Care (QOC) review activities is reported to the QI Committee at least quarterly. Reports to the State occur routinely as needed.

Performance Improvement Team (PIT). Sunflower's Performance Improvement Team (PIT) is an internal, cross-functional quality improvement team that meets monthly and 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 QI Committee and/or its supporting subcommittees, monitoring the outcomes of those improvement efforts and reporting back to the designated committee. The PIT includes leadership representation from: Medical Affairs, Quality Improvement, UM, Service Coordination, Network Development, Customer Service, Provider Relations, Operations, Vendor Management, Compliance, Pharmacy, and other health plan staff as needed to develop appropriate interventions (which may vary from meeting to meeting). The PIT also includes the following five subcommittees:

Member Advisory Committee (MAC) (5.9.1.N.10). The MAC functions as a focus group to gain member and community input on the quality of care and services offered by Sunflower and to offer recommendations for improvement to our processes and systems of care. The MAC meets as least quarterly and its responsibilities may include review of member satisfaction survey results, Customer Services telephone performance levels, member education materials for relevance, understanding and ease of use, and/or other topics. MAC membership is representative of our member population, including members with LTSS and BH needs, and parents/foster parents/guardians of children who are plan members including those in foster care and Children with Special Healthcare Needs (CSHCN). The MAC may also include other community members and plan staff, as appropriate. Sunflower informs members about the

MAC through member materials such as the Member Handbook and quarterly member newsletters, and through member contacts at community events. Members can also learn about how to volunteer for the MAC through the Member Portal. On an annual basis, Sunflower submits to the State an annual calendar of MAC meetings as well as a MAC plan for approval that addresses procedures for implementing and operating the committee, including how Sunflower will ensure meaningful representation from all member stakeholder groups. Sunflower also sends meeting agendas and related materials to both MAC members and the State at least two weeks prior to each meeting and, on a quarterly basis, submit a written report to the State with information regarding MAC meetings held during the quarter, including a list of attendees and how issues raised are being addressed. Sunflower designates an employee to present to groups designated by KDHE regarding these quarterly reports and answer questions.

LTSS Advisory Committee (5.9.1.N.10). This committee, comprised of LTSS providers, associations, member advocacy groups, and Sunflower leadership meets at least quarterly, or more often as needed, to provide recommendations on ways to improve outcomes for members receiving HCBS. Meeting topics include LTSS outcomes measures, member satisfaction survey results, value-based payment strategies, State and Sunflower policy and processes, proposed legislation, and other LTSS initiatives. The committee is chaired by the Sunflower LTSS Director or designee.

Physician Advisory Committee (PAC). This committee, comprised of practicing primary care physicians in Sunflower's network (including but not limited to Pediatricians and Family Practice and Internal Medicine physicians), provides Sunflower with clinical advisement and quality oversight from the physician perspective and meets at least twice a year, or more often as needed. The PAC works in close partnership with our CMD and Network leadership to ensure that Sunflower maintains the highest of standards of care quality, efficiency and transparency, and relentlessly pursues healthy outcomes for our members. PAC meetings are led by the CMD. Other Sunflower participants include the Vice President of Network Development and Contracting, Manager of Contracting and Development, Provider Network Director, Senior Manager of Provider Relations, Director of Quality Improvement.

Sunflower Provider Joint Operations Committees (Provider JOCs) (5.9.1.N.10). The Provider JOCs are active provider committees with high volume providers whose primary function is to provide input on the following: plan policies, programs and processes; payment and UM activities; provider satisfaction and profiling activities; and assistance to identify concerns and provide input for recommendations for improvement of provider relations and support. Additionally, from time to time, Sunflower may engage providers to provide input on implementation of new policies, processes, and tools. The Provider JOCs meet at least quarterly, but may meet monthly or as requested by our large provider groups. The Provider Network Specialist that is responsible for the relationship with the provider leads the meeting and includes representatives from other area departments as needed, based on the agenda.

Sunflower Delegation Oversight Committee (called the "Vendor Joint Operations Committee, or JOC) (5.9.1.N.10). The JOC meets at least quarterly with each subcontractor and has the responsibility for oversight of all delegated entities to ensure that delegated services meet State, KDHE, federal, and NCQA requirements. In this role, the JOC reviews periodic activity reports from subcontractors, coordinates annual audits, and recommends actions to address any identified opportunities for improvement in delegated services. The JOC includes representation from all functional areas as well as subcontractor representatives. JOC meetings are coordinated by Sunflower's Subcontractor Oversight staff.

Grievance and Appeals Committee (GAC). The Grievance and Appeals Committee (GAC) meets at least quarterly or more frequently as needed. The GAC is responsible for maintaining compliance with contractual, federal, State, and accrediting body requirements such as NCQA related to member and provider appeals and grievances. The scope of the GAC includes tracking and analysis of member grievances and appeals including type and timeliness of both acknowledgement and resolution, performing barrier and root cause analysis and making recommendations regarding corrective actions as indicated. The GAC, as required by State Contract, may also be responsible for review and determination of member grievances and non-clinical appeals and facilitating requests for administrative review filed by members (and providers who file on behalf of members regarding administrative reviews) including, as applicable, determinations by a delegated entity. The GAC is chaired by the QI Director or designee, and is comprised of leadership representatives from the following areas: Medical Affairs, Quality Improvement, UM, Service Coordination, Network Development, Customer Services, Provider Relations, Compliance, Operations, Vendor Management, and Pharmacy. Additional plan staff may participate at the discretion of the chair.

LTSS Quality Assurance Committee. In 2018, Sunflower is adding the LTSS Quality Assurance Committee that will be charged with reviewing LTSS-related appeals, grievances, and State fair hearings; over/under-utilization of LTSS services; members who are not utilizing LTSS services that have been authorized; HEDIS results for the LTSS population; LTSS member/provider satisfaction; LTSS service plans; LTSS-related Quality of Care events and Adverse Incidents; utilization of LTSS services; and NCQA LTSS designation/accreditation status. This committee will report up to the QI Committee and will be chaired by the LTSS Medical Director and/or designee. The committee will consist of Sunflower leadership, members of the LTSS staff, and representatives from the following areas: QI Department, Medical Affairs, Provider Relations, Contracting, Claims, Compliance, Vendor Management, Customer Service and UM.

QAPI Program Governing Documents

Sunflower's QAPI Program incorporates an ongoing documentation cycle that applies a systematic process of quality assessment, identification of opportunities, action implementation, as indicated, and evaluation. Several key QI instruments demonstrate Sunflower's continuous quality improvement cycle using a pre-determined documentation flow. They include:

- QAPI Program Description
- QAPI Work Plan
- QAPI Annual Program Evaluation

These documents are reviewed and approved by Sunflower's QI Committee and the BOD at least annually.

QAPI Program Description. The QAPI Program Description includes the following: specific roles, structure and function of the QI Committee and other committees, including meeting frequency; accountability to the governing body; a description of resources that are devoted to the QAPI Program; behavioral health care involvement; and patient safety. The QAPI Program Description is reviewed on an annual basis. Changes or amendments made are noted in the 'Revision Log'. The QI Program Description may describe in the form of "Amendments," those QI activities or projects to be undertaken for the following fiscal year. We submit substantial QAPI Program Description changes to KDHE for review and approval as required by our State Contract.

QAPI Annual Work Plan (5.9.1.N.5). To implement the comprehensive scope of the QAPI Program, Sunflower's Annual QAPI Work Plan sets measurable goals, establishes specific objectives, identifies strategies and activities to be undertaken, monitors results and assesses progress towards stated goals. This includes the activities that must be completed by each department and all supporting committees throughout the measurement year. The annual QI Work Plan will specify 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 Work Plan will be reviewed by the QI Committee on an annual basis and at regular intervals throughout the year, as needed.

QAPI Annual Program Evaluation (5.9.1.M, 5.9.1.N.6). The QAPI Program Evaluation, completed within the first quarter of each year, includes an executive summary of the QAPI, a summary of all QI activities, the impact the program has had on members' care, an analysis of the achievement of stated goals and objectives and the need for program revisions and modifications. Program evaluation findings are used to develop the annual QAPI Program Description and QAPI Work Plan for the subsequent year. For example, the 2016 QAPI evaluation found that 137 of Sunflower's 631 total grievances in 2016 related to Access to Service or Care, and that many of these grievances pertained to transportation difficulties. As a result, Sunflower is continuing to work closely with our transportation subcontractor and has set a goal to reduce total grievance volume to 4.5/1000 members in 2017. The CMD and the QI Committee evaluate the QAPI Plan at least annually. The QI Director is responsible for coordinating the evaluation process and assuring that a written description of the evaluation and work plan are provided to the QI Committee and BOD for approval annually. Sunflower submits the approved annual QAPI Program Evaluation report to KDHE and/or the EQRO, as specified by the State.

The annual QAPI evaluation includes the following:

- An evaluation of the overall effectiveness of the QAPI Program, including progress toward influencing network-wide safe clinical practices and effectiveness of care management
- Member demographic information, including age, race, ethnicity and other characteristics, as well as any changes or inconsistencies seen year over year which allows Sunflower to implement or adapt quality strategies as appropriate
- A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service
- Trending and analysis of measures collected over time to assess outcomes, effectiveness and ongoing performance in the quality of clinical care and services
- Interventions implemented to address the issues chosen for performance improvement projects and focused studies
- Measurement of outcomes and the effectiveness of interventions
- An analysis of whether there have been demonstrated improvements in the quality of clinical care and/or quality of services
- Identification of health care disparities and limitations or barriers to achieving program goals
- Any corrective actions which are recommended, implemented, or in progress
- Goals and recommendations for the upcoming year's QAPI Work Plan, including recommendations for continuous quality and service improvement
- An evaluation of the scope and content of the QAPI Program Description to ensure that it covers all types of services in all settings, and reflects demographic and health characteristics of Sunflower's membership
- An evaluation of the adequacy of resources and training related to the QAPI Program
- The communication of necessary information to other committees when problems or opportunities to improve patient care involved more than one committee's intervention

Accountability across the Organization (5.9.1.N.7). As a quality-driven organization, Sunflower has adopted continuous quality Improvement as a core business strategy for the entire health plan, not just as part of a separate QAPI Program. Our executive and management teams use data-driven decision-making methodologies in strategic planning and daily operations. Each operational area has defined service metrics with accountability to the Senior Leadership team and reported up through the QI Committee. Key leaders are trained on quality improvement methodologies such as Rapid Cycle Improvement or PDSA. Senior Leadership and appropriate staff representatives from across functional areas engage in monthly meetings (more frequently as needed) to review utilization and other quality

Sunflower scored 49.44 out of a possible 50 points on NCQA standards during our April 2017 onsite NCQA review demonstrating the quality and efficiency of our quality management processes which are fully integrated across all Sunflower functional areas.

data (e.g. HEDIS, CAHPS, and provider satisfaction survey results) for variances and to develop improvement strategies to address any variances.

Established QI Processes (5.9.1.N.8). To directly support QAPI activities, each department is responsible for monitoring, analyzing and making recommendations regarding identified trends, follow-up, barrier analysis, and interventions to improve the quality of care and service to members. Information is reported up through the QI Committee and/or the appropriate Senior Executive as defined in policy. All staff have access to the QAPI Program Description, Work Plan, Annual Evaluation, and P&Ps and are held responsible for ensuring alignment between quality goals and activities and the work they perform through monthly and quarterly reporting and participation in quality committees and subcommittees.

Written Policies and Procedures. Sunflower's policies and procedures (P&Ps) ensure compliance with State, federal, NCQA, and Contract requirements, and accountability for quality across all Sunflower functional units. Our quality P&Ps clearly define roles, functions, and responsibilities for all QM and QAPI activities, providing for regular quality reporting to Sunflower's committees, management, and providers, and dissemination of information to members and key stakeholders. Sunflower's P&Ps promote continuous quality improvement processes, including systematic data collection, analysis, evaluation, ongoing monitoring, and reporting of performance and results. They outline procedures for remedial action for deficiencies, time lines for correction, and assign a specific staff person to be responsible for ensuring compliance and follow-up. A sample list of QM P&Ps is included in ***Table 5.9.1.E Sample Quality Improvement Policies and Procedures*** below.

Table 5.9.1.E_Sample Quality Improvement Policies and Procedures

QI Program Description	
Clinician Documentation of HEDIS Data	Members with Special Health Care Needs
Continuity and Coordination between PH and BH	Monitoring Quality of Care
Continuity and Coordination of Care	Oversight of Delegate Vendors
Cultural Competency Plan	Peer Review Committee and Process
Evaluation of Accessibility of Services	Preventive Health and Clinical Practice Guidelines
Evaluation of Practitioner Availability	Provider Experience Analysis
Grievance System	QI Data Integrity of HEDIS Supplemental Database
Health Promotion for BH	QI Documentation Cycle
HEDIS Rate Analysis	QI Program Operations
HEDIS Reporting	QOC Investigations
Medical Record Keeping	Quality Performance Improvement Projects
Member Experience Analysis	Supplemental Data Sources for HEDIS Reporting

Communication on Quality Improvement to Key Stakeholders (5.9.1.N.9). On an annual basis and as requested, Sunflower makes information about its QAPI program available to the State and to key stakeholders (including members, family members and providers), including a description of the QAPI program and a report on Sunflower's progress in meeting QAPI Program goals. At a minimum, these communications include information about QI program goals, processes and outcomes as they relate to member care and service (including subcontractor

and provider quality improvement information) and include plan specific data results such as HEDIS, CAHPS, and results of Performance Improvement Projects (PIPs). This information may be included in Member Newsletters or in a separate mailing and on Sunflower's website. Information about how to obtain a hard copy description of the program is included on the website and in the Member Handbook and Provider Manual. In addition, Sunflower engages with members, providers and community stakeholder advisory committees to communicate program results and obtain feedback on proposed interventions, including through staff interactions at community events.

Solicit Feedback and Recommendations from Key Stakeholders (5.9.1.N.10). As noted above and in our response to Section 5.9.10 below, Sunflower provides multiple opportunities for key stakeholders, subcontractors, members and family members to provide feedback regarding quality improvement. These include but are not limited to our Member Advisory, LTSS Advisory and Physician Advisory Committees outlined above as well as through satisfaction surveys and our Grievance Process. We monitor stakeholder feedback for trends and use this information to enhance or develop programs to improve member outcomes and quality of care.

5.9.2. STATE AND FEDERAL MONITORING

Sunflower is committed to effective oversight of our subcontractors and delegates, in compliance with all regulatory and Contract requirements, and full cooperation with State and federal oversight and monitoring activities as further described below.

SUBCONTRACTOR OVERSIGHT

Sunflower has developed an extensive subcontractor oversight program to ensure subcontractor compliance and adherence to all Contract requirements. Sunflower understands that we are ultimately responsible for all products, services and obligations agreed to by Sunflower and the State of Kansas and that we must certify and warrant all subcontractor work. Our subcontracts include appropriate provisions and contractual obligations to ensure the successful fulfillment of all contractual obligations. All Sunflower subcontractors with delegated services enter into a written agreement that meets the requirements of 42 CFR §438.230 and that includes all applicable terms and conditions of the Contract, including, but not limited to:

- Responsibilities of the plan and the subcontractor
- Specific delegated activities, required business and regulatory reporting requirements
- Explicit Statement of consequences, corrective action process if the subcontractor fails to meet the agreement terms, up to, and including revocation of the delegation agreement

Sunflower applies a rigorous process for evaluating subcontractors to perform services under our contracts. We carefully monitor each subcontractor's performance throughout their service for us and do not renew agreements with poorly performing subcontractors.

Summary of Subcontractor Oversight Activities

Pre- and Annual-Delegation Audits. Sunflower, in partnership with our parent company Centene Corporation (Centene), conducts pre- and annual delegation audits of all subcontractors. To ensure a comprehensive audit, we use a standardized Delegation Review Tool that reviews subcontractor performance related to specific areas, such as policies and procedures, member files, reports, marketing material, compliance program, and clinical guidelines, if applicable.

Ongoing Monitoring. In addition to formal reviews, Sunflower monitors subcontractor performance on an ongoing basis. We maintain written subcontractor monitoring plans through our subcontractor oversight program that clearly define the type and frequency of reporting and monitoring for each subcontractor, establishes specific performance metrics, and evaluates performance against identified metrics. These plans are stored and continually monitored/updated within Sunflower's comprehensive Compliance Management System, described below.

Meetings of the Delegation Oversight Committee (called the Vendor Joint Operations Committee, or JOC). Sunflower hosts quarterly JOC Meetings with each subcontractor that include a focused review of performance dashboards and reports, complaints and grievances, quality initiatives, and pertinent regulatory updates. Minutes from each meeting are recorded, approved, and stored for follow up within our Compliance Management System. Coordinated by Sunflower's Subcontractor Oversight Staff, JOC meetings include representation from the subcontractor and other Sunflower staff related to the subcontractor's delegated functions, including, but not limited to, Sunflower leadership, Service Coordination, Utilization Management (UM), Quality Improvement, Finance, and/or Network Development. We have found cross-functional representation at the JOC to be helpful, resulting in a faster and more effective solution to identified issues. More frequent JOC meetings may be held as deemed necessary by Sunflower and the subcontractor.

Additional Oversight Activities. Other ongoing subcontractor monitoring processes, depending on each entity's delegated function(s), include:

- Analyzing subcontractor network listings and changes
- Analyzing call center, utilization (specific to each delegated function), and claims metrics
- Approval of delegated (re)credentialing files by the Credentialing Committee
- Verification of monthly monitoring for provider exclusions and reinstatements and (re)credentialing
- Conducting/tracking investigations resulting from encounters, appeals, grievances, quality of care complaints or fraud issues
- Compliance review and follow up on feedback from Advisory Committee meetings

Organizational Infrastructure that Supports Subcontractor Oversight

Sunflower takes a collaborative approach to subcontractor oversight. Although our Subcontractor Oversight Staff leads subcontractor oversight activities, most of our other

departments participate to ensure that delegates meet Sunflower and Kansas Department of Health and Environment (KDHE) standards in each respective area. All Sunflower staff are trained to report any subcontractor issues to Subcontractor Oversight Staff upon identification, and, as described, a variety of team members participate in JOC meetings to provide additional input.

Committee and Operational Meetings. Sunflower conducts a number of committee and operational meetings to support subcontractor oversight. This includes, at a minimum, JOC meetings, chaired by Sunflower's Manager of Vendor/Subcontractor Management or designee, where subcontractor performance is reviewed by internal business leads. In addition, our cross-departmental Performance Improvement Team (PIT), chaired by the Quality Improvement (QI) Manager or Director, meets monthly and monitors all health plan performance metrics, including those related to subcontractors; identifies opportunities for quality improvement; and monitors subsequent interventions and results. The PIT reports to the Quality Improvement Committee (QI Committee), which is chaired by the Chief Medical Director or designee and reviews subcontractor quality program documentation and/or corrective action plans (CAPs), if applicable.

Technology Infrastructure. Sunflower uses a Compliance Management System that supports our contractual and regulatory oversight capabilities, manages our compliance with Contract requirements, and tracks all compliance activities. Sunflower's system has the ability to accept required and ad hoc reports from subcontractors via secure file transfer protocols (SFTP). This system stores contract requirements, documents to demonstrate compliance, and related policies and procedures. Any contract compliance issue identified with a subcontractor is tracked within the Compliance Management System along with progress on any identified issues.

Types of Reports Required from each Subcontractor

Sunflower requires subcontractors to submit monthly, quarterly, and annual (as well as ad hoc, when necessary) reports. Upon contracting, Sunflower reviews with each subcontractor the robust reporting process and all reporting requirements, including required data/information, reporting frequency, and report submission process. Network Development, UM, Service Coordination, Pharmacy, and Quality staff review and use subcontractor reports in the daily administration of Plan responsibilities and in the ongoing monitoring of delegated functions. Required reports depend on each subcontractor's delegated functions and address areas such as:

- Prior authorization turnaround time, approvals, and denials
- Call center volume and accessibility
- Service utilization
- Claims processing
- Complaints, grievances, and appeals
- Network access reports

- (Re)Credentialing activity

For additional detail on our subcontractor oversight program, see our response to ***Section 5.5.13.***

COOPERATION WITH STATE AND FEDERAL OVERSIGHT AND MONITORING

As further described in ***Table 5.9.2 Ensuring Compliance with Monitoring Requirements*** below, Sunflower commits to full cooperation with State and federal oversight and monitoring activities and requests.

Table 5.9.2_Ensuring Compliance with Monitoring Requirements

Ensuring Compliance with Monitoring Requirements	
Cooperation with State and Federal Monitoring of Contract Performance (5.9.2.A)	Since our inception in 2013, Sunflower has demonstrated our ability to cooperate, and will continue to cooperate, with both State and federal oversight activities, including operational reviews, audits and evaluations by KanCare's independent, external quality review organization (EQRO). Sunflower's Compliance Officer serves as the point of contact for requests regarding State and federal reviews and, in this capacity, coordinates with the applicable business owners, including subcontractors.
Providing Data and Information requested by the State (5.9.2.B)	Upon request, Sunflower promptly locates and makes available to the State or its outside reviewers any requested medical and other records, including records and documentation maintained by subcontractors, for review of quality of care, access, financial, and other issues, including required documentation pertaining to KDHE's Quality Management Strategy. Documentation is provided at no charge and is submitted within required timeframes.
Office workspace available upon request (5.9.2.C)	Upon request, Sunflower provides, at no cost, an adequate workspace at Sunflower's Lenexa office for the State or federal agency, or their authorized representatives, to review data, medical records, or other information.
External Quality Review (5.9.2.D)	Sunflower has successfully completed many external audits since our inception and has worked with the Kansas Foundation for Medical Care (KFMC), KDHE's external reviewers, for our annual External Quality Review Organization (EQRO) audit. Sunflower looks forward to continued collaboration with KFMC and other State agencies as an integral component of our continuous quality management efforts, including in the development of studies, surveys and other QAPI activities, performance measurement, and the completion of annual quality reviews. Sunflower also commits to responding to recommendations made by the EQRO within established timeframes. For example, Sunflower has successfully implemented recommendations from KFMC's 2013 and 2015 BBA audits by completing the system changes needed in 2017 to ensure that letters pertaining to members who are children are addressed to their parent or guardian, including grievance letters (implemented in 2013) and UM and appeal letters (implemented in 2017).

5.9.3. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT GOAL, OBJECTIVES, AND GUIDING PRINCIPLES

Sunflower complies with and supports KDHE's Quality Management Strategy (QMS) and aligns with the State's guiding principles, goals, and objectives, and will fully integrate them into our Quality Assessment and Performance Improvement (QAPI) Program and infuse them throughout Sunflower. Sunflower ensures adoption and full alignment by our subcontractors

through our subcontractor contract requirements and through our subcontractor oversight and monitoring activities described in ***Section 5.9.2*** above.

GUIDING PRINCIPLES (5.9.3.A)

Sunflower currently embraces and adheres to the guiding principles listed in Section 5.9.3.A, as illustrated by the examples provided below, and will update our QAPI Program Description to formally adopt them.

Promote a Culture of Quality, Innovation, and Service Excellence (5.9.3.A.1, 5.9.3.C.7)

Sunflower is a quality-driven organization that has adopted continuous quality improvement as a core business strategy and for the entire health plan. Our executive and management teams use data-driven decision-making methodologies in strategic planning and daily operations. Each operational area has defined service metrics with accountability to the Senior Leadership team that reports up through the Quality Improvement (QI) Committee. Key leaders are trained on quality improvement methodologies such as Rapid Cycle Improvement which includes using the method of PDSA. For example, our Sunflower analytics team used the PDSA process to improve Provider Profiles by first testing a new algorithm to generate profiles based on attributed members rather than solely assigned members. The new logic proved successful. Providers who received the new profiles confirmed that the members attributed were current patients which enabled the providers to schedule appointments when needed to close care gaps. Providers are also sending Sunflower medical records by way of the secure Provider Portal which was new in 2017. The new logic was then applied to subsequent Provider Profiles and updated as needed. Sunflower will engage with Community Service Coordinators to implement a culture of quality throughout the community.

Senior Leadership and appropriate staff representatives from across functional areas engage in monthly meetings (more frequently as needed) to review utilization and other quality data (e.g. appeals, grievances, quality of care, HEDIS, CAHPS, and provider satisfaction survey results) for trends or variances. This allows Sunflower to determine root causes and to develop improvement strategies to address any trends or variances. To directly support QAPI activities, each department is also responsible for monitoring, analyzing and making recommendations regarding identified trends, follow-up, barrier analysis, and interventions to improve the quality of care and service to members.

Empowering Staff Excellence (5.9.3.A.2, 5.9.3.C.2)

As further described in our response to ***Section 5.17*** Staffing, Sunflower maintains a seasoned team of over 400 staff members with many years of Medicaid experience. Our member-facing LTSS Service Coordinators, for example, have an average of over 9 years of health care experience. Our experienced Kansas-based leadership team is dedicated to helping transform the communities where we live, work and serve with a strong focus on talent development and training. Sunflower's goal is to attract, develop, challenge, and retain the best and brightest talent available. Training is important in creating an ideal work environment, raising the confidence and expanding the abilities of employees, and improving our ability to serve our

members. Our training begins with an overview of Sunflower operations and the KanCare program. After the Kansas based Medicaid program training, each new employee participates in an extensive computer-based training (CBT) program called "Centene 101," which covers a wide variety of topics including the role of key functional areas and operational policies and internal procedures. Sunflower also uses Cornerstone, a corporate wide learning management system complete with online courses available to all affiliates, to enhance our classroom training. The tutorials provide on-demand, anytime learning, at a pace set by each individual. Examples of applicable course content includes communication skills, conflict resolution, basic problem-solving skills, behavioral and interpersonal competencies, time management skills, computer skills, and health care reform.

Using Data to Drive Improvement (5.9.3.A.3, 5.9.3.C.1, 5.9.3.C.3)

Sunflower takes a data-driven approach to performance improvement and improving outcomes for members. Our internal monitoring processes are supported by Centelligence, Centene's award-winning family of integrated decision support and health care informatics solutions that facilitates our use of data by collecting, integrating, storing, analyzing, and reporting data from all sources. Centelligence provides expansive business intelligence support, including flexible desktop reporting and online Key Performance Indicator Dashboards with "drill down" capability, allowing users to focus on a specific piece of content in an interactive manner. Centelligence also powers our provider practice patterns and provider clinical quality and cost reporting information products. Through Centelligence, we have been able to report on all datasets in our platform, including those for HEDIS, EPSDT services, claims timeliness, and other critical aspects of our operations for all provider types, including physical health (PH), behavioral health (BH), long term services and supports (LTSS), dental and vision. Centelligence also includes a suite of best-of-breed predictive modeling solutions incorporating evidence-based, proprietary Care Gap/Health Risk identification applications that identify and report significant health risks at population, member, and provider levels.

Sunflower is also expanding our existing caseload monitoring capabilities through TruCare to provide an interactive dashboard for Service Coordinators and their Supervisors. The CareLink daily dashboard aims to drive action by providing actionable analytics presented in a user-friendly format. For Service Coordinators, CareLink enables them to view member ED utilization and inpatient admission alerts, upcoming member contacts and visits, care gaps, and a caseload planner displaying members coming on and off the caseload and members with upcoming Medicaid recertification, all updated in near real-time. For Supervisors, CareLink provides them with views of subordinate Service Coordinator case assignments and caseload tracking, including views of past-due contacts for Service Coordinators under their supervision.
The CareLink daily dashboard empowers Service Coordinators to engage with members and providers and proactively address the member's complex, unique needs as they come up, and allows Supervisors to provide critical leadership and support for Service Coordinators.

Using Rapid Cycle Improvement Methods to Drive Improvement (5.9.3.A.4, 5.9.C.3 – 4).

Sunflower employs the evidence-based Institute for Healthcare Improvement (IHI) Model for Improvement with rapid cycle process improvement using the PDSA test of change for Action Planning, developing specific objectives and designing and implementing interventions. The IHI Model starts with three questions:

- Setting Aims: What are we trying to accomplish?
- Establishing Measures: How will we know that a change is an improvement?
- Selecting Changes: What changes can we make that will result in improvement?

To develop specific objectives, identify appropriate measures, and design interventions, we use a wide range of data and our sophisticated analysis and reporting capabilities available through Centelligence. Workgroups use this data to assess performance on measures related to each goal, compare it to established benchmarks, and develop objectives as steps to achieve each goal.

Sunflower staff use the Rapid Cycle Process Improvement that includes PDSA, described in ***Table 5.9.3.A Plan Do Study Act Rapid Cycle Improvement Process*** below, to test selected high priority interventions on a small scale and to modify them as needed to improve their effectiveness prior to full implementation.

Table 5.9.3.A_Plan Do Study Act Rapid Cycle Improvement Process

Step	Description
Plan	• Plan the test or observation, including a plan for collecting data State the objective of the test • Make predictions about what will happen and why • Develop a plan to test the change. (Who? What? When? Where? What data needs to be collected?)
Do	• Try out the test on a small scale • Carry out the test • Document problems and unexpected observations • Begin analysis of the data.
Study	• Set aside time to analyze the data and study the results • Complete the analysis of the data • Compare the data to predictions • Summarize and reflect on what was learned.
Act	• Refine the change, based on what was learned from the test • Determine what modifications will be made • Decide whether to abandon, maintain, or expand the intervention.

We use data, including structure, process, and outcome measures, to monitor our success in implementing change (intervention). Sunflower runs PDSA cycles sequentially to rapidly test each change or group of changes to see if they result in improvement. We modify, refine, or replace the intervention as needed to improve its efficiency and efficacy and then gradually increase the scale of the intervention until we are confident that the changes can be adopted more widely. Use of these QI models and tools has produced statistically significant improvements. Examples include Comprehensive Diabetes Care (CDC) Eye Exam rates (which increased by 4.1% from measure year (MY) 2015 to MY 2016), CDC HbA1c Control (<8) measure

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Percentage of Change for HEDIS Measures 2014-2016:

BMI Percentile = 22.43%
Nutrition Counseling = 21.46%
Physical Activity = 18.21%

rates (which increased by 13.8% from measure year (MY) 2015 to MY 2016), and CDC HbA1c testing rates (which increased by 2.1% from measure year (MY) 2015 to MY 2016). Interventions to achieve these improvements included, in part, partnering with subcontractors to increase member-specific outreach by providing clinic contact information near their addresses; partnering with Quest Diagnostics to provide in-home A1c screening for members lost to follow up; provider education, provider profiles, provider incentive arrangements based on quality metrics and other member education.

Focus on Year-over Year Improvement (5.9.3.A.5, 5.9.3.C.3)

On an annual basis, Sunflower evaluates its QAPI Program to assess the impact that the program has had on members' care, analyze the achievement of stated goals and objectives, and determine the need for program revisions and modifications. The annual evaluation measures, in part:

Pharmacotherapy Management of COPD Exacerbation – Percentage Increase for HEDIS Measures 2014-2016:

Systemic Corticosteroid = 10.63%

- Progress toward influencing network-wide safe clinical practices and effectiveness of care management
- Trending and analysis of measures collected over time to assess outcomes, effectiveness and ongoing performance in the quality of clinical care and services
- Outcomes and the effectiveness of interventions

Demonstrated improvements in the quality of clinical care and/or quality of services as illustrated in ***Table 5.9.3.B Sunflower Selected Year over Year HEDIS Measure Improvements, 2014-2016*** below.

Table 5.9.3.B_Sunflower Selected Year over Year HEDIS Measure Improvements, 2014-2016

Measure Name	Submeasure	Final Submitted Rate			Percentage Increase	
		MY 2016	MY 2015	MY 2014	2015 -2016	2014 -2016
Annual Dental Visit (ADV)	Total	63.49%	61.21%	60.17%	3.72%	5.52%
Appropriate Testing for Children With Pharyngitis (CWP)	All Members	60.77%	54.0%	51.60%	12.35%	17.77%
Avoidance of Antibiotic Treatment Adults w/ Acute Bronchitis (AAB)	All Members	39.08%	35.71%	35.64%	9.44%	9.65%
Comprehensive Diabetes Care (CDC)	Eye Exams	70.70%	67.92%	61.42%	4.09%	15.11%
Comprehensive Diabetes Care (CDC)	HbA1c Control (<8) Adequate Control	53.26%	45.58%	40.13%	16.85%	32.72%

Measure Name	Submeasure	Final Submitted Rate			Percentage Increase	
		MY 2016	MY 2015	MY 2014	2015 -2016	2014 -2016
Comprehensive Diabetes Care (CDC)	HbA1c Poor Control (>9)*	40.23%	46.68%	50.55%	-13.82%*	-20.42%*
Comprehensive Diabetes Care (CDC)	HbA1C Testing	87.44%	85.62%	84.48%	2.13%	3.50%
Follow-Up After Hospitalization for Mental Illness (FUH)	Follow Up Within 7 Days of Discharge	68.62%	67.20%	59.54%	2.11%	15.25%
Immunizations for Adolescents (IMA)	Combo 1 (Tdap, Meningococcal)	65.38%	63.59%	61.58%	2.81%	6.17%
Medication Management for People With Asthma (MMA)	Total Age 5 to 64 (Total Population) 75% Covered	33.87%	28.94%	27.85%	17.04%	21.62%
Pharmacotherapy Management of COPD Exacerbation (PCE)	Dispensed Bronchodilator Within 30 Days of Event	46.38%	44.99%	40.96%	3.09%	13.23%
Pharmacotherapy Management of COPD Exacerbation (PCE)	Dispensed Systemic Corticosteroids Within 14 Days of Event	37.79%	35.26%	34.16%	7.18%	10.63%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	BMI Percentile Documentation	58.89%	50.71%	48.10%	16.13%	22.43%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	Counseling for Nutrition	61.78%	50.48%	49.76%	22.39%	24.16%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	Counseling for Physical Activity	56.01%	46.90%	47.38%	19.42%	18.21%
***Lower rate – better performance**						

Implementing a System of Measurement and Monitoring (5.9.3.A.6, 5.9.3.C.1)

Practical use of performance measure results is fundamental to Sunflower's culture of quality that permeates our daily operations. HEDIS and other performance rates are not just produced to meet mandated reporting requirements. These rates are produced monthly and outcomes are validated for data accuracy; comparison to national, regional and local thresholds;

investigated for opportunities for improvement; and analyzed against interventions and progress towards goals. The ongoing assessment of HEDIS data allows us to use the PDSA method to evaluate success of interventions or identify the opportunities to modify, add or discontinue interventions in an effort to continue to pursue continuous quality improvement. Our QI staff analyzes and tracks a variety of performance and outcomes data to identify potential areas for improvement in clinical outcomes or service delivery. ***Table 5.9.3.C Sample Listing of Performance Measures*** below provides a sample listing of performance measures used to analyze delivery of service and quality of care, and ***Figure 5.9.3.A Centene Clinical Initiatives Screen Shot,*** provides a screen shot of the Centene Clinical Initiatives Dashboard that allows Sunflower to track performance against both Sunflower's goals and Centene's corporate-wide goals. Sunflower can also run reports that drill down to the member level. Also, ***Figure 5.9.3.B Centene P4P Dashboard Screen Shot*** provides a screen shot of the Centene P4P Scorecard, another way that Sunflower's performance on critical HEDIS is tracked.

Table 5.9.3.C_Sample Listing of Performance Measures

CATEGORY	Performance Measures Examples (not all inclusive)	Reporting Mechanism Examples
Over- and Under Utilization	Emergency room visits/1,000; admissions/1,000; inpatient average length of stay; NICU days/1,000 and NICU average length of stay; narcotic prescriptions, prescribers and pharmacies; HCBS service authorizations; chronic condition medication fill data; child and adult preventive health screenings; immunizations; prenatal and postpartum care; and HEDIS measures	UM Dashboard, Inpatient Leading Indicators Dashboard (Actual Length of Stay, Admissions and Membership), Quarterly Utilization Report, Top ER Diagnosis Report, HEDIS reports, Provider Profiles, Annual UM Evaluation, Population Health Report
Management of Chronic Conditions	Prescriptions for and compliance with recommended medications for chronic conditions (e.g., asthma, heart disease, sickle cell disease, and diabetes); screening tests and ongoing monitoring such as diabetes screenings	Clinical Initiatives Dashboard (Sickle Cell Assessment and Hydroxyurea Utilization), HEDIS Dashboard, Predictive Modeling Reports, Behavioral Health HEDIS Dashboard
Acute Disease and Conditions	Flu vaccines; appropriate treatment of pharyngitis; upper respiratory infection and acute bronchitis; gestational age and birth weight	Inpatient Census (Diagnosis, Admission Date, Readmission Risk Score), Behavioral Health HEDIS Dashboard, Flu Leading Indicators (Influenza Medications, Tests and Hospital Admissions)
Reductions in Health Disparities	Utilization of services by race/ethnicity/language and geographic location; access to care including primary care and specialty providers; use of interpretive and transportation services	Stratified data included in: Population Health Report (adults, children, those with a disability or behavioral health diagnosis), Quarterly Utilization Report (population segmentation for services), HEDIS, Regional Service Coordination reports
Prevention	Well child visits, immunizations, breast cancer and cervical cancer screening	Non Inpatient Leading Indicators (Primary Care, Other Medical and Specialist Spend), Start Smart for Baby

CATEGORY	Performance Measures Examples (not all inclusive)	Reporting Mechanism Examples
	rates, prenatal and postpartum care, high blood pressure control rates	reports (Currently Pregnant without an NOP, Currently Pregnant NOP, NOP Care Management Success, etc.)

Figure 5.9.3.A_Centene Clinical Initiatives Screen Shot

Kansas YTD through Oct 2017 Line of Business: Medicaid

Measure	Plan Target	Plan Actual	Centene Target	Centene Actual
START SMART				
Deliveries with an NOP - Rate	>= 73.2%	68.9%	>= 65.5%	56.6%
NOP Outreach Timeliness Rate	>= 90.0%	92.0%	>= 90.0%	79.1%
NOP CM Success (30 Days) Rate	>= 30.0%	35.7%	>= 30.0%	29.5%
NOP CM Success (60 Days) Rate	N/A N/A	36.6%	N/A N/A	31.3%
Neonatal Rate	<= 15.0%	21.9%	<= 15.0%	13.6%
Risk Adjusted C-Section Rate	<= 10.6%	11.7%	<= 13.7%	15.0%
NICU Note in 7 Days rate	>= 90.0%	98.8%	>= 90.0%	95.1%
17P Utilization Rate	>= 41.1%	43.0%	>= 44.1%	38.4%
NICU Rate	N/A N/A	N/A	N/A N/A	N/A
DISCHARGE PLANNING				
Average Length of Stay	<= 4.1	4.3	<= 4.0	4.3
Post-Hospitalization Outreach (3 Days) Rate	>= 90.0%	69.4%	>= 90.0%	44.3%
Post-Hospitalization Outreach (10 Days) Rate	>= 90.0%	92.5%	>= 90.0%	66.4%
ED DIVERSION				
ED Utilization Rate	<= 745	756	<= 767	724
SICKLE CELL				
Sickle Cell Assessment Efficiency Rate	>= 0.500	0.436	>= 0.500	0.214
Sickle Cell Hydroxyurea Utilization Rate	>= 118.55	99.15	>= 124.26	137.61

Figure 5.9.3.B_Centene P4P Dashboard Screen Shot

Medicaid P4P Critical Measure Rate Monthly Report

FL	IL	IN	KS
LA	MI	OH	OR
SC	WA	WI	

EDW refresh date: 11/27/2017

Measures/Submeasure	Category	2017 HEDIS Year		2018 HEDIS Year				
		2017 HEDIS Final Rate	2017 HEDIS Incentive Goal	1 Yr Ago Comparison	Rate	Incentive Goal	Absolute Diff. From Goal	Goal Gap
KS								
ALL								
Annual Dental								
All members	Administrative	63.5 %	--	57.8 %	59.27 %	54.9 %	4.3%	3056
Cervical Cancer								
Cervical Cancer	Hybrid	49.2 %	--	46.6 %	47.48 %	54.2 %	6.7%	941
Childhood Imm								
Combination 10 Immunizations	Hybrid	31.0 %	--	23.1 %	30.24 %	33.1 %	2.9%	138
Comp Diabetes Care								
HbA1c Adequate Control (<8)	Hybrid	53.3 %	--	6.6 %	4.10 %	48.9 %	44.8%	2285
Imms Adolescents								
Combination 2 Immunizations	Hybrid	17.8 %	--	18.2 %	18.16 %	19.8 %	1.6%	66
Prenat Post Care								
Timeliness of prenatal care	Hybrid	70.3 %	--	24.2 %	26.25 %	75.3 %	49.0%	1751
Use Antipsy Ch Ad								
Total	Administrative	4.8 %	--	4.4 %	4.32 %	4.8 %	.4%	--
Well Child 3-6 Yr								
Well Child 3-6 Yr	Hybrid	63.2 %	--	56.7 %	53.87 %	68.2 %	14.4%	2573

Pursuing Innovative Use of Telehealth, E-visits and Alternative Payment Arrangements (5.9.3.A.7, 5.9.3.B.5-6)

As discussed in greater detail in our response to ***Section 5.7***, Sunflower is committed to pursuing innovative value based models and purchasing strategies such as telehealth partnerships that expand access to quality care, meaningful provider payment arrangements that reward providers for delivering exceptional levels of quality care, and programs designed to impact outcomes for our members with the most complex health care needs such as those receiving LTSS and our youth members in foster care. For example**,** Sunflower has designed and implemented a robust portfolio of meaningful value based purchasing (VBP) strategies that are designed to promote higher quality care. Examples include:

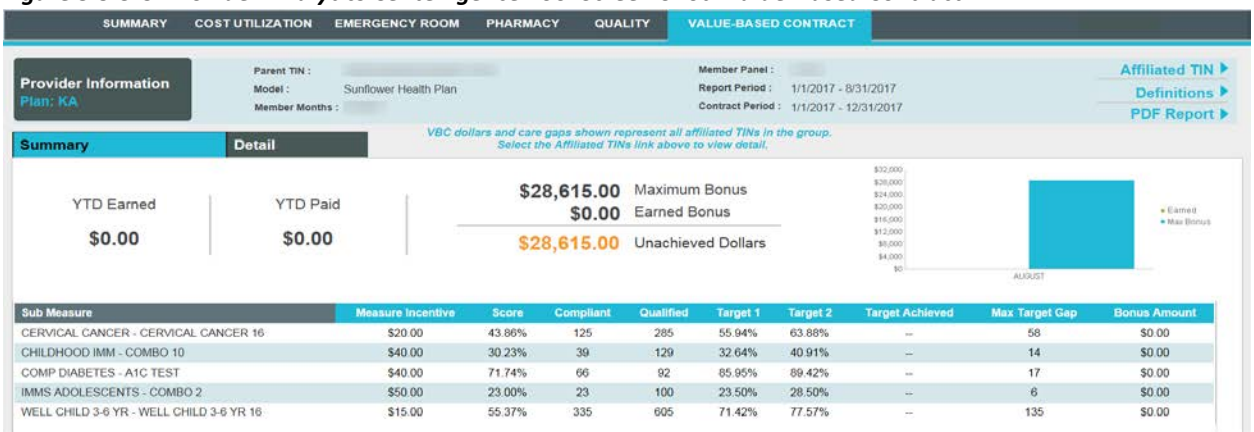
- Adult and Pediatric Quality-Based P4P Program. This VBP program enhances quality of care through a focus on preventive and screening services which align with State P4P and Sunflower goals. Sunflower proposes to increase the number of large provider systems participating in our Adult and Pediatric Quality-Based P4P Program from seven to 25 by end-of-year 2019. Participating providers are rewarded through incentive reimbursement for achieving predetermined, KDHE-aligned quality target results
- Pediatric Quality and Loyalty-Based P4P Program. Pediatric care providers are rewarded for maintaining loyalty among Sunflower's membership while enhancing quality of care through a focus on preventive and screening services. Sunflower proposes to increase the number of large provider systems participating in our Pediatric Quality and Loyalty-Based P4P Program from one to six by end-of-year 2019. Participating providers are rewarded through incentive reimbursement for achieving predetermined, KDHE-aligned quality target results
- Timeliness of Prenatal Care Incentive Program. This program rewards providers for successful completion of the Notice of Pregnancy (NOP) form during the first trimester or

within 42 days of enrollment coupled with a component to increase the number of Sunflower deliveries over the OB/GYN's prior year delivery rate by 10%. Sunflower has six participating providers in our Timeliness of Prenatal Care Incentive Program. Participating providers are rewarded through an activity-based reimbursement for each timely, electronic NOP submission and increasing year-over-year delivery volume

- BH P4P Program for CMHCs. This program rewards providers for impacting quality of BH care through four BH-focused HEDIS measures while reducing IP Readmission following discharge for a psychiatric condition. Sunflower proposes to increase the member populations participating in our BH P4P Program for CMHCs to include members with Substance Use Disorder (SUD) by end-of-year 2019. Participating providers will be rewarded through shared savings reimbursement for achieving predetermined, KDHE-aligned quality target results and reducing IP Readmission rates following discharge for a psychiatric condition. CMHCs serving members who are on a waitlist for Psychiatric Residential Treatment Facility (PRTF) admission would continue to be eligible to receive an enhanced payment for successful completion of post-admission follow-up activities

Provider Analytics Dashboard. Sunflower's Provider Analytics dashboard, powered by Centelligence, brings together a collection of the most important medical cost and utilization, pharmacy, emergency department, potentially avoidable events, clinical, population health, and quality data to help Sunflower staff and providers form a cohesive understanding of performance and membership trends as demonstrated in ***Figure 5.3.9.C Provider Analytics Centelligence Tool Screen Shot: Value-Based Contract*** below.

Figure 5.9.3.C: Provider Analytics Centelligence Tool Screen Shot: Value-Based Contract



Sub Measure	Measure Incentive	Score	Compliant	Qualified	Target 1	Target 2	Target Achieved	Max Target Gap	Bonus Amount
CERVICAL CANCER - CERVICAL CANCER 16	$20.00	43.86%	125	285	55.94%	63.88%	--	58	$0.00
CHILDHOOD IMM - COMBO 10	$40.00	30.23%	39	129	32.64%	40.91%	--	14	$0.00
COMP DIABETES - A1C TEST	$40.00	71.74%	66	92	85.95%	89.42%	--	17	$0.00
IMMS ADOLESCENTS - COMBO 2	$50.00	23.00%	23	100	23.50%	28.50%	--	6	$0.00
WELL CHILD 3-6 YR - WELL CHILD 3-6 YR 16	$15.00	55.37%	335	605	71.42%	77.57%	--	135	$0.00

Available to providers through our secure Provider Portal, provider analytics dashboards offer varying levels of information to provider user groups and allow for, among other uses, provider performance analysis, cost and utilization trending, quality measure performance, active and non-active member pattern analysis, disease -State prevalence, readmission analysis, and population health trend analysis. Users are also offered many of these metrics on a risk and severity adjusted basis. Authorized users can interact with the dashboards through extensive custom selection, drill-down, and export capabilities, to identify factors behind clinical and cost

performance. As more providers shift to P4P and pay-for-outcome measures, the availability of such data to determine contract performance will become paramount. By using provider analytics, providers will be able to monitor their performance versus contractual or bonus goals. Sunflower will help facilitate CSC proficiency and awareness and use of tools, data, and analytics in their coordination activities.

Collaborations with Members, Providers and Stakeholders (5.9.3.A.8, 5.9.3.B.3-4, 5.9.3.C.5-7)
Community engagement has been, and will continue to be, a key cornerstone and guiding principle of our approach to serving our KanCare members. This includes members, families, caregivers, providers, State agencies, community organizations, schools, churches, associations, and other key stakeholders. To customize and ensure barriers to care are understood and addressed adequately, we incorporate community level input from all constituents. Soliciting feedback and recommendations from a range of advisors in the communities ensures our service and programs are tailored for the needs of the unique populations being served. A range of input from different providers (e.g. PH, BH, LTSS, and pharmacy) and members with different needs (e.g. cultural needs, clinical needs, social needs) also promotes integrated approaches and caring for the whole person. Individual perception of care and services can also affect service utilization and member wellness and can indicate not-yet evident trends that need to be addressed before they become pervasive. Sunflower will actively seek and document member, family, caregiver, provider, and other key stakeholder input on our programs and performance. In addition, Sunflower will collaborate with providers on the CMS HCBS settings Final Rule to ensure access for services and types of services offered are compliant to promote the highest level of independence. Methods and frequency are described in Table 5.9.3.D ***Sources and Mechanisms to Encourage Feedback*** below.

Table 5.9.3.D_Sources and Mechanisms to Encourage Feedback

Methods and Frequency		Sources	Description
Stakeholder (Member, Family/Caregiver, Provider, Community Representatives, etc.) Participation in Quality Committees and Advisory Groups	Meetings held Quarterly	QI Committee, Member Advisory, Physician Advisory, P&T, LTSS Advisory Committee	Stakeholders review programs and documents (e.g. member materials, satisfaction surveys, QAPI Program) and report on perceptions, concerns, recommendations, and general plan feedback. Information collected is documented in meeting minutes and assigned to appropriate staff to follow up. Information on how the feedback was used is brought back to the committee and measured and monitored as appropriate.
Member and Provider Satisfaction Surveys	No less than annually	CAHPS, LTSS Member Survey, Annual Provider Satisfaction Survey, Care Management Survey	Surveys are a direct source for identifying and designing interventions. Information is reviewed at the committee level. A workgroup is then assigned to develop improvement initiatives and communications to address opportunities for improvement and to maintain strengths.
Trends in Member and Provider Grievances and Complaints	Reviewed monthly	Trend reports on member appeals grievances and complaints and	Trend reports are reviewed with the QI leadership and other appropriate committees for additional feedback and appropriate intervention. Reports are sorted by different

Methods and Frequency		Sources	Description
		provider grievances and complaints. Monthly Performance Improvement Team meetings	member demographics, providers, subcontractors, and other identifying variables.
Operational Contact Points	Ongoing	Provider visits, trainings and calls; incoming/out- going member calls; Service Coordinator outreach;·community trainings and forums; and staff participation in community events	Sunflower uses every stakeholder contact as an opportunity to solicit and document feedback as appropriate. Information collected through these interactions is maintained in the appropriate system (e.g. CRM, TruCare) and then consolidated and analyzed through our Centelligence data platform. Immediate issues and concerns are addressed in real time, with appropriate documentation to ensure follow up and inclusion in future analytics as indicated.
Targeted Channels	As needed	Focus groups, targeted outreach	Sunflower solicits specific feedback on new programs, proposed interventions and as a method for evaluation. Targeted outreach may focus on subpopulations such as child welfare, I/DD, and homelessness.

Sunflower uses the input and recommendations received through all of these channels to improve programs and plan performance. Issues and trends identified are reported up to the QI Committee where the QI team or impacted business unit makes recommendations for improvement initiatives which are monitored and tracked through the QAPI process.

As further described in our response to ***Section 5.9.6*** below, Sunflower also uses a variety of peer review processes and methods to evaluate the appropriateness of care and services rendered by our participating providers. We regularly examine aggregate and provider-level compliance with preventive health and clinical practice guidelines (CPG's), utilization trends for inpatient, emergency, pharmacy, outpatient physical health (PH), behavioral health (BH), long term services and supports (LTSS), and transportation services, morbidity and mortality rates, grievances, quality of care (QOC) referrals, as well as factors such as appointment access and after hour's availability, authorization and billing practices, and appropriateness of services. If an aberrant provider practice pattern is detected, our Provider Relations staff, with the participation of the Medical Director as required, discuss with the provider the identified pattern, comparison to peer performance and any evidence-based relevant guidelines. Potential QOCs requiring intervention are reported to the QI designee, and QOCs with a medium or higher severity level (as determined by the Medical Director) are referred to the Peer Review Committee (PRC) for evaluation and action.

Maximize the Quality of Life of All Members (5.9.3.A.9, 5.9.3.B.1)

Through our QAPI Program, we systematically implement and evaluate initiatives to improve quality outcomes across the continuum of care; maximize health, functioning, and wellness; maintain members in the least restrictive setting, and improve quality of life. We understand the impact of social determinants (such as transportation, housing, food, employment and

other non-clinical needs) and functional deficits on health outcomes, and have therefore designed our Service Coordination Program to support whole person care, which includes all of the individual's PH, BH, LTSS and social needs, including employment, and addresses those needs in an integrated, seamless and person-centered manner. As further described in ***Section 5.4***, our integrated and comprehensive Service Coordination model is designed to enhance access to services across the full continuum of care and achieve optimal health and quality outcomes through:

- Member-centric and culturally responsive coordinated care that encourages personal responsibility and member engagement
- Population-based predictive modeling that incorporates claims and administrative system data to identify members at risk for future adverse events that can benefit from service coordination activities
- Health Screenings, Health Risk Assessments (HRAs) and needs assessments designed to help stratify members into levels of Service Coordination and identify each member's whole person needs
- Plans of Service and Person-Centered Planning that address PH, BH, functional needs emergency back-up planning and social determinants of health and are responsive to each member's preferences and chosen goals
- Integrated Care Teams (IC Teams) that work together and in collaboration with the member's PCP, member's chosen circle of support, and providers to support members' health and wellness and meet the diverse and whole-person needs of members across the continuum of care
- Technology solutions that support communication and coordination among members of the IC Team, provider network and contracted Community Service Coordinators entities

Sunflower delivers services through a multidisciplinary internal team of nurses, BH clinicians, social workers, health coaches, experts on HIV/AIDS, intellectual and development disability, and traumatic brain injury, and non-clinical support staff led by the member's assigned Service Coordinator. Also, our local and experienced Service Coordination staff have deep community roots that enable them to help members access community resources to address their social support needs. This allows us to foster a relationship with the member while providing specialized expertise to address multiple co-morbidities.

Promote the Highest Level of Independence (5.9.3.A.10, 5.9.3.B.2)

Sunflower understands that supporting individuals with LTSS needs requires a unique ability to support a member's goals while encouraging them to work toward the highest level of independence. We strive to combat the continuously perpetuated mainstream assumptions that people who are aged, have multiple chronic conditions or persons with disabilities cannot live rewarding, independent, and high-quality lives. Each member joins our health plan with a unique personal history, specific and sometimes complex

Sunflower has successfully transitioned 513 LTSS members from nursing facility services to HCBS since 2014.

functional limitations, and a fluid support network, all of which impact his or her personal goals. As a result, our members' paths towards increased quality of life and independence will vary and require access to a wide range of creative and flexible supports, such as supportive yet competitive employment, self-direction, and the use of family and other natural supports. As further described in ***Section 5.4***, Sunflower's LTSS Service Coordination Program is designed to meet the unique needs of individuals with a wide range of disabilities and functional limitations to promote independence, quality of life, and community living.

Person-Centered Models (5.9.3.A.11, 5.9.3.B.1-2)

Sunflower is dedicated to providing person-centered, whole person integrated care to individuals living with multiple complex, co-occurring conditions that cross PH, BH, LTSS, other special health care needs, and social service needs. We bring a wealth of knowledge and experience from serving complex members receiving LTSS in Kansas since 2013, as well as evidence based practices from affiliate health plans across the country serving LTSS members since 2006. We take a person-centered approach to all service coordination processes to support members, caregivers and families as the drivers of their own health care. As described in ***Section 5.4.4 Plans of Service and Person-Centered Service Planning***, our Service Coordinators accomplish this by:

- Supporting members to identify their needs, barriers, preferences, and goals
- Providing individualized education and supports tailored to the member's strengths, needs, and preferences
- Supporting members to assume an active role in planning and implementing a holistic, individualized, culturally responsive individualized Plan of Service to meet the full range of their health, BH, LTSS, functional, social, and other needs
- Facilitating a continuous Plan of Service review and improvement process that ensures the member is at the center of defining quality and developing solutions unique to his or her needs

Sunflower's Centelligence LTSS KPI Dashboard provides actionable reports for our teams across service coordination, quality, operations, member satisfaction, enrollment and financial metrics. The dashboard includes metrics on quality of life (e.g., ability to see friends and family, ability to volunteer/work, etc.), member satisfaction (e.g. with Service Coordinator, with personal care worker, etc.), and integration risk factors that can lead to institutionalization (e.g., wounds, falls, etc.)

MONITORING COMMUNITY SERVICE COORDINATORS

Sunflower recognizes that our role and responsibility will be to ensure a focused attention is provided for CSCs to monitor quality and ensure accountability. Our person-centered Service Coordination model, supported by evidence-based protocols, policies, procedures, job aids, training, data analytics and decision support tools, will provide consistency in the delivery of service coordination activities across our Sunflower Service Coordination team and delegated partners.

QAPI GOALS (5.9.3.B)

Sunflower has formally adopted and will continue to build on the goals listed in RFP Section 5.9.3.B, and fully integrate them into our QAPI Program which also includes the following goals:

- 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 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
- Compliance with all applicable regulatory requirements and accreditation standards will be maintained

QAPI OBJECTIVES (5.9.3.C)

Sunflower has formally adopted and will continue to build on the objectives listed in RFP Section 5.9.3.C, and fully integrate them into our QAPI Program which also includes the following objectives:

- To continue to build and maintain a health system that promotes continuous quality improvement
- To continue 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 continue to utilize 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 continue 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 continue to oversee peer review procedures that will address deviations in medical management and health care practices and devise action plans to improve services
- To continue 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 continue to recommend and institute "focused" quality studies in clinical and non-clinical areas, where appropriate

5.9.4. PERFORMANCE MEASURES

Sunflower acknowledges and agrees to continue to comply with the requirements specified in Section 5.9.4, including the performance measure requirements and methodologies in the State's QMS and any other performance measure requirements that may be included in the Contract at any time by the State, CMS, or other federal authority (5.9.4.A – B).

USING DATA TO IMPROVE THE QUALITY OF CARE AND SERVICES DELIVERED TO ALL MEMBERS

Sunflower uses a data-driven approach to design, implement, and continuously evaluate and improve our QAPI and other programs and services. We use data to identify and select improvement opportunities that are relevant to KanCare members, establish performance measures and goals (in alignment with KDHE goals), develop and implement interventions, measure improvement, and develop post-measurement activities. We also use quality indicators that are objective, measurable and based on current knowledge and clinical expertise from nationally recognized sources, for example, NCQA and CMS.

Data Sources and Reporting Capabilities

Sunflower QI staff analyzes claims and other data to identify potential areas for improvement in clinical outcomes or service delivery. Such data may include, but is not limited to:

- Demographic information relevant to health risks or indicative of health care disparities
- Performance on standardized clinical measures, such as HEDIS
- Utilization trends and other medical management data
- External data related to conditions or risks for similar populations
- Member and provider grievance, and appeal trends
- Quality of care data and Adverse Incident data
- Access and availability audits
- Claims payment statistics
- Member and provider satisfaction survey results

Additional data sources include issues identified during service coordination and referrals from any source indicating potential problems or suspected fraud or abuse, including those identified

by affiliated hospitals and contracted providers. QI staff reviews this array of data using appropriate analytic tools to identify the most prevalent or persistent issues or those that affect members, providers and may span multiple departments.

Approach to Receiving Accurate and Complete Information

Sunflower ensures the integrity, validity and completeness of the information we receive from our subcontractors and providers (and send to KDHE/designee) through four general architectural components that make up our integrated MIS. These components trace the flow of data through our health plan to KDHE:

- Our external facing applications include all the capabilities and controls we deploy to support data entered or viewed online by providers using our secure Provider Portal; members using our secure Member Portal; and Sunflower staff using any of our internal business applications (such as claims or clinical management)
- Our data and file communications protocols, controls and supporting systems allow us to send and receive formatted data (including HIPAA transactions, as well as State proprietary formats) with integrity, confidentiality, reliability, and assured delivery
- Once we receive or collect inbound data, the Master Data Management design of our MIS will ensure that our data is represented and stored accurately, completely and uniquely (e.g. no data discrepancies or duplicates)
- Our Centelligence system integrates and consolidates data, and creates the information products we supply to our State clients and Sunflower staff

In addition, we use audit tracking mechanisms such as date/time, user ID, and record level update tracking throughout our MIS to ensure data integrity and transparency.

Audits to Ensure Systems and Data Integrity

Sunflower's parent company, Centene, undergoes regular internal and external audits to ensure the integrity, timeliness, accuracy, validity and completeness of all data we receive, process and store. Our audits will include all aspects of system processing such as financial and claims controls, network and physical security, application security and regulatory compliance. These audits include monthly penetration tests conducted by our IT Security Department to proactively test for security exposures; risk profile audits conducted by Ernst & Young; ongoing routine data accuracy and completeness audits; annual SAS/70 Type II audits conducted by KPMG; and our annual Sarbanes-Oxley (SOX) audits on management controls. Our subcontractors use similar controls to ensure accurate data submissions.

Using Program Data to Monitor and Improve Quality of Care and Services

Overseen by our QI Committee, and other associated workgroups, our senior leadership team monitors progress on HEDIS, other clinical and non-clinical performance targets. Those targets may include but are not limited to quality measures, member and provider experience, and cost of care. Various data metrics are reviewed on an ongoing basis across multiple Sunflower departments to allow process issues to be identified early and addressed timely. Some of the

data reviewed include HEDIS data, claims data, member and provider grievances, appeals, State fair hearings, Adverse Incidences, Quality of Care concerns, member engagement in Service Coordination, and authorization data. Issues or concerns identified are then escalated to leadership and the appropriate committees. The QI department works with all departments to complete the quality process through gathering and analyzing performance measure rates, performing barrier analysis and root cause analysis for indicators falling below desired performance levels, and making recommendations regarding corrective actions or interventions to produce improvement. This analysis gives focused attention to potential barriers members may experience, such as barriers related to social determinants of health or accessibility of care, which can be related to geographical location, language and health literacy limitations, cultural practices, ethnicity, special health care needs, transportation needs, and other issues that may lead to health care disparities. Our QI process uses QI tools and methodologies to assess barriers to success, develop interventions/process changes, evaluate outcomes, and recommend improvement actions. As any intervention is implemented, project workgroup and QI staff monitor key metrics for improvement as they use Rapid Cycle Process Improvement which includes utilization of the PDSA methodology. Should the expected improvement not be realized, the QI staff may recommend modification or replacement of the intervention to achieve performance targets. These steps enable us to identify effective strategies along with those that are found to not be effective in achieving the desired outcomes. All of these steps reflect components of the PDSA methodology.

While UM, Service Coordination and QI staff work closely together to monitor and improve care, all Sunflower departments use the data collected to conduct a wide range of monitoring and improvement activities related to the quality and appropriateness of care furnished to our members, including LTSS members and those with special health care needs, including the following activities:

- Our HEDIS Coordinator generates monthly HEDIS reports to track performance towards goals demonstrating care gap closure for the total member population served as well as for the LTSS population specifically
- QI leadership provides other health care quality reports and data to committees to track performance toward goals, such as utilization trends, member and provider grievances and appeal trends, quality of care and adverse incident data, access and availability audits, claims payment statistics, and member and provider satisfaction
- Information on care gaps is available to our Service Coordinators, provided through our Provider Portal, and also available in our Customer Relationship Management system enabling our call center staff to identify a member's needs and help connect them with the right care to close care gaps; we also outreach to members regarding care gaps and healthy behaviors through newsletters, mailers, and, beginning in 2018, email and text options
- The EPSDT Coordinator and QI Leadership review monthly reports of EPSDT periodicity compliance to identify members for outreach

- UM staff review quarterly reports of measures such as utilization (or lack of utilization) of authorized HCBS services, rates of occurrence of certain diagnoses, over/under-utilization, ER utilization, and readmission rates
- UM staff also reviews complications of care (sentinel events), never-events, critical incidents, preterm delivery, NICU admission, and inpatient lengths of stay to monitor compliance with evidence based care and patient safety, and makes referrals to the Peer Review Committee as appropriate
- (UM staff review authorizations trends to determine whether prior authorization requirements can be removed, and for trends of increases in or reductions of HCBS services
- Sunflower has an LTSS dashboard with information that is updated weekly on member enrollment and transitions, approved services, quality and quality of life measures
- The Director of Service Coordination reviews daily reports on admissions and discharges, and calls to our nurse advice line to identify admissions, readmissions and ED visits that were avoidable or potentially avoidable. Trended data for admissions and ED visits are also reviewed to identify opportunities within a diagnosis category, provider, or individual members that are high utilizers of these services so outreach and intervention is initiated
- Behavioral Health staff monitor crisis service use and connect members to needed community services and collect data as needed to determine members are accessing the services they need to stabilize them in the community
- The PMUR team monitors medication usage for children that would be considered excessive or off label and conducts peer to peer reviews on other interventions that would not require the use of atypical/antipsychotics
- The Director of Long Term Services and Supports (LTSS Director) monitors reports concerning percent of members who choose to self-direct, transitions to the community to evaluate member choice and least restrictive environment, utilization of approved HCBS services, service coordination visits, type and amount of changes in service plans, member satisfaction, transitions, quality and quality of life measures and critical incidents. Additional reporting will be developed to also monitor the level of member and supporting caregivers involvement in service planning
- QI, UM and Pharmacy staff generate monthly reports to assess provider compliance with our clinical practice guidelines (CPGs), and several of the indicators on our provider profiling reports measure compliance with CPGs and identify outliers
- QI staff monitors reports of member and provider feedback to identify potential issues with provision of medically necessary or functional support services and satisfaction with Sunflower operations

PMUR Results – Sunflower Foster Care Members

- ***Reduction in psychotropic medication utilization from 33.5% in 2013 to 28.9% in 2016***
- ***Decrease in 60+ day psychotropic medication utilization from 13.4% in 2013 to 11.6% in 2016***

Sunflower also evaluates care management process and outcome measures at least annually, including services provided by our Service Coordinators. These measures encompass care management services for members with special needs as well as the level of integrated competitive employment achieved by members with intellectual and developmental disabilities (I/DD). Sunflower works closely with LifeShare, a nationally COA-accredited community-first solution for neurodiverse people as well as individuals with I/DD, behavioral health needs, children in the child welfare system and others with complex needs. LifeShare uses a whole-person approach to long term care. Its Pathways Integrated Care Model is designed to eliminate silos that exist within the service delivery system by bridging network providers, defining quality outcome measures, and maximizing technology to reduce costs, improve communications and support members' goals. In all cases, the QI Committee will assess the information for potential areas of improvement or corrective action at the member, provider, or program level.

RAPID CYCLE IMPROVEMENT EXAMPLES

Beginning in 2013, Sunflower initiated Rapid Cycle Process Improvement initiatives utilizing the method of PDSA to improve processes, policies and services provided to Sunflower members. Three examples of Rapid Cycle PDSA initiatives are described below.

Improving the integration of Physical, Behavioral and LTSS Service Delivery

Care Gap Checklist. In 2015, Sunflower identified closure of care gaps for our LTSS members as a focus area for improvement as an integration measure to enhance the physical health support that our Service Coordination team was providing for our membership. To do this, we developed, piloted, implemented, and then revised a Care Gap Closure Visit Checklist to be used by our LTSS Service Coordinators. We also completed focused training with staff on reviewing care gap information prior to each contact with every LTSS member and developed a goal regarding the number of educational resources to be accessed and shared with members by all Services Coordinators, both physical health and LTSS. As a result, we achieved a 7% improvement in overall care gap closure improvement in 2016 compared to 2015, increasing from a rate of 28.8% in 2015 to 36.3% in 2016. Following this success, we revised the checklist in 2017, conducted additional, ongoing training of our Service Coordinators, and also provided process reminders during team meetings. We are continuing to monitor the outcomes of these process improvements and refinements.

Primary Care Provider (PCP) Provider Profiles. Sunflower sends PCPs individualized Provider Profiles that detail how a PCP is performing on specific HEDIS measures. PCPs expressed frustration, however, that the reports did not reflect their active patients. Sunflower's Quality Department therefore worked with the Provider Relations and Customer Service Departments to improve member PCP assignment, based on the providers' feedback, with the expectation that improved PCP assignment would improve the accuracy of the quality measurement reports and also lead to closure of care gaps and improved health outcomes. We also worked to improve the Provider Profile reports. The Sunflower Clinical Analytics team used the Rapid Cycle PDSA process to test a new algorithm using claims date to generate profiles based on

attributed members rather than solely assigned members. Also, members attributed by claims to another provider were removed from the assigned provider's report. Based on the submission of care gap reports from providers receiving the revised Provider Profiles, Sunflower determined that the new profiles were more accurate in capturing a PCP's active patients better enabling those providers to schedule appointments when needed to close care gaps. The new logic was then applied to subsequent Provider Profiles and updated as needed

Improving Access and Availability of LTSS and Behavioral Health Providers

Transportation Grievances. In 2014, transportation grievances accounted for 51.6% of Sunflower's total number of grievances (327 out of 633), prompting Sunflower to partner with our transportation subcontractor (LogistiCare) in efforts to evaluate and take steps to reduce the number of member transportation grievances, improve access to care and improve member satisfaction. Further drill down data showed that the highest number of grievances per 1000 was attributed to our members with physical disabilities and showed a trend of grievances around issues related to inadequate vehicles, support personnel, or driver knowledge deficit of special needs being dispatched to meet the member's transportation needs. The goal was to reduce transportation-related grievances by 5% in 2015 compared to 2016 overall. With this information, the following interventions were initiated:

- Sunflower initiated required training for all LogistiCare staff members serving the Sunflower population that focused on the special needs specific to the population and person first language
- Sunflower provided LogistiCare with a list of members known to use a wheelchair or with a bariatric need so that LogistiCare could update its system to ensure the proper vehicle was dispatched for those members' scheduled transports
- Sunflower developed scripting to be used by LogistiCare's customer service representatives when speaking to a new member requiring wheelchair accommodations to ensure the transportation provider is able to meet the member's needs
- Sunflower worked with LogistiCare to coordinate consistent preferred drivers for members who have regularly scheduled transportation needs (such as dialysis patients) to avoid missed appointments and adverse experiences
- Sunflower reviewed all transportation providers/drivers that had three or more grievances with LogistiCare and LogistiCare undertook targeted outreach with these providers

These focused efforts resulted in an 8.3% reduction (from 327 in 2015 to 300 in 2016) in transportation-related grievances in 2015. ***(Table 5.9.4 Transportation Grievances Received as a Percent of Total Grievances Received 2014—2016).*** For 2016, Sunflower's goal was to achieve an additional 5% reduction. In addition to continuing the previous interventions, Sunflower focused on addressing grievance data related to mileage reimbursement. Sunflower and LogistiCare therefore worked together to implement a more efficient and timely debit card system in the fall of 2016

Total transportation grievances dropped from 300 in 2015 to 207 in 2016 – a 31% reduction.

to replace the previous practice of mailing reimbursement checks to members. Total transportation grievances in 2016 dropped by 31% compared to 2015.

Table 5.9.4_Transportation Grievances Received as a Percent of Total Grievances Received 2014—2016

	2014	2015	2016
Total Number of Member Grievances	633	646	631
Total Transportation Grievances	327	300	207
Transportation Grievances as a Percent of Total Grievances	51.6%	46.4%	32.8%

5.9.5. PERFORMANCE IMPROVEMENT PROJECTS

Continuous Quality Improvement (CQI) is a core business strategy for Sunflower. We use core CQI methodologies to identify, design, implement, and evaluate the effectiveness of interventions or process changes both in Performance Improvement Projects (PIPs) and in daily management throughout the organization.

DESIGN, IMPLEMENTATION AND EVALUATION OF PIPS. (5.9.5.A-C, E-F, H)

As part of our QAPI Program, Sunflower will conduct a minimum of three clinical and two non-clinical State-approved PIPs annually. At least one of the non-clinical PIPs will address a State-approved LTSS opportunity for improvement which is expected to have a favorable effect on health outcomes and member satisfaction. Sunflower also agrees to develop an additional PIP for EPSDT Screening and Community outreach plans when overall CMS 416 rates drop below 85%. Sunflower will adhere to all CMS EQR PIP protocols and each PIP will include:

- Identified benchmarks and achievable performance goals
- Measurement of performance using objective quality indicators
- Implementation of interventions to improve quality
- Objective measurement of intervention effectiveness
- Activities planned to sustain or increase improvement
- Status reports and results to KDHE and EQRO using the State specified PIP template
- Timely completion to complement an annual reporting cycle

Project Selection

Sunflower identifies opportunities and selects improvement projects specific to the needs of our members. Sunflower staff reviews qualitative and quantitative data using a variety of analytic tools to identify the most prevalent opportunities for improvement and those impacting multiple departments. Facilitated by Centelligence, our award winning proprietary and comprehensive family of integrated decision support and health care informatics solutions, we consider data such as:

- Demographic information relevant to health risks or disparities
- Related conditions or risks for similar populations
- HEDIS data
- Utilization and condition prevalence trends
- Performance on clinical and operational performance measures
- Access and availability studies
- Quality of care and Adverse Incidents
- Results of EQRO reviews, KDHE audits, and Contract monitoring
- Member and provider grievance trends and satisfaction survey results

The focus of projects may be clinical, quality of life, or operational, and address a spectrum of members and services including PH, BH and LTSS. Sunflower analyzes data on preventive health, other health care, claims and service measures to compare differences by race/ethnicity and region (rural/frontier compared to urban). We use evidence of disparities to help select the most appropriate target populations for our projects and to support collaborative preventive care projects with peer MCOs. We also evaluate social determinants of health to identify barriers that can be mitigated when working with the target populations to ensure better outcomes. Sunflower emphasizes preventive care services as the most efficient route to improve health outcomes, and actively outreaches to members, including face-to-face and phone contacts, using culturally appropriate educational materials, to encourage compliance with our evidence-based preventive care guidelines. We measure our success in these efforts and use these data to guide project selection and to support our participation in collaborative projects with peer MCOs. When selecting PIPs, Sunflower also has access to our parent company, Centene's, virtual catalog of PIPs that promotes best practices and sharing among our affiliated State health plans.

RAPID-CYCLE PROCESS IMPROVEMENT PRINCIPLES (5.9.5.D)

Regular, periodic re-measurement and assessment of success are basic components of Sunflower's process improvement model. We conduct both interim checks and assessments following full measurement periods, using rapid cycle process improvement with the PDSA methodology to test changes or additions to the intervention dependent on the evidence of improvement. With that methodology we:

- **P**lan the change, needed data and the goal
- **D**o a trial of the changed intervention, documenting any barriers
- **S**tudy the results, comparing them to the goal

- **A**ct to further refine the intervention based on the results

We then repeat the cycle with incremental changes to the interventions, or replacement of ineffective measures as approved by the State, until improvement is achieved and sustained.

Sunflower re-measures each project's established performance measures, compares them to the established benchmarks and goals at the intervals determined at the beginning of the project, and tests the comparisons for statistical significance. Intervals are based on the timeframe in which an anticipated improvement in performance is expected to occur. To ensure comparability, the re-measurement methodology is the same as that used for baseline measurement. We may also track additional measures related to the project, such as intermediate process indicators or member or provider satisfaction, including monitoring the quality and appropriateness of care delivered to members with special health care needs.

ESTABLISH PERFORMANCE GOALS AND IMPLEMENT IMPROVEMENT STRATEGIES (5.9.5.G)

The QI Committee evaluates and approves objective, well-defined, measurable indicators for each PIP such as HEDIS or other Agency for Healthcare Research and Quality indicators, or KDHE-specified measures. We use industry-standard operational indicators for projects involving, for example, call center, service authorization, or claims adjudication processes. We determine a baseline and establish goals for each indicator that reflect the desired level of performance. Goals may be established as "perfection," an industry benchmark, KDHE requirement, or a projected percentage change from baseline measurement reflective of a demonstrable improvement.

Sunflower's Performance Improvement Team (PIT) solicits input from health plan and external subject matter experts, members, providers, and community resources when considering interventions. With this input, QI and other staff identify barriers to performance and develop interventions that specifically addresses the identified barriers and that are most likely to succeed. The PIT establishes implementation plans that include clearly defined, specific tasks to be accomplished by specific departments, accountability for each task, timelines for intervention, and a plan for how and when the effectiveness of the intervention will be measured.

Most interventions implemented are cross-departmental. For example, our Centelligence care gap alerts are visible to our Service Coordinators and Customer Services staff so that we can take advantage of every member contact to educate and remind members of preventive health services for which they are due. Care gaps are also visible to providers on our Provider Portal so that they can engage members as well. Though clinical interventions may be coordinated by Service Coordination or Utilization Management staff, QI staff coordinate most interventions, monitor for effectiveness, and provide progress reports to the PIT. The PIT will track all interventions and report to the QI Committee.

POST-EVALUATION ACTIVITIES (5.9.5.I-J)

If re-measurement does not demonstrate significant improvement and performance does not exceed established goals, the quality improvement cycle begins again. In such cases, the PIT, in conjunction with the QI Committee, evaluates each intervention, identifies barriers that may be interfering with the achievement of performance goals, and revises the intervention, or replaces or supplements it with new interventions to address identified barriers. We conduct re-measurement at periodic intervals, using the PDSA cycle, to test the changed or new interventions quickly and further redesign them as appropriate.

We consider improvement to be sustained if the level of performance is maintained or further improvement occurs one year after significant improvement has been achieved and if the improvement likely was a result of the project interventions. After three years, and consistent with the State's evaluation criteria, Sunflower will propose if one or all of the non-LTSS PIPs should be continued. We will maintain successful interventions, report them to KDHE as possible best practices for other contractors, and communicate them as best practices to other Centene plans. Sunflower will seek the State's prior approval to discontinue a PIP and initiate a new PIP. We understand that the State reserves the right to tie PIP requirements to P4P indicators, or implement a corrective action plan, if we fail to meet PIP improvement or benchmark standards.

EXAMPLES OF SUCCESSFUL PERFORMANCE IMPROVEMENT PROJECTS

All of the PIP examples described below include both the LTSS and BH populations.

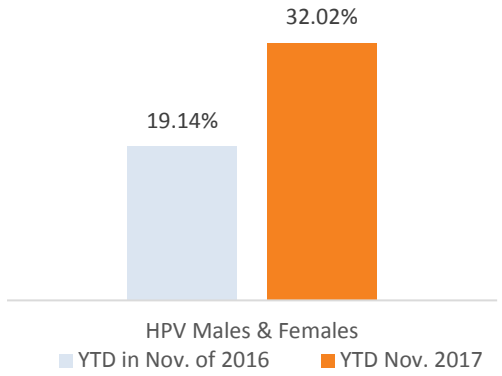
Human Papilloma Virus Vaccination (HPV) PIP

As a result of the State requirement for collaborative PIPs, Sunflower worked in collaboration with the other two KanCare MCOs in 2015 to propose a new PIP focused on increasing HPV vaccination rates in Kansas, which were noted in 2015 to be the lowest in the nation with regard to HPV vaccination in adolescents. Upon initiation, the PIP was based on the HEDIS measure for HPV vaccinations that measures the number of female adolescents who turn 13 years old in the measurement year who have completed the series of three HPV vaccinations. This includes adolescents enrolled in an HCBS waiver. The initial Sunflower PIP goal was to increase the HEDIS HPV rate from our 2014 measurement year (MY) baseline of 21.67% to 22.75% for MY 2015. Because the collaborative PIP was approved for implementation in late 2015 allowing less than one quarter to implement interventions, Sunflower did not meet the MY 2015 goal with a final rate of 18.81%. Because of the short timeframe for intervention implementation and impact in 2015 for the PIP, it was recommended that MY 2016 be utilized as the baseline with an established 2017 goal (for MY 2016) of 19.75% which would constitute a 5% increase from the previous year's performance. Sunflower demonstrated a final rate of 21.74% for MY 2016 achieving the goal of a 5% improvement over the MY 2015 final result. It is important to note that the HEDIS Technical Specifications were updated for MY 2016 to include males along with females to establish the baseline and then for re-measurement for MY 2017.

Interventions to increase HPV vaccination rates have included:

- Provider profiles to raise provider awareness and enlist their assistance with member compliance
- Letters to the parents/guardians of members who are non-compliant to provide educational material to help increase awareness, resources available to get vaccinations in their communities, and understanding related to the importance of the vaccination
- Working with multiple clinics to offer dedicated or extended hours to provide well child visits and vaccinations that were not limited to just the HPV vaccination
- Outreach to parents/guardians of members by phone to provide education on vaccination, assist in scheduling appointments and arranging transportation to promote attendance with appointments
- Provider educational materials, including a webinar offering CME credits, available on the Sunflower website designed to assist providers with having conversations related to HPV vaccinations with parents of adolescents and an in-person CME offering
- Partnering with health departments to engage members by promoting walk-in clinics and community events
- Provider and staff CME event in 2017 in partnership with the American Cancer Society and fellow MCOs related to challenges with HPV vaccination discussions, approach in practice, and experiences

Figure 5.9.5.A_HPV Immunizations for Adolescents, Year to Date (through November) MY 2016 – MY 2017



HEDIS methodology updated in 2017 to deem a two-shot series as compliant

As a result of these efforts, we achieved a 2017 HPV (females only) HEDIS rate (for MY 2016) of 21.74%, a 15.6% improvement over our 2016 (MY 2015) rate of 18.81%. Preliminary data through November for 2018 (MY 2017, males and females), shown in ***Figure 5.9.5.A HPV Immunizations for Adolescents, Year to Date (through November) MY 2016 – MY 2017***, demonstrates additional improvement as evidenced from the updated HEDIS 2018 technical specifications. Interventions utilized in 2017 will be evaluated for effectiveness and repeated or revised as appropriate by December 31, 2017, for the 2018 measurement year, and the lessons learned from the HPV PIP will be used to improve the outcomes of other KanCare PIPs. This allows Sunflower to evaluate potential impact to members that can be served utilizing the methods applied in this PIP to increase vaccination rates, as appropriate.

Thus far, we have learned that setting aside clinic days for members to receive immunizations at participating provider offices and health department initiatives including a farmers' market event have not proved to be successful strategies for increasing HPV immunization rates.

Additionally, Sunflower learned through member and provider feedback that many parents and guardians have knowledge deficits regarding HPV vaccinations. However, Sunflower is continuing its efforts to gain additional feedback and look for other opportunities to demonstrate continuous improvement, for example, through ongoing outreach to parents and guardians of members to impact those knowledge deficits. Also, as a result of feedback from Sunflower's LTSS Advisory Committee, Sunflower and fellow MCOs have proposed new interventions that would focus on Community Developmental Disability Organizations, Community Mental Health Centers, and Psychiatric Residential Treatment Facilities to close the immunization gaps for adolescent members served by those providers.

Diabetic Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications ("SSD PIP")

Studies show that persons with severe mental illness (SMI) die at a younger age from chronic diseases, such as diabetes and heart disease, than the general population. To improve care for persons with SMI through earlier identification and treatment of diabetes, Sunflower initiated a PIP in CY 2017 to increase compliance with glucose or HbA1c testing for members 18-64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication. The PIP goal is to increase screening rates (using the HEDIS "SSD" measure) by 5% over the baseline (CY 2016) in year one of the PIP (CY 2017). Interventions include provider education, member education and care management, internal staff training, and community mental health center (CMHC) outreach and collaboration. Specific interventions include:

- Telephonic outreach by the Service Coordination team to members who are non-compliant with recommended screening
- Educational mailings to PIP eligible members
- Sunflower Senior Leadership team meetings with the Association of Community Mental Health Centers and high volume CMHCs to establish a plan and provide education
- Distribution of educational newsletters and other outreach to providers
- Distribution to CMHCs of quarterly screening rates for members in their assigned catchment area and identification of members in need of screening
- Implementation of a CMHC pay for performance initiative that rewards improved screening rates
- Notices to antipsychotic prescribers regarding members that have not been screened
- Training for Sunflower Service Coordination staff on diabetes, antipsychotic medications and the relationship to the schizophrenia and bipolar diagnosis

While final data are not yet available for year one of the PIP, preliminary data results show that Sunflower's administrative rate for the HEDIS SSD measure was 75.10% in November 2017 compared to 71.37% for the November 2016 administrative rate. The final rate for HEDIS 2017, measurement year 2016, was 76.10%.

Through our commitment to Rapid Cycle improvement, Sunflower has achieved early indicators of success in our 'Diabetic Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications' PIP (SSD PIP). 2017 Year to date (YTD) results (through November) compared to 2016 results through November reflect a 5% improvement in the SSD HEDIS measure, from 71.3% to 75.1%.

Interventions implemented in 2017 will be evaluated for effectiveness and repeated or revised as appropriate for the 2018 measurement year two, and the lessons learned from the SSD PIP will be used to improve the outcomes of other KanCare PIPs by evaluating other members that can be served utilizing the methods applied in this PIP to increase diabetes screenings or other necessary screenings as appropriate. During 2017, Sunflower has already identified the following lessons learned:

- Full integration in medical management in 2017 to improve communication and service delivery
- More can be done to leverage CMHC resources to drive interventions and communication with members given the CMHCs' established and trusted relationship with many members. Some members are less likely to answer calls from individuals they do not know but are more willing to listen to a trusted source (e.g., a CMHC) about health-related recommendations. We therefore provide CMHCs with a monthly list of attributed members who have not yet completed their diabetic screening for the year and have put in place a CMHC pay-for-performance initiative to support this effort
- Pharmacy data limits impacted our provider initiatives. For prescribers that work with multiple agencies within Sunflower's network, we found that our pharmacy data provided a prescriber name but did not indicate which practice the provider was working out of at the time the antipsychotic prescription was written. This prevented Sunflower from sending notices to these prescribers informing them which of their Sunflower clients had not completed their diabetic screening for the year as a location indicator is needed to ensure Sunflower is sending the notice to the correct practice and following HIPAA regulations. Sunflower is continuing to explore options for informing these prescribers about their patients' diabetic screening rates

Activity Name: Increasing the rate of Initiation and Engagement of Alcohol and Other Drug Dependence Treatment ("IET")

Research has demonstrated that providing timely services following diagnosis can decrease continued substance abuse. The IET PIP (in place from 2014 – 2016), was therefore focused on identifying members earlier for referral to Service Coordination. Referrals were derived from the State's KCPC data system (which identifies members with substance use disorders, or "SUDs"), but also from member self-referrals, provider-initiated referrals, Notice of Pregnancy (NOP) reports, SED waiver budgets, daily census reports, and clinical information from discharges from psychiatric hospitals. Members identified for the PIP were offered the following service coordination interventions:

- A smart phone application called ACHESS designed to support members in maintaining active engagement in treatment, support members with their recovery efforts, and connect members to a recovery network

- The myStrength program which provides education and recovery support to members
- Assistance with transportation
- Assistance establishing SUD and BH services
- Help to identify barriers to treatment and finding solutions to overcome those barriers
- Coordination with and between treatment providers
- Follow up calls to the member by the Service Coordinator to engage the member in continued treatment, ensure appointments for care are scheduled, assess treatment compliance and barriers, identify resources to improve access, develop a care plan, and provide member education as needed
- Technical assistance and training for SUD providers, including monthly provider performance reports

The interventions discussed 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.

For purposes of this PIP, and at the direction of the State, an IET HEDIS–like measure was developed that included an extended calendar year for a member to become part of the measure and the addition of members 12 years of age. The PIP goals were (1) to increase the rate for members receiving SUD treatment within 14 days of identification of an SUD from 43.3% (baseline) to 44.4% (initiation rate), and (2) to increase the rate for members attending two or more follow-up appointments for SUD use within 30 days of the initiation appointment from 37.1% (baseline) to 40.0% (engagement rate). While the PIP goals were not met (see ***Table 5.9.5.A Initiation and Engagement Rates, 2014 – 2016*** below), the PIP data revealed a clear difference between the rates for members who engaged in the Service Coordination Program and those who did not, as shown in ***Table 5.9.5.B Initiation and Engagement Rates by Service Coordination Status, 2014 – 2016.*** This difference can be seen in the overall rates in all three years of the PIP.

Table 5.9.5.A_Initiation and Engagement Rates, 2014 – 2016

Year	INITIATION %	ENGAGEMENT %
2014	43.75%	17.24%
2015	40.14%	13.48%
2016	39.07%	13.52%

Table 5.9.5.B_Initiation and Engagement Rates by Service Coordination Status, 2014 – 2016

Year	Initiation Rate		Engagement Rate	
	Service Coordination	No Service Coordination	Service Coordination	No Service Coordination
2014	52.31%	36.08%	23.02%	12.06%
2015	50.12%	30.72%	22.42%	5.03%
2016	49.60%	35.80%	19.03%	11.81%

Other lessons learned by Sunflower from the IET PIP that will be used to further improve member care include the following:

- Members who were referred to Service Coordination upon SUD identification had higher rates of initiation and engagement than those who were already engaged in Service Coordination for other reasons
- Members who accepted myStrength had higher rates of initiation and engagement than those who did not accept myStrength
- Successfully contacting members with SUDs was a challenge as they frequently changed phone numbers and addresses. We therefore used provider information and Community Health Worker staff to help find the members
- Because the State's KCPC reporting system limitations slowed down referrals to our Service Coordination team, we identified additional data sources to help identify SUD members, including SED Waiver budgets, NOP report, inpatient census reports, and claims
- Member barriers to treatment included phone access, transportation, and distance to providers

5.9.6. PEER REVIEW

Sunflower uses a variety of peer review processes and methods to evaluate the appropriateness of care and services rendered by our participating providers. We regularly examine aggregate and provider-level compliance with preventive health and clinical practice guidelines (CPG's), utilization trends for inpatient, emergency, pharmacy, outpatient physical health (PH), behavioral health (BH), long term services and supports (LTSS), and transportation services, morbidity and mortality rates, grievances, quality of care referrals, as well as factors such as appointment access and after hour's availability, authorization and billing practices, and appropriateness of services. All of our affiliated health plans serving Medicaid programs in other States also utilize processes and procedures similar to those described below.

REVIEW OF PROVIDER PRACTICE PATTERNS (5.9.6.A.1–5)

Utilization Management (UM) Reviews (5.9.6.A.1–2, 4–5)

Our UM staff review standard and ad hoc reports to identify events over which providers could have exercised control and which were associated in whole or in part with medical intervention, rather than with the condition for which the intervention occurred. UM data is reviewed at the Utilization Management Committee (UMC). The UM Department will review quarterly reports

of measures such as rates of occurrence for certain diagnoses, pre-term delivery, NICU admission, re-admission, complications of care (sentinel events), never events, inpatient length of stay, and relevant HEDIS measures to identify potential gaps in needed services. When potential gaps are identified, Quality Improvement (QI) staff work with UM and Service Coordination staff to conduct case studies and determine whether medically necessary services are being provided. Staff will track claims data back to the case to identify how to improve services to the member and providers.

Concurrent Reviews (5.9.6.A.1–2, 4–5)

Our Concurrent Review Clinician staff (CRCs) use our daily Inpatient Census Report populated by authorizations created in our clinical documentation system, TruCare, to manage their daily reviews. Our CRCs obtain clinical information from the facility and apply both clinical inpatient criteria and level of care criteria to determine ongoing medical necessity for the admission. Clinical reviews are completed with every initial admission review and with every concurrent review. During the concurrent review process, CRCs will assess the clinical status of the member, determine the appropriateness of treatment rendered, verify the need for continued hospitalization or transition to lower level of care, and monitor the quality of care to verify professional standards of care are met. Information assessed during the review will include:

- Clinical information to support the appropriateness and level of service proposed
- Whether the diagnosis is the same as provided on admission or if it has changed
- Additional days/services/procedures proposed
- Reasons for extension of the treatment or service
- Assessment of member status to determine special requirements to facilitate a safe discharge to another level of care

CRCs monitor for sentinel events and potential quality of care concerns as part of the concurrent review process by gathering initial data, addressing immediate concerns with the Medical Director, and referring to the QI department as appropriate.

Monitoring Prescribing Patterns (5.9.6.A.1–2, 4–5)

Our extensive Drug Utilization Review (DUR) Programs are designed to promote appropriate utilization at every opportunity and monitor and engage prescribers in adopting appropriate prescribing practices. DUR programs consist of both prospective (Pro-DUR) and retrospective (Retro-DUR) initiatives. The DUR programs are designed to alert prescribers and/or dispensing pharmacists of overuse, underuse, inappropriate or medically unnecessary care, potential drug interactions, and other safety concerns associated with specific drugs. The programs identify opportunities to improve quality of care, including, but not limited to adherence to prescribed therapies, while improving a patient's medication regimen consistent with their diagnoses or conditions.

Pro-DUR system edits address drug interactions, medication overuse, medication underuse, subtherapeutic dosage, improper drug selection, etc. Pro-DUR functions are provided at the point-of-sale (POS) and include real-time notification to the dispensing pharmacy. A compiled database provided by Medispan, generate electronic alerts to dispensing pharmacies via standard POS messaging when potential drug conflicts exist. The Pro-DUR system edits use predetermined standards based upon peer-reviewed medical literature and references such as American Hospital Formulary Service Drug Information, United States Pharmacopoeia Drug Information, Clinical Pharmacology and Facts and Comparisons. The POS system uncovers potentially dangerous or inappropriate prescribing by comparing prescribed medications against previous drug history, such as for drug-to-drug interactions, and ingredient and therapeutic duplications, and by identifying high or low dosing or age contraindications, which may either require prior authorization (PA) or pharmacist oversight.

Sunflower in Action…

In July 2017, Prescriber SH, a general practice nurse practitioner, was identified to have 22 members that exceeded 120mg Morphine Milligram Equivalent (MME) in the last 60 days. Of the 22 members, only 6 had cancer diagnoses in 2016 to 2017. Of the ones without cancer, the average daily MME was 150-200 or more. Sunflower reached out to the prescriber's practice and arranged a multidisciplinary call with the prescriber, the prescriber's practice Medicaid Director, Sunflower Medical Director, Dr. Haake, board-certified in pain medicine, and Sunflower's Pharmacy Director. During the call, Dr. Haake provided guidance and practice resources for pain management. The Prescriber agreed to re-evaluate her patients. When the prescriber titrated down her patients, some became disgruntled and distraught. The prescriber reached out to Sunflower for additional support. Sunflower was able to connect those members with our care managers for support and further discussion. As of November 2017, the number of members under this prescriber with 120 morphine equivalence in the last 60 decreased by 64%.

Retro-DUR aims to detect patterns in prescribing, dispensing or administering drugs. Monthly and quarterly reports on Retro-DUR programs are evaluated by Sunflower to assess therapeutic appropriateness, cost-effectiveness, quality of care, fraud and abuse, over/underutilization, adverse drug events, and manage outcomes. Based on these reports, target interventions are developed to prevent recurrence of inappropriate medication use or abuse. Examples of Retro-DUR intervention include provider outreaches regarding potential inappropriate use of medication or patient drug non-adherence to aid prescribers in improving the care of their patients. Additionally, potential overutilization or inappropriate prescribing can be further monitored and reviewed by our Lock-In Committee and Quality of Care Committee.

Medical Record Reviews (5.9.6.A.5)

Sunflower's minimum standards and policies for provider and subcontractor medical record keeping practices comply with all applicable NCQA, State, and federal standards. These requirements also include requirements for medical record content, medical record organization, ease of retrieving medical records, and maintaining confidentiality of protected health information (PHI), in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable record retention laws. Medical record review is completed

concurrently as member records are accessed by the plan for business operations. Concerns related to completeness and accuracy are filed in the QI Department, investigated as Quality of Care issues, and shared with the Credentialing Department to be considered at the time of re-credentialing if remedial action is not pursued and resolved appropriately. Subcontractor compliance with the standards is reviewed annually as part of the Delegated Vendor Oversight audit. Outcomes if a subcontractor is not in compliance may include re-education with re-audit, corrective action plan (CAP), intervention by the QI Committee, contracting, etc., and/or termination of the contract.

Grievances Relating to Medical Treatment (5.9.6.A.1)

Sunflower routinely monitors trends in aggregate and individual provider data for appeals, grievances and State fair hearings to identify opportunities for improvement, determine the root cause, and apply Rapid Cycle Process Improvement methods of PDSA to test for appropriate interventions that will drive improvement. When grievances are filed against network providers relating to their medical treatment, they are referred to the Provider Relations staff or the QI designee (as are providers who are not participating in the Sunflower network) described below (under Corrective Action When Aberrant Practice Patterns Confirmed).

Data Sources Including Data from Subcontractors and Delegated Networks

Our comprehensive Enterprise Data Warehouse (EDW) powered by high performance Teradata technology systematically receives, integrates, and transmits internal and external administrative and clinical data, including medical, behavioral, LTSS, and pharmacy claims data, as well as lab test results, health assessment information and data from our subcontractors. EDW supplies the data needed for all of Centelligence's analytic and reporting applications and allows staff to generate standard and ad-hoc reports from a single data repository. The review processes described above use our Centelligence clinical decision support, claims and outcome data, and medical record audits. We also track member grievances regarding providers and potential quality of care and service events. Many of the provider-level indicators we track are also shared with providers in our multi-dimensional provider scorecard along with national benchmarks and State goals. Information is assessed at all levels of care, and can be broken down by providers' utilization of services by gender and age. Aberrant practice patterns may also be detected by suspicious billing trends identified by specialized Fraud, Waste and Abuse (FWA) software that is used in Sunflower's claims adjudication process.

Corrective Action When Aberrant Practice Patterns Confirmed (5.9.6.A.3)

If an aberrant provider practice pattern is confirmed, the provider is referred to Provider Relations staff, with the participation of the Medical Director as required, for discussion of the identified pattern, comparison to peer performance and any evidence-based relevant guidelines. If analysis identifies a potential Quality of Care incident (QOC) requiring intervention (including an analysis resulting from an incident processed through the grievance system), the incident is reported to the QI designee who undertakes a review to determine if it is a QOC and, if it is, assigns a preliminary severity rating. Cases with a severity level of medium, high or

critical are referred to the Medical Director for review. If the severity level is confirmed, the Medical Director refers the QOC to the Peer Review Committee (PRC) for evaluation and action. The PRC assigns a final severity level to those cases reviewed and can also recommend cases be referred to the Credentialing Committee for a review related to continuation as a network provider.

The Medical Director then notifies the provider in writing of the final QOC severity determination and the recommendations made to address the QOC, including corrective actions, and the timeframe for completion. We may impose many levels of corrective action such as:

- Informal education such as telephonic counseling by the Medical Director or an educational letter sent to the provider regarding the specific event that occurred
- More intensive actions such as formal oral or written counseling, Medical Director review of authorization requests, proctoring by a designated physician, or mandatory skills training
- Probation or termination of network status for the most serious adverse events

For additional information on our QOC and Adverse Incident processes and procedures, please see our response to ***Section 5.9.9 Adverse Incident Management and Reporting System***.

USING DATA TO IMPROVE THE DELIVERY OF CARE AND SERVICES THROUGH PROVIDER PROFILING (5.9.6.A.1–2, 4–5)

Provider profiling is a highly effective tool that Sunflower utilizes to compare individual provider practices to normative data, so that providers can improve their practice patterns, processes, and health care outcomes in alignment with evidence-based clinical practice guidelines. Sunflower's practice of provider profiling is statistically valid and based on five key elements:

- Data is normalized for variations (e.g. geography, panel size, population demographics, acuity and clinical conditions)
- Performance measure sets are customized for each provider based on services provided
- Reporting allows for easy identification of the problem
- Reporting includes drill down functionality so that providers can filter to specific tax ID numbers (TIN), national provider identifier (NPI), measures and/or members
- The frequency of reporting is quarterly, providing sufficient data samples and adequate time for claims submission and processing

Sunflower's Profiling Program is based on five key elements:

- Normalized for variation
- Customized by provider type
- Easy identification of problem
- Drill down functionality
- Quarterly profile reports

Provider profiling increases provider awareness of performance, identifies opportunities for improvement, and facilitates plan-provider collaboration in the development of clinical improvement initiatives. Sunflower has jointly developed our approach with participating

providers to ensure the process has value for providers and members. Our Chief Medical Director (CMD) has final authority and responsibility for our provider profiling program, which encompasses a variety of provider types in addition to Primary Care Providers (PCPs) and OB/GYNs, such as behavioral health providers and facilities. Through the QI Committee and Physician Advisory committees, we work closely with providers to select profile indicators and help providers understand and use feedback to improve care. This collaborative effort fosters provider acceptance of profiling and helps Sunflower motivate providers to continuously improve performance in targeted areas. Our Provider Relations Specialists work with assigned providers to educate them about the drivers behind performance and identify opportunities for improvement. We conduct discussions directly with providers and work with them to develop action plans to improve compliance with clinical practice guidelines, reduce the occurrence of provider preventable conditions and otherwise improve their performance. Our Provider Relations Specialists are highly trained and have the necessary skill set to assist providers in accessing the tools available on our provider portal to understand and analyze data that can be used to improve their performance and the care provided to members. Sunflower also uses profiling reports internally to develop clinical programs, quality improvement initiatives, network contracting strategies, and innovative provider payment strategies including pay for performance.

Sophisticated Analysis and Reporting Capabilities

To ensure the best possible results, we use both health plan and Centene analysis capabilities as the foundation for profiling, since effective improvement requires complex analysis and feedback at several levels of the care process. Our provider profiles are produced from Centelligence, our robust, integrated business intelligence platform, supported by Centene's Teradata-powered Enterprise Data Warehouse. Centelligence components can generate all required performance indicators, and have the additional capabilities of producing refined peer-to-peer comparison groups within specialties, regions, and programs, and risk-adjusting performance scores based on member acuity. Our profile reports for different provider types include unique sets of indicators that are relevant to the services rendered by those providers and that promote compliance with evidence based CPGs.

Determining Providers for Profiling

Sunflower reviews program participation criteria annually to ensure that we include as many providers as possible in our profiling program. The Sunflower QI Committee, which includes network primary care (including OB/GYN) and other specialist providers, reviews and approves the proposed provider types to be profiled; the participation criteria for individual providers or group practices; and the performance indicators to be used in the profiling reports. The QI Committee considers the average number of members served and the specific needs of enrolled members when determining the types of providers to include, such as cardiologists and pulmonologists. All primary care providers and select specialty providers meeting the minimum panel size requirements are included in our profiling program.

Rationale for Selected Measures

Each year, the QI Committee reviews profile indicators that provide a multi-dimensional assessment of performance, using clinical, administrative, and member satisfaction-related data aligned with the dimensions of the Triple Aim, KDHE's Quality Management Strategy, Sunflower's unique quality goals and the needs for the entire member population being served, including LTSS members and members with BH and other special health care needs. The indicators are measurable, reliable, and valid; have available, reliable benchmark data; and are relevant to our members, providers, and our QI program. These categories address preventive health visits, screening for disease, management of chronic health conditions such as diabetes and heart disease, prescribing patterns and utilization of services. Reports for different provider types have unique sets of indicators that are relevant to the services rendered by those providers and that promote compliance with evidence-based clinical practice guidelines. For example, internal medicine providers have measures related to adult preventive care services while pediatricians have measures related to well child screenings. OB/GYNs have measures related to prenatal and postpartum care. A family practice physician may have a combination of these measures depending on member age, diagnoses, and services provided.

To establish trends and to permit assessment of improvement efforts over time, we measure the same indicators for multiple years. Sunflower will continue to refine and develop key performance indicators that align with the Triple Aim of improving outcomes, improving member experience of care, and reducing per capita costs.

Proposed Frequency of Profile Reporting

Each quarter, individual PCPs receive a performance profile scorecard that includes specific quality indicators. The profiles increase provider awareness of performance, help identify opportunities for improvement, and facilitate plan-provider collaboration in the development of clinical improvement initiatives. The quarterly scorecards use claims data and provide national Medicaid NCQA data or Sunflower goals, as appropriate, as benchmarks for each indicator.

For additional information regarding our Enterprise Patient Analytics web-based tool within the Provider Portal that allows all providers to view member level detail and performance on select quality metrics, see our response to ***Section 5.7.*** Our pay for performance (P4P) reports that show how providers participating in the P4P program are performing on P4P metrics are also described in ***Section 5.7.***

PEER REVIEW COMMITTEE (PRC) (5.9.6.A.6-8)

The Peer Review Committee (PRC) is an ad-hoc committee of the QI Committee and is responsible for reviewing services where the plan or others may have identified (verbally or in writing) potential QOC incidents, Adverse Incidents, or sentinel events, and an initial investigation indicates a significant potential or a significant, severe adverse outcome has occurred. These cases may also come as a result of referrals arising from reviews done for other health plan purposes. Other cases may be reviewed at the discretion of the Chief Medical Director (CMD). The PRC is expected to use their clinical judgment in assessing the

appropriateness of clinical care and may request the provider or facility under review to provide the CAP it has already implemented or recommend a CAP that will best suit the situation and mitigate potential events from occurring in the future. Each PRC will include three or more network physicians who represent a range of specialties including at least one physician with the same or similar specialty as the provider and/or issue under review. Network physician members are not standing members of the committee and their attendance may change based on the type of case being reviewed. The Committee is chaired by the CMD or plan Medical Director as designated by the CMD.

Sunflower in Action…

The Peer Review Committee (PRC) received a QOC referral regarding quality of care in a nursing facility. The PRC reviewed the adequacy of the facility's corrective action plan (CAP) to address the QOC and determined that all direct care staff at the nursing facility should receive additional training within a specified timeframe to avoid future wound development by members served by this provider. This CAP was shared with the provider. The provider followed up and demonstrated completion of this education, which was accepted by the PRC. This example demonstrates the active, ongoing partnership between Sunflower and its providers to ensure that member care meets the appropriate standard of care.

Integration of Peer Review and Credentialing Processes

If the PRC makes a recommendation for termination of the practitioner, the recommendation will be presented to the Credentialing Committee and/or Sunflower Board of Directors for final determination. Final determinations are also reported to the QI Committee. Reviews resulting in the reduction, suspension, or termination of a provider's participation are reported to the National Practitioner Data Base (NPDB) as outlined in the Practitioner Disciplinary Action and Reporting Policy and Procedure and to the State as appropriate. Sunflower ensures that no decision made by the PRC is overturned by the Credentialing Committee or other committee without the knowledge or consensus approval of the PRC.

Maintenance of Peer Review Data

PRC meeting minutes are confidential and are maintained in a secure area with limited access. Complete documentation is maintained in the QI Department files and is subject to ongoing review for trends and repeat occurrences. This information is incorporated into re-credentialing and other quality improvement processes. Reporting of Quality of Care (QOC) review activities is reported to the QI Committee at least quarterly. Reports to State occur routinely as appropriate.

EDUCATION REGARDING PEER REVIEW PROCESSES (5.9.6.A.9)

Sunflower believes that members should have their concerns and issues heard and addressed as soon as possible. We educate our members about how to contact Sunflower's Customer Services Department if they have an inquiry or concern, including a quality of care-related concern that would be referred for review as appropriate, and about the grievance process. Information is made available in the Member Handbook, on the Sunflower website, Member

Portal, and at least annually in our Member Newsletters. All materials are written in easy-to-understand language. A member or member's authorized representative may contact Sunflower at any time with an inquiry on behalf of a member. They may contact Sunflower orally, in writing, by mail, facsimile, electronic mail, through the Sunflower Member Portal, by dialing Sunflower's toll-free Customer Services Helpline, or in person. We take pride in our responsive customer service, and attempt to resolve the issue or inquiry for the caller at the time of the call. All Sunflower staff, including Member Advocates and QI staff, are trained to identify, document, and when appropriate, route verbal or written issues, inquiries, grievances or appeals to the Grievance Coordinator or the Clinical Appeals Coordinator (CAC) who investigate the matters as requested and also make referrals for potential QOCs as appropriate.

5.9.7. NATIONAL COMMITTEE FOR QUALITY ASSURANCE ACCREDITATION

Sunflower is proud of our achievement of becoming the first KanCare health plan to achieve NCQA Accreditation for our Kansas line of business in 2014. Sunflower is also proud to have increased our accreditation status to the "Commendable" level as of August 2016 based on our HEDIS 2016 and CAHPS results, and again in August 2017 based on HEDIS 2017 and CAHPS results. Our current NCQA certificate reflecting our Commendable accreditation status is shown as ***Figure 5.9.7 Current NCQA Certificate*** below.

Figure 5.9.7 Current NCQA Certificate

NCQA
Measuring quality. Improving health care.

National Committee for Quality Assurance
has awarded

Sunflower State Health Plan

Medicaid HMO

an accreditation status of

COMMENDABLE

for service and clinical quality that meet or exceed

NCQA's rigorous requirements for consumer

protection and quality improvement.

ACCREDITED NCQA HEALTH PLAN

CHAIR, BOARD OF DIRECTORS | PRESIDENT | CHAIR, REVIEW OVERSIGHT COMMITTEE

August 31, 2017 — DATE GRANTED

May 10, 2020 — EXPIRATION DATE

We further commit to obtaining NCQA's Long-Term Services and Supports (LTSS) Distinction no later than December 31, 2020. NCQA's LTSS Distinction is awarded to health plans that have demonstrated their ability to effectively coordinate LTSS in addition to physical and behavioral health services by meeting certain requirements in areas such as conducting comprehensive assessments, managing care transitions, performing person-centered assessments, and planning and managing critical incidents.

Our parent company, Centene Corporation (Centene), is one of the 30 "early adopter" health plans and community-based organizations that are currently working towards LTSS Distinction. Centene is in the process of attaining NCQA Corporate Health Plan Accreditation and will be demonstrating compliance with several 2017 LTSS Distinction standards and elements as part of the corporate accreditation survey. Documented processes submitted for the corporate survey, essential to meeting the NCQA requirements for LTSS Distinction, include the LTSS Care Management/Service Coordination Program Description, Home and Community Based Services Policy, the Member Contingency Plan for In Home Services Policy, and the Transition of Residence Policy. The policies and procedures adopted by Centene for these elements are applicable to, and will be adopted by, Sunflower as well.

All Centene health plans, including Sunflower, will benefit from a consistent proven approach to operationalizing the LTSS policies and procedures necessary to attain LTSS Distinction. A Centene work group, which includes Sunflower's Senior Director of LTSS, is currently implementing the policies and processes required to meet the LTSS Distinction standards, as well as providing ongoing support. Sunflower will leverage Centene's experience and has initiated the process of attaining LTSS Distinction status locally, and expects to achieve distinction when our NCQA accreditation is next renewed in the second quarter of 2020. Sunflower is actively working with Centene and our Service Coordination staff to align with the current NCQA standards, including updates to current forms and process changes to meet NCQA-required timelines. Many standards are already in effect at Sunflower for the complex care management population.

Since our inception, Sunflower has included the LTSS membership in data, reports, and other activities critical to demonstrating compliance with NCQA standards, improving quality of care and services provided, including achievement of our current Commendable status. Sunflower has also gone beyond these requirements by providing more descriptive information regarding our LTSS membership in our data, reports and other activities, including the generation of HEDIS reports specific to the LTSS population and implementation of an LTSS member satisfaction survey for the first time in 2017. During the first quarter of 2018, Sunflower will also establish the LTSS Quality Assurance Committee charged with focusing on a variety of metrics specific to the LTSS members including grievances, appeals, Quality of Care, Adverse Incident Reports, member experience/satisfaction, utilization data, and HEDIS measures.

5.9.8. HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET AND CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS

Sunflower's ongoing dedication to continuous quality improvement and our plan-wide culture of quality is evident through our strong performance on HEDIS measures and the high level of member satisfaction reported in our CAHPS surveys. Sunflower was the first KanCare Managed Care Organization (MCO) to achieve full NCQA accreditation for our Kansas line of business in 2014 and we are also proud to be the first KanCare MCO to achieve the "Commendable" accreditation status" level based on our 2016 HEDIS results and then again in 2017.

HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS)

Recent Results

Table 5.9.8.A Selected Sunflower HEDIS Measure Improvements, 2014-2016 and ***Table 5.9.8.B Sunflower HEDIS Measure Results with Both One-Year and Two-Year Improvements, 2014-2016*** below summarize our demonstrated HEDIS measure improvements between 2014 and 2016, reflecting improved quality of clinical care and/or quality of services for our members over this time period.

Table 5.9.8.A_Selected Sunflower HEDIS Measure Improvements, 2014-2016

Measure Category	Recent Improvements
Well-Child Visits	Year over year improvements in HEDIS results for: • Well Child 15 month – 6 or more visits • Well Child 3-6 Years • Weight Assessment for Children/Adolescents – BMI, Nutrition and Physical Activity • Adolescent Immunizations – Combo 1 (Tdap and Meningococcal), HPV for female adolescents
Annual Dental Visits	• 3.7% increase from 2015 to 2016 • 5.5% increase from 2014 to 2016 • Exceeding 75th percentile rank for Measure Year (MY) 2016
Diabetes Care	Hemoglobin A1c Testing: • 2.1% increase from 2015 to 2016 • 3.5% increase from 2014 to 2016 • Exceeding 50th percentile ranking for MY 2016 Hemoglobin A1c Control less than 8: • 16.9% improvement from 2015 to 2016 • 37.7% improvement from 2014 to 2016 • Exceeding 66th percentile ranking for MY 2016 Hemoglobin A1c Poor Control (>9): • 13.8% improvement from 2015 to 2016 • 20.4% improvement from 2014 to 2016 • Exceeding 66th percentile ranking for MY 2016 Retinal Eye Exams • 4.1% increase from 2015 to 2016 • 15.1% increase from 2014 to 2016 • Exceeding 95th percentile ranking for MY 2016
Behavioral Health Follow Up	7 Day Follow-Up after Discharge • 2.1% increase from 2015 to 2016 • 15.3% increase from 2014 to 2016 • Exceeding the 90th percentile for MY 2016

Table 5.9.8.B_Sunflower HEDIS Measure Results with Both One-Year and Two-Year Improvements, 2014-2016

Measure Name	Submeasure	Final Submitted Rate			Percentage Increase	
		MY 2016	MY 2015	MY 2014	2015 -2016	2014 -2016
Adult BMI Assessment (ABA)	With Exclusions	82.38%	82.38%	62.29%	0.00%	18.89%
Annual Dental Visit (ADV)	Total	63.49%	61.21%	60.17%	3.72%	5.52%
Antidepressant Medication Management (AMM)	Effective Acute Phase Treatment	51.02%	50.06%	49.09%	1.92%	3.93%
Appropriate Testing for Children With Pharyngitis (CWP)	All Members	60.77%	54.0%	51.60%	12.35%	17.77%
Appropriate Treatment for Children With Upper Respiratory Infection (URI)	All Members	78.61%	75.82%	73.87%	3.68%	6.42%

Measure Name	Submeasure	Final Submitted Rate			Percentage Increase	
		MY 2016	MY 2015	MY 2014	2015 -2016	2014 -2016
Asthma Medication Ratio (AMR)	Total (age 5-64 Ratio > 50%)	61.70%	59.48%	58.49%	3.73%	5.49%
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)	All Members	39.08%	35.71%	35.64%	9.44%	9.65%
Comprehensive Diabetes Care (CDC)	Eye Exam w/exclusions	70.70%	67.92%	61.42%	4.09%	15.11%
Comprehensive Diabetes Care (CDC)	HbA1c Control (<8) Adequate Control	53.26%	45.58%	40.13%	16.85%	32.72%
Comprehensive Diabetes Care (CDC)	HbA1c Poor Control (>9)*	40.23%	46.68%	50.55%	-13.82%*	-20.42%*
Comprehensive Diabetes Care (CDC)	HbA1C Testing	87.44%	85.62%	84.48%	2.13%	3.50%
Controlling High Blood Pressure (CBP)	Total	55.45%	50.67%	52.65%	9.43%	5.32%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Using Antipsychotic Medications (SSD)	Diabetes Screening	76.10%	75.27%	72.69%	1.10%	4.69%
Follow Up After Hospitalization for Mental Illness (FUH)	Follow Up Within 7 Days of Discharge	68.62%	67.20%	59.54%	2.11%	15.25%
Immunizations for Adolescents (IMA)	Combo 1 (Tdap, Meningococcal)	65.38%	63.59%	61.58%	2.81%	6.17%
Immunizations for Adolescents (IMA)	HPV (Females only)	21.74%	18.81%	21.67%	15.58%	0.32%
Medication Management for People With Asthma (MMA)	Total Age 5 to 64 (Total Population) 75% Covered	33.87%	28.94%	27.85%	17.04%	21.62%
Pharmacotherapy Management of COPD Exacerbation (PCE)	Dispensed Bronchodilator w/in 30 Days of Event	46.38%	44.99%	40.96%	3.09%	13.23%
Pharmacotherapy Management of COPD Exacerbation (PCE)	Dispensed Systemic Corticosteroids w/in 14 Days of Event	37.79%	35.26%	34.16%	7.18%	10.63%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	BMI Percentile Documentation	58.89%	50.71%	48.10%	16.13%	22.43%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	Counseling for Nutrition	61.78%	50.48%	49.76%	22.39%	24.16%

Measure Name	Submeasure	Final Submitted Rate			Percentage Increase	
		MY 2016	MY 2015	MY 2014	2015 -2016	2014 -2016
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	Counseling for Physical Activity	56.01%	46.90%	47.38%	19.42%	18.21%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)		63.22%	62.99%	62.03%	0.37%	1.92%
Well-Child Visits in the First 15 Months of Life (W15)		55.71%	55.22%	44.33%	0.89%	25.67%

**Lower rate – better performance*

Sunflower exceeded the 50th percentile in numerous HEDIS metrics contributing materially to our NCQA Commendable status. The following examples highlight a few accomplishments involving access to care, behavioral health and chronic disease management.

- Improvement in Comprehensive Diabetes Care metrics previously less than the 50th percentile, now meeting or exceeding 50th Percentile
  - HbA1c testing
  - HbA1c < 8
  - HbA1c >9* (lower rate compared to previous years)
- Met or Exceeded the 75th percentile
  - Adults' Access to Preventive/Ambulatory Health Services
  - Annual Dental Visit
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics
  - Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase
- Met or Exceeded the 90th percentile
  - Follow-Up After Hospitalization for Mental Illness: 7 and 30 day metrics
  - Comprehensive Diabetes Care: Diabetic Eye Exam

Effectiveness of Care: Interventions Taken to Improve Comprehensive Diabetes Care

As noted in ***Tables 5.9.8.A*** and ***5.9.8.B*** above, Sunflower has achieved substantial improvement in the HEDIS chronic diabetes care measures between 2014 and 2016. During this time period, Sunflower continued to work on this HEDIS measure and its submeasures. Our goal was to impact those members who were non-compliant with diabetes monitoring and to allow them the option to have their lab draws, blood pressure, height and weight measurements taken in their own home by a Quest/ExamOne staff member. Other interventions included:

- Referrals of members with an A1c reading ≥ 8 for disease management services

- Corporate "Healthy Reminders" mailed each year highlighting the submeasures completed and those still needing compliance
- Member HEDIS outreach by Envolve Vision regarding Diabetic Retinopathy exams
- Outreach to non-compliant members and diabetic members in care management by the Service Coordination team
- Member mailer postcards and letters with measure/test dates and reminders
- Customer Service and Service Coordination training on measure and how to discuss care gaps with members on calls; reminders sent prior to care gap reports going out to members
- Use of educational materials to educate members about diabetes care
- Detailed information on the importance of screenings, and proper diabetes care included in the member newsletter
- Provider profiling reports distributed to providers of non-compliant members with member specific opportunities to improve their compliance and care
- Articles related to plan performance and goals included in the provider newsletter
- P4P measures reviewed and discussed in oversight meetings with subcontractors who have the ability to assist members
- P4P Champion committee focused on assessing data, identifying additional opportunities, and additional interventions
- Partnered with Federally Qualified Health Centers to close member care gaps

Use of Services: Interventions Taken to Improve Well-Child, 15 Month – 6 or More Visits

Sunflower has also achieved year-over-year improvement, including a significant 2-year percentage increase of 25.67% (2016 over 2014), in the Well-Child, 15 Month – 6 or More Visits (W15) measure. During this time period, Sunflower continued to work on this HEDIS measure through a variety of interventions aimed at members and providers including the following:

- Educating parents/guardians on the importance of well child exams through a variety of communications including education about care gaps from Customer Service and Service Coordination staff when speaking to members
- Birthday card mailings the month prior to the member's birthday, "Healthy Reminder" mailers, and newborn mailers to parents/guardians which include the Periodicity schedule
- New member packets containing a well-child appointment schedule and a magnet that was developed by Sunflower and allows appointments to be written on the magnet for ease of viewing and to promote compliance
- Community Health Worker hospital visits to parents/guardians of premature babies with NICU kits and follow-up calls by Service Coordination staff
- Smart Start for Babies® program which provides member education on well child visits
- Televox messaging to non-compliant members to remind them of the Periodicity schedule and automated calls to remind members of needed visits
- CentAccount Program incentives for well child visits

- Provider education about the availability of care gap information through our Provider Portal which includes a member panel roster that allows providers to quickly review and filter on detail level information and export and print a care gap report. These alerts notify a provider about the potential need for interventions, diagnostic tests, and labs for certain conditions, or for EPSDT and preventive services, including well child exams
- Other provider educational materials such as the HEDIS Quick Reference Guide, provider presentations including the Periodicity Schedule and concerns, and provider newsletter pieces about check-ups and vaccinations for children

HEDIS Data Collection and Reporting Approach (5.9.8.B-F)

Sunflower will continue to conduct HEDIS data collection and reporting in compliance with NCQA requirements and will also continue to comply with the HEDIS requirements in the State's Quality Management Strategy (QMS), including completing all HEDIS measures designated by NCQA as relevant to Medicaid. As required by NCQA, we will use the "Hybrid" measure methodology that relies on both administrative and medical record data collection, and will use Centene's nationally contracted NCQA-certified software that applies a series of clinical rules and algorithms to automatically convert raw data from Centelligence into statistically meaningful information. Data is updated on a monthly basis (and upon the State's request) and allows Sunflower to view standard data summaries, produce outcome reports by member group as specified by the State (e.g., TANF, Foster Care, LTSS, I/DD, SMI), geographic region, etc., to identify and/or assess for disparities in health outcomes. Our QI staff will also be able to drill down into the data or create ad-hoc queries when needed. Sunflower will also use Centene's nationally contracted NCQA-certified auditor to audit HEDIS rates and will submit the audit report to NCQA and KDHE annually by August 15th of each calendar year, as well as a detailed explanation for any HEDIS measure marked as "Not Reported."

EXPERIENCE WITH CAHPS SURVEYS (5.9.8.G)

Sunflower continually measures member satisfaction with the goal of continuing to be the KanCare health plan of choice. Sunflower's Quality Department is responsible for conducting the CAHPS survey in accordance with Contract requirements and NCQA guidelines. Our assessment of our members' experience with health care is not limited to formal CAHPS surveys; we take a cross-departmental approach, through the following mechanisms to ensure that we meet members' expectations and aid in improving the quality of care provided:

- LTSS Member Satisfaction Surveys
- Mental Health Consumer Perception Surveys
- Disenrollment Surveys
- Ad hoc surveys
- Complaints, Grievances and Appeals
- Member Advisory Committees
- Customer Service Calls

CAHPS Member Satisfaction Survey Approach

Sunflower conducts formal and comprehensive CAHPS Member Satisfaction Surveys annually as required by the State, including the CAHPS® Adult Survey and the CAHPS Children with Chronic Conditions (CCC) Survey (which includes responses and data for both the general child population and children with chronic conditions), following NCQA guidelines using a NCQA certified vendor. Sunflower conducts three separate CAHPS surveys: one for the adult membership, one for Title 19 children (Medicaid) and one for Title 21 children (CHIP). Through our survey vendor, Sunflower ensures that both child Surveys (the Title 19 and Title 21 surveys) include a statistically valid sampling methodology. In 2017, for example, 4,537 Title 19 and 3,689 Title 21 child members were randomly selected to participate in the 2017 CAHPS 5.0H Child Medicaid with CCC Survey, totaling 8,226 child members. Of this total, 3,936 were part of the CCC Supplemental Sample consisting of members with the prescreen status code of two (children more likely to have a chronic condition) who were not already selected for the CAHPS 5.0H Child survey sample.

Sunflower believes that CAHPS surveys are the best way to obtain an unbiased, statistically valid and accurate measure of members' experiences with health plan operations and providers. The Quality Department analyzes the survey results and forms a cross-functional team to review the results, develop a plan for improvement and implement the actions. Audited CAHPS results will be submitted to KDHE, NCQA and KDHE's External Quality Review Organization annually by August 15th of each calendar year in which the survey is conducted.

Sunflower deployed interventions that ultimately resulted in high 2017 adult and child CAHPS satisfaction survey results. To achieve these results, Sunflower reviewed CAHPS member satisfaction results annually for the Adult, Title 19 and Title 21 populations to identify strengths and areas for improvement. For both the Title 19 and Title 21 surveys, the results are available for the general population and also the Child with Chronic Conditions to allow for more insight into the satisfaction for those members. From the most recent review of the 2017 survey results, the following areas were noted as strengths:

- Getting needed care
- Customer service
- Overall rating of health care
- Provider and specialist

Those areas noted for improvement were noted to be coordination of care which focuses on primary care providers being informed of care members receive from other providers. Also, shared decision making which focuses on providers communication with members about their medications including the benefit/risk of taking a medication and what is best for the member when starting/stopping a medication.

Sunflower implemented a variety of interventions to impact these areas noted for improvement but also to continue to improve satisfaction on other areas where results were good and continued satisfaction is important there as well. The interventions are aimed at both

members, providers and Sunflower as well to continue to drive up the satisfaction of Sunflower members. Some of the interventions that were new for implementation based on the 2017 CAHPS member satisfaction survey include:

- A brochure for educating CMHC's on services available to ensure that Foster Care members are receiving the appropriate coordination of care
- Health plan staff to complete the CAHPS survey to increase their knowledge and understanding of the survey
- Customer service trainings to be developed for the health plan to increase knowledge and understanding of each team member's impact potentially on member satisfaction regardless of their role at the plan
- Letters sent to providers who filed a member grievance about the services or care received by the provider or their staff in 2016, along with provider resource tools to help increase their understanding of the CAHPS survey with helpful hints on how to impact

As shown in ***Table 5.9.8.C Sunflower 2017 CAHPS Adult Medicaid Survey Highlights*** below, our 2017 CAHPS Adult Survey reported high levels of member satisfaction, particularly regarding care coordination and how well their doctors communicated with them. As shown in ***Tables 5.9.8.D Sunflower 2017 CAHPS Child Medicaid with CCC Survey Highlights (Title 19 and 21 Combined) , 5.9.8.E Table 5.9.8.E_Sunflower 2017 CAHPS Child Medicaid with CCC Survey Highlights (Title 19) , and 5.9.8.F Table 5.9.8.F_Sunflower 2017 CAHPS Child Medicaid with CCC Survey Highlights (Title 21)*** below, the 2017 CAHPS Child Survey also indicated high levels of satisfaction, particularly regarding the ability of members to get needed care quickly and with how well their doctors communicated with them.

Table 5.9.8.C_Sunflower 2017 CAHPS Adult Medicaid Survey Highlights

Summary Rate Scores (% Positive Response)			
Composite Scores	**2017**	**2016**	**2017 Score Versus 2016 Quality Compass: Met/Exceeded the Quality Compass Percentile**
Getting Care Quickly	88%	83%	90th
How Well Doctors Communicate	94%	93%	90th
Care Coordination	90%	88%	90th
Getting Needed Care	86%	87%	90th
Customer Service	90%	91%	75th
Overall Ratings Scores			
Health Care	78%	74%	75th
Personal Doctor	84%	80%	75th
Specialist	85%	82%	90th

Table 5.9.8.D_Sunflower 2017 CAHPS Child Medicaid with CCC Survey Highlights (Title 19 and 21 Combined)

Summary Rate Scores (% Positive Response)		
Composite Scores	**2017**	**2017 Score: Met/Exceeded the 2017 Quality Compass Percentile**
Getting Care Quickly	92%	50th
How Well Doctors Communicate	95%	75th*
Getting Needed Care	90%	75th*
Customer Service	89%	75th
Shared Decision Making	80%	50th*
Overall Ratings Scores		
Health Care	89%	90th
Personal Doctor	90%	90th
Specialist	89%	90th
Health Plan	89%	90th

2017 Score Versus 2016 Quality Compass Percentile

Table 5.9.8.E_Sunflower 2017 CAHPS Child Medicaid with CCC Survey Highlights (Title 19)

Summary Rate Scores (% Positive Response)		
Composite Scores	**2017**	**2017 Score Versus 2016 Quality Compass: Met/Exceeded the Quality Compass Percentile**
Getting Care Quickly	93%	75th
How Well Doctors Communicate	96%	90th
Care Coordination	85%	50th
Getting Needed Care	88%	75th
Customer Service	89%	50th
Shared Decision Making	79%	50th
Overall Ratings Scores		
Health Care	88%	75th
Personal Doctor	91%	75th
Specialist	89%	75th
Health Plan	89%	75th

Table 5.9.8.F_Sunflower 2017 CAHPS Child Medicaid with CCC Survey Highlights (Title 21)

Summary Rate Scores (% Positive Response)		
Composite Scores	**2017**	**2017 Score Versus 2016 Quality Compass: Met/Exceeded the Quality Compass Percentile**
Getting Care Quickly	92%	50th
How Well Doctors Communicate	95%	75th
Getting Needed Care	91%	90th
Customer Service	90%	75th
Shared Decision Making	80%	50th
Overall Ratings Scores		
Health Care	89%	75th
Personal Doctor	90%	50th
Specialist	89%	75th
Health Plan	89%	75th

5.9.9. ADVERSE INCIDENT REPORTING AND MANAGEMENT SYSTEM

ADVERSE INCIDENTS

Sunflower currently complies and will continue to comply with all statutory, regulatory, and Contract requirements for reporting, investigating, and addressing actual and suspected Adverse Incidents, including utilization of the Kansas Aging and Disability Services' (KDADS') web-based Adverse Incident Reporting and Management System (AIRS) (5.9.9.A). Adverse Incidents, as defined by KDADS, include potentially serious events or outcomes, including preventable deaths, physical abuse, inappropriate sexual contact, misuse of medications, psychological abuse, neglect, suicide or suicide attempt, serious injury, elopement, and natural disasters and other high-profile events. These Adverse Incidents are included in the routine review of Quality of Care events completed at the plan (and described further below).

As required and through direct entry into the AIRS, Sunflower and its subcontractors report, investigate and address:

- Adverse Incidents that harm or bring potential harm to any member served by a KDADS HCBS waiver program, Older American Act program, Senior Care Act program, or Behavioral Health (BH) Services program (5.9.9.B)
- Abuse, neglect, exploitation, or fiduciary abuse that must also be reported to the Department of Children and Families (DCF), as required by DCF and KDADS for Adult Care Homes (5.9.9.D.1)
- BH Adverse Incidents, in compliance with BH guidelines, including inappropriate use of restraints for members on HCBS waivers (5.9.9.D.2)

Adverse Incident Reports are made within 24 hours of a staff member of Sunflower or its subcontractors becoming aware of the incident or event (5.9.9.C).

Receipt of Adverse Incident Notifications from the State (5.9.9.D)

In addition to Adverse Incident Reports submitted by Sunflower and its subcontractors, KDADS' AIRS receives Adverse Incidents Reports directly from providers, facilities licensed by KDADS or anyone else with knowledge of such incident. Report data is then transmitted by the State to Sunflower when it pertains to a Sunflower member and is documented and tracked within our TruCare, our integrated clinical documentation platform, utilized by both our Quality, UM and Service Coordination teams.

Investigation, Tracking and Disposition of Adverse Incidents. When Sunflower becomes aware, or is notified by the State of an Adverse Incident, our QI Designee reviews the incident and requests that the Service Coordinator for the affected member investigate the Adverse Incident, determine the follow-up actions needed to mitigate the potential harm, and approve or make referrals for additional services for the member. Our QI Designee then completes the initial review with input from the Service Coordinator, determines whether the Adverse Incident should also be addressed as a potential Quality of Care event (QOC), and reports back

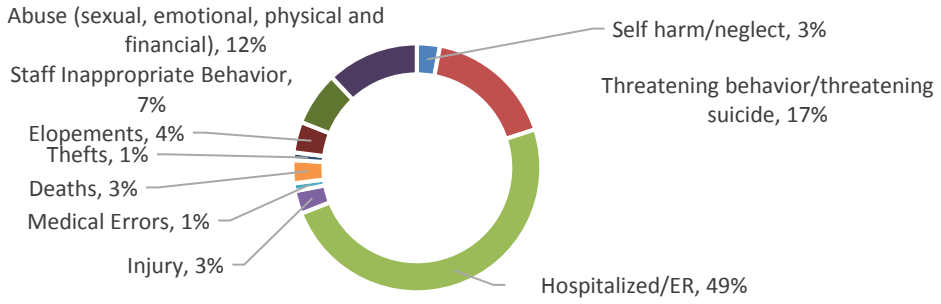
to the State on the steps taken by Sunflower to address the Adverse Incident. Our investigation of the report may also include the following:

- Review of claims data
- Review of clinical notes
- Medical record audit
- Consultation with patients/members
- Consultation with the provider
- Consultation with member's family and other persons who may have knowledge of the issue in question
- Consultation with the local Community Developmental Disability Organization (CDDO) if related to a member receiving services under the HCBS Waiver
- Consultation with KDADS Quality Management Specialist staff

Adverse Incidents rising to the level necessitating more in-depth review by the Quality Department and/or Medical Director take a parallel path as a potential QOC (described further below), as well. Also, as appropriate, we participate in joint Adverse Incident reviews with KDADs designated quality manager to determine whether further review or investigation is needed. Reviews and investigations are completed in full compliance with KDADS policies and procedures (5.9.9.E). Incidences that are reportable to other agencies and/or law enforcement are also completed by Sunflower staff as appropriate, including but not limited to Child Protective Services or Adult Protective Services.

2016 Adverse Incidents. In 2016, Sunflower was notified of 1,169 individual Adverse Incidents. As shown in ***Figure 5.9.9.A Adverse Incidents, CY 2016*** below, hospitalized/ER visits was the most frequently reported type of Adverse Incident (577 reports), followed by threatening behavior/threatening suicide (201 reports) and abuse (sexual, emotional, physical and financial) (140 reports).

Figure 5.9.9.A_Adverse Incidents, CY 2016



Sunflower cooperates with the State and any authorized investigating agency in documenting, investigating, and addressing actual and suspected Adverse Incidents. In 2017, Sunflower

actively participated in meetings and partnered with the State as improvements were discussed, evaluated and implemented to the AIRS policy and system.

QUALITY OF CARE EVENTS

In addition to reporting, investigating, and addressing Adverse Incidents, as described above, Sunflower monitors the safety of its members through identification of potential and/or actual quality of care events (QOCs). Sunflower's Quality Improvement (QI) Department monitors both member and provider issues related to QOCs and Adverse Incidents on an ongoing basis.

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 long term care (LTC)
- Enrollee elopement/escape from facility
- Enrollee Injury or Illness during behavioral health (BH) Admission
- Enrollee suicide attempt
- Falls/Trauma
- Fetal Demise
- Hospital Acquired Infections
- Medication errors that occur in an acute care or HCBS setting
- Newborn Admission within 30 days of newborn discharge
- Post-op Complications – air embolism; surgical site infections, DVT/Pulmonary Embolism
- Readmission (within 30 days)

Sunflower in Action…

An Adverse Incident report was made by an Aging and Disability Resource Center (ADRC) worker who was seeking approval for a crisis exception to the Physical Disability (PD) Waiver for a Sunflower member living in an Emergency Homeless Shelter that was no longer able to meet the member's needs. When the Sunflower Service Coordinator (SC) began working with the ADRC staff person, they were unable to locate the member suddenly. While homeless shelter staff were unable to provide the SC with a forwarding address, they did report the name of the apartments where the member was believed to have moved. The SC worked with Sunflower's Community Health Worker staff to visit the member's home and contact information was obtained and passed on to the ADRC and Adult Protective Services. The PD Waiver had been approved by that time. Since the member had signed a one year lease, she was provided personal care services (PCS), lifeline and home meals. The SC ensured that a PCS provider was located and had agreed to provide a worker for the member. During a follow up home visit, the SC discovered that the member did not have a bed. The SC helped the member obtain a bed, and also helped her schedule transportation to attend a PCP appointment and go to the hospital for outpatient lab work. Results were available within an hour, eliminating a trip to the Emergency Room.

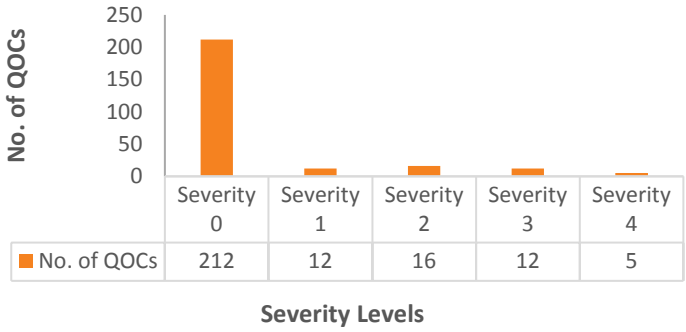
- Unexpected Member Death / Fetal Demise
- Unplanned return to the operating room
- Urinary Tract Infection in an LTC facility

QOC Severity Levels

A QOC Severity Level rating system is used to classify issues into one of five levels based on the potential or actual serious effects: None, Low (without potential for serious adverse effects, but could become a problem if a patter develops), Medium (moderate potential for serious adverse effects), High (significant potential for serious adverse effects), and Critical (serious, significant adverse outcomes). If the severity level is determined to be as none or low, the case can be closed by the QOC Nurse. If the case severity level is medium, high or critical, the case is sent to the Medical Director for review and confirmation (or assignment) of severity level. **As noted above, Adverse Incidents rising to the level necessitating more in-depth review by the Quality Department and/or Medical Director follow the QOC process.**

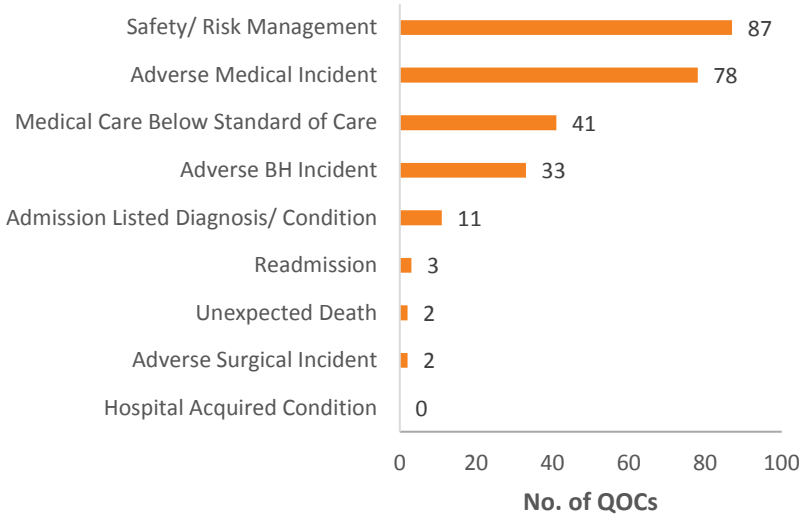
Sunflower reviews events both at an aggregate and provider/facility level. ***Figures 5.9.9.B 2016 QOC Events -- Severity Summary*** and ***5.9.9.C 2016 QOC Events By Type*** below show the type and severity of QOCs reviewed by Sunflower in 2016. Sunflower's data on QOCs demonstrates that the majority of the cases referred for review as potential QOCs are determined to not meet the criteria for a QOC or received the lowest severity level of zero, which accounted for 212 cases in 2016.

Figure 5.9.9.B_2016 QOC Events -- Severity Summary



Sunflower also looks at QOC data to determine the most common types of QOC cases. In 2016, "Safety/Risk Management" was the most frequent type of QOC referral, followed by "Adverse Medical Events" and "Medical Care Below Standard." Sunflower utilizes the Peer Review Committee to review cases, assign a final severity level 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 occurrences and may make recommendations for education to occur with staff responsible for specified care to members to help avoid future occurrences that present risk to members served.

Figure 5.9.9.C_2016 QOC Events By Type



ANALYSIS, TRACKING AND TRENDING OF ADVERSE INCIDENTS AND QOCS AND PROCESS FOR CORRECTIVE ACTION

Sunflower collects, and analyzes data regarding Adverse Incidents as outlined in KDADS "HCBS Adverse Incident Reporting and Management Policy" (5.9.9.F). All Adverse Incident and QOC cases are entered into a database and trended data are reviewed quarterly for global opportunities with members, providers, or individual event types. As they occur, cases with a severity level of medium, high or critical are referred to the Medical Director for review, severity assignment and next step processing. If a final severity is none or low the case is closed. Anything above a low categorization is referred to the Peer Review Committee for evaluation and action; PRC assigns a final severity level to those cases reviewed and can also recommend cases be referred to the Credentialing Committee for a review related to continuation as a network provider. Adverse Incident and QOC reports are also provided to the QI Committee and provider specific data is provided to the Credentialing Department for consideration at the time of provider re-credentialing. Issues are tracked and trended for patterns and any applicable corrective action plans (CAPs) put into place when issues warrant further action. Upon Peer Review Committee determination, we notify the provider or facility in question of our recommendations, including corrective actions, and the timeframe for completion. We may impose many levels of corrective action such as:

- Informal education such as telephonic counseling by the Medical Director or an educational letter sent to the provider regarding the specific event that occurred

- More intensive actions such as formal oral or written counseling, Medical Director review of authorization requests, proctoring by a designated physician, or mandatory skills training
- Probation or termination of network status for the most serious adverse events

For events involving facility staff or functions, the Medical Director will contact the facility risk management department to develop an action plan for the facility-based parties involved in the incident, in addition to the individual network practitioner. In instances where a CAP is requested, the provider's response will be reviewed by the Peer Review Committee to make a determination if it is acceptable or if there are other recommendations required to complete the CAP. In the case of any incidents involving self-directing HCBS members, Service Coordinators will work directly with members, representatives and Financial Management Service (FMS) providers to create any CAPs necessary to resolve the identified issue and ensure they are implemented. In the case of suspension or termination, we will follow the process outlined in our Practitioner Disciplinary Action and Reporting Policy that includes notification to the National Practitioner Data Bank, appropriate State agency, and KDHE. We will inform the provider of the Sunflower Provider Dispute and Appeal Process.

HOW ADVERSE INCIDENT, QOC AND GRIEVANCE DATA IS USED TO IMPROVE QUALITY OF CARE

Through analysis of Adverse Incident and QOC data, as well as grievance data, Sunflower assesses the health and safety of members served and determines where opportunities for improvement exist. Those may include process changes, changes to service provision, or staff training to reduce the number and severity of Adverse Incidents and QOCs to improve the quality of care delivered to Sunflower members including LTSS and those with special health care needs. All providers identified with Adverse Incidents or QOCs will be monitored for trend analysis regardless of the severity level assigned. Provider-specific outcomes will be referred as potential Quality of Care concerns through the appropriate channels and also as appropriate to the Credentialing staff to be included in the provider's credentialing file and considered during recredentialing. The QI Committee will review aggregated peer review actions quarterly.

Our Grievance data is captured within our Customer Relationship Management (CRM) platform. Our CRM platform facilitates a responsive, high quality service experience for our members and providers. CRM affords a 360-degree view of our relationship with members and providers for our Customer Service Representatives (CSRs) and Provider Service Representatives (PSRs). CRM is also integrated with our Centene Document Management System (CDMS) for indexing, storing, and retrieving electronic document images. We capture, manage, resolve and report appeals through the Complaints, Grievances, and Appeals (CGA) module that supports appeals with workflow enabled automation and auditing. The CGA module is an integrated component of our CRM platform for provider and member service support. To ensure confidentiality of the QOC and Peer Review process is maintained, QOC data is documented in our TruCare integrated care management platform that supports our service coordination processes.

TruCare provides and ensures confidentiality by limiting access to QOC documentation to only those with appropriate Quality role based permissions.

Our CAP process relies on case specific determinations from the Peer Review Committee and may include a request for additional training of staff, review of a provider's implementation of a facility CAP to determine if it meets the expectations of the Peer Review Committee to mitigate reoccurrence of event(s), or an ongoing review process to minimize any further incidents. The CAP with members who self-direct may include additional training for the member, a plan for feedback to the member's caregivers, further documentation of services provided or other steps to reduce the likelihood of future concerns. All Adverse Incidents or QOCs are reviewed to identify the need for any system-wide training or changes in policies and procedures to further protect the health, safety, and welfare of all Sunflower members and specifically the LTSS members exercising the self-direction option. Sunflower staff work closely with the member and/or her support team to identify the risks, develop strategies to mitigate the risk, and provide additional training to support the member's success with self-direction prior to seeking KDADS approval of the involuntary termination of self-direction services in accordance with our Termination of Self-Direction policy and procedures. Sunflower will include a requirement to assist with the investigation of Adverse Incidents in Community Service Coordinator (CSC) contracts.

For significant Adverse Incidents or QOCs involving a member residing in a nursing facility, Sunflower convenes an appropriate cross-departmental team to evaluate the actions needed to ensure that the member's needs are appropriately met, which could include relocating the member to another residential provider until the original provider can demonstrate the ability to meet the member's needs appropriately. For example, an LTSS member was in a residential setting and the member's guardian notified Sunflower that there were several safety issues in the member's care plan that the residential provider was not complying with to ensure his safety given his particular needs and history. As a result, a cross-departmental team comprised of staff from the Network Management, Provider Relations, UM, Service Coordination and Quality departments met to determine the course of action after sending someone onsite to confirm the allegation and notifying the residential provider of the findings. The Sunflower team put a plan into motion to transfer the member to another residential provider that could meet the needs of that member if the team's findings could not be corrected by a certain time that same day. The provider, however, was able to make those corrections that day and the member was able to avoid a disruptive move to another facility.

As another example, the spouse of a member residing in a nursing facility filed a grievance indicating the member was not receiving the appropriate care. This case was referred as a potential QOC and at the same time our Service Coordination team was brought in by the QI Department leadership to go onsite to evaluate the member's condition in real time. The visit to the member in the nursing facility confirmed the member's care was less than ideal. The member was transferred to a hospital where he received treatment to correct the concerns and was later transferred to a different nursing facility. The member made significant improvement

and his wife called back to thank the Grievance team for initiating a sequence of events that helped her husband get the appropriate care.

EDUCATION AND TRAINING ON ADVERSE INCIDENTS

We require all staff and KDADS licensed providers who have personal contact with members to comply with the State's Adverse Incident reporting standards. Sunflower provides training to staff, Service Coordinators, providers and provider agencies about Adverse Incident policies and procedures. Our call scripts include prompts to ask questions of members that might trigger referral for further investigation of possible exploitation, abuse or neglect and our Health Risk Assessment (HRA) includes questions regarding whether the member feels safe at home, questions related to depression and hopelessness, and other questions which assist in identifying potential health, behavioral or safety risks. We include information in the Provider Manual about Adverse Incident reporting obligations to the State and to Sunflower. We also include questions about feelings of safety within our LTSS Quality of Life reporting metrics and LTSS Member Satisfaction survey. Each of these are based upon member report and are completed at least annually. We will also provide training on responding to incidents, documentation requirements, and provider obligations to cooperate in any investigation conducted by Sunflower or any outside agency, including the State.

We understand that LTSS members exercising the self-direction option may be particularly vulnerable and our training of our own Service Coordinators as well as other stakeholders is reflective of incidents that may be unique to self-direction. As with traditional LTSS waiver services, members, their representatives and FMS providers are trained (as part of initial and ongoing training) on their role recognizing and reporting Adverse Incidents, including suspected abuse, neglect, or exploitation as well as a recent injury or medication management error.

Sunflower includes information in our member materials that educates members about how they can report concerns that may rise to the level of an Adverse Incident. They are provided with information on not only how to contact Sunflower, but also how to reach out to the State's Long-Term Care Ombudsman and Disability Rights Center as part of their training and in written materials available to members and providers, which applies to Adverse Incidents that may be unique to self-direction. For instance, members recruit and hire their own workers, and because of this, additional protocols (that are respectful of the member-worker relationship) are required to ensure directly hired workers and subcontractors are informed of their responsibility to report critical incidents and/or any concerns they may have about the member's health, safety, or welfare. Sunflower also works with trusted community partners, such as the Area Agencies on Aging to provide training on issues such as recognizing elder abuse.

In addition to compliance with KDADS Adverse Incident reporting process, Sunflower encourages any staff member, participating provider, or member, to advise the QI Department of potential QOC cases. Sunflower continues to educate staff on the definitions of and indicators for identifying these types of events and conditions, and instructs them to report any

suspected concerns to the QI Department, within one business day, for appropriate investigation and follow up.

5.9.10. MEMBER SATISFACTION SURVEYS

Sunflower continually measures member satisfaction with the goal of continuing to be the KanCare health plan of choice. Sunflower will continue to comply with all requirements in the State's QMS regarding member satisfaction surveys will continue to comply with all federal and State confidentiality laws while conducting member satisfaction surveys. To improve care for our members, we incorporate our survey results, and results from the State's National Core Indicators (NCI) and NCI-Adults with Disabilities (AD) consumer satisfaction surveys for the elderly and adults with disabilities, into our (and our subcontractors) QAPI Program and work with the State to ensure that the State is able to include a representative sample of managed LTSS and behavioral health (BH) members in its NCI and NCI-AD survey process. Upon the State's request, we continue to make the results of each member satisfaction survey available to the State, providers, members, families and caregivers, and other interested parties. We will also make survey data results available to the State in a form that allows seamless integration with the State's Enterprise Data Warehouse. Sunflower will continue to ensure that the sampling methodology for Sunflower member satisfaction surveys includes a statistically significant sample for members receiving home and community-based services (HCBS) and BH services. (5.9.10.A – F)

In addition to conducting Adult and Child CAHPS surveys, Sunflower recently implemented a new LTSS member satisfaction survey (results included below in ***Table 5.9.10.B 2017 LTSS Satisfaction Survey Summary Results by Waiver Type***). Sunflower also fields an annual Care Management phone survey. Both surveys are described below.

LONG TERM SERVICES AND SUPPORTS (LTSS) MEMBER SATISFACTION SURVEY

In 2017, Sunflower launched our first Long Term Services and Supports (LTSS) Member Satisfaction Survey, developed as a pilot project with our parent company, Centene Corporation (Centene). While the LTSS survey has not been evaluated through a formal validation process, survey questions were selected based on a review of the HCBS CAHPS survey questions, the MLTSS Health Plan Association's performance measures, and LTSS performance measure information from the National Quality Forum. The survey was conducted by mail by SPH Analytics, formerly known as The Meyers Group, (SPH), an NCQA Certified Survey Vendor, from June to August in 2017. Sunflower also sent letters to LTSS members notifying them that the survey would be coming from SPH and encouraging them to participate. We also had our Service Coordinators notify members during regular visits.

Sampling Methodology and Response Rate

SPH mailed surveys to all of our LTSS members for whom we provide service coordination services and who receive HCBS services through one of the following HCBS waivers:

- Intellectual and Developmental Disability (I/DD) waiver
- Frail Elderly (FE) waiver

- Physical Disability (PD) waiver
- Technology Assisted (TA) waiver
- Traumatic Brain Injury (TBI) waiver

Table 5.9.10.A 2017 LTSS Satisfaction Survey Response Rates by Waiver Type below summarizes the response rate by waiver type. Sunflower received an impressive response rate on the number of surveys returned compared to expected benchmarks.

Table 5.9.10.A_ 2017 LTSS Satisfaction Survey Response Rates by Waiver Type

	WAIVER TYPE					Total
	I/DD	FE	PD	TA	TBI	
Number of Surveys Sent	4,142	1,790	2,025	145	114	8,216
Number of Surveys Returned	977	612	611	24	16	2,240
Percent Returned	23.6%	34.2%	30.2%	16.6%	14.0%	27.3%

Survey Results

As shown in ***Table 5.9.10.B 2017 LTSS Satisfaction Survey Summary Results by Waiver Type*** below, the survey results demonstrate high HCBS waiver member satisfaction across all waiver types.

Table 5.9.10.B_ 2017 LTSS Satisfaction Survey Summary Results by Waiver Type

Survey Question	Percentage Satisfied by Waiver Type					Total Percentage Satisfied
	I/DD	FE	PD	TA	TBI	
How satisfied are you with the help you receive from your **Sunflower care manager**?	94.3%	97.2%	96.4%	95.8%	93.8%	95.5%
When you call your **Sunflower care manager**, do they respond within 1 business day?	92.9%	95.1%	95.7%	100%	100%	96.7%
Does your **Sunflower care manager** respect your personal beliefs and preferences during your discussions?	97.9%	98.5%	98.3%	100%	100%	98.9%
Has your **Sunflower care manager** talked with you about services that might meet your needs and goals?	79.4%	90.3%	93.9%	95.7%	100%	91.9%
Overall, how satisfied are you with the Home and Community Based Services you receive?	96.1%	96.9%	95.3%	91.3%	100%	95.9%
Do the people who are paid to help you do things in the way you want them done?	96.3%	95.9%	96.1%	95.7%	100%	96.8%
How often do the people who are paid to help you treat you the way you want them to?	98.3%	98.2%	98.2%	100%	100%	98.9%

Survey Question	Percentage Satisfied by Waiver Type					Total Percentage Satisfied
	I/DD	FE	PD	TA	TBI	
Overall, how safe do you feel with the people that help you?	98.5%	98.0%	98.5%	100%	100%	99.0%
How often do you do things with your friends, your family or in your community?	93.7%	74.2%	69.2%	87.0%	80.0%	80.8%
If you scheduled transportation through Sunflower, how satisfied are you with the transportation service you received?	93.1%	90.4%	87.2%	50%	90%	82.1%
Overall, how satisfied are you with the care you receive from Sunflower Plan?	97.3%	97.1%	97.9%	95.8%	86.7%	95.0%

Barrier Analysis

Sunflower focused on the results for the I/DD Waiver population for the question regarding how often the Service Coordinator talks to the member about services that meet the member's her needs and goals, as it was notably lower than most other survey results. After reviewing relevant data, we determined that it was likely that the lower result was due to the fact that members with I/DD also have targeted case managers and Community Developmental Disability Organizations (CDDOs) that play a role in providing the information referenced in the question rather than always coming from the Sunflower Service Coordinator.

Sunflower reviewed data with their LTSS Advisory Committee and received recommendations related to the FE Waiver and PD Waiver results for the question "How often do you do things with friends, family or in the community," as these results were also low, relative to other survey results. We are also able to monitor this metric on an ongoing monthly basis through our Centelligence LTSS KPI Dashboard as we ask members this question at least once each year during an in-person visit and upload new responses that come in each month to the LTSS dashboard.

Interventions Taken or Planned and Lessons Learned

Sunflower continues to work to develop and implement the following types of interventions to address the barriers noted above:

- Offer peer-to-peer support, through our Member Advocate, for LTSS members who need assistance with access to community activities
- Offer training to our Service Coordinators from the Independent Living Center Association or an individual Independent Living Center (ILC) on services ILCs provide to increase community access

Sunflower has also learned that a mail-only survey may be less effective for certain waiver populations and is considering conducting follow up phone surveys for populations that had a lower response rate on the 2017 survey (i.e., the TA and TBI waivers).

CARE MANAGEMENT MEMBER SATISFACTION PHONE SURVEY

Sunflower has adopted our parent company's, Centene's, Care Management phone survey (CM Phone Survey) as it allows us to benchmark our performance against our affiliated State health plans. The survey was conducted by Sunflower staff during the second quarter of 2017 to assess members' experience with our Service Coordination Program. The CM phone survey was developed internally by Centene staff with extensive CM and NCQA-related experience, but has not been subjected to a formal, external validation process.

Survey Methodology and Response Rate

Survey completions were attempted with all Sunflower members in active physical or behavioral complex care management at the time of survey who had been enrolled for a minimum of forty-five days; no sampling was performed. During the survey period, 640 members were identified as meeting the criteria and outreach was attempted to all 640 members. In total, 192 Sunflower members were successfully contacted and consented to completing the survey, for a completion rate of 30%.

Survey Results

Table 5.9.10.C 2017 CM Phone Satisfaction Survey Summary Results summarizes the survey results showing high member satisfaction with our service coordination services.

Table 5.9.10.C_2017 CM Phone Satisfaction Survey Summary Results

Survey Question	Percentage Satisfied
How satisfied are you with the help you are receiving or have received from your Care Manager?	97.92%
Were you able to understand the information about your health condition(s) given to you by your Care Manager?	95.08%
Have you been able to follow any of your Care Manager's health care suggestions to improve your health?	92.35%
Was your Care Manager available to speak with you at times that were convenient for you?	97.37%
Did your Care Manager help you get the health care services that you needed?	95.74%
If you required additional services, (or services from the community), how satisfied are/were you with those that your Care Manager offered?	96.72%
How satisfied are you with any learning and/or resource health information materials you received from your Care Manager?	96.22%
Did your Care Manager consider and include your personal beliefs and preferences during your discussions?	96.17%
How satisfied are you that the goals worked on by you and your Care Manager have improved your health and understanding of your health?	98.84%
Did we exceed your expectations?	94.41%

Barrier Analysis

Results from the 2017 CM Phone Survey demonstrate Sunflower members enrolled in either physical or behavioral complex care management were mostly satisfied with the care management program. Survey results indicate members had an overall satisfaction rate of 96.08% across all surveyed questions. All but one individual survey question resulted in satisfaction greater than 94%. The only question that did not meet the 94%, "Have you been able to follow any of your Care Manager's health care suggestions to improve your health?", demonstrated a slight decrease of satisfaction compared to the 2015 result with 92.35% of members indicating they were satisfied specific to this question, compared to 94.02% in 2015. Overall, Sunflower exceeded our 90% goal for each question and demonstrating a cumulative increase in score over 2015 of 2.11%. However, Sunflower did identify the following barriers related to our 2017 CM Phone survey performance:

- Low survey participation rate
- Lack of complete survey responses
- Inaccurate demographic information and unable to consistently reach members by phone
- Member perception of service coordination not exceeding their goals
- Member difficulty following education and training provided by staff

Interventions Taken or Planned and Lessons Learned

Sunflower took the following actions to address the barriers noted above:

- Provided ongoing training and updates for staff on updating demographics
- Provided training for staff on the importance of gathering more detailed information for negative survey responses so data can be used to address improvement
- Developed a process for a real time telephonic survey with members transferred to the Project Manager following phone contact with their Service Coordinator, to increase the number of completed surveys

As noted above, Sunflower has learned that lack of accurate demographic information limits our ability to reach members by phone, underscoring the importance of using every incoming call from a member to Sunflower or the member's Service Coordinator as an opportunity to update that information.

5.9.11. PROVIDER SATISFACTION SURVEYS

Sunflower believes that regularly soliciting and acting on the valuable feedback given by providers enables us to improve the service we provide to providers, members and KDHE. Sunflower currently complies and will continue to comply with all requirements in the State's Quality Management Strategy (QMS) regarding provider satisfaction surveys, and will continue to comply with all State requests to include specific questions in the surveys. We will incorporate the results into our Quality Assessment and Performance Improvement (QAPI) program to improve care for our members and services to our providers and make a summary of the results of each provider satisfaction survey available to the State and interested parties. Sunflower has adopted our parent company's, Centene's, provider satisfaction survey which includes questions about our providers' degree of satisfaction with Sunflower's services

including credentialing, utilization management, claims processing, and the professionalism and level of knowledge demonstrated by Sunflower's staff. The survey also evaluates satisfaction with communication between behavioral health (BH) practitioners and primary care practitioners and levels of primary care practitioner satisfaction with BH practitioner communication. Sunflower utilizes SPH Analytics, formerly known as The Meyers Group, (SPH), an NCQA Certified Survey Vendor, to conduct the provider satisfaction survey for all Centene health plans. To validate the survey instrument (included as ***Figure 5.9.11 2017 Sunflower Provider Satisfaction Comparison***), SPH conducted a pilot test with eight health plans and conducted a reliability analysis (using Cronbach's alpha values) to ensure that the survey provides a reliable measure of provider satisfaction. While BH providers were not included in the 2017 survey, Sunflower will ensure that SPH's sampling methodology for the Sunflower Provider Satisfaction Survey includes a statistically significant sample for both home and community-based services (HCBS) providers and BH providers in 2018 and future years.

SUNFLOWER'S 2017 PROVIDER SATISFACTION SURVEY SUMMARY

SPH Analytics followed a one-wave mail and Internet, with phone follow-up, survey methodology to administer Sunflower's provider satisfaction survey from August to September 2017.

Sampling Methodology and Response Rate

Sunflower provided SPH with a database consisting of 5,997 Sunflower providers representing a statistically valid sample our primary care, specialty care, nursing facility, and HCBS providers. SPH then cleaned the database by removing any records with duplicate addresses or NPIs. From the database of unique providers, 1,500 providers were pulled. From this sample, a total of 221 surveys were completed (106 mail, 26 Internet, and 89 phone), yielding a response rate of 9.1% for the mail/Internet data component and 13.3% for the phone data component, after adjusting for ineligible providers.

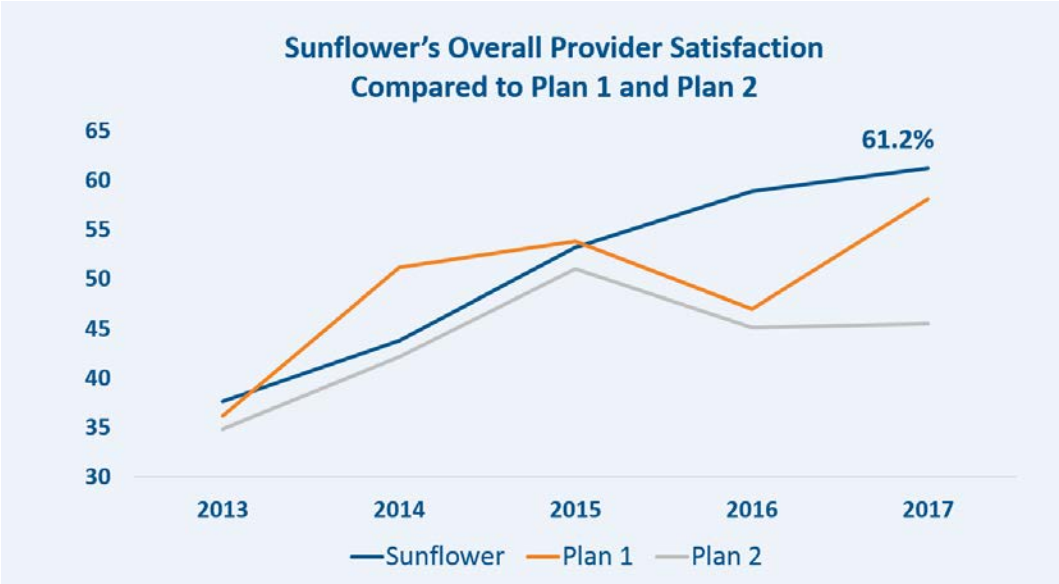
Profile of Survey Respondents

The 2017 survey results demonstrated the following: 59.5% of the responses were from primary care providers, followed by 26.2% from specialty practices, 20.0% from nursing facilities, and 11.9% of the responses from HCBS providers. Of those who responded to the survey, 54% were responses from the office manager, 39.1% from nurse/other staff, and 7.0% were from physicians.

Survey Results

Shown below in ***Figure 5.9.11.A 2017 Sunflower Provider Satisfaction Comparison***, Sunflower has consistently improved provider satisfaction results and has achieved high provider satisfaction scores, receiving the highest score of all MCOs for overall satisfaction.

Figure 5.9.11.A_2017 Sunflower Provider Satisfaction Comparison



As shown in ***Table 5.9.11.A 2017 Sunflower Provider Survey Results, 2014-2017*** below, Sunflower has demonstrated year over year improvement for all the composite areas except for Network/Coordination of Care, which demonstrated a slight decrease in 2016 compared to 2015, and Recommend to Other Physicians' Practices which decreased between 2014 and 2015, but has steadily increased since then.

Table 5.9.11.A_2017 Sunflower Provider Survey Results, 2014-2017

Composites	2017 Summary Rates	2016 Summary Rate	2015 Summary Rate	2014 Summary Rate
Overall Satisfaction	61.2%	58.9%	53.2%	43.8%
Comparative Rating of Sunflower compared with all other contracted health plans	34.6%	32.2%	24.0%	13.9%
Finance Issues	37.3%	33.8%	22.9%	18.0%
Utilization and Quality Management	29.6%	26.7%	18.1%	17.9%
Network/Coordination of Care	22.4%	21.6%	22.0%	18.4%
Pharmacy	16.6%	14.7%	12.7%	10.2%
Health Plan Call Center Service Staff	30.8%	29.7%	22.1%	21.0%
Provider Relations	36.5%	36.1%	25.0%	26.5%
Recommend to Other Physicians' Practices	82.3%	77.2%	73.9%	80.9%

Barrier Analysis

The Network/Coordination of Care composite focuses on the number and quality of specialists in the Sunflower provider network, timeliness of feedback/reports from specialists, timeliness of exchange of information/communication/reports from BH providers and also how frequently BH providers provide verbal/written communications to other providers on their patients. When receiving the survey results annually, Sunflower applies a PDSA improvement process using a multi-departmental workgroup to review and assess the results produced from the previous year's interventions and develop a work plan of interventions for the following year to address continuing or new opportunities for improvement. From this activity, Sunflower has identified the following barriers related to the exchange of information between medical and BH providers and continues to work to address them:

- Members do not have an established relationship with a primary care provider (PCP)
- Staff are unable to identify the member's PCP, and therefore cannot facilitate the exchange of information
- Members have a knowledge deficit regarding the importance of and process for providing consent to share treatment records that include HIV/AIDS or substance abuse treatment information
- Physicians are unaware that their patients are seeing BH clinicians and/or who the BH providers are
- BH clinicians are not aware of who the member's assigned PCP is
- Members leaving an acute inpatient setting 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 BH issues
- Members with acute psychosis are difficult to coordinate services for as they are resistant to others outside of their perceived support group
- Members in Foster Care often move frequently resulting in provider service gaps, including BH gaps

Interventions Taken

Sunflower continues to work to develop and implement the following types of interventions to address the barriers to improved communication between BH providers and primary care noted above:

- 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 BH providers
- Member education regarding importance of sharing information between providers
- Education of BH providers regarding a member's PCP

- Member education regarding importance of sharing information between providers
- Treatment record review for all high volume BH providers to identify attempts to coordinate care and provide technical assistance to providers who do not meet the standards
- Working 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
- Limiting the number of people who are contacting the member to one Service Coordinator that will coordinate with other members of the care team
- Development of an educational brochure on Foster Care and the importance of communication between providers to include BH providers

Outcomes of the Interventions and Lessons Learned

As shown in ***Table 5.9.11.B Selected 2017 Year to Date (Through November) Sunflower HEDIS Results, Foster Care and Total Sunflower Population ,*** 2017 year-to-date (through November 2017) HEDIS results show statistically higher results for the Foster Care population compared to the total Sunflower population providing early indicators of success regarding the interventions described above.

Table 5.9.11.B_Selected 2017 Year to Date (Through November) Sunflower HEDIS Results, Foster Care and Total Sunflower Population

HEDIS Measure	Submeasure	Foster Care	Total Pop
Initiation and Engagement of Alcohol and Other Drug Abuse Dependence Treatment (IET)	Initiation Total	48.61%	35.13%
	Engagement Total	29.72%	10.49
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	7 day	73.42%	60.46%
	30 day	77.22%	72.87%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	7 day	16.67%	15.66%
	30 day	23.33%	20.25%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)		40.00%	38.06%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)		46.01%	42.13%

In addition to the interventions described above, Sunflower has taken other actions since 2015 to improve provider satisfaction including implementing Customer Service call-backs to providers on the status of claims adjustments, delivering provider claims education when directed by the claims adjustment team, and modifying the interactive voice response (IVR) system to add number prompts in addition to voice prompts.

Figure 5.9.11.C_2017 Provider Satisfaction Survey Instrument

sunflower health plan

KanCare

PHYSICIAN SATISFACTION SURVEY

Answer **all** the questions by marking the box with blue or black ink. Like this ☒.
If you want to know more about this study, please call SPH Analytics at 1-877-499-2538.

Demographics

Please answer the following questions about you and your practice.

A. Please indicate your area of medicine.
(Mark all that apply)
- ☐A Primary Care
- ☐B Specialty
- ☐C HCBS
- ☐D Nursing Facility

B. How many physicians are in your practice?
- ☐1 Solo
- ☐2 2-5 physicians
- ☐3 More than 5 physicians
- ☐4 N/A

C. How many years have you been in this practice?
- ☐1 Less than 5 years
- ☐2 5-15 years
- ☐3 16 years or more

D. What portion of your managed care volume is represented by Sunflower Health Plan?
- ☐1 None
- ☐2 10% or less
- ☐3 11-20%
- ☐4 21-30%
- ☐5 31-50%
- ☐6 51-75%
- ☐7 76-100%

E. Please mark who is completing this survey.
(Mark only one)
- ☐1 Physician
- ☐2 Office Manager
- ☐3 Nurse
- ☐4 Other staff

F. What is your preferred method of receiving communications from this health plan?
- ☐1 Mail
- ☐2 Telephone
- ☐3 Fax
- ☐4 Online portal
- ☐5 E-mail (Please indicate your e-mail address): _____
- ☐6 In person from your Provider Representative
- ☐7 Other

G. Please indicate the number of insurance companies with which you or your practice participates.
- ☐1 3 or fewer
- ☐2 4 to 7
- ☐3 8 to 11
- ☐4 12 to 15
- ☐5 More than 15

Comparative Rating

This first question asks you to think about Sunflower Health Plan in comparison to all of the other health plans that you work with.

	Well below average	Somewhat below average	Average	Somewhat above average	Well above average	Not applicable
1A. How would you rate Sunflower Health Plan compared to all other health plans you contract with?	☐1	☐2	☐3	☐4	☐5	☐6

1

Figure 5.9.11.C_2017 Provider Satisfaction Survey Instrument

Finance Issues

These questions ask about Finance Issues.

Please rate Sunflower Health Plan in the following service areas when compared to your experience with other health plans you work with.

		Well below average	Somewhat below average	Average	Somewhat above average	Well above average	Not applicable
2A.	Consistency of reimbursement fees with your contract rates.	☐1	☐2	☐3	☐4	☐5	☐6
2B.	Accuracy of claims processing.	☐1	☐2	☐3	☐4	☐5	☐6
2C.	Timeliness of claims processing.	☐1	☐2	☐3	☐4	☐5	☐6
2D.	Resolution of claims payment problems or disputes.	☐1	☐2	☐3	☐4	☐5	☐6

Utilization and Quality Management

These questions ask about Utilization and Quality Management.

Please rate Sunflower Health Plan in the following service areas when compared to your experience with other health plans you work with.

3A.	Access to knowledgeable UM staff.	☐1	☐2	☐3	☐4	☐5	☐6
3B.	Procedures for obtaining pre-certification/referral/authorization information.	☐1	☐2	☐3	☐4	☐5	☐6
3C.	Timeliness of obtaining pre-certification/referral/authorization information.	☐1	☐2	☐3	☐4	☐5	☐6
3D.	The health plan's facilitation/support of appropriate clinical care for patients.	☐1	☐2	☐3	☐4	☐5	☐6
3E.	Access to Case/Care Managers from this health plan.	☐1	☐2	☐3	☐4	☐5	☐6
3F.	Degree to which the plan covers and encourages preventive care and wellness.	☐1	☐2	☐3	☐4	☐5	☐6
3G.	Extent to which UM staff share review criteria and reasons for adverse determinations.	☐1	☐2	☐3	☐4	☐5	☐6
3H.	Consistency of review decisions.	☐1	☐2	☐3	☐4	☐5	☐6

Network/Coordination of Care

These questions ask about Sunflower Health Plan's network providers.

Please rate Sunflower Health Plan in the following service areas when compared to your experience with other health plans you work with.

4A.	The number of specialists in this health plan's provider network.	☐1	☐2	☐3	☐4	☐5	☐6
4B.	The quality of specialists in this health plan's provider network.	☐1	☐2	☐3	☐4	☐5	☐6
4C.	The timeliness of feedback/reports from specialists in this health plan's provider network.	☐1	☐2	☐3	☐4	☐5	☐6
4D.	The frequency of feedback/reports from specialists for patients in your care.	☐1	☐2	☐3	☐4	☐5	☐6
		Excellent	Very Good	Good	Fair	Poor	Not applicable
4E.	Please rate the timeliness of exchange of information/communication/reports from the behavioral health providers.	☐1	☐2	☐3	☐4	☐5	☐6
		Always	Usually	Sometimes	Rarely	Never	Not applicable
4F.	How often do you receive verbal and/or written communication from behavioral health providers regarding your patients?	☐1	☐2	☐3	☐4	☐5	☐6

2

Figure 5.9.11.C_2017 Provider Satisfaction Survey Instrument

Pharmacy

These questions ask about Sunflower Health Plan's formulary.

Please rate Sunflower Health Plan in the following service areas when compared to your experience with other health plans you work with.

		Well below average	Somewhat below average	Average	Somewhat above average	Well above average	Not applicable
5A.	Consistency of the formulary over time.	☐1	☐2	☐3	☐4	☐5	☐6
5B.	Extent to which formulary reflects current standards of care.	☐1	☐2	☐3	☐4	☐5	☐6
5C.	Variety of branded drugs on the formulary.	☐1	☐2	☐3	☐4	☐5	☐6
5D.	Ease of prescribing your preferred medications within formulary guidelines.	☐1	☐2	☐3	☐4	☐5	☐6
5E.	Availability of comparable drugs to substitute those not included in the formulary.	☐1	☐2	☐3	☐4	☐5	☐6

Health Plan Call Center Service Staff

These questions ask about your experiences when calling Sunflower Health Plan's call center.

Please rate Sunflower Health Plan in the following service areas when compared to your experience with other health plans you work with.

6A.	Ease of reaching health plan call center staff over the phone.	☐1	☐2	☐3	☐4	☐5	☐6
6B.	Process of obtaining member information (eligibility, benefit coverage, co-pay amounts).	☐1	☐2	☐3	☐4	☐5	☐6
6C.	Helpfulness of health plan call center staff in obtaining referrals for patients in your care.	☐1	☐2	☐3	☐4	☐5	☐6
6D.	Overall satisfaction with health plan's call center service.	☐1	☐2	☐3	☐4	☐5	☐6

Provider Relations

These questions ask about your experiences with Sunflower Health Plan's Provider Relations department.

Please rate Sunflower Health Plan in the following service areas when compared to your experience with other health plans you work with.

7A. Do you have a Provider Relations representative from this health plan assigned to your practice?

☐1 Yes . . . . . **Go to question 7B**
☐2 No . . . . . **Go to question 7C**

7B.	Provider Relations representative's ability to answer questions and resolve problems.	☐1	☐2	☐3	☐4	☐5	☐6
7C.	Quality of provider orientation process.	☐1	☐2	☐3	☐4	☐5	☐6
7D.	Quality of written communications, policy bulletins, and manuals.	☐1	☐2	☐3	☐4	☐5	☐6

Overall Satisfaction

These questions ask about your overall satisfaction with Sunflower Health Plan.

Additionally, please rate your satisfaction with the other plans listed and provide feedback on how Sunflower Health Plan can improve.

8A. Would you recommend Sunflower Health Plan to other physicians' practices?

☐1 Yes
☐2 No

3

Figure 5.9.11.C_2017 Provider Satisfaction Survey Instrument

Overall Satisfaction (continued)

Please rate your overall satisfaction with each of the following health plans:	Completely dissatisfied	Somewhat dissatisfied	Neither dissatisfied nor satisfied	Somewhat satisfied	Completely satisfied	Does not apply
8B. Sunflower Health Plan	☐1	☐2	☐3	☐4	☐5	☐6
8C. United Health Care	☐1	☐2	☐3	☐4	☐5	☐6
8D. Amerigroup	☐1	☐2	☐3	☐4	☐5	☐6

9A. What can Sunflower Health Plan do to improve its service to your organization?

_____

_____

_____

_____

9B . Would you like Sunflower Health Plan to follow-up with you regarding your above open-ended comment? If so, your contact information will be forwarded to the health plan for further outreach.

☐1 Yes
☐2 No
☐3 N/A

10. Please rate your satisfaction with obtaining precertification and/or authorization for Sunflower Health Plan's members.

☐1 Very satisfied
☐2 Somewhat satisfied
☐3 Neither satisfied nor dissatisfied
☐4 Somewhat dissatisfied
☐5 Very dissatisfied

11. Please rate your satisfaction with the availability of specialists.

☐1 Very satisfied
☐2 Somewhat satisfied
☐3 Neither satisfied nor dissatisfied
☐4 Somewhat dissatisfied
☐5 Very dissatisfied

12. Please rate your satisfaction with Sunflower Health Plan's demonstration of their commitment to high quality of care for their members.

☐1 Very satisfied
☐2 Somewhat satisfied
☐3 Neither satisfied nor dissatisfied
☐4 Somewhat dissatisfied
☐5 Very dissatisfied

Thank you. Please return the completed survey in the postage-paid envelope.

SPH analytics

SPH Analytics
Attn: Survey Processing Department
PO Box 100072, Duluth, GA 30096-9876
Toll-Free: **1-877-499-2538**

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5.9.12. CLINICAL AND MEDICAL RECORDS

MEDICAL RECORD DOCUMENTATION STANDARDS (5.9.12.A)

Sunflower's policies require providers and subcontractors to maintain clinical and medical records that are current, detailed and organized, and which permit effective and confidential patient care and quality review, administrative, civil and/or criminal investigations and/or prosecutions. The minimum standards and policies for provider and subcontractor medical record keeping practices comply with all applicable NCQA, State, and federal standards and requirements which include requirements for medical record content, medical record organization, ease of retrieving medical records, and maintaining confidentiality of protected health information (PHI), in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable record retention laws. These policies are outlined in the Sunflower Provider Manual, are available on our website, and are distributed to practice sites. Consistent with these policies, medical records must be maintained by the provider for at least 10 years for adult patients and 13 years for minors, must be signed by the medical professional that rendered the service, and must include the following information:

- Patient identification information on each written page or electronic file record
- Personal biographical data
- Entry date
- Provider identification
- Allergies
- Past Medical History
- Immunizations
- Medical Information
- Consultations
- Referrals
- Medical conditions and health maintenance concerns
- Written instructions for living wills or durable power of attorney for health care when the patient is incapacitated and has such a document
- A record of outpatient and emergency care
- Specialist referrals
- Ancillary care
- Diagnostic tests and findings
- Prescriptions for medications
- Inpatient discharge summaries
- Histories and physicals, including a list of smoking and chemical dependencies
- EPSDT services

Medical record review is completed concurrently as member records are accessed by the plan for business operations. Concerns related to completeness and accuracy are filed in the QI Department, investigated as Quality of Care issue, and shared with the Credentialing Department to be considered at the time of re-credentialing if remedial action is not pursued and resolved appropriately. Subcontractor compliance with the standards is reviewed annually as part of the Delegated Vendor Oversight audit. Outcomes if a subcontractor is not in compliance may include re-education with re-audit, corrective action plan (CAP), intervention by the QI Committee, contracting, etc., and/or termination of the contract.

ENSURING CONFIDENTIALITY OF CLINICAL AND MEDICAL RECORDS (SECTION 5.9.12.B.1)

Sunflower, backed by Centene Corporation's (Centene's) over 33 years of operational experience, conducts all operations under policies regarding the protection and use and disclosure of member health and enrollment information in accordance with the requirements set forth in the Health Insurance Portability and Accountability Act (HIPAA). Sunflower has a complete program to ensure compliance with all applicable sections of HIPAA, including Privacy, Security, Transactions and Code Sets rules. Sunflower and Centene update their policy and procedure libraries each year in response to changes in HIPAA and applicable State regulations. All changes are reflected in Sunflower's new employee and annual training as needed.

Below we outline our plan to ensure the confidentiality of all medical records and other pertinent information is used in accordance with 42 CFR 438.224 and fully complies with HIPAA Privacy Rule (45 CFR parts 160, 162, and 164, subparts A and E), 42 CFR Part 2, 45 CFR 164.308, and HITECH.

Culture of Information Security Best Practices

Sunflower and Centene promote a "culture of information security", which means that all employees, consultants and business partners of the organization must exhibit security diligence through their day-to-day actions and behaviors. That diligence is supported by a comprehensive array of best practice information security technical controls. We ask everyone to be vigilant and identify areas of opportunity or gaps in work related activities as they relate to the Culture of Information Security, and that everyone:

- Partner with management and Centene's Information Security Team to address those areas where protections are unclear or inadequate
- Create a plan to address protection gaps and culture improvements or training needed
- Follow up on plan and reassess situation periodically

Sunflower receives support and guidance from Centene's Corporate Compliance Department to keep up with HIPAA and State updates and HITECH changes. This support comes in the form of research and written guidance, formal training presentations, corporate policies and procedure documents to which Sunflower employees can refer, audit feedback, carefully drafted business associate agreement templates to personalize for use with our subcontractors and consultants, and web-based mini-training sessions for all employees deployed throughout the year. These

are some of the many steps Sunflower takes to ensure that our employees consistently use health and enrollment information in accordance with HIPAA requirements.

Plan to Ensure Protection of Member Data

Sunflower maintains a HIPAA Compliance Program and a library of policies and procedures on HIPAA privacy and security including policies for the disclosure of Protected Health Information (PHI) and confidentiality of mental health and substance use disorder (SUD). Centene's Ethics and Compliance Department also uses this information to help train staff on different, relevant aspects of HIPAA, federal, and State regulations pertaining to health maintenance organizations. Sunflower's Compliance Officer serves as the designated Privacy Officer and works with Centene's Compliance Department to assist with the daily implementation of HIPAA regulations. Our plan utilizes the following activities to ensure proper use and protection of data.

Staff Training and Communication. Sunflower and Centene use Cornerstone Learning (Cornerstone), an online learning management system for social learning, training, and compliance courses. Accessible through our Intranet, Cornerstone offers both on-demand and classroom training for proper handling and protection of member PHI/member confidential information (e.g., HIPAA and email retention). We also utilize and create educational "prompts" to post in the office to remind employees of the importance of HIPAA and the protection of PHI. As an example, Sunflower created and distributed a "Stop Sign" reminder which provides a checklist of HIPAA safeguards to follow at the end of each employee shift.

Ongoing Training. To ensure that our employees understand how they are to use and protect member data, Sunflower includes HIPAA Privacy, Security and Confidentiality training in all new hire programs and reinforces that training as part of annual Compliance training. All Sunflower employees and board members sign an acknowledgment of their HIPAA training and confidentiality agreement, and all Sunflower physician reviewers, consultants, and quality committee members sign a HIPAA Business Associate Agreement with Sunflower. Sunflower trains all new employees and provides refresher training to all staff every year on physical security and technology security of information at our facility.

Workspace Audit. Periodically, Sunflower staff complete an audit of desks, cubicles, copy rooms and other workspaces before or after the workday to ensure all PHI is secured. Results of the audit are distributed in writing to each employee, department manager, senior management, and in summary form to Centene's Corporate Compliance Department. Additionally, Sunflower ensures that all employees that work with PHI have locking file cabinets and desk drawers. Sunflower also ensures the security and confidentiality of member information with our staff in the field by issuing lock bags to all staff who transport documents, ensuring all physical information and relevant equipment is stored under lock and key, and requiring home security attestations. For example, our field workers must attest and agree to:

- Not leave PHI and/or Electronic PHI (EPHI) in unsecured areas (e.g. home office where family members can gain access, kitchen table, etc.)

- Not leave any company issued electronic devices (i.e. laptop, tablet, cellphone, etc.) unattended in a vehicle or public area (i.e., coffee shop, kitchen counter table)
- Use a dedicated, work-issued device solely for business purposes
- Physically lock down laptops with company issued security cord and key when unattended
- No discuss PHI/EPHI in public areas (e.g. elevators, hallways, coffee shops)
- Dispose of PHI in a secured shredding receptacle
- Return any and all PHI/EPHI upon dissolution of employment
- Keep the home or work environment private, quiet and secure
- Designate adequate space so that all equipment and related furniture can be in the same area/room with a locking door

HIPAA Activity Log. Sunflower keeps a complete, up-to-date HIPAA activity log of all individual member authorizations, member requests for records, member requests to limit disclosures, disclosures made as allowed by law without authorization (e.g., for law enforcement, for workers compensation), signed business associate agreements, privacy complaints and resolutions.

Compliance and Ethics Annual Training Course. Sunflower prepares, conducts and documents staff attendance at annual HIPAA refresher training as part of the Compliance and Ethics annual mandatory training sessions.

Review and Approval Process. Sunflower has an established process for reviewing and approving requests from any members, or a member's representative, to release member PHI other than in the regular course of business. Sunflower prepares and securely transmits the information to the member or the party they have designated. Measures are taken to oversee preparation of de-identified information for release if needed, such as for a research project.

Quality Improvement Department. Sunflower's Quality Improvement Department investigates and resolves any member grievance regarding the privacy or security of their information in collaboration with the Sunflower and Centene Compliance departments.

Privacy Notice to Members and Providers. Sunflower provides the current Privacy Notice text to Customer Services, Provider Relations and the Marketing and Communications Department for publication in the Member Handbooks, Provider Manuals and Newsletters.

Document Collection. Sunflower maintains secure collection sites for documents that are scheduled to be shredded.

Verifying and Using Data Appropriately

Sunflower's Customer Services Department, Customer Services Representatives (CSRs) and Member Advocates are responsible for assisting members and their representatives with a

wide variety of issues and questions. If a CSR must disclose PHI to successfully close an issue, the representative always verifies the requester's identity and relationship to the member, using multiple data points, before disclosing the minimum amount of information needed to resolve the issue. The Customer Services Department maintains detailed records of all such authorizations and releases. CSRs follow a rotating schedule to ensure that on each day there is a CSR accountable for checking all printers on a regular basis throughout the day to ensure that printed PHI is not left unattended. At the end of the day, all unclaimed documents are shredded. In the both the Customer Services and Network Development Departments, Sunflower staff assist providers and their office staff with claims, authorization and coverage questions. Before any PHI is revealed, including claim payment information, the providers are asked to verify the requester's identity and relationship, using multiple data points, before disclosing only the information relevant to the claim or question at hand. The Network Development department uses the same schedule and process described above to ensure that printers remain free of unattended PHI.

Member Data Privacy

These practices are combined with rigorous safeguards, policies, strong authentication, monitoring tools and automated business processes to ensure systematic, ongoing and auditable adherence to HIPAA regulations, mandates, rules, and standards. Sunflower Heath and Centene take pride in demonstrating compliance with HIPAA on or before the respective effective dates of each HIPAA rule. Our ability to create, access, transmit, and store Protected Health Information (PHI) in accordance with KDHE and HIPAA Security (including Confidentiality) and Privacy mandates stems from our design, maintenance, and use of administrative, technical, and physical security safeguards and controls under the guidance of Centene's Chief Compliance Officer, Chief Information Security Officer, and General Counsel. These mechanisms ensure that:

- Only appropriately authorized personnel are granted access to Sunflower and Centene systems based on specific job roles
- Physical access to sensitive computer facilities is restricted
- Systems are deployed and processes defined to safeguard data and monitor security events

Confidentiality of Sunflower Records

Centene and Sunflower understand that we are the trustees of valuable and confidential information that belongs to our members and KDHE. Sunflower rigorously employs the most thorough administrative, technical, and physical security safeguards and processes.

Administrative Safeguards (45 CFR 164.308 and 42 CFR 438.224). Our Administrative Safeguards are the policies and procedures that make up the foundation of our programs. We engage our internal users; subcontractors; contractors and clients through documented policies and systematically enforced procedures. This includes policies that:

- All clinical and medical records of enrolled members will be confidential and not released without the written consent of the member or responsible party except as required
- Written consent of the member is required for the transmission of the clinical and medical record information of a former enrolled member to any physician not connected with the Sunflower or its subcontractor
- The extent of clinical or medical record information to be released in each instance is based upon tests of medical necessity and a "need to know" on the part on the practitioner or a facility requesting the information
- SUD information may only be released in compliance with policies set forth in 42 CFR Part 2

Access Management. Sunflower and Centene enforce strict control in our Management Information System (MIS) over global application and systems access via a series of technical and administrative controls. In particular, we have implemented Role Based Access Controls throughout our MIS to restrict access to PHI, based on an employee's job function which eliminates problems inherent with assigning access rights on an individual basis. Through Role Based Access Controls, data can only be accessed, created, or changed by those who have the authority to do so, and in compliance with HIPAA Minimum Necessary rules. In addition, our Role Based Access Controls provide auditing support and serve as a strong basis for separation of duties while simplifying security administration by assigning privileges to a role (as opposed to a user) and then assigning role(s) to users. The Centene Information Security Team and applicable Sunflower manager must approve an employee's access to information if that access request is not part of a standard security profile commensurate with the normal responsibilities of the employee's position. Depending on the type of access being requested, the Centene Information Security Team and applicable manager may need to obtain the approval and sign-off from the appropriate functional vice president.

Furthermore, our monitoring regimen mitigates the risk of security personnel modifying their own roles, or provisioning new roles for themselves, by logging all changes to access, issuing privileged access reports for periodic review by management, and by notifying oversight personnel when there are any changes to highly privileged administrative roles.

Device and Media Controls

We track the receipt, storage, deployment, movement, and disposal of all PC workstations, laptops, and Personal Electronic Devices (PED's) through our ServiceNow System. When we reassign, dispose, or donate any PC, we erase all data on the machine. Our data erasure tools and methods fully comply with HIPAA Security and US Department of Defense Clearing and Sanitizing Standard 5220.22-M.

All Centene and Sunflower users who are issued PC's, laptops, and/or PED's must follow stringent policies on the use of this equipment. Desktop machines are physically locked to fixed structures in our offices. Users must attach their laptops to docking stations with cable locks or lock those laptops in filing cabinets in their offices when not in use. Sunflower Compliance

regularly checks that this policy is followed. Users are required to store all PHI and other confidential information on the Local Area Network (LAN) servers instead of using the hard drives of their desktop PCs. To prevent disclosure of PHI, if a device is lost or stolen, access to that device (laptop, iPad, etc.) is automatically revoked and data is deleted remotely by authorized IT staff.

Technical Safeguards (45 CFR 164.312). Network Security

To secure the internal data network, Sunflower provides an array of industry best-practice technologies such as firewalls; Access Control Lists (ACL); Terminal Access Controller Access-Control System Plus; Demilitarized Zones (DMZ); Intrusion Prevention Systems (IPS); Virtual Private Networks (VPN); Data Loss Prevention (DLP); Secure communication protocols (SSH, SFTP, etc.); and SSL encryption for secured web communications. Our IT supervisors monitor network security using advanced event management on a routine basis, and our network engineers routinely implement restrictive VPNs for secure connectivity with our external Trading Partners, such as our State clients. All such implementations are audited and approved prior to production by our Information Security staff to ensure adherence to policy and observance of least privilege (we provision access according to necessity). For additional information on Technical Safeguards employed by Sunflower, please refer to ***Section 5.15.2 Safeguarding Data***.

Audit Functions to Ensure Confidentiality and HIPAA Compliance

Throughout Sunflower and Centene Operations, we have a culture of continuous process improvement through monitoring and oversight. Below we describe a few of these additional controls we have in place.

HIPAA Assessment. The Centene and Sunflower Compliance Departments audit and evaluate compliance with the HIPAA privacy and security standards by periodically assessing environmental or operational changes that may impact adherence to the standards. In the event the evaluation results in a determination of non-compliance, immediate steps are taken to remediate any deficiencies and reinstate compliance.

Penetration Testing. Our Information Security Department conducts penetration testing on our systems, networks, and websites on an on-going basis. During these penetration tests, we attempt to compromise our websites and email systems via such mechanisms as vulnerability exploitation, phishing, spoofing, and other tactics, as well as occasional social engineering tests, such as false emails allegedly from Centene or MHD employees inviting the receiver to click a malicious link. We also periodically retain reputable third party firms to perform independent penetration tests. These independent tests have been performed yearly since 2010. Once completed, all identified vulnerabilities are prioritized by risk, remediated, and retested to ensure compliance. Additional third-party firms will be contracted to provide penetration testing services in 2018 to independently verify the security of Centene applications, systems, and networks.

ACCESS TO CLINICAL AND MEDICAL RECORD DOCUMENTATION MAINTAINED BY SUNFLOWER (5.9.12.B.2)

Sunflower maintains and provides authorized access (consistent with the HIPAA standards discussed above) to complete member clinical and medical records using our Centelligence health informatics platform. Centelligence is a proprietary, comprehensive family of integrated decision support and health informatics solutions that integrates data from multiple sources, and provides actionable population and member-level information to the right person for the right task, at the right time, improving clinical, operational, and financial outcomes. The foundation of the Centelligence proprietary data integration and reporting strategy is a comprehensive Enterprise Data Warehouse (EDW) powered by high performance Teradata technology. Our EDW systematically receives, integrates, and transmits internal and external administrative and clinical data, including medical, behavioral, and pharmacy claims data, as well as lab test results, health assessment information and medical records.

Images of medical records received from providers for the purposes of medical record review, grievances and appeals, and prior authorization are uploaded and stored in our Centene Document Management System (CDMS) for secure image storage and retrieval by authorized staff. We also capture machine readable data from these documents via Optical Character Recognition (OCR) that can be loaded into the EDW. Through these systems and our policies and procedures for medical record documentation, Sunflower collects and maintains complete beneficiary information to support our utilization management activities in compliance with all NCQA, State and federal requirements, including 42 CFR §456.11 and 42 CFR §456.211.

As described above, Sunflower treats member medical information with the utmost confidentiality in accordance with all State and federal laws and regulations. Our ability to create, access, transmit, and store Protected Health Information (PHI) in accordance with HIPAA Security and Privacy mandates stems from our design, maintenance and use of administrative, technical and physical security safeguards and controls. These mechanisms ensure that:

- Systems are deployed to safeguard data and monitor security events
- Only appropriately authorized personnel are granted access to Sunflower and Centene systems, commensurate with a person's specific job role
- Physical access is restricted to sensitive computer facilities

Sunflower's Compliance Officer is responsible for all local compliance activities, and is designated by Sunflower's Chief Executive Officer to act as the liaison between Sunflower and KDHE for the duration of the Contract. Sunflower's Compliance Officer assists with the timely production of physical and electronic records as applicable upon reasonable request. Sunflower ensures that no charges are imposed for audit or examination of Sunflower records. Sunflower and its subcontractors will continue to timely furnish information as reasonably requested by duly authorized and identified agents or representatives of the State of Kansas and/or the federal government.

SUNFLOWER RECORDS RETENTION (5.9.12.C)

Sunflower is committed to creating and maintaining complete, accurate, and trustworthy records of all of our business activities and complies with all State and federal record retention requirements as applicable to the data type: claims, encounters, payroll records, supporting medical information, etc. We maintain policies and procedures addressing the maintenance of records pertaining to our performance under the Contract as well as an infrastructure to support continuous oversight for compliance with those policies and procedures. We use IBM Tivoli Storage Manager (TSM), an automated hierarchical storage management system to administer our data retention and storage policies. We also use TSM for data recovery operations if needed. After the retention period, we dispose of stored data, unless it is subject to a legal hold, e.g., due to an open investigation prior to the expiration-of-retention date.

Sunflower's Record Retention policies and procedures require that clinical and medical records, claim forms and supporting management systems include all pertinent information related to the member. This includes contractually requiring subcontractors to maintain adequate documentation for services provided to members for all delegated activities including Quality Improvement, Utilization Management, Member Rights and Responsibilities, and Credentialing/Recredentialing. Our policies strictly prohibit deliberately creating false or misleading records. Sunflower has also adopted a Records Retention Schedule to ensure the proper documentation and archival of plan activities, decisions and compliance with all Federal, State and contract requirements, including but not limited to, accounting, audit, KDHE Contract requirements and tax requirements.

Sunflower will require a record retention period of at least 10 years and maintain the following:

- Current, and complete records of the financial activity of this Contract, which documents and calculates all applicable charges billed to the State during the entire term of this Contract which may include but not be limited to any extensions or renewals thereof, and for a period of at least 10 years from the date of final payment or completion of any required audit
- Records of services provided to individuals under the Contract for a period of at least 10 years from the date of the termination of the Contract, or for the duration of contested case proceedings, whichever is longer
- Non-medical and medical client records for a period of at least 10 years from the date of the termination of the Contract
- Records associated with any litigation, claim, negotiation, audit or other action (collectively referred to as "Claims") until resolution of all issues arising from such Claims, or for a period of 10 years from the date of the termination of the Contract, whichever occurs first
- All financial accounting records will be maintained in accordance with applicable National Association of Insurance Commissioner (NAIC) guidelines
- All accounting records, including performance and financial data of risk bearing subcontractors will be maintained separately for a period of at least 10 years from the date of the termination of the Contract

Sunflower's Records Management Policy and its associated Records Retention Schedules establish controls to ensure the proper management of its records. We annually review and update our Records Management policies and procedures, which outline records storage requirements for the onsite and offsite storage of physical records as well as the electronic storage of records, with the prior written consent of the State. These requirements ensure that records are maintained in a secure environment, can be retrieved quickly and efficiently, and are retained for the appropriate time period according to the Records Management policy and procedure.

Records Management Structure.

Sunflower and Centene are both actively involved in record management risks, controls, policies, programs and monitoring. As described further in ***Table 5.9.12 Records Management Structure*** below, Leadership staff at Centene includes the General Counsel, the Records Management Steering Committee, Director of Records and Information Governance (IG), the Corporate Records Liaison, and the Chief Technology Officer. At Sunflower, the Compliance Officer, business/process owners and all employees and subcontractors are responsible for upholding all records management requirements.

Table 5.9.12_Records Management Structure

Centene Records Management Roles and Responsibilities	
General Counsel	Responsible for: updating policies and schedules required by changes in applicable law or by the company's needs; issuing legal hold notices to appropriate departments as required by litigation or government inquiry, and fielding inquiries concerning implementation and compliance with record management policies.
Records Management Steering Committee	Advises on policy matters, and reviews program effectiveness. Members include the Centene Vice President of Compliance, Corporate Records Liaison, Office of General Counsel, the Chief Technology Officer (CTO) and Director of Records and IG.
Director of Records and Information Governance (IG)	Develops and implements strategies to ensure a compliant and structured plan to organize, review, coordinate and establish controls for company records; formulates and oversees implementation of records and information governance policies and procedures; works with CTO to develop and maintain processes to support a sound records management program and ensure accountability, protection of company interests and mitigate risks; advises on records and information governance principles in connection with enterprise acquisitions and new business planning processes; and oversees the day-to day implementation of the records management policy (the "Policy").
Corporate Records Liaison	Assists the Director of Records and IG with the day-to day implementation of the Policy; coordinates sending and retrieving hard copy records in long-term storage; and coordinates guidance and training to Sunflower staff.
Chief Technology Officer	Responsible for: assisting the Director of Records and IG and the Sunflower Records Coordinator in determining appropriate locations, equipment, and methods for the retention of electronic information, including imaged records; assisting management in determining the appropriate method for tracking and destroying duplicate copies of electronic and imaged documents and information; and coordinating with the Centene Corporate Records Liaison and the Sunflower Records Coordinator with respect to long-term storage and destruction of

Centene Records Management Roles and Responsibilities	
	electronic and imaged documents and information, including security of and access to company records stored electronically.
Sunflower Records Management Roles and Responsibilities	
Sunflower Plan President & CEO	Responsible for compliance with the Policy within Sunflower and for appointing a Records Coordinator with responsibility and authority to implement the Policy within Sunflower.
Sunflower Records Coordinator	Coordinates with the Corporate Records Liaison on matters relating to records management and ensures employee training on the retention and destruction of company records meets the requirements of the Policy; ensures records are managed and retained according to functional requirements and in compliance with State and federal regulations and requirements, including records from external vendors; establishes requirements for physical and logistical access to records and ensures company records subject to legal hold notices are retained irrespective of retention schedule destruction requirements. Sunflower's Compliance Officer serves as the Records Coordinator.

Sunflower's commitment to robust record keeping is reinforced by the involvement and oversight of Centene corporate resources. Specifically, Centene provides training regarding the Records and Information Governance Program and Policy and conducts an annual review of the records retention schedule. This review includes research and updates to the Policy and records retention schedule to reflect changes in relevant laws, regulations or company business operations. Centene also audits compliance with the Policy on a periodic basis and takes corrective actions, as needed, based on the results of audit. Furthermore, Sunflower's Compliance Officer ensures that all health plan records management policies and procedures meet federal, State and Contract requirements, and are carried out appropriately.

5.10 Member Services

5.10. MEMBER SERVICES

SUNFLOWER DEMONSTRATED SUCCESS

Sunflower Health Plan (Sunflower) has served Medicaid members in Kansas as a participant in the KanCare program since 2013. A combination of skilled, compassionate, well-trained staff and state-of-the-art communications and data management technology, allows Sunflower to consistently provide excellent customer service to members and providers that contact our Service Center. Sunflower's Service Center performance exceeds the industry standards and those of the State:

- The monthly CSR call audit average score has not fallen below 95% in the last two years and is routinely above 97%.
- 87% of calls answered within 30 seconds or less (KanCare 2.0 Standard is 80%)
- 2% average abandonment rate (KanCare 2.0 Standard is 4% or less)
- 100% of calls answered resolved during initial contact (KanCare 2.0 Standard is 90%)
- Through our systematic materials development and review process, Sunflower develops award-winning member education materials that are culturally competent, user friendly and designed to engage members in their care.
- Through our robust technology solutions and highly trained staff, Sunflower offers multiple means of communication to meet members where they are and provide customer service, member engagement and service coordination support in a way that is most effective.

COMPLIANCE WITH SCOPE OF WORK

Sunflower is currently in compliance with all KanCare contracts and all KanCare 2.0 requirements described in Section 5.10 of the Scope of Work (SOW). Below we describe in detail our overall approach for Member Services, advance directives, member materials, customer service center, member crisis assistance, and member rights and responsibilities, including accountability, oversight, and evaluation for complying with each element of the SOW. For ease of review we have included SOW references in headers and within the narrative.

5.10.1. MEMBER SERVICES GENERAL REQUIREMENTS

OVERVIEW OF MEMBER SERVICES

Sunflower acknowledges, understands, and will comply with all SOW requirements regarding the provision of member enrollment materials. Sunflower operates a comprehensive Member Services program, ensuring meaningful and relevant member education and engagement, answering member inquiries, addressing member concerns, and improving the member experience. Our multi-faceted approach to health education and literacy is community-based; grounded in cultural sensitivity; and promotes personal accountability. Our Member Services programs, materials, tools, and outreach are designed to be:

- ***Member-Centric.*** We meet members where they are, going beyond traditional member services to give members flexible options for connecting with Sunflower. We convey information to members and potential members via written materials, telephone, internet, and face-to-face communications, and ensure our materials identify differences among the categories of eligibility.

- ***Local and Individualized.*** Our support is local, individual, responsive, and ensures no wrong door.
- ***Culturally Competent.*** We recognize that culture includes more than race, language and ethnicity, but also disability, gender/sexual orientation and shared life experiences such as trauma, poverty, homelessness, health literacy, education, and occupation.

Member Services Organizational Structure

The Member Services Director oversees all member call center functions; provides strategic planning and departmental goal-setting; provides oversight for staff training; develops all related policies, procedures, and work processes; ensures compliance with State, federal, and Sunflower requirements and guidelines; and works with the management team and Workforce Analyst to ensure the call center is properly staffed to meet State performance standards. The Member Service Director works closely with other business units to ensure member-centric service delivery, and also oversees the two Member Advocates. Our Member Advocates are trained to assist all members, regardless, of eligibility category. However, one has special training dedicated to assisting members with LTSS and the other to behavioral health needs. Placement of the member and provider call center under a single Director provides cross-functional integration by ensuring consistency in our technologies, training programs, policies, and interface protocols.

The Customer Services Management Team, comprised of a manager and two supervisors, oversees the daily functions of the team such as floor supervision; coaching and providing guidance to call center staff as needed; and developing and monitoring adherence to department and individual performance goals and shift schedules.

Customer Services Representatives (CSRs) are the core of our member call center who respond to telephonic inquiries from members and their representatives. CSRs are hired from the local community since local staff are best prepared to recognize and respond appropriately to our members across the State of Kansas. Our staff are prepared to assist and serve our diverse membership in a culturally competent manner including those who may have special needs including members for whom English is not their primary language, our members with disabilities and our members with BH challenges. CSRs educate and provide information to members on:

- Covered services and how to appropriately access them
- Accessing other health care services within the community
- Submitting grievances or appeals
- Reporting fraud or abuse
- Locating a provider
- Health crisis support
- Balance billing issues
- Cost-sharing and patient liability inquiries
- Sunflower's CentAccount incentive program

EXPERIENCE MEETING MEMBER SERVICES REQUIREMENTS

Sunflower's member-centric model is designed to meet Physical Health (PH), Behavioral Health (BH) and Long Term Services and Supports (LTSS) needs through "no wrong door" access via the member call center. Sunflower provides one phone number to Members for access to all services. Customer Services Representatives (CSRs) are trained to identify specific needs such as behavioral health needs or crisis and will warm transfer the caller to BH staff on the Integrated Care Team or our 24/7 nurse advice line, who are equipped with training, expertise and resources to support the member. Sunflower's Member Services staff is supported by the Customer Relationship Management (CRM) system, which supports members as well as interdepartmental Sunflower staff. Our Member Orchestration platform ensures our member outreach and engagement materials are disseminated to all members and potential members accurately, in the format that best meets their needs, including written materials, telephone, internet and face-to-face communications (5.10.1 A) and identifies differences among the categories of eligibility (5.10.1 B). Our Member Services Department will continue to maintain compliance with all the requirements of 5.10.1, including:

Sunflower in Action…

A Sunflower Customer Service Supervisor received a call from a member reporting her happiness with a Sunflower Customer Service Representative named Michelle. The member was having troubling obtaining some needed medical equipment and has difficulty with literacy. The member said, "Michelle was very patient and encouraged me to file a grievance for further review. She explained the entire situation, helped me with spelling and making sure what I said made sense. Thank you for hiring such outstanding help!"

- Ensuring we provide written notice with at least 30 calendar days of any significant change in policies concerning Members' disenrollment rights, right to change PCPs or any significant change to any of the items listed in Member Rights and Responsibilities (5.10.1 C)
- Ensuring Sunflower makes information available in paper form without charge within five business days of Member request (5.10.1 D)
- Ensuring all member information is posted electronically on our website and in such a format that can be easily printed by members.(5.10.1 E)
- Compliance, with RFP Section 5.10.1 F policy regarding objection on moral or religious grounds.

The below response describes how Sunflower is compliant with all of the requirements listed in RFP Section 5.10.

5.10.2. ADVANCE DIRECTIVES

OVERVIEW AND EXPERIENCE

As a part of their New Member Enrollment Packet, Sunflower members receive written information on advance directive policies, including their rights under state law to make decisions concerning their medical care and the right to formulate advance directives. CSRs are

fully trained on Sunflower's written policies and procedures for advanced directives and will use Welcome Calls to answer any questions members may have about advance directives to ensure the members are informed about their choices. In 2016, Sunflower included an Advance Directive flyer to the annual Member Handbook mailing as a standalone piece and will continue this practice moving forward.

Sunflower provides written information about our advance directive policies to all members and providers, and upon request to potential members. Our policies and procedures for notifying and educating members about Advance Directives is fully compliant with 42 CFR § 438.3(J), 42 CFR § 422.128, AND 42 CFR § PART 489 SUBPART I. When State law relating to advance directives changes, we will update our policies and procedures and notify members and providers 30 calendar days before the effective date of the change.

PROMOTION OF ADVANCED DIRECTIVES

Member Education

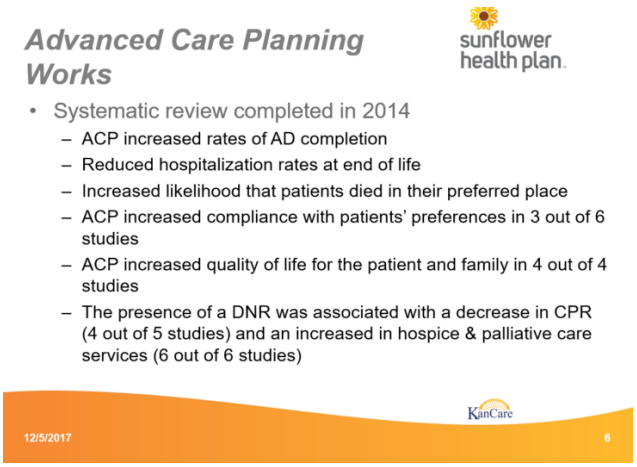
We provide written information to members on their rights under Kansas law to make decisions regarding their medical care. Written information on advance directives is in compliance with all State and federal language, format, content and other requirements. We provide information in our Member Handbook, Member Newsletter, on our website, through Service Coordinators and by providing material for providers to distribute to members. Written and oral member education includes, but not be limited to the member's right to file a grievance if the member is dissatisfied with Sunflower's advance directive policy and procedure or our administration of our policy and procedure. Our written materials define what constitutes an advance directive, emphasizing that it is designed to enhance an incapacitated individual's control over medical treatment, and describe State and federal law concerning advance directives.

If a member is incapacitated at the time of initial enrollment or when medical care is initiated and is unable to articulate their advance directive, Sunflower will offer advance directive information to the member's family or surrogate in the same manner that we issue other materials about our policies and procedures, in accordance with State law. If the incapacitating condition is temporary, we will communicate this information directly to the member once they regain capacity. We ensure the information is given to the individual directly at the appropriate time by requiring Sunflower Service Coordinators to document the provision of information in TruCare, our member-centric health management platform. These same expectations will apply to Community Service Coordinators as well.

Provider Education

We educate during our provider workshops and quarterly provider orientations about advance directive requirements, including but not limited to PCP responsibility to discuss advance directives with adult members at the first medical appointment and documenting in the medical record whether or not the member has an advance directive. Our Provider Manual and

Figure 5.10.2.A: Advanced Directives Value Training



provider website also include information on providers' responsibilities related to Advance Directive. We have also discussed Advance Directives at our Physician Advisory Committee meetings to obtain feedback from the PAC on how best to encourage PCPs to have discussions with their patients on this topic. Many providers post Rights & Responsibilities in their offices, which includes Advanced Directive information. ***Figure 5.10.2.A: Advanced Directives Value Training*** is an example of presentation information used to train providers on the value of Advance Directives.

Staff Education

Sunflower provides training to our staff including Member Services staff and Service Coordinators during initial training and at least annually thereafter or upon significant change to applicable laws. We will continue to ensure that staff providing services to and interacting with members, complete training on topics such as State and federal requirements regarding advance directives and how to engage the member about completing an advance directive, to include Community Service Coordinators.

DOCUMENTATION AND MONITORING COMPLIANCE

We require providers to comply with all State and federal laws relating to advance directives. Neither Sunflower nor our providers will condition the authorization or provision of care or otherwise discriminate against a member based on whether or not the member has executed an advance directive. We require providers to prominently document in the medical record whether the member has executed an advance directive and, if so, to include the advance directive in the medical record.

5.10.3. STATE APPROVAL PROCESS OF MEMBER MATERIALS

Sunflower acknowledges, understands, and will comply with all SOW requirements regarding the submission and State approval of member materials. Our existing member materials policies clearly outline and align with all provisions in Section 5.10.3. At least 45 Calendar Days before their printing and distribution, Sunflower will submit all member materials to the State for review in electronic file media, in the format prescribed by the State. We will provide the State with advance notice of any changes made to written materials and will maintain and provide to the state upon request, documentation verifying that the Member Handbook is reviewed and updated at least annually. The Manager of Marketing and Communications is accountable for ensuring continued compliance with

all member materials policies and requirements, including oversight of the member mailing process. All member materials are reviewed, approved, and tracked through Sunflower's internal, inter-disciplinary Member Education and Advisory Committee (MEAC) before being submitted to the State for approval. This process ensures accuracy as well as the continuity of knowledge among staff for purposes of meeting State requirements for member materials.

5.10.4. ELECTRONIC SPECIFIC AND WEBSITE REQUIREMENTS FOR MEMBER INFORMATION

PUBLIC WEBSITE

Sunflower acknowledges, understands, and will comply with all SOW requirements regarding member website requirements included in RFP Section 5.10.4. Sunflower currently hosts and maintains a public website that is fully compliant with the requirements of KanCare and the upcoming KanCare 2.0. Following the communication trends of our members, we have deployed a suite of digital tools. We have also achieved the first eight NCQA Member Connections (MEM) standards on our public website and Member Portal. NCQA MEM standards are a nationally recognized gold standard for MCO websites, and span a comprehensive array of interactive health management tools (including Health Appraisals and self-management health tools) to actively engage members in their care and ongoing wellness. Our Sunflower public website is mobile friendly and 508 compliant (5.6.3 C.7), with a compelling presentation of content, resources, and communication features whether experienced from a personal computer or mobile device.

The website is well organized providing ease of member use. We organize our member website content by audience and program and include information relevant for KanCare members. The public member page includes accurate, up-to-date information on benefits, health management and health education, frequently asked questions, and Sunflower contact information; all available in both English and Spanish and worded at or below a 6th grade reading level, unless otherwise approved by the State. Available member resources include the Member Handbook, Provider Directory, Pharmacy Formulary, Benefits description, information on oral translation services, and hot links to all subcontractor websites. Members can also search our Provider Directory and log in to the secure Member Portal to access a new member welcome toolkit. The new member welcome toolkit includes all the links and forms that new members may need such as Health Risk Screening, Notification of Pregnancy, Member Handbook and more. (5.10.3 C-D)

Compliance with State Requirements

All Sunflower website content relating to KanCare will comply with all marketing policies and procedures and requirements for written materials described in the RFP.

Ensuring Accurate and Updated Information

Timely and accurate information is critical to ensuring an effective website and promoting a positive member and provider experience. With our use of industry standard web technologies such as HTML5, and best in class web content management systems such as Adobe Experience

Manager (AEM), we can quickly update content on our websites while maintaining a consistent user experience. Our use of AEM and our web content versioning capabilities, along with a best practices approach to change management, allows us to prepare new and modified web content that is up-to-date and accurate. We also include HIPAA compliant controls to ensure web content is appropriately secured and are audited regularly to ensure ongoing compliance.

Driven by the Manager of Marketing and Communications, we have a working team of cross-functional directors, including member services, provider services, marketing and outreach, operations, medical management, and quality, that are accountable for reviewing web content and making appropriate recommendations for change. This team identifies new content to promote seasonal activities or educational opportunities, such as announcements and tips.

SECURE MEMBER PORTAL

Our secure, web-based **Member Portal** offers members online access to their Sunflower information and many supporting "self-service" functions, such as the ability to:

- View their clinical service and medication history
- Change primary care providers
- Update their contact information
- Take an online Health Risk Screening
- View a health alert, gap-in-care, or member-centric care plan
- Request an electronic copy of explanation of benefits with all information required in RFP (5.10.4. E. 1)
- Obtain claim or authorization status information (5.10.4. E. 2)
- Provide information regarding Sunflower's records for the inquirer (5.10.4. E. 3)
- Communicate with Sunflower staff

Members can also check the status of their CentAccount® incentive balance. Sunflower's CentAccount® Program, described in more detail below, actively promotes personal health care responsibility and ownership by offering our members financial incentives for certain healthy behaviors and adherence to their care plan regimens. In addition, we offer support for Microsoft HealthVault Personal Health Record (PHR) for our members who wish to maintain their own electronic PHR, using Microsoft's industry leading PHR platform.

Figure 5.10.4_A: Secure Member Portal Home Page Screen Shot

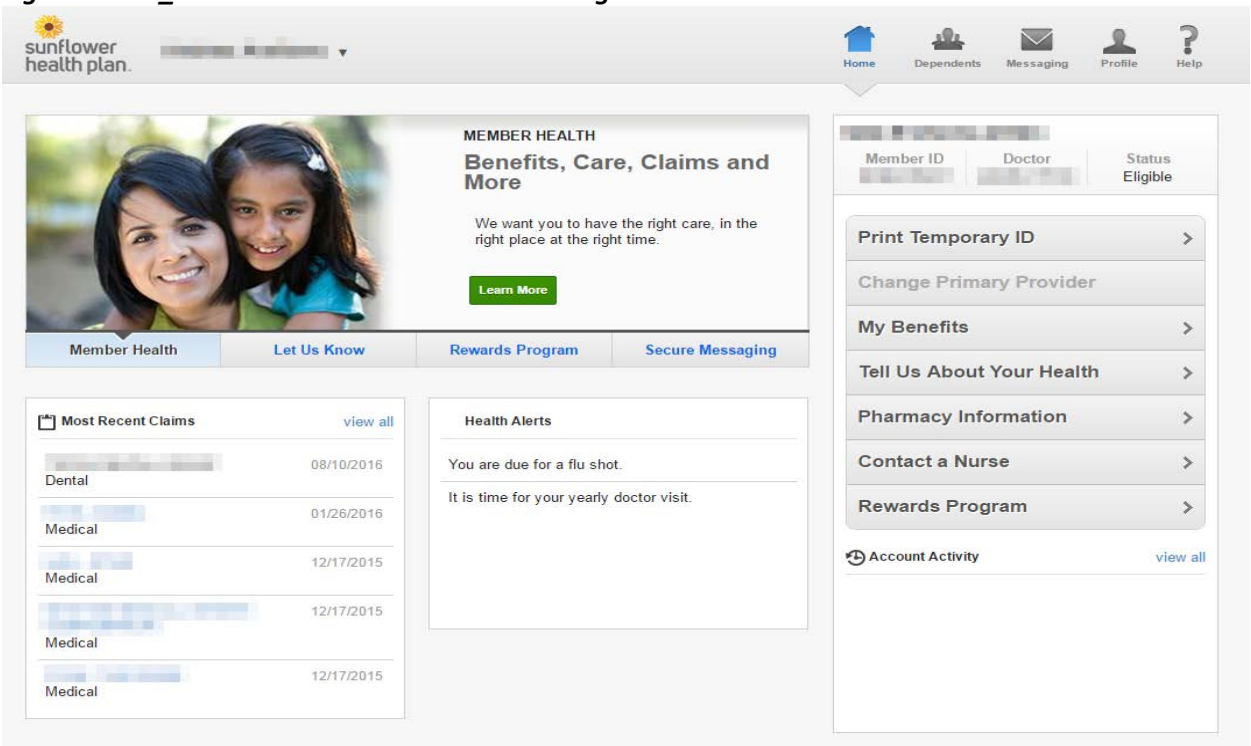


Table 5.10.4_A: Secure Member Portal Features

Secure Member Portal Features	Description
Contact Us and Secure Messaging	Members can utilize our secure messaging capability behind the member's login to contact Sunflower staff.
Member Profile	Members can change their registration information and preferences, contact information such as e-mail and password, and add dependents through their member profile page.
CentAccount® Reward Program	The Sunflower CentAccount® program promotes personal health care responsibility and ownership by offering our members financial incentives for certain healthy behaviors. The CentAccount® program uses leading technology to restrict card purchases to health care and personal hygiene items. Our members can view their CentAccount® incentive balance and recent CentAccount® reward card activity through the Member Portal.
Personal Health Record (PHR)	Sunflower supports those members who want to maintain their own electronic PHR through Microsoft HealthVault, one of the most prevalent PHR platforms in the market today. We view PHRs as an increasingly popular way to reinforce and empower member engagement, as well as allowing members to keep a portable online health record beyond the time of their active membership in Sunflower.
Health Risk Screening and Care Gaps	Members have the option to take the Health Risk Screening on our Member Portal. All information collected on the screening is electronically imported into TruCare and is used by our clinical staff to support service coordination.
Notification of Pregnancy	Through our Member Portal, members can fill out and submit a notification of pregnancy (NOP) form.
Wellness Assessment	Sunflower's easy-to-complete wellness assessment directs members to programs based on the members' current health status, personal life, health risk factors, and readiness to change for specific health behaviors. The assessment uses a dynamic algorithm and branching logic to

	provide questions that are relevant to each member. Upon completion, members receive an individualized report with recommendations to complete self-service behavior change programs personalized to fit their needs. For example, an individual identified as tobacco dependent will be directed toward a tobacco cessation program. Behavior change programs include stress management, nutrition, physical activity, weight management, tobacco cessation and financial wellness.
Pharmacy	We offer access to pharmacy information that support day to day management, treatment, or maintenance for our members. Further, members can view real-time cost pricing of drugs, view potential drug-to-drug interaction alerts, manage their medication adherence using calendar reminder alerts, as well as manage their drug refill orders.
Care Plan	Sunflower offers members access to view their care plans (i.e., asthma and pediatric asthma, diabetes, congestive heart failure, and chronic obstructive pulmonary disease) maintained in TruCare. These care plans include member health problems, goals and objectives, milestone dates, and progress written in plain language and State-required grade reading level.
Choose, Change, or Search for a Primary Care Physician (PCP)	Members can choose or change their PCP at any time through the secure Member Portal. The member can search for and select a provider based on their needs (i.e., geographic proximity, languages spoken, gender, office hours, and other information). Once selected, the new PCP request from the member is electronically promulgated throughout our Management Information System (MIS) for use in our system.
Value Added Benefits	A description of Start Smart for your Baby services, and other value-add benefits

Find-a-Provider

Members can access, search for, and locate information on all providers (e.g., PCP, specialist, dental, vision, behavioral health) and pharmacies through our online provider directory, Find-a-Provider. Using geo-centric functionality, members can easily locate providers within a specific geographic location and radius. Our detailed search options allow members to search for providers based on location, gender, language, office hours (including weekend and evening hours), whether they are accepting new patients, and accessibility to people with disabilities. Members can also quickly search for providers by name and save favorites. Our provider directory is updated daily, and search results include practice details such as hours, specialties, cultural training completed, and any age or gender limitations. Members can access our provider directory through our public website, secure Member Portal, or on their mobile device.

For Sunflower's affiliate plans that have implemented Start Smart® texting, the frequency of prenatal care improved 6.6%, and the timeliness of prenatal care improved 3.2% at the 90-day mark following member enrollment.

MySunflower Member Mobile App

Sunflower's member mobile application, MySunflower**,** is designed to be a comprehensive and integrated mobile "one stop shop" for our members, free of charge. Available on both iOS and Android operating systems, MySunflower is uniformly branded for Sunflower Health Plan, so users will know where to turn to for any assistance. Keeping in mind the needs of our

members, MySunflower can also be made accessible to parents or legal guardians, and is available in English and Spanish.

Table 5.10.4_B: MySunflower Member Mobile App Features

MySunflower Member Mobile App Features	Description	Availability
Administrative Features		
Member ID Card	Members can securely present their Member ID Card to present at the point of delivery of services.	Available
Contact Sunflower	Members can find contact information for Sunflower and contact our CSRs or 24/7 nurse advice line via a pop-up phone number for immediate telephone call using "touch to call" technology.	Available
View Member Benefits	Provides members with information on plan benefits.	Coming Soon
Update Contact Information	Members can update and edit their contact information, as well as update or reset their MySunflower password.	Available
My Doctor	Members can easily view their PCP's contact information.	Coming Soon
Nearest Hospital	Members can locate the nearest hospital and urgent care via GPS capabilities	Available
Health Engagement Features		
Find-a-Provider	Through the Find-a-Provider feature, members can use search for providers and pharmacies automatically obtain directions from their location to the provider, and call the provider instantly. In an urgent situation, a member will be able to locate the nearest urgent care center, obtain hours of operation, GPS-powered directions, and call the provider.	Available
Health Risk Screening	Just as with our Member Portal, members can complete their health risk screening. Once complete, that information is viewable to the care team through our TruCare collaborative health management platform and Centelligence® Predictive Analytics system.	Coming Soon
CentAccount Rewards	Members can access their CentAccount® rewards status and information, including account balance and reward points earned to date.	Coming Soon
Health Alert Notification	Members will automatically be alerted when they (or their dependents) have a health alert or care gap through notifications and/or when a user logs in. The same health alerts and care gaps are also displayed on the secure Member and Provider Portal supporting service coordination.	Coming Soon
Start Smart for Your Baby® (Start Smart Mobile)	Start Smart Mobile is an extension of our award-winning Start Smart for Your Baby® Pregnancy Management Program. Start Smart Mobile is personalized, based on the expecting mother's due date, and helps track weekly prevention and pregnancy milestones. Start Smart Mobile also features podcasts and access to educational guides and resources (e.g., breast feeding, newborn topics, pregnancy information, tips for new moms).	Coming Soon
Online Health Library	Our Online Health Library, powered by Krames, and free to members, will be available as a feature within the MySunflower mobile app. The Online Health Library provides a flexible, web-based solution for delivering patient education at the point of care, with over 4,000 health-related topics in multiple languages. The library is searchable and easy to navigate, and materials include books, and health sheets. For example, the health sheets	Coming Soon

MySunflower Member Mobile App Features	Description	Availability
	explain conditions, procedures, and specialty areas along with over 2,000 drug information sheets with information on prescription, over-the-counter, and nutritional products.	

Start Smart for Your Baby®

In addition to encouraging and assisting all pregnant members, we will offer our **Start Smart® for Your Baby (Start Smart) Texting Program** which sends members 18 and over, who opt-in to the program, texts with prenatal education and an email that promotes breastfeeding. The program also tracks maternal weight and encourages timely postpartum and well child visits. The program has resulted in higher timeliness of prenatal care and frequency of ongoing prenatal care HEDIS rates for members.

Breastfeeding and Lactation Consultation Mobile App

As an extension of our Start Smart program, we will provide a Breastfeeding consultation mobile application. Sunflower will begin to identify potential candidates for enrollment as early as the third trimester. This mobile health app focuses exclusively on delivering new parents unlimited access, via video consultation, to an expert network of lactation, diet, and nursing experts 24/7 (including lactation consultants, pediatric nutritionists, and nurse advice line staff).

Online Behavioral Health Supports

MyStrength. myStrength is a self-directed, on-demand, and anonymous online peer support tool referred to as a "mental health club for your mind," and is offered at no charge to members. Accessible through a computer and through a member's smart phone, myStrength's customizable tool offers a range of resources to improve mental health and overall well-being. myStrength offers members the ability to take responsibility for their health care and learn more about their diagnoses, track their symptoms, receive motivational ideas and information, and speak with trained, online behavioral health coaches directly, to work toward solutions. Family caregivers of members with behavioral health issues can also enroll and use myStrength for support and to better understand their family member's behavioral health condition and needs. Members can participate in myStrength to increase awareness of mental health needs and engage in personalized e-Learning programs to help overcome depression and anxiety in a safe, confidential environment.

In 2017, over 330 members used the myStrength online peer support tool for depression, anxiety, drug and alcohol abuse, parenting and relationship challenges.

Sunflower's members will have access to myStrength's message-based coaching service, which will be integrated within the myStrength platform. This coaching service will further support members' and family caregivers' access to a broad range of evidence-based resources. Health coaches, through individual interactions, will employ motivational interviewing interventions to reinforce positive behavior change of members and family caregivers. Additionally, myStrength

will be deploying advanced technologies as part of this new coaching service to increase the level of personalized support members and family caregivers experience with myStrength.

Additional Member Education Topics

Dual Eligible-Specific Member Education. Sunflower provides multiple resource materials for members who are dually eligible, including a review of Medicare benefits, designed to help members and stakeholders with fiscal management, self-direction, community living, employment, and other opportunities for independence and empowerment.

On.Demand Experience. Our diabetes home monitoring and clinical support program provides remote monitoring of glucometer, phone based clinical support, and diabetes management coaching.

CentAccount Rewards Program. In an effort to better align our member incentives around how members interact with their environment and the health care system on a day-to-day basis, Sunflower is expanding our CentAccount® rewards program to offer additional member rewards for completion of health and wellness activities. Through CentAccount®, Sunflower offers financial rewards to members based on evidence-based, preventive and primary care interventions that address Social Determinants of Health and Independence (SDOHI), have the greatest impact on health outcomes, and are most relevant to our members. When a member completes a reward activity, rewards are loaded onto a Sunflower-issued CentAccount® card**. In 2019, the CentAccount® card and member ID card will be combined into one card** – making it more convenient for members to access and use their CentAccount® rewards. Members (or their parents/caregivers) can use the card at merchants they already use every day, such as nationally recognized retail stores. They can purchase a wide variety of health-related items including some over-the-counter medications as well as goods and services not covered by Medicaid such as transportation (e.g. bus passes), utilities, pest control, childcare, and items promoting member wellness and safety (e.g. smoke detectors, fans, light bulbs).

Personalizing Member Incentives. Our new CentAccount® rewards program is personalized and tailored based on member preference and can be accessed through a member's smartphone or through our Sunflower member mobile application. As part of our Centelligence® data and analytics platform, we will have the ability to customize a member's experience by sending targeted messages to eligible members notifying them of the potential to earn rewards for completing healthy behaviors specific to them. Using machine learning and complex algorithms, we will be able to detect patterns and predictive responses to create a smart system that better anticipates members' needs and delivers customized rewards to improve member experience.

Promoting Member Wellness: Healthy Behavior Activity Tracker. To promote wellness and keep members engaged in their health we will offer them access to an interactive application for fitness and activity tracking, accessible through their PC, smartphone, or tablet device. Though this application, members can track their health-related behaviors, including steps, activity, nutrition, and sleep. Additionally, our application is Integrated with more than 100

leading health and fitness apps and devices available on the market (including dozens that are free or low-cost), allowing members to see a holistic view of their health, and inform their next best, and data-driven health action.

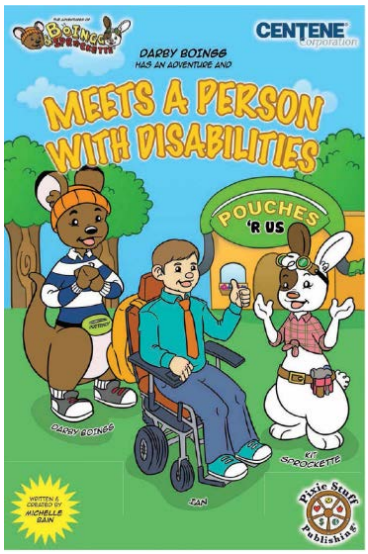
5.10.5. WRITTEN MEMBER MATERIALS REQUIREMENTS

OVERVIEW AND EXPERIENCE

Sunflower's member materials have won numerous national awards, including the 2015 Hermes Creative Platinum and Modern HealthCare IMPACT Award.

Sunflower acknowledges, understands, and will comply with all SOW requirements regarding written member materials included in RFP Section 5.10.5. Sunflower provides all members with consumer-friendly, easily understood and actionable written material. We inform our content with input from providers, members, our Member Advisory Committee, LTSS Advisory Committee and valued stakeholders, to develop publications that motivate each member toward self-management and improve member health and wellness. We also will leverage Centene Corporation's (Centene) award winning publications to provide an age-leveled, culturally competent health literacy library. Using the sophisticated technology offered by our Member Orchestration platform, we will deliver these materials in an orchestrated campaign across multiple communications channels, **delivering the right message in the right format at the right time for maximum impact and member engagement.** We also will use every traditional opportunity to deliver health literacy messaging from on-the-ground distribution, such as through our in-field Community Health Workers (CHWs), Service Coordination (SC) Teams, Community Relations Representatives, and via mobile-friendly web files, podcasts, webinars, texts, and emails. Since the inception of KanCare, Sunflower has supported a member engagement approach that meets members where they are and enhances the impact of written member materials through in-person engagement with members.

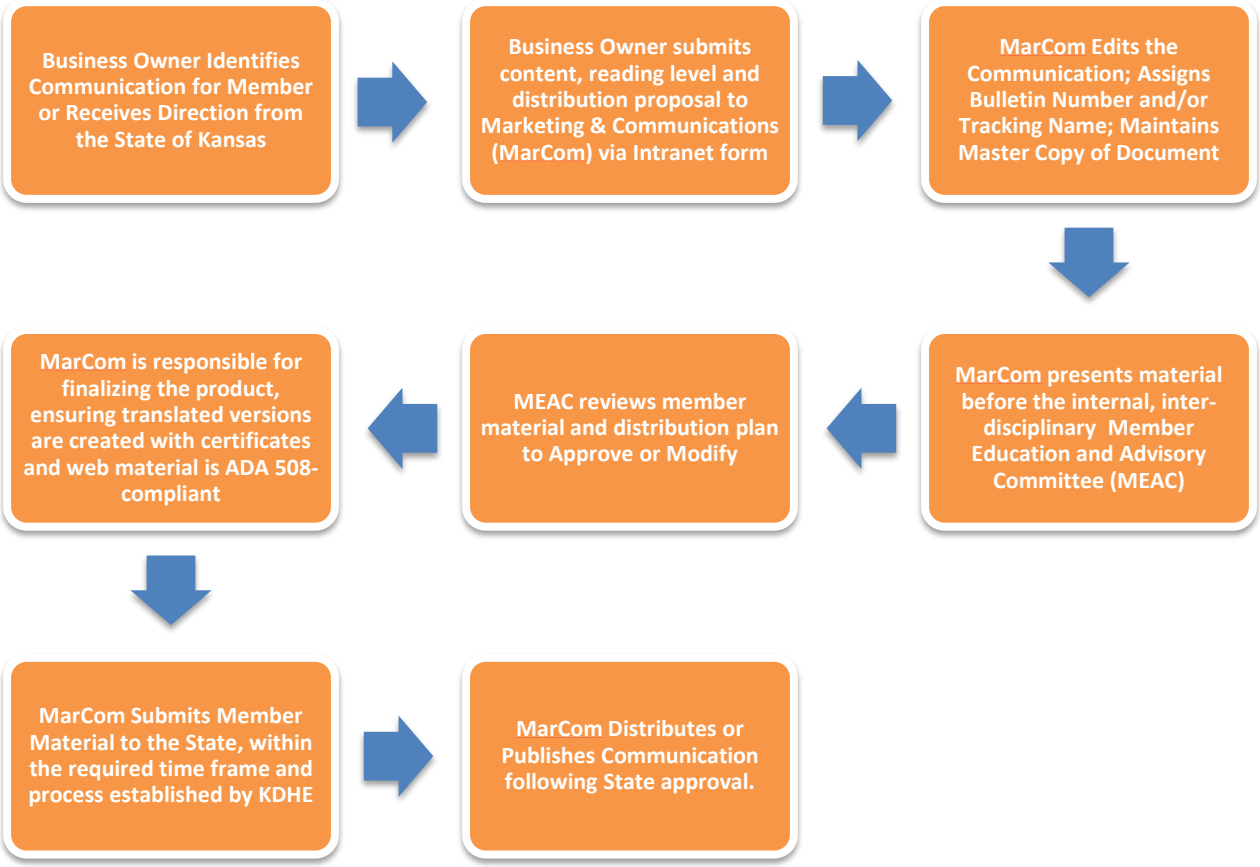
Sunflower deploys "boots on the ground" CHWs, hired from and working in the community, who develop and maintain community contacts, serve as local ambassadors to stakeholders, launch wellness activities such as health fairs and baby showers, and provide direct member support at provider network offices, neighborhood locations, and in members' homes. Statewide, we have 19 certified Community Health Workers who have received specialized training in areas such as SDOHI, integrated and person-centered care, and trauma informed care. Sunflower and its parent company, Centene, are well recognized for developing original, engaging, high quality Medicaid member materials. Our Marketing and Communications Department includes staff who have taken health literacy training through organizations such as America's Health Insurance Plans (AHIP) to enhance our ability to communicate effectively at all reading levels. We also collaborate on member materials with nationally recognized health literacy experts, such as Children's National Health System and Howard University, to ensure



that our member materials are accurate, engaging and culturally competent. We partner with nationally known children's author Michelle Bain to create an entertaining and educational series of comic-books and graphic novels, such as *Off the Chain,* a dynamic self-management book covering all aspects of a teen's life and health, and *Darby Boingg Helps a Friend on a Foster Care Journey,* an activity book. We "road test" these materials with Medicaid consumers to determine their efficacy, appeal, and readability, developing best practices for our materials. For instance, in 2014, focus group testing demonstrated that the more action-oriented the content, the more likely members will read and respond; so we began adding checklists and schedules to member educational materials. Consumers also reported that, when faced with a form, they prefer contrasting colors and empty spaces clearly identified as "intentionally blank," which make it easier to complete the form, ideas Sunflower has incorporated into its design of the Health Risk Screening and PCP selection tools.

To ensure maximum impact, we obtain feedback on Sunflower materials from our Member Advisory Committee (MAC), LTSS Advisory Committee, network providers and their office staff, and from community stakeholders. For example, based on feedback from our MAC, we developed an office checklist for members to use when they go to an appointment, to make sure they get all of the information they need from their provider at the visit. The Manager of Marketing and Communications is ultimately accountable for quality and compliance tracking of member materials. ***Figure 5.10.5_A: Member Materials Development Process*** below describes the process for developing and updating member materials.

Figure 5.10.5_A: Member Materials Development Process



Providing Alternative Formats. Sunflower provides member administrative and educational materials in alternative formats, through the provision of auxiliary aids and services and in an appropriate manner that takes into consideration the special needs of members or potential members with disabilities. (5.10.5.D) Alternative formats include large print, braille, audio tape, and CD. Our website is ADA Section 508-compliant and does not require anything beyond a reasonably up-to-date browser to access. In 2015, Sunflower hosted a Project SEARCH intern who is visually impaired and used a screen reader software to carry out projects for the health plan's Marketing and Communications Department. As part of his job, the intern used his JAWS screen reader software to review all content developed for Sunflower's new website, including PDF documents, to ensure that he could access the information easily. He made recommendations to improve the website's readability and user-friendliness for individuals who are visually impaired or use assistive technology.

Sunflower hosted an intern who was visually impaired and used assistive technology to review our public website and make recommendations to improve readability and user friendliness.

Members can obtain immediate, personal assistance 24/7 from Member Services and nurse advice line staff who will read, explain, or provide translation assistance for member materials, or arrange for alternative formats. **For members with literacy challenges, visual impairment, and/or limited English reading proficiency***,* we have trained all member-facing staff to read and explain materials in a sensitive and culturally appropriate manner. *For members who are deaf or hard of hearing,* we employ Kansas Relay in English and Spanish, and continue to train staff in the effective, appropriate, courteous delivery of service, such as speaking directly to the member and not the Relay Operator. Our member publications and website display the Kansas Relay number prominently.

Providing Member Materials in Other Languages. We offer our Member Handbook, website, and other member materials in both Spanish and English, and we will print materials in any prevalent language. We use certified professional translators for all material translations and maintain certificates of accuracy to ensure translation is accurate and culturally appropriate.(5.10.5 F) When submitting to the State for review and approval, we provide a certificate that the translation has been reviewed by a qualified individual for accuracy, in accordance with RFP section 5.10.3 requirements. Member Services will provide members with real-time interpretation of materials in any language through our national interpretation partner with medical expertise and meeting CMS, HIPAA, ACA and other regulatory requirements.

Making Alternative and Non-English Materials Easily Accessible. We will inform members of the availability of member materials in alternative formats and other languages. We will also inform members how to access these alternative formats and prevalent languages, on our website, Member Handbook, correspondence, and in all member touch points, such as via the Service Coordination Team and Member Services. The Sunflower Member Handbook, website, and all critical plan materials will advise members in Spanish, and any other Prevalent Non-English language, to call our 24/7 toll-free telephone number to request information in other languages. The Member Handbook, and other member materials will be available in English, Spanish, and any languages which may be deemed necessary by the Kansas Department of Health and Environment. All written materials include a statement that members may access oral interpretation for any language at no expense to the member, along with instructions for accessing oral interpretation services. (5.10.5 G) Also, Sunflower will identify languages used by network providers, including American Sign Language. The hardcopy and online Provider Directory will list which non-English languages are used by each provider.

Identifying and Delivering the Right Materials to the Right Members. Through Member Orchestration**,** our member outreach approach is omni-channel, targeting preferred communication channels for the member, such as email, mail or phone. We then reinforce the outreach through other channels. Whether the action is to complete a health risk assessment, remind a member about an appointment, or close a care gap, we utilize our Omni-channel approach to provide a consistent experience and message. An integral part of the Member Orchestration strategy also includes tracking trends, and refining targeted outreach using the channels most likely to lead to member engagement and action for optimal clinical outcomes.

Ensuring Accessibility through Appropriate Reading Levels. We write our member materials using minimum 12-point font and at a 6th grade reading level or below; testing for readability using the Flesch-Kincaid Readability Test. When developing member materials, we write the way a person talks; we use a friendly tone, active voice, common words, and short sentences; and provide examples. We adhere to People First Language and the National Institutes of Health Easy-To-Read Guidelines for health materials. The Manager of Marketing and Communications will review member materials for all federal, state and contract requirements before submission to the State for final approval prior to production. (5.10.5.B-C)

Cultural Appropriateness. We will customize our member educational materials to ensure that they are geared toward the ethnicities within our membership and are consistent with member cultures and local idioms. All written member materials are printed with the assurance of non-discrimination. (5.10.5.E) Materials with pictures will include appropriate representation of minority populations and, when applicable, will include information about race or ethnicity-related risk factors. As a Project SEARCH business internship site, Sunflower staff have the opportunity to work with individuals with disabilities and obtain their perspective on cultural appropriateness for member materials and all other aspects of customer service.

Written Notice of Contracted Provider Termination. Within 15 calendar days from issuance of the provider termination notice, Sunflower will send members written notice of termination of a contracted provider. In these instances, Sunflower will use TruCare to identify members who receive primary care from, or were seen on a regular basis by, the terminated provider. TruCare is our member-centric health management platform for collaborative service coordination, including LTSS, behavioral health, and disease case management, as well as utilization management. (5.10.5.H)

5.10.6. MEMBER ENROLLMENT MATERIAL REQUIREMENTS

OVERVIEW OF MEMBER WELCOME PACKET

Sunflower acknowledges, understands, and will comply with all SOW requirements regarding the provision of member enrollment materials. Sunflower understands that it is essential for KanCare program members to receive all their new member materials in a timely fashion. We will continue to fulfill the State's requirement to provide, within ten calendar days of receiving initial enrollment notification from the State, a **New Member Packet**. The New Member Packet includes all necessary new member materials including information on how to obtain these member materials and other member information online. Paper versions of the Member Handbook are mailed to members within five business days upon request. (5.10.6. C). In our five years of serving KanCare members, Sunflower has learned that a multi-step approach is needed to ensure that communication is provided to members in the format that they desire. We can deliver information to our new members through secured email, over the phone, through U.S. mail and SMS Text messaging outreach. We also make at least three attempts to reach a new member through telephonic outreach via welcome call activities. We audit member welcome packet mailings to ensure the delivery is within the ten days of initial notification of enrollment and contains all required pieces. (5.10.6. B)

Our Member Services department works in conjunction with Centene Operations and Communications Department (CRM Team) to generate these welcome packets, which include all of the information required in accordance with RFP Section 5.10.6. Part of the new member welcome packet, the Member Handbook, includes detailed information regarding the KanCare program. We also include a Welcome Letter, which provides program details including how to select a PCP and how to use the ID card. Other materials in the welcome packet include:

- Benefits Booklet providing details on contact information, benefit coverage, authorization requirements, and how to obtain an authorization
- Link to online New Member Welcome Page on Sunflower member portal
- Value Added Benefits, Formulary, and Provider Directory, including how to access the searchable online Provider Directory.
- CentAccount information which outlines the Cent Account Program, the member incentive program which is unique to Sunflower
- Member Forms Booklet, which includes a member to do list about how to get started as a Sunflower member, such as how to log on to the Secure Member Portal to access Sunflower's large array of online and self-help tools
- HIPAA privacy notice and member rights and responsibilities
- Sunflower magnet with important phone numbers

Based on feedback from our member focus groups, we have designed the pages with call out boxes to help quickly guide the reader to find important information they might be seeking, as well as tips that foster personal responsibility. For the convenience of our members, we have summarized much of this information in a Member Benefit Booklet. This guide includes information about the Grievance and Appeals process, serves as a snapshot of the Member Handbook and is included in our New Member Enrollment Packets.

Timely Delivery

The State's enrollment broker supplies new member data information to Sunflower via a daily 834 FTP eligibility file, plus a monthly enrollment file. Sunflower loads this new member information into the member management systems, which is transferred electronically to our fulfillment vendor. The fulfillment vendor mails new member welcome packets/ID cards to members within ten business days of receipt of the member on the 834 eligibility file. Sunflower monitors compliance with mailing timeframes through a weekly turnaround time report. If a new member welcome packet and ID card is returned, Sunflower CSRs look in the member management system for a new address and resend. If a new address is not on file, the CSR will flag the member record to ensure that when that member contacts Sunflower they are asked to provide an updated address. The Sunflower Customer Service Director and Sunflower Manager of Marketing & Communications will be responsible for oversight of the member enrollment material mailing process and oversight of the mailing vendor conducting the mailings.

5.10.7. MEMBER HANDBOOK REQUIREMENTS

OVERVIEW

Sunflower acknowledges, understands, and will comply with all SOW requirements regarding the Member Handbook and member notification of program changes. The Sunflower Member Handbook is contained within one electronic file (5.10.7. D), contains all the information required in accordance with 42 CFR 438.10 and RFP Section 5.10.7, and was designed and tested with the help of the member focus group. Once focus group feedback was incorporated, Sunflower took the revised Member Handbook to our Member Advisory Committee for their review and feedback before submitting to the State for approval. Sunflower will continue to partner with the State and/or its designee to update the Member Handbook based on the state-determined joint model Member Handbook. We will also continue our established processes to update, and submit for State approval, all required information. (5.10.7. B) On an annual basis, Sunflower provides the State with a "clean" current electronic copy of the Member Handbook. We include a summary of all Member Handbook changes by noting the pages changed and a brief description of the content changed. (5.10.7.C) Updates may include information related to current plan benefit descriptions, provider network information (updated every day online), and all other information contained in the Member Handbook regarding the KanCare 2.0 program.

We will draw on our experience, as well as established policies and procedures for maintaining written policies and procedures for orienting new Sunflower members to their benefits and educating them on the PCP role, service utilization, how to handle emergencies, member rights and responsibilities, the grievance process and their right to disenroll. The Sunflower Customer Service Director and Sunflower Manager of Marketing & Communications will be responsible for oversight of the member handbook updates and mailing process.

Program Changes

Written Notice. When there are program changes, we notify members by first-class mail at least 30 calendar days before implementation. (5.10.7. A) The notice explains to members what the change means to them, and provides contact information for our Sunflower Call Center and Member Portal with any additional questions they may have. Members and providers who have shared e-mail addresses with (or established e-mail addresses through) Sunflower also receive electronic notification. Members and providers also receive notice through the Sunflower website, and Provider and Member Newsletters.

Telephone Notice. Sunflower also conducts automated calls to all members explaining to members the change and providing the Toll-Free Call center number and Member Portal for members to contact for more information. Call center staff also receive training to deal with all member and provider questions. To ensure our staff in all areas are aware of updates and changes and are providing accurate, consistent messaging we use "Training Bulletins" internally and route appropriately via email or SharePoint to all affected staff.

Member Portal and Provider Portal. We post notice of the change on both our Member and Provider Portals. This also allows the public, caregivers, and non-participating providers to access information regarding the material change.

Personal Contacts with Providers. Through our regional Provider Relations Representatives also occur, answering any questions related to the program change.

5.10.8. PROVIDER DIRECTORY

OVERVIEW OF PROVIDER DIRECTORY

Sunflower acknowledges, understands, and will comply with all SOW requirements regarding the Provider Directory. Sunflower understands that the first step in a member's journey toward personal responsibility for health care is the selection of the right Provider. To make selection easy and to provide accurate, timely information about our provider network to members, Sunflower currently offers a web-based searchable and printable Provider Directory, called Find-a-Provider. Upon request, Sunflower will provide any member and the State with a printed customized list of providers that is tailored to the requested specifications. We notify members within 10 days of enrollment, via the new member welcome packet, of the availability of the online Provider Directory and how to access it along with members' right to request a hard copy. (5.10.8 E) We deploy an on-line Provider Data Management (PDM) application for the management of the Sunflower Provider Directory. The application uses enhanced graphics, with comprehensive provider detail that members can set filters for viewing and printing purposes, including printable mapping, making provider selection more efficient and welcoming. The Provider Directory, including text and overall information, is produced consistent with the format approved by the State. (5.10.8 D)

Find-a-Provider

Members can access, search for, and locate information on all providers (e.g., PCP, specialist, dental, vision, behavioral health, LTSS) and pharmacies through our online provider directory, Find-a-Provider. Using geo-centric functionality, members can easily locate providers within a specific geographic location and radius. Our detailed search options allow members to search for providers based on location, provider type, gender, language, office hours (including weekend and evening hours), whether they are accepting new patients, and accessibility to people with disabilities. Members can also quickly search for providers by name, compare multiple providers' information at one time through user filter selections and customize the directory listing based on user specifications. (5.10.8 F 4) Our directory includes, and is searchable by, all the information required by RFP Section 5.10.8 B. Our Provider Directory also includes licensure/accreditation status, service area listings, special needs accommodations, and availability of public transportation, as optionally required by RFP section 5.10.8 C.

Timely and Flexible Delivery

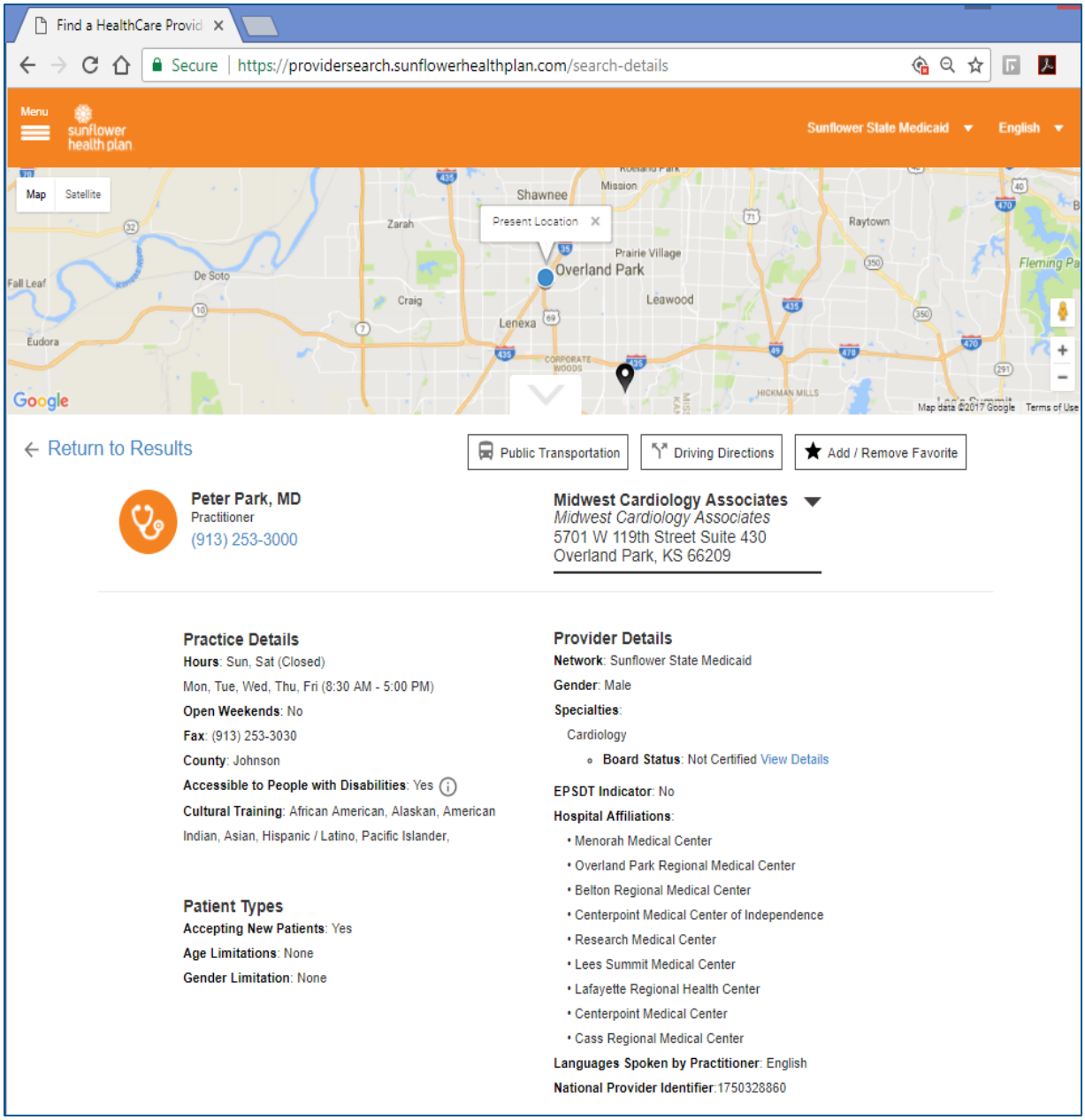
Members can access our provider directory through our public website, secure Member Portal, or on their mobile device. We recognize that not every KanCare member has access to a computer. Upon request, Member Services will provide members with a printed customized list

of providers that is tailored to the member's specifications (i.e. type of provider, language, geo-mapping) within five business days of the request. (5.10.8. G) Members receive immediate, personal assistance in locating and selecting a provider when a member calls our Member Services, including information on the participation status of any Providers. (5.10.8 H) The Sunflower new member Welcome Packet and our welcome activities, which include various member touches, encouraging members to contact Member Services for additional personal assistance with provider selection, if needed. In addition, we will be implementing online chat capabilities in 2018 to allow for real-time discussion and assistance with PCP selection, specialist search, and other member questions and needs. Sunflower Customer Service Representatives (CSRs) consult with members about their needs and, using the on-line Directory, search for the right provider for each member. CSRs also are available to help members with literacy barriers, those who speak a language other than English, and those who require alternate formats such as audio tape or Braille. Sunflower updates the on-line Directory daily and the current print version of the Directory is printed in-house via Member Services and mailed to the member. This ensures that the print version is as accurate and up-to-date as possible. Per RFP requirements, the online Provider Directory will include a disclaimer that the online Provider Directories are updated more frequently than the printed directory. (5.10.8 F. 3)

Ensuring Directory Accuracy

Sunflower's provider directory is updated daily, based on the most recent data available in our **Provider Data Management (PDM)** system which manages our provider network activities. The PDM System serves as a single repository for all our core provider functions, which also include enrollment, credentialing, financial affiliation configuration, and data management. Our PDM Department enters and updates provider data in the PDM system, ensuring that all provider data comes from one governing source. Our provider data management processes support the HIPAA National Provider Identification Number (NPI), from provider set up, thru provider directory updating, to claims and encounter processing. PDM stores multiple provider numbers, including Tax ID and the NPI, enabling cross-referencing between different IDs. PDM also provides geo-mapping for our Provider Network Department. Sunflower offers Provider Directory users to report incorrect Participating Provider listing information to the PDM for follow up, verification, and correction.

Figure 5.10.8_A: PDM System Screenshot



5.10.9. MEMBER IDENTIFICATION CARDS

OVERVIEW OF MEMBER IDENTIFICATION CARDS

Sunflower acknowledges, understands, and will comply with all SOW requirements regarding the Member ID Card. Sunflower member ID cards are made from durable material and comply with all State and Federal requirements, including the fact that they are not overtly different in design from the ID card issued to our non-Medicaid members (5.10.9. C and D). In 2017, to more effectively align members with their choice of providers, Sunflower conducted a review of claims to identify which PCP members were using most frequently. Based on this claims analysis, Sunflower sent new Member ID cards with updated PCP assignment information. We included a letter explaining to members that their PCP assignment had been updated to reflect who they were most frequently seeing for primary care and that they could change their PCP at any time. In 2018 we will add the date of birth and co-payment information to the Member ID in compliance with RFP requirement 5.10.9.

Timely and Flexible Delivery

Sunflower sends a member ID card to members within ten calendar days of enrollment. Sunflower members are instructed to request ID card replacements by calling the Call Center or requesting on line via Sunflower website. Requests are filled and processed at no cost to the member and distributed within ten calendar days. (5.10.9 A and B) Additionally, our MySunflower mobile app allows members to securely present their Member ID Card at the point of delivery of services.

5.10.10 CUSTOMER SERVICE CENTER – MEMBER ASSISTANCE

OVERVIEW OF LOCAL SUNFLOWER HEALTH CUSTOMER SERVICE CENTER

Sunflower acknowledges, understands, and will comply with all SOW requirements regarding the Customer Service Center. Sunflower's dedicated Member Service Center provides members and their authorized representatives, culturally competent assistance with their inquiries, issue resolution, health literacy, and service and resource needs. Our toll-free Member Services number is listed prominently on the member ID card, all member materials, and our website, connecting members to personal services from expertly trained CSRs who respect our members' time, dignity and privacy. Our Call Center, operating in Lenexa, Kansas, is staffed with qualified CSRs who understand Kansas communities and provide superior service aimed at first-call resolution on even the most complex issues. Through one toll-free number, Sunflower connects members to knowledgeable CSRs who help members address issues such as PCP selection, changes, and appointment scheduling. They also facilitate access to BH, service coordination, Start Smart for Your Baby pregnancy management services, Appeals and Grievances, and refer members to the Fraud and Abuse Hotline whenever necessary.

Our Service Center will be staffed Monday through Friday from 8:00 a.m. to 5:00 p.m. Central Time, except for State-approved holidays. (5.10.10 B) After hours, on weekends, and on State-declared holidays, our 24/7 nurse advice line Representatives answer our phone line to provide members with administrative assistance as well as nurse advice. We understand and will comply with all State requirements for Service Center operations, including but not limited to the RFP. Additional and enhanced Member Service Center features are described below.

Technology as a Platform for Efficient, Accurate Service

Our Service Center shares the same call management platform as our nurse advice/BH line, and all internal Sunflower departments. Sunflower's Call Management System, provides seamless call answering, reporting, monitoring and transfers to speed communications and ensure accuracy. Our **Automated Voice Response System (AVRS)**, available in both English and Spanish, offers newly enhanced self-service features so members can verify eligibility, or request a replacement ID card. For members with physical, cognitive, or communication impairments, Sunflower uses a best practice "stay on the line" feature, which directs callers automatically to a CSR if the caller cannot press phone keys or determine how to respond to the menu options. Regardless of queue selection, all calls are answered promptly by a live person on average of 30 seconds or less. We provide sufficient in-bound toll-free lines to meet all performance standards. (5.10.10 B) Sunflower currently has a toll-free, secure fax line that is HIPAA compliant, and has sufficient capacity to handle incoming volume and meet all of the performance requirements detailed in RFP Section 5.10.10 P and Q.

Customer Relationship Management (CRM). CSRs document all calls in our CRM tracking, workflow, and data management system. CRM houses eligibility, demographic, PCP selection, and authorization information; the Care Manager's name, if applicable; the member's preferred language; CentAccount® balance information; Care Gap and Wellness Alerts; and Special Needs status. Our **Unified Member View (UMV)**, to be integrated with CRM in 2018, provides an enhanced, real-time assist module for CSRs to quickly search, pull up, and save relevant content and documents to easily assist members/providers without accessing multiple systems through separate logons. Through Unified Member View (UMV) CSRs can view the single source of truth for all informational aspects of our members' relationship with Sunflower, including member demographics, current and historic benefit plan eligibility across all of our products (Medicaid and Medicare), alternate contact information, member communication options, and more. For instance, CSRs will be able to quickly access a newly-enrolled member's prior PCP after reinstatement of eligibility.

In 2018, Sunflower will deploy **Computer Telephone Integration (CTI)** technology, fully integrated with our CRM system. CTI automatically matches the inbound calling number (with the member's record (call history, demographics, care gaps, etc.) and populates the member record on the CSR's desktop screen supporting member call resolution and customer service excellence. Also, for personalized assistance and customer service, Sunflower integrates our secure Member and Provider Portals with a **Support-a-User** capability for CSRs to view what the

provider or member is viewing (with caller's permission). This feature bolsters customer service excellence and member satisfaction by enabling CSR's to be faster at visualizing, understanding, and resolving barriers to care.

Call Tracking. Sunflower's Workforce Analyst oversees the process for tracking and analyzing call center calls. Our telephony platform, along with call manager system software, provides automatic call distribution (ACD) across our member call queues. Our call manager system software tracks and reports information processed through the ACD and enables seamless and efficient call answering, monitoring, and reporting capabilities. Our telephony and voice portal platform enables the Workforce Analyst or Supervisor to see who is on a call and the length of the call as calls are taking place. This helps them determine if the CSR is having any trouble so they may provide live assistance if needed. Our call manager system software can also categorize call duration by half hour increments for call trending and reporting. In addition, it allows the Workforce Analyst or Supervisor to monitor what a CSR is scheduled to be doing and compares in real time to what the CSR is actually doing. This confirms CSRs are where they are assigned and helps ensure Sunflower is sufficiently staffed at all times for the member and provider calls.

For evaluation purposes, Sunflower uses a quality monitoring platform that records, reviews, and evaluates member and provider calls handled by CSRs including all Centene affiliated solutions that use the same telephone platform such as our nurse advice and BH lines. Our quality monitoring platform is a scalable solution that will continue to grow and evolve with Sunflower's evolving business needs.

Routing Calls. Calls normally are not routed among call center staff because all CSRs have similar comprehensive training plus information online or at their workstations to minimize the need for routing. Whenever a transfer is necessary, all call transfers are "warm" or three-way transfers, during which the CSR stays on the line and orally introduces the member to the appropriate staff person to ensure continuity and to remain in touch with the caller. Members need to use only one phone number and place only one call.
The following are key examples of routing calls to Sunflower staff *outside* the call center:

- CSRs have immediate access for urgent (described below) and non-urgent matters to RN and behavioral health (BH) Service Coordinator when clinical expertise is needed.
- After answering a member's questions, when a CSR sees a clinical *Care Gap Alert* in CRM system, the CSR will assist with closing a Care Gap through education and/or by assisting the member in making an appointment. The CSR may also suggest to the member to transfer the call to a Service Coordinator, if they have an assigned Service Coordinator.
- Members calling about complaints or appeals follow up are warm transferred to a Grievance and Appeal Coordinator for assistance with the complaint and appeal process.

Call Quality Monitoring. Sunflower's Customer Service Optimization Tool (CS Optimization Tool) is our quality evaluation software system, to record, review, and evaluate customer

service calls. The CS Optimization Tool records all audio calls handled by CSRs during normal business hours and all after hours nurse advice line calls. In addition to call recording, the CS Optimization Tool has the capability for phonetics-based speech analytics, which detects key words and phrases as well as silence detection for both English and Spanish speaking callers. Speech analytics can be used to proactively identify CSRs who may need coaching to more closely follow best practices.

Staffing Levels. Sunflower deploys our innovative IEX Workforce Management System (IEX) to predict staffing needs and maintain metrics. For instance, rather than a static staffing ratio, IEX uses factors specific to LTSS and Dual Eligible populations (e.g., longer call times due to benefit complexity) to predict staffing. Our full time Analyst adjusts staffing in real-time for unexpected events (e.g. staff illness). This forecasting model assists Sunflower in meeting or exceeding service levels, as we have been doing so to date.

Escalation for Crisis Calls, Urgent Clinical Situations, and Non-Clinical Issues. CSRs are trained to quickly identify triggers indicating a medical or behavioral health crisis call or other urgent or emergency situation in which escalation is appropriate. CSRs listen for triggers such as key emergency words and phrases, member voice volume and tone, and other indicators of stress. When the CSR identifies triggers, they use instant messaging to immediately obtain RN or Behavioral Health Service Coordinator participation in the call, and, if necessary, dial 911 for the member while keeping the member on the line. (5.10.10 M) CSRs are prepared to serve all members in crisis, including members not enrolled with Sunflower. As an example of our readiness to assist members in crisis, 23 CSRs have completed a three-year certification program for Mental Health First Aid. Sunflower CSRs are prepared to assist members with cognitive impairment or limited communication skills, LEP, financial stress, and hard-to-pin-down fears such as lack of trust of “the system.” In most cases, non-clinical issues requiring escalation to a Supervisor would relate to new program requirements such as a change in covered services, a new program or process that has not yet been fully implemented, or a member’s request to speak with a Supervisor. CSRs will escalate non-clinical questions to a Supervisor of Member Services.

24/7 Nurse Advice Line. Our medical triage phone service provides 24-hour health care advice and assistance. In addition to providing routine health care advice to enrollees as described in the previous paragraph, our nurse advice line provides effective clinical triage services for our Behavioral Health Line, as well as academic institutions, physicians, hospitals, military facilities and managed care organizations. Nurse advice line triage nurses are experienced professionals armed with the knowledge to help patients access the appropriate care, at the appropriate place and at the appropriate time.

CUSTOMIZED MEMBER SERVICES ASSISTANCE BASED ON POPULATION NEEDS

LTSS Members

Given their functional, cognitive, communication, and/or caregiver challenges, LTSS members require an education and member service approach that:

- Includes multiple member "touch points" and methods for interaction that are responsive to various learning styles, abilities, and levels of caregiver support
- Assesses, with members, the level of assistance (e.g., the use of a representative) needed to support members' receipt and application of information
- Encourages the ongoing involvement of informal caregivers and circles of supports
- Allows for trust to develop between the member, informal caregivers, providers, and Sunflower, ultimately creating a safe environment to ask questions and have a meaningful dialogue about health barriers and solutions

'No Wrong Door' Approach. While our Community-Based CMs are the single point of contact for LTSS members, Sunflower implements a "no wrong door" approach to ensure members receive accurate and timely information, regardless of when or how they come into contact with our health plan. This means that members may also receive orientation and outstanding education by other health plan employees, including our Community Health Workers, CSRs, Program Coordinators, and our 24/7 nurse line. Sunflower members have access to our toll-free member services call center, and we use any member contact through this toll free line as an opportunity to educate the member. Sunflower's CSRs are prepared to answer questions about covered LTSS and provide warm transfers to Community-Based CMs as needed. Our CSRs are trained to respond in a respectful and courteous manner to questions, inquiries, or complaints from members, their families, and providers.

Families with Children in Foster Care. Families with Sunflower members in foster care have a direct phone line they can call to connect with Sunflower foster care program staff. Because we have dedicated foster care case managers, should we receive a call from someone who is new to foster care, we can see the foster care case manager assigned in our customer service window and reach out to our foster care team for a call.

Highly Trained Customer Service Representatives (CSRs)

Our Trainer, with assistance from Sunflower's Human Resources team, designs the course using instruction, role-playing, hands-on demonstrations, and interactive online modules provided by Centene University on topics such as Practical Ethics. Sunflower submits CSR training plan, evaluation standards and tools to the State for approval 90 days after contract award. (5.10.10. E) Every CSR learns the "why" of an answer and not merely the answer. For example, our CSRs can clearly explain the benefits of establishing a medical home and obtaining all needed preventive services. The chart below summarizes our CSR training program topics.

Figure 5.10.10_A: CSR Training Program

Fundamentals. Overview of Kansas Medicaid programs; Centene and Sunflower history; ethics and confidentiality of enrollee information, including HIPAA; review of Sunflower departments with emphasis on BH, MM; and the roles of our subcontractors.
Providers. Role of the PCP, how to schedule appointments and the importance of the medical home; our Provider network; the role of and processes for prior authorizations; appropriate use of emergency services; and effective delivery of Care Gap and Wellness Alerts to the member.
Programs. Covered Services, limitations and exclusions; Enhanced Benefits; eligibility and enrollment requirements; member rights and responsibilities; grievance and complaint procedures; reporting fraud, waste and abuse.
Job Functions. Customer service, Avaya, Instant Messaging (IM), CRM; all call documentation standards, including emergent, urgent and BH crisis call protocols; appropriate warm-transfers; State-approved interactive scripts during member calls; document a caller's satisfaction at call conclusion; and transportation scheduling.

After completion of the core training, the new CSR takes calls side-by-side with an experienced staff person or supervisor who monitors for competency, accuracy, consistency and appropriate use of all documentation and desktop tools. Call monitoring continues until the CSR consistently demonstrates accuracy and proficiency on live calls. After training, a Team Lead is always available for calls requiring escalation or special handling.

Cultural Competency. Upon hire and annually, we require all CSRs to complete training based on the Enhanced National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards). We require disability sensitivity training, including People-First Language, Americans with Disabilities Act, misconceptions about persons with physical and behavioral disabilities and those receiving Medicaid, and how to accommodate specific communications needs. Annually, Sunflower will host training provided by a Kansas advocacy group such as Community Living Opportunities to provide staff with locally-focused, disability sensitivity training and awareness of services for members with intellectual and developmental disabilities.

Care Management Training. Our CSR training includes an in-depth review of all Care Management programs and functions. Additionally, CSRs are trained on how members can access Care Management services and how providers can refer members for those services.

Ongoing. Sunflower's Customer Service team meets weekly to cover new procedures and technologies, current policy changes and/or issues, and online modules on topics like Conflict Resolution. Weekly staff meetings/trainings also cover subjects such as appropriate transfers for ICC services, performance issues, and State issued bulletins. Ad hoc training "huddles" include Medicaid and KanCare 2.0 updates, "Late Breaking News" articles, network changes, and member outreach programs, like Fluvention. Annually, Compliance, Appeals/Grievance and Cultural Competency training is conducted with the staff. We provide targeted training for all

member- and provider-facing department staff through our Corporate Learning modules and in-house training conducted by Customer Service management team.

Member Advisory Committee Feedback. As part of our effort to continually improve customer service, Sunflower's Quality Development team met with the MAC to explore ways to improve member's experience with the Call Center. The following MAC feedback has been incorporated into trainings:

- It is great when the agent repeats the caller's request back to the caller. This ensures understanding and lets the caller know the agent is actively listening.
- If the caller has an urgent issue, the agent needs to display a recognition of that urgency (mirroring)
- Agents should tell the caller what steps are being taken, or will be taken, to resolve the issue. This lets the caller know that there is a *plan of action* to resolve the issue, which is particularly important with more complex issues.

Call Tracking and Reporting

Sunflower uses State Required Call Center standards to monitor performance, such as an Average Speed of Answer (ASA) of no more than 30 seconds, and 80% of calls answered in < 30 seconds. In addition, we comply with the Division standard of an Abandonment Rate of less than four percent. (5.10.10. J, K, L) Since we do not impose call duration limits on any caller, we do not use average length of call as a performance standard. The same performance standards apply to our BH and our 24/7 nurse advice Line. With 24/7 coverage of Sunflower's toll-free number, members never receive a busy signal or drop into a voice mailbox. Our Call Center meets, or exceeds, the required Call Center standards, as demonstrated through our 2017 results included below:

Table 5.10.10_A: Sunflower Customer Service Standards Performance

Performance Standard	KanCare 2.0 Standard	Sunflower Performance
Incoming and outgoing calls must be documented and recorded	100%	100%
Calls answered without receiving busy signal	99%	100%
Calls will be answered within 30 seconds or less	80%	87%
Average Speed of Answer	30 seconds or less	21 Seconds
Average Abandonment Rate	4% or less	2%
Calls answered resolved during initial contact	90%	100%
100% calls recorded and retained	100%	100%
100% calls left on voice mail returned within 1 business day	100%	100%
95% of inquires resolved within 2 business days	95%	100%
98% of all inquiries resolved within 5 business days	98%	100%
100% of all inquiries resolved within 15 business days	100%	100%
Email inquiries will be answered within 1 business day	100%	100%
Quality monthly average fully trained staff	90% (NEW)	NA
Hold times equal to or less than 1 minute for inbound and outbound calls	95% (NEW)	NA

CUSTOMER SERVICE EXCELLENCE

To maintain our service level standards, we will continue to use our innovative IEX Workforce Management System (IEX) to support a responsive, scalable staffing model that includes sufficient staffing to meet contracted standards of our dedicated member line. (5.10.10 G) Based on years of call data analyses for Kansas and other Centene affiliate health plans with similar populations, IEX factors in call-type complexity, historical call duration, call patterns including seasonal variation, market maturity, and eligibility categories specific to Kansas to determine appropriate staffing, analyzing down to 30-minute increments when needed. This approach allows for effective staffing by notifying us of rapidly changing situations in volume/call duration, so we can dispatch Quality Specialists and Team Leads to back up CSRs.

Sunflower in Action…

"Valencia (CSR) was a joy to speak with. I could hear it in her voice that she is caring, patient and tender hearted. I was impressed with the kind of service she gave me."

- *Member Quote*

To ensure call quality and accuracy, Sunflower's full-time Quality Specialists audit CSR interactions using a software audit tool integrated with our call management platform that performs all of the functions required in RFP section 5.10.10. J. The audit tool records 100% of CSR phone calls and the CSR's simultaneous use of desktop resources. (5.10.10 H) Supervisors and CSRs monitor no less than 10 calls per agent per month for compliance with customer care guidelines and our Quality Specialists provide immediate follow up and coaching as necessary. Monthly, supervisors review audit results with each CSR. This industry *best practice* as cited by the Call Center Optimization Forum compares individual performance to goals in areas such as documentation, courtesy and call quality. The monthly CSR call audit average score has not fallen below 95% in the last two years and is routinely above 97%. Sunflower will use our software audit tool and CSR performance report cards, maintain all call recordings, and create and submit monthly audit reports for the State in accordance with the requirements in the RFP. CSRs offer a post call survey to measure caller's satisfaction at the end of each call. The Director or designee will review any reports that a caller was not satisfied and call the member back within 48 hours, for follow-up and resolution.

Table 5.10.10_B: Sunflower Post Call Member Satisfaction Survey Results

2017 Post Call Member Satisfaction Survey Results				
AVRS QUESTIONS	Were you treated with courtesy and respect during your call today?	Was the Sunflower team member able to address or resolve your need today?	Are you satisfied with Sunflower Health Plan?	Would you recommend Sunflower to a friend or family member?
SATISFACTION RATE	98.5%	96.7%	97.3%	97.3%

Culturally Competent Service Center

Sunflower trains CSRs to provide seamless service to every member regardless of language spoken or disability. With our AVRS system, members with physical, cognitive or communication differences can simply "stay on the line" without pressing any menu prompts and our *best practice* feature automatically connects them to a CSR. Members may also immediately reach a trained CSR by saying "agent." CRM alerts the CSR to a member's special needs and language requirements.

For Limited English Proficiency (LEP) Callers. Our AVRS system greets callers in English and Spanish, and offers all self-service options, like verifying eligibility, in both English and Spanish. For LEP callers, Sunflower (as well as our BH, transportation, and 24/7 nurse advice line) offers, free-of charge, real-time interpretation through our interpretation partner, Voiance, that has expertise in medical interpreting, and meets CMS, HIPAA, and ACA regulatory requirements. Sunflower members can also speak with a Spanish speaking agent based at our local Call Center. Sunflower CSRs are trained on the use of and proper etiquette for interpretation services, including speaking to the caller and not the interpreter. Upon request, CSRs also will arrange for face-to-face interpretation services for a member's medical appointments. (5.10.10. F)

For Callers who are Deaf or Hard of Hearing. Our TTY/TDD phone number is prominent on our website, Member ID Card, Member Handbook and other member materials. Sunflower CSRs are trained on the use of and proper etiquette for TTY/TDD service. The phone is tested regularly. We also train CSRs to accept calls through Kansas Relay and Video Relay services.

For Callers with Visual Impairments. CSRs are always available to read and explain member materials over the phone to any member. Community Health Workers are always available for in person assistance as well. Sunflower offers printed materials in alternative formats upon request, including Braille, large print, audio tape, and compact disc. Wellness, disease prevention, and important administrative information are available for podcast download or audio playback on our Section 508-Compliant website. Sunflower Marketing hosted an intern through Project SEARCH. After learning that he uses the JAWS audio-reader program due to severe visual impairment, we asked him to test all our web files before they were used in a live environment. This gave us the assurance we needed to move forward with publishing our website and made sure anyone with an audio-reader would be able to access all the content as needed.

Expanding the Boundaries of Traditional Customer Service

Written and Web-based Information. On our 508-compliant website, Sunflower will provide easy to read materials, helpful tools, and web-based support to empower members to be partners in improving their own health, ultimately increasing access to cost-effective, integrated care. This includes ongoing education via our online free **Health Library** described above. Available to members and non-members, the Library includes books and health sheets on a wide range of topics. Available health sheets, for example, cover 4000 topics, ranging from specific disease states like asthma to potential reasons for vomiting. For example, the provided

health sheets explain conditions, procedures, and specialty areas along with over 2,000 drug information sheets with information on prescription, over-the-counter, and nutritional products. Members will receive a quarterly newsletter, via email and US mail, that highlights healthy living and wellness strategies. Every issue will remind members to call Sunflower with any questions, or to request written materials and/or assistance making and keeping appointments. We will also conduct special mailings to members, such as our comprehensive diabetes support material that includes reminders and information about the four types of diabetic screenings, along with a notice of any screenings due. Our Secure Member Portal will include enhanced educational materials and opportunities, and secure messaging with sufficient capacity to handle the incoming volume. (5.10.10 O) Our portal allows for electronic media educational opportunities such as podcasts and personalized email reminders regarding preventive care appointment reminders and other communications. Our Sunflower website will also offer a common, role-based entry point for all Sunflower web application users to our secure Centelligence Health Record. Our role based approach allows for a seamless integration of content, and navigation attuned to, and authorized for, specific user types (providers, members, Caregivers) The Centelligence Health Record empowers members in accountability for their health and wellness and supports authorized caregivers as they assist our members with their healthcare needs.

Appointment Wizard ™. Sunflower will offer members real-time appointment scheduling through **Appointment Wizard™**, which allows Customer Service Representatives (CSRs) (or Service Coordinators and Community Health Worker staff) to schedule appointments with participating providers and issue text or email reminders for members. Staff will have access to an online appointment-scheduling portal, and can set-up appointments while on the phone or while meeting with members, without the need for multiple calls to-and-from provider offices. In addition, Sunflower staff can securely attach documentation to the member appointment for specific care gaps (e.g., EPSDT needs) to ensure a thorough member office visit. By leveraging cloud-based appointment scheduling technology, Sunflower strives to lower administrative burdens for providers while ensuring better outcomes for our members through more closely monitoring care gap closure and improving quality measures. As a value-added benefit, CSRs can also support members in accessing transportation for non-medical reasons, such as job interviews and other social services and supports.

Click-to-Chat. As an additional communication channel for members to quickly connect with and resolve any questions or comments, Sunflower will offer Click-to-Chat, accessible to members through the secure Member Portal. Click-to-Chat will allow members to start a live chat conversation with our CSRs who can offer comprehensive support and immediate, personalized assistance for members in real-time.

Life Ally Program Helps Address SDOHI. Sunflower understands that health is more than just physical, and that SDOHI are just as critical to understand and treat as physical determinants. As part of our approach to addressing SDOHI, Sunflower will support members in overcoming their life barriers and promoting healthy communities through our our Life Ally program. The

cornerstone of Life Ally is our **Community Resource Database**, a comprehensive online social utility for access to local social services and community resources, such as, food, housing, transportation, employment, and education services that best fit members needs and can impact their health and wellbeing. Accessible to all members of the Integrated Care Team, such as Service Coordinators, Community Service Coordinators, Community Health Workers, members, and providers, our Community Resource Database allows users to complete a life barriers assessment and quickly locate recommended resources near them. The Community Resource Database will include features such as:

Translating Research Into Practice… Through a research study with Centene members, The Envolve Center for Health Behavior Change, a unique partnership between Centene, Washington University in St. Louis, and Duke University, found that members with diabetes are 55% more likely to be admitted when they have life barriers based on the SDOHI.

- Search capability by both keyword and filters
- Graphical resource mapping display and directions from as a little as a mile up to 50+miles
- Favorites and save functionality

Closing the Loop. Sunflower will provide members, as well as the Service Coordinators/Community Service Coordinators that serve them, closed loop referral tracking and coordination with contracted community organizations. Through this program, Sunflower will have the capability to track, trend, and report on membership needs (e.g., assistance with utilities) and utilization by geographic area and resolution of life barriers.

Through our population health based SDOHI approach, we leverage technology to effectively and efficiently engage and support members. Our Life Ally program, coupled with our Integrated Service Coordination Model, community-based approach, and innovative member programs such as our Double Up Food Bucks (DUFB) program, Life Course training, PRAPARE, and Sunflower Transitions to Employment Program (STEP) provide needed services and supports to positively impact SDOHI.

HealthVault Personal Health Record. Sunflower supports those members who want to maintain their own electronic personal health record (PHR) through Microsoft HealthVault, one of the most prevalent PHR platforms in the market today. We view PHRs as an increasingly popular way to reinforce and empower member engagement, and allow members to keep a portable online health record beyond the time of their active membership in our health plan. Available via our secure Member Portal, the PHR stays with the member regardless of health plan or insurance. All claims and pharmacy data are delivered to the PHR, and members' parents and caregivers can also be granted access.

5.10.11 MEMBER CRISIS ASSISTANCE

PROPER, RESPONSIVE HANDLING OF MEMBER CALLS WITH IMMEDIATE MEDICAL NEEDS

Sunflower acknowledges, understands, and will comply with all SOW requirements regarding the provision of member crisis assistance. Sunflower is committed to network adequacy and

crisis responsiveness consistent with contractual obligations and to meet member needs, including operating a toll-free 24/7/365 crisis response number (5.10.11. A). Some crisis responsiveness considerations include: referrals to psychiatric and other community services, emergency consultation by law enforcement, assessment of a person, follow up, discharge planning and transitioning care.

Sunflower has built comprehensive networks to serve our members. Our goal is to prevent crisis through appropriate services and care management; however, we are fully prepared to respond to emergencies and crisis. Sunflower has contracts in place with all 26 Community Mental Health Centers (CMHC) which are designated as crisis assessment and intervention providers for members. CMHC staff members are on call 24 hours a day, seven days a week, 365 days a year to respond to crisis situations, and typically the member will turn first to the CMHC. Members in crisis can receive crisis risk assessment and telephone crisis intervention services, described in detail below, by calling our toll-free number, which is published in the Member Handbook, Member ID card and associated materials. (5.10.11 B)

If a Member, a representative, law enforcement, or others contact Sunflower's call center or the nurse advice line regarding a Member's situation, Sunflower has processes in place to ensure timely response to a potential crises situation. If a call comes into our call center, the CSR will electronically notify a Sunflower or behavioral health clinician to come directly to the CSR's phone and assist the caller. In this way we ensure that no crisis call is ever dropped. The clinician uses verbal de-escalation techniques and assesses the Member's situation using our standardized crisis assessment protocol located in TruCare. Our 24/7 BH clinicians are trained to conduct a preliminary screening and connect members with local Regional Alcohol and Drug Assessment Center (RADAC), Social Detoxification unit, or Certified Gambling Counselor or Mental Health Center, as appropriate. The nurse advice Line contacts a member of our management team (in med management) immediately for calls related to urgent service authorizations or non-medical issues (no food, no electricity, my caregiver didn't show up, etc.) If in HCBS, Sunflower utilizes the member's emergency back-up plan, as appropriate, to determine course of action.

When a member's crisis cannot be deescalated verbally by our clinicians and addressed through either an urgent or routine appointment, our staff work directly with First Responders or the CMHCs to arrange in person crisis assessment through the CMHC on call staff to provide crises assessment and/or de-escalation. Sunflower's BH clinician determines whether onsite intervention is possible, or whether emergency transportation and/or immediate referral to a hospital may be needed. A licensed BH technician or clinician is then dispatched to go to the Member, either in the community for intervention or to the admitting hospital. In an emergency call, Sunflower CSRs are trained to maintain contact with the caller at all times, and never place them on hold.

Member Crisis Text Line

It is estimated that 98% of all text messages are opened and therefore are 4 times more likely to be read by an individual than an email. With this staggering percentage in mind, Sunflower is

seizing the opportunity to reach as many members in need particularly in times of crisis. In effort to reach members in the most rural areas, Sunflower members can also access crisis support 24/7 through our collaboration with **Crisis Text Line**. Sunflower's collaboration with Crisis Text Line is member-focused with our most vulnerable populations in mind including members who are pregnant, depressed, or substance use issues. Sunflower members are able to connect with a Crisis Text trained specialist via text for support. Sunflower understands that many of our members prefer communication through text as it provides anonymity and when in crisis, accessing this support may also allow the member to engage with the crisis specialist openly and freely. According to the American Foundation for Suicide Prevention, an average of 1 person dies every 18 hours in the state of Kansas by suicide and is the 2nd leading cause of death for ages 10-34. Sunflower believes that members should have access to every crisis resource possible in response to these high suicide rates.

23 Sunflower CSRs have completed an eight-hour training on Mental Health First Aid and obtained a three-year certification.

How Crisis Text Line Works. The member experiences thoughts of self-harm and wants to talk about his/her feelings. The member texts to a Sunflower dedicated number. Crisis services are available 24/7. A **live trained** Crisis Specialist texts back quickly (approximately five minutes). The Crisis Specialists engages in text conversation with the member to keep the member safe and provides support as applicable. Member's crisis state is stabilized by Crisis Specialist. Sunflower members will be provided this resource via our member website and printed resource mailings to members. Sunflower staff will also continuously promote this new resource to Sunflower members for crisis intervention.

Qualified and Trained Staff

Sunflower's Lead Trainer has a doctorate degree in Suicide Prevention and brings his considerable expertise to crisis response training for all CSRs and Service Coordination staff. For instance, 23 CSRs have completed an eight-hour training on Mental Health First Aid and obtained a three-year certification.

All CSRs are trained to quickly identify triggers indicating a medical or behavioral health crisis call or other urgent or emergency situations in which escalation is appropriate. All Sunflower licensed clinical staff, including all Case Management team members, are required annually to complete a Crisis Call training which serves as a review of how to clinically assess a person who is experiencing a BH emergency.

Culturally Competent Crisis Line

Sunflower offers in-person interpreters, language line services, sign language interpreters, and Telecommunications Relay Services free of charge, and our CSRs are trained on how to access these services and alternative material formats for members.

Call Tracking, Reporting, and Follow Up

After the call, the CSR documents the call in CRM and alerts staff for appropriate follow-up. We monitor calls for response time, handoff and dropped calls to track results and identify opportunities for improvement if needed.

Crisis Response Network (5.10.11.C)

Sunflower has extensive experience providing crisis stabilization services in Kansas. Through our network relationships with all 26 Community Mental Health Centers (CMHCs). Community Mental Health Centers are charged by statute with providing the community-based public mental health services safety net. In addition to providing the full range of outpatient clinical services, Kansas's 26 CMHCs provide comprehensive mental health rehabilitation services, such as psychosocial rehabilitation, community psychiatric support and treatment, peer support, case management and attendant care. Rehabilitation services have been proven to be key factors in supporting adults with severe and persistent mental illness (SPMI) and children/youth with Severe Emotional Disturbance (SED) in their recovery. Kansas law designates CMHCs as the gatekeepers for admission to state mental health hospitals. Under contract with Sunflower, CMHCs also carry out similar functions for nursing facilities for mental health, psychiatric residential treatment facilities and Medicaid-funded community hospital psychiatric services. Several CMHCs across Kansas have enhanced models of crisis services that serve members for an extended period of time. COMCARE of Sedgwick County, RSI at The Wyandot Center and Valeo Behavioral Health have all develop crisis centers to support the community. Sunflower has supported the use of these crisis centers and works closely with service coordinators when members are accessing these services frequently.

INNOVATION FOR I/DD CRISIS SUPPORT

Sunflower has worked with State providers and LifeShare to develop a Rapid Crisis Response System (RCRS) as additional support to the Kansas I/DD and TBI providers and members. RCRS program has proven very effective in diverting both children and adults from higher intensity placements by using a whole-person approach to proactive crisis management. Available 24 hours a day, seven days a week, RCRS support services are staffed by a multidisciplinary team of care managers. Services include telephonic crisis support and early intervention services to mitigate escalation to a critical crisis point with subsequent case conferencing to collaborate on next steps and available options. The RCRS team establishes a person-centered case conference with the member, member's caregivers and other social supports to evaluate the trigger for behavior and strategize for solutions. Through this collaborative approach, the RCRS team has been able to divert emergency room utilization and admission to residential treatment facilities. Sunflower does not require prior authorization for emergency services or treatment for a BH crisis. Additionally, the team reviews medication regimes and has been successful in reducing total prescriptions, medication redundancy and adverse medication side effects.
The RCRS involves a multi-disciplinary whole person clinical approach to interventions and behavioral supports:

- A continuous integrated triage process for clinical and medical "hot spots"

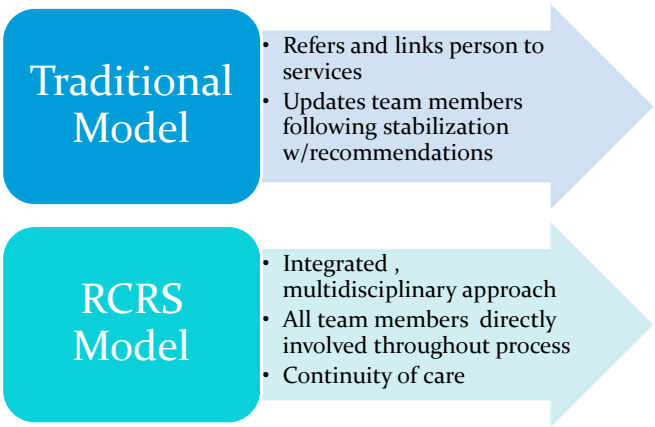
- A system of care management that provides the best interventions and circumstances for the individual and facilitates provider/team adherence
- A Relationship-Centered whole person model for care management (planning, implementation, coordination, monitoring). This is not a treatment model but includes necessary interventions that results in:
    - Consistent and integrated response to crisis intervention
    - Expedited stabilization and continuous care in the community
    - Decrease in emergency room visits and inpatient hospitalizations

If a Member with I/DD diagnosis is experiencing a crisis, the provider calls the member's Service Coordinator, or a LifeShare team member (when already referred), to provide specific information. The service coordinator makes an immediate referral to the Rapid Crisis Response clinician who offers a multi-disciplinary team meeting within 24 hours of initial referral. The clinician facilitates this telephonic consult to discuss the member's situation, medical and social history, Person Centered Support Plan and recent assessments. Following completion of the consultation form and initial consultation, the clinician conducts a Comprehensive Medical and Psychiatric Assessment (CMPA), and offers recommendations to the member's team. The CMPA includes:

- In-depth review of diagnoses, medications, medical and psychiatric history, current living arrangement/environment and presenting issues.
- Possible stressors, antecedents to behavior, decompensated psychological state
- Differential diagnosis/baseline
- Identify Global Assessment of Functioning Score (GAF)
- Preliminary findings
- Recommendations and suggested timeframes
- Additional assessments may be available including the Brief Psychiatric Rating Scale (BPRS), Quick Neurological Screening Test (QNST), Autism Diagnostic Interview (ADI) or Functional Behavior Assessment (FBA)

The Rapid Crisis Response clinician may make a referral to other LifeShare team members to provide a Quality of Life assessment or functional behavioral assessment with the member and his/her team. The Rapid Crisis Response clinician provides follow along telephonic reviews on the member's status until it is determined the member is stable and has an effective plan for prevention of future crises. Member consultation was completed for over 200 members in 2016/2017.

Figure 5.10.11_A: Traditional Versus RCRS Models



5.10.12 MEMBER RIGHTS AND PROTECTIONS

MEMBER RIGHTS AND PROTECTIONS

Sunflower acknowledges and will comply with all applicable Federal and State laws that pertain to Member rights. Our written policies and procedures on notification and education of member rights are training topics for all member-facing staff including CSRs, Service Coordination, and Community Health Worker staff. (5.10.12. A). Currently, training on member rights and responsibilities occurs for new employees during onboarding. This will also be a requirement for Community Service Coordinators who wish to work with Sunflower members.

Informing Members of Their Rights

Sunflower includes information about member rights and responsibilities in the Member Handbook, Newsletter and secure Member Portal. Sunflower Service Coordinators educate and review rights and responsibilities with members receiving Service Coordination support at least annually, at a minimum. This begins during the initial HRA assessment, and during each HRA re-assessment. Rights and responsibility education and reviews are also completed and acknowledged by the member and the Service Coordinator within the PCSP (Person Centered Service Plan) document. This will be a Sunflower requirement for all new Community Service Coordinators as well, as they begin to take responsibility for development of PCSP's for Sunflower members.

CSRs educate members on Rights and Responsibilities during the new member welcome call and any other time members may call with questions or concerns about their health care experience. Our Member Handbook, Member Portal and other materials also include information related to member Rights and Responsibilities in a manner and format that is easily understood and is readily accessible, including compliant with modern accessibility standards, and State requirements. As with all of our member materials, the information is available in alternative formats as needed/requested. Our CSRs, and Member Advocates, are trained to assist members with filing appeals and to assist with gathering any needed paperwork related

to appeals. The following information, compliant with all of requirements in RFP Section 5.10.12, is in our Member Services Policies and Procedures and in our Member Handbook:

Member Rights. A description of how we will ensure that the rights of members are safeguarded and how the health plan will (1) comply with any applicable federal and state laws that pertain to member rights (5.10.12. B), and (2) ensure that our staff and in-network providers take those rights into account when furnishing services to members. The members' rights include the right to:

- ***Dignity and privacy.*** Each member is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.
- ***Receive information on available treatment options.*** Each member is guaranteed the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
- ***Participate in decisions.*** Each member is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment.
- ***Be free from restraint or seclusion.*** Each member is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- ***Obtain a copy of medical records.*** Each member is guaranteed the right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR, part 164.
- ***Freely exercise these rights.*** Each member is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the health plan and its providers or the state agency treat the member.
- ***Member will not be held liable for Sunflower debts.*** The member shall not be held liable for Sunflowers debts in the event of insolvency; not be held liable for the covered services provided to the member for which the State does not pay Sunflower, and all other liability restrictions as detailed in RFP Section 5.10.12 C.

Member Responsibilities

We will also continue to include in our member services policies and procedures, policies that address the members' responsibilities for working with their providers. These member responsibility policies will be supplied in writing to all providers and members and should address the member's responsibilities for:

- Providing, to the extent possible, information needed by providers in caring for the member;
- Contacting their primary care provider as their first point of contact when needing medical care;
- Following appointment scheduling processes; and
- Following instructions and guidelines given by providers

Educating Providers on Member Rights. Sunflower educates providers on member rights and responsibilities in the Provider Manual, Provider Newsletter and in our Provider Orientations. We emphasize the importance of Member Rights with providers to ensure members can:

- Advocate for their health care
- Feel comfortable asking questions of providers to determine the potential risks, benefits and costs of treatment alternatives
- Make care decisions after carefully weighing all pertinent factors

Member Advisory Committee. The Member Advisory Committee (MAC) is a group of members, parents, guardians, and SHP staff as appropriate, that reviews and reports on a variety of QAPI issues. Our Member Advisory Committee Plan, which includes procedures for implementing the MAC and an annual meeting calendar, is submitted to the State annually for approval. (5.10.12 D. 1, 2, 3)

The purpose of the MAC is to solicit member input into the approach and effectiveness of Sunflower's programs, policies, and services, and to promote a collaborative effort to enhance the service delivery system in local communities. Two weeks prior to each quarterly meeting, Sunflower sends a meeting agenda and other materials to both the committee members and the State. (5.10.12.3) The MAC meets in-person in addition to a conference line and web connection to promote two-way communication where members can provide input and ask questions and Sunflower can ask questions and obtain feedback from members. Video conferencing is used as needed to provide opportunities for members to attend regional meetings. MAC responsibilities may include review and discussion of topics such as member satisfaction results, customer service and/or quality improvement efforts, member education materials for relevance, understanding and ease of use, and/or other topics as defined by the Performance Improvement Team (PIT) or Quality Improvement Committee (QIC). Each quarter, Sunflower submits and presents a written report to KDHE with information about meetings held, how Sunflower addressed issues raised by the MAC and who attended the meetings. (5.10.12 4). Sunflower acknowledges and complies with the prohibition from restricting a Provider from advising or advocating on behalf of a Member. (5.10.12 E)

Member Advisory Committee Member Quote…

As a Sunflower member, the most rewarding thing to serving on the MAC is seeing your recommendations make functionality better and access to care easier. Sunflower has set up an opportunity to connect directly to the contacts for even their third-party providers. One example of this is working directly with their provider for non-emergency ride service in improving access for home health companies and caregivers to be better advocates for the patient. The only opinion that doesn't get heard on Committee, and cannot help bring better care for the families of Sunflower, is the one that isn't voiced.

Objectives of the MAC and Relationship to Strategic Objectives. The MAC solicits member and community input into the QAPI Program. Based on Sunflower size and distribution, the MAC may include regional committee meetings that will report up to the central MAC. Sunflower selects members randomly in accordance with the Managed Care Reform and Patient Rights Act. Sunflower specifically outreaches to members in Foster Care and those with Special Health Care Needs (SHCN) for participation while trying to structure the committee with representation of all KanCare eligibility groups. We inform our members about this committee through such materials as the Member Handbook, Member Newsletters, contact with Sunflower staff, and through contacts at community events. Information about these committees will also be available on the Sunflower website. Overall objectives of the MAC meetings include:

- Providing Sunflower with feedback regarding its performance from a member perspective
- Making recommendations related to program enhancements based on the needs of the member and local communities
- Assisting Sunflower to identify key issues related to programs that may specifically affect specific member or community groups
- Providing community input on potential health plan service improvements
- Offering effective approaches for reaching or communicating with members or other issues related to Sunflower member population

5.11 Grievances and Appeals

5.11. GRIEVANCES AND APPEALS

SUNFLOWER DEMONSTRATED SUCCESS

Sunflower Health Plan (Sunflower) has served Medicaid members in Kansas as a participant in the KanCare program since 2013. Sunflower has established, implemented, and maintains a fully developed, member-centric grievance and appeal processes, policies and procedures. Sunflower strives to ensure that members and providers are not treated differently for initiating a request for a grievance, appeal or State Fair Hearing. Our success is demonstrated by our:

- Commitment to improving operational performance through ongoing grievance, appeal, and State Fair Hearing data analysis. For example, between 2014 and 2017, Sunflower had a 32% reduction in transportation grievances.
- Established systems, policies and procedures, and processes to support timely resolution of member and provider grievances and appeals
- Written reporting to KDHE on schedule and as requested

Compliance with Scope of Work

Sunflower is in full compliance with all Grievances, Reconsiderations, Appeals and State Fair Hearings regulations as outlined in Attachment D (Sections 1.0 through 5.5), as well as all applicable Federal and State laws and regulations and will continue to demonstrate compliance with these regulations and requirements. Sunflower also abides by the definitions and principles laid out by KDHE in Attachment D. Our written policies and procedure comply with the requirements of Attachment D and detail the member grievance, appeals and State Fair Hearing processes and the provider grievance, reconsideration, appeal and State Fair Hearing processes. Sunflower will continue to comply in a timely manner with any changes to Attachment D, Attachment G with reference to Liquidated Damages, State, or Federal requirements. Sunflower also abides by the definitions and principles laid out by KDHE in Attachment D. For ease of review we have included the Scope of Work (SOW) and Attachment D references in headers and within the narrative.

INTRODUCTION

Sunflower's grievance and appeals processes and systems support continuous improvement that demonstrate our commitment to quality operations. Sunflower's leadership supports a process that includes additional training, ongoing updates for staff reference, and a collaborative effort with our locally-based analytics department to quickly and accurately identify outlier situations. Sunflower has established lead roles within our grievance and appeals procedure to provide staff more immediate mentoring and assistance, which has improved our operational output significantly. For our members grievance and appeal turnaround time in 2017, please see the following ***Table 5.11_Timely Resolution of Member Grievances and Appeals***.

Table 5.11_ Timely Resolution of Member Grievances and Appeals

MEMBER GRIEVANCES, APPEALS AND STATE FAIR HEARINGS (ATT. D 4.0)

Sunflower has developed a Member Grievance System that captures the documentation related to member grievances, appeals and state fair hearings. This system allows for notices to be sent out for acknowledgement and resolution of the grievances, appeals and also the deliverables for state fair hearings. Sunflower offers all of our members a grievance process, an appeal process and a State Fair Hearing process to achieve member satisfaction. Records of every grievance and appeal filed by our members or by their authorized representatives are kept, along with records of the responses, for ten years. Sunflower does not take punitive actions against members or their representatives for requesting grievances, appeals, or state fair hearings.

The methods Sunflower uses to inform all members and providers of their grievance and appeals process, include, but are not limited to:

- Member Handbook
- Sunflower Member website
- Notice of Adverse Benefit Determination to Members
- Notice of Appeal Resolution to Members
- Notice of Action to Providers
- Notice of Provider Reconsideration Resolution
- Notice of Provider Appeal Resolution
- Provider Manual
- Sunflower Provider Website
- Provider Bulletins
- Provider Orientation and Ongoing Quarterly Trainings
- Verbally Through our Utilization Management, Service Coordination, or Customer Service Teams

Member materials are available in English and Spanish, and can be made available in writing or oral interpretive services in any other prevalent non-English language identified by the State.

MEMBER GRIEVANCE SYSTEM (ATT. D 4.1)

Sunflower wants to fully resolve all member problems or concerns as quickly and effectively as possible. Members may file a grievance themselves, allow someone else to file on their behalf, or seek assistance from Sunflower in filling out any forms needed for the process. Filing a grievance will not affect a member's health care services. Sunflower provides Member Advocates who provide assistance including, but not limited to auxiliary aids and interpreter services. Sunflower has dedicated Grievances Coordinators who also serve as Member Advocates to assist members based on their individual needs. The Grievance Coordinators are valuable assets in assisting members and communicating with members, providers and other health plan departments to gain an accurate understanding of the matter being grieved while also working to resolve the grievance. The KanCare Ombudsman is also a resource to members for assistance, should a member feel they have not received culturally appropriate care.

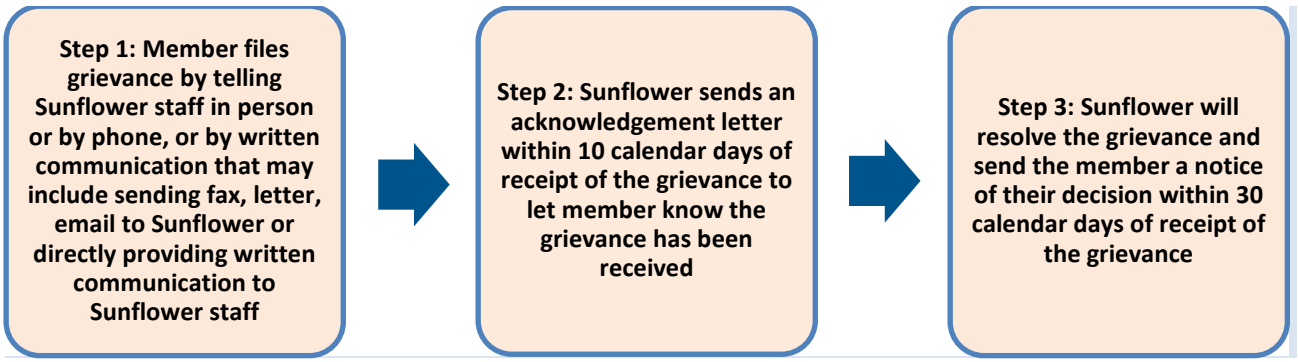
Any member may submit a grievance at any time; the grievance process is the same for all members. A Grievance is defined as any expression of dissatisfaction about any matter other than an Adverse Benefit Determination, as "Adverse Benefit Determination" is defined in this Attachment, or an Action, as "Action" is defined in this Attachment. Possible subjects for Grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievances include a member's right to dispute an extension of time proposed by Sunflower to make a Service Authorization decision, resolution of expedited appeal, or Sunflower request for additional time.

A member filed a grievance about her PCP discussing her hospitalization with her home health provider without including the member in the process. In 5 days, the provider received etiquette training on how to communicate with the member and other providers.

MEMBER GRIEVANCE PROCESS (ATT. D 4.2)

Sunflower provides written grievance receipt acknowledgement on grievances within 10 calendar days of receipt, unless they are resolved on the day of receipt and in those instances the Notice of Member Grievance resolution serves as both the acknowledgment and resolution communication. Sunflower works to resolve 98% of grievances within 30 calendar days from the date the grievance is received and 100% within 60 calendar days. Sunflower will continue to comply with contract requirements with regard to sending the Notice of Member Grievance Resolution and will modify processes to ensure that these are sent within the 3 calendar days following the grievance resolution date as specified.

Figure 5.11.A_Member Grievance Process Timeline



Grievances resolved at time of call are communicated immediately upon receipt to the Quality Improvement (QI) department to initiate processing to allow for proper documentation which includes the acknowledgement and resolution notices per the State and Federal requirements. This also ensures the ability for tracking, trending and state reporting. Sunflower maintains a record keeping system for oral and written grievances and appeals and records of disposition.

Sunflower ensures that none of the decision makers involved in resolving grievances were involved in any of the previous levels of review or decision making. All decision makers are individuals with clinical expertise in treating the member's condition or disease when either the grievance is regarding the denial of an expedited resolution of an appeal or the grievance involves clinical issues. Grievance coordinators complete an initial resolution, though a request for a second review would be completed by the Medical Director or Quality leadership.

Sunflower records a written record for all member grievances. Each record includes the following details:

- Date the Member or Member's Authorized Representative filed the Grievance
- Identification of the individual filing the Grievance;
- Date received by Sunflower
- Date acknowledgement letter was sent
- Identification of the individual recording the Grievance
- Nature of the Grievance
- How Sunflower resolved the Grievance
- Corrective action required
- Date resolved
- Date Notice of Member Grievance Resolution was sent to the member

NOTICE OF ADVERSE BENEFIT DETERMINATION FOR MEMBERS (ATT. D 4.3)

Sunflower complies with providing official notices to the member on decisions made by the plan as noted below:

- The denial or limited authorization of a requested service, including the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service;
- The failure to provide services in a timely manner, as defined by the State;
- The failure of Sunflower to act within the timeframes provided in 42 CFR § 438.408(b)(1) and (2) regarding the standard resolution of Grievances and Appeals;
- For a resident of a rural area with only one CONTRACTOR, the denial of a member's request to exercise his/her right, under 42 CFR § 438.52(b)(2)(ii), to obtain services outside the network; or
- The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

Notices of Adverse Benefit Determination also include details of what additional steps are available to the member if they are not satisfied with the decision made by the health plan which notes opportunities for grievances, appeal rights and state fair hearing rights. Forms are provided to assist in facilitation of those steps per the member's wishes, or the member's authorized representative.

The content of a Notice of Adverse Benefit Determination for members includes, but is not limited to:

- Dates, types and amount of service requested, if applicable
- Date of the Notice of Adverse Benefit Determination
- Date the Notice of Adverse Benefit Determination was sent
- Adverse Benefit Determination Sunflower has made or intends to make
- Reasons for the Adverse Benefit Determination, including the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the member's Adverse Benefit Determination.
- Date the Adverse Benefit Determination was made or will be made
- Member's rights to request an appeal and rights to request a State Fair Hearing
- Statute, regulation, policy or procedure supporting the Adverse Benefit Determination, if applicable
- Circumstances under which an appeal can be expedited and how to request it
- Circumstances under which a member may continue to receive benefits pending resoltuion of the apeal or State Fair Hearing, the procedures by which the member may request that benetifs be continued and the circumestances under which the member may be required to pay the costs of these services

- The member's right to represent him/herself or be represeted by an Authorized Representative when requesting an Appeal or State Fair Hearing
- A toll-free number that the member can call to request the assistance of a member representative, submit an appeal or request a State Fair Hearing.

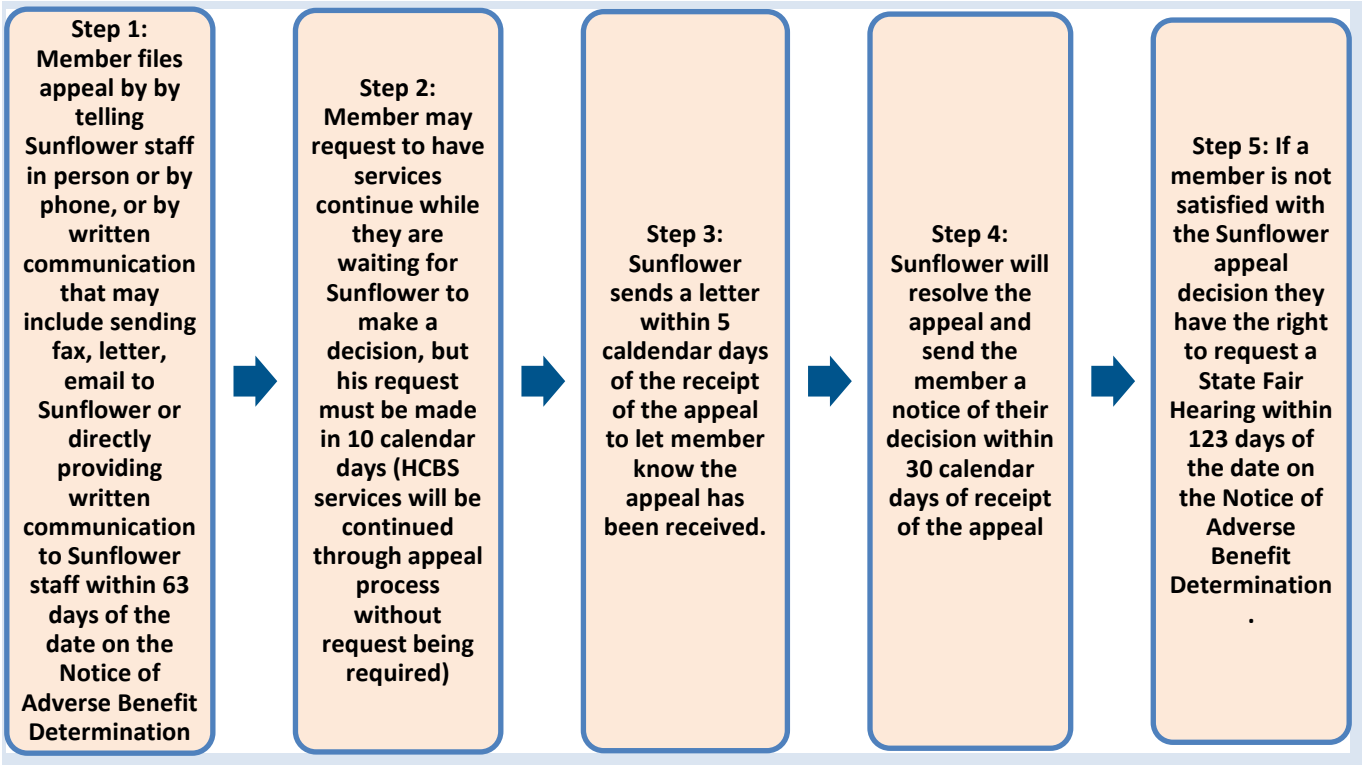
MEMBER STANDARD APPEALS SYSTEM, PROCESS AND RESOLUTION (ATT. D 4.4)

Sunflower has dedicated staff to work both standard and expedited member appeal requests. An appeal is a request to review an action taken by Sunflower. A member can initiate an appeal request with Sunflower by requesting in person, by phone or in writing to Sunflower and must be filed within 60 calendar days of the date of the Notice of Adverse Benefit Determination plus 3 additional calendar days if the notice is mailed. Sunflower acknowledges standard appeal requests in writing within 5 calendar days of the earliest request for appeal. In the event that the appeal request is received verbally or by phone, the date of that request is utilized to determine the start of that 5 calendar days to acknowledge. Sunflower resolves standard appeals within 30 calendar days with written Notice of the Member Appeal Resolution to provide notice of the resolution of the member appeal related to an Adverse Benefit Determination. In the event additional time is needed to resolve member appeals, Sunflower will comply with the process to request an additional 14 calendar days at least 2 calendar days prior to end of the 30-calendar day resolution timeframe for standard appeals.

Sunflower provides the member with information on the next steps available to the member, process to initiate an appeal, designation of a representative for the member in the appeal or grievance step. We provide all potentially necessary forms. For the State Fair Hearing process, all the same information is included in the action letter the member receives. The letter will explain the member's appeal rights, which can also be found in the Member Handbook, and on the Sunflower website. Appeal requests received verbally are addressed and written requests are not required for resolution.

Sunflower ensures that none of the decision makers were involved in any previous levels of review and that all decision makers are individuals with clinical expertise. A Clinical Appeal Nurse completes the initial review and can approve, but cannot deny appealed action. If denial is recommended, the Medical Director reviews the appeal and makes the final determination. Sunflower makes a commitment to its members, that we will resolve standard appeals within 30 calendar days. Sunflower agrees to comply with resolution of standard member appeals at 100% within 30 calendar days of receipt.

Figure 5.11.B_Member Standard Appeal Process Timeline



MEMBER EXPEDITED APPEAL SYSTEM, PROCESS, AND RESOLUTION (ATT. D 4.5)

For appeals in which taking the time for a standard resolution could seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum function, the member or member representative may file an expedited appeal request, which will be resolved within 72 hours. A request for an expedited appeal can be submitted verbally, they do not have to be submitted in writing. Sunflower utilizes appropriate clinicians, i.e. Medical Director, Pharmacist, etc., to make the determination of whether expedited criteria have been met. Expedited appeal requests are worked as expeditiously as the member's condition warrants. Sunflower makes reasonable attempts to communicate the expedited appeal resolution to the member requestor verbally and follows up with written Notice of Expedited Appeal Resolution within 72 hours of expedited appeal request. Sunflower resolves 100% of expedited appeals within 72 hours of receipt.

In the event the determination is made by the clinician that an expedited appeal requests does not meet the criteria to be resolved in that 72 hours timeframe for resolution, Sunflower makes reasonable attempts to notify the requestor verbally and sends written notification within 2 calendar days of that decision and informs of the right to file a grievance about this decision if the member or their representative disagrees with that decision. Those expedited appeal requests that do not meet criteria as expedited, are transferred to the standard appeal process for resolution within the 30 calendars days from the initial receipt by Sunflower and will follow that process. Members may file a grievance with Sunflower if they are not satisfied with an expedited appeal request being transferred to the standard appeal process for completion.

Sunflower records a written record for all member standard appeals. Each record includes the following details:

- Date of the Notice of Adverse Benefit Determination
- Date notice was sent
- Effective date of the Adverse Benefit Determination
- Date the Member or Member's Authorized Representative requested the Appeal
- Date received by Sunflower
- Date acknowledgement letter was sent
- Identification of the individual filing the Appeal
- Identification of the individual recording the Appeal
- Nature of the Appeal
- How Sunflower resolved the Appeal
- Corrective action required
- Date resolved
- Date of the Notice of Appeal Resolution
- Date the Notice of Appeal Resolution was sent

Sunflower records a written record for all member expedited appeals. Each record includes the following details:

- Date of the Notice of Adverse Benefit Determination
- Date notice was sent
- Effective date of the Adverse Benefit Determination
- Date the Member or Member's Authorized Representative requested the Expedited Appeal
- Date received by Sunflower
- Identification of the individual filing the Expedited Appeal
- Identification of the individual recording the Expedited Appeal
- Nature of the Expedited Appeal
- How Sunflower resolved the Expedited Appeal
- Corrective action required
- Date resolved
- Date the Notice of Appeal Resolution was sent

In the event additional time is needed to resolve the expedited appeal request and the delay is in the member's interest, Sunflower will comply with the process to request up to an additional 14 calendar days and make reasonable attempts to notify member of the delay and also notify of their right to file a grievance if they do not agree with that decision.

MEMBER STATE FAIR HEARING SYSTEM AND PROCESS (ATT. D 4.6)

Members may request to have a Sunflower appeal decision reviewed by a judge from the Office of Administrative Hearings (OAH) via the State Fair Hearing process. A State Fair Hearing may be requested once the member has completed the internal process of Sunflower appeal, and Sunflower will inform members of these rights. This applies in both standard and expedited hearings. The member, or their representative, can ask the Kansas Office of Administrative Hearings to review Sunflower's appeal decision by submitting a verbal or written request to Sunflower to file a State Fair Hearing request or by mailing in a Request for Administrative Hearing form to OAH. The member has the right to have a representative of their choice at the State Fair Hearing and to be provided any documentation to support the matter being disputed at hearing.

Members have the right to request a State Fair Hearing for 120 calendar days plus 3 additional calendar days from date the Notice of the Appeal Resolution is sent by Sunflower. Sunflower will continue to comply with providing all the necessary documents timely, accurately and in cooperation with the State on State Fair Hearings.

Sunflower complies with the continuation of Non-HCBS services during the appeal or State Fair Hearing if all of the following criteria are met:

- The member or his/her authorized representative (excluding a provider) requests an appeal timely and continuation of benefits, with timely defined as on or before the later of the following: within ten (10) calendar days of Sunflower sending the Notice of Adverse Benefit Determination or the intended effective date of Sunflower's proposed Adverse Benefit Determination
- The appeal request involves the termination, suspension, or reduction of a previously authorized course of treatment
- The services were ordered by an authorized provider
- The original period covered by the authorization has not expired
- The member timely files for continuation of the benefits

Sunflower complies with the continuation of HCBS services during the appeal or State Fair Hearing process if all of the following criteria are met:

- The member or authorized representative requests an appeal timely, with timely defined as on or before thirty-three (63) calendar days of the date of Sunflower's Notice of Adverse Benefit Determination that terminates, suspends or reduces the previously authorized services and benefits
- The appeal involves the termination, suspension or reduction of a previously authorized course of treatment
- The services were ordered by authorized provider
- The original period covered by the authorization has not expired

PROVIDER GRIEVANCES, RECONSIDERATION, APPEALS, & STATE FAIR HEARINGS (ATT. D 5.0)

Sunflower offers all providers the opportunity file grievances, the optional reconsideration, appeal and state fair hearing options to resolve matters that a provider may not be fully satisfied with. Sunflower wants to fully resolve matters of concern or issue for providers. Sunflower has established a system to address provider grievances, optional reconsiderations, appeals and state fair hearings.

Sunflower in Action…

A member had exhausted the allowed amount for a specific service. This case went all the way through the appeal process and to a State Fair Hearing related to physical therapy services for a specific condition. At the time of the hearing, the parent testified that this child member had developed additional needs since the physical therapy had started and that was why the additional therapy was needed. This was not reflected in the request for continued therapy services as documentation was tied to the previous condition being treated. Upon learning of this new information, the Quality Improvement Director shared it with the QI Nurse on this case and the new information was shared with the member's CM to educate the child's parent so they could pursue the physical therapy needed based on the member's new condition/needs that were identified. This communication and education was provided to the member's parent. As a result of that follow up, the member did indeed receive further assessment for physical therapy needs secondary to the new development.

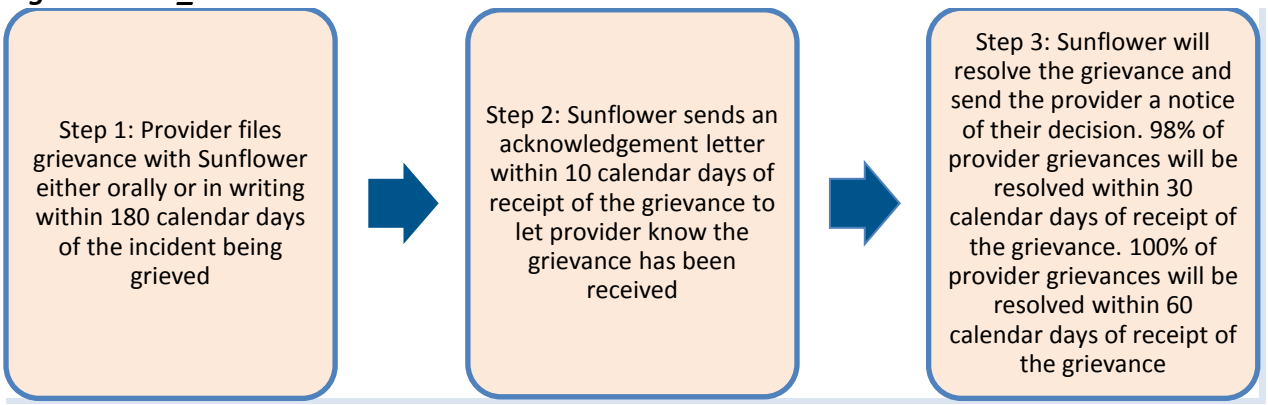
PROVIDER GRIEVANCE SYSTEM (ATT. D 5.1)

Sunflower provides information to providers on the Grievances process through the Provider Handbook, provider bulletins, initial orientation training as they enter Sunflower network and then through additional quarterly provider trainings available. Sunflower is committed to an informed provider network and treating both participating and non-participated providers the same, consistent with KDHE's principle of ensuring equivalent due process treatment across all providers. Sunflower does not take punitive action against a provider or his/her representative for making a Grievance.

PROVIDER GRIEVANCE PROCESS (ATT. D 5.2)

Provider grievances must be filed within 180 calendar days of the event that is being grieved and Sunflower will provide written acknowledgement of grievance request to the provider within 10 calendar days of receipt. All provider grievances will be resolved and providers notified of resolution within 30 calendar days of receipt. The Notice of Provider Grievance Resolution will be sent to the provider within 5 business days following the date of the grievance resolution.

Figure 5.11.C_Provider Grievance Process Timeline



Sunflower records a written record for all provider grievances. Each record includes the following details:

- Date the Provider or Provider's Authorized Representative requested the Grievance
- Identification of the individual filing the Grievance
- Date received by Sunflower
- Date acknowledgement letter was sent
- Identification of the individual recording the Grievance
- Nature of the Grievance
- How Sunflower resolved the Grievance
- Corrective action required
- Date resolved
- Date Notice of Provider Grievance Resolution was sent

NOTICE OF ACTION FOR PROVIDERS (ATT. D 5.3)

Sunflower staff provides the written Notice of Action to providers to communicate the notice of an action made by Sunflower. The action communicated in the Notice of Action may include a denial, in whole or in part, of payment for a service to a provider. Sunflower will send the Notice of Action within 1 business day following the date of action affecting the claim. This Notice of Action also contains the provider rights and steps to follow in requesting an optional reconsideration, required appeal step to allow the provider to proceed to state fair hearing should they disagree with the initial or subsequent decisions related to the claim.

PROVIDER RECONSIDERATION SYSTEM, PROCESS AND RESOLUTION (ATT. D 5.4.1-5.4.5)

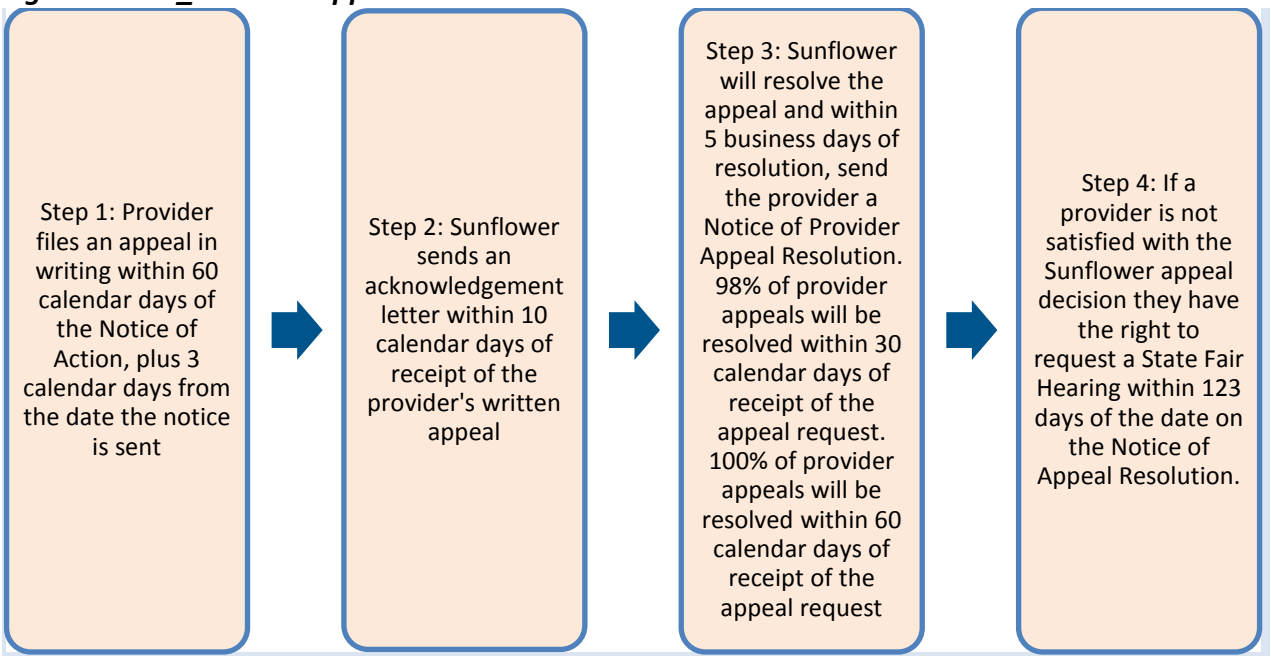
Providers are educated and information is available to providers of the appeals process through the Notice of Action information provided, Provider Manual, initial orientation provided upon becoming network provider and through ongoing quarterly trainings available. A provider request for reconsideration is an optional step in Sunflower's appeals process. Providers should clearly indicate that they are requesting a reconsideration and send the reason for the request and supporting documentation to allow Sunflower to fully review. Providers have 120 calendar

days of the date of the Notice of Action, plus three calendar days from the date Sunflower's notice is sent to submit a request for reconsideration. Sunflower has set an internal timeframe for resolution of reconsiderations within 30 days. We will resolve a request for reconsideration within 30 calendar days from the date received. All provider rights of appeal are preserved throughout the reconsideration process. If a provider chooses to request a reconsideration, a provider may terminate the reconsideration process and submit an appeal request to Sunflower within 60 calendar days of the date of the notice of Action, plus 3 calendar days from the date Sunflower's notice is sent. If a provider does not submit an appeal request within 63 calendar days of the date of the Notice of Action, the provider must wait to receive the Notice of Reconsideration resolution before filing an appeal. The provider has 60 calendar days from the date of the Notice of Reconsideration Resolution, plus 3 calendar days from the date of Sunflower's notice to request an appeal. Should a request submitted not clearly indicate whether the request is a reconsideration, then the request will be processed by Sunflower as an appeal.

PROVIDER APPEALS SYSTEM, PROCESS AND RESOLUTION (ATT. D 5.4.6-5.4.8)

Provider appeals must be submitted to Sunflower in writing using the Provider Appeal Request form or clearly indicate they are requesting an appeal. Providers have 60 calendar days plus 3 calendar days if the notice was mailed from the date on the notice of action to request their appeal and Sunflower will acknowledge the appeal request in writing within 10 calendar days of receipt. Sunflower resolves the appeal request in writing within 30 calendar days of receipt. The written Notice of Provider Appeal Resolution is sent to the provider within 5 business days of the appeal resolution date. Providers must complete the Sunflower appeal process before proceeding to the State Fair Hearing process.

Figure 5.11.D_Provider Appeals Process Timeline



PROVIDER STATE FAIR HEARING SYSTEM AND PROCESS (ATT. D 5.5)

Following completion of the Sunflower provider appeal step, providers may proceed to a State Fair Hearing if they are not satisfied with the outcome of the appeal decision made by Sunflower. After exhausting the internal provider appeal process, Providers may request to have a Sunflower appeal decision reviewed by a judge from OAH. Providers must submit a written State Fair Hearing request to either OAH or Sunflower within 120 calendar days plus 3 additional calendar days of the date on the Provider Appeal Resolution notice. Any written request for a State Fair Hearing received by Sunflower must be submitted to OAH within 1 business day of receipt.

Sunflower records a written record for all provider State Fair Hearing requests. Each record includes the following details:

- Date of Notice of Action
- Date notice was sent;
- Effective date of the Action
- Date the Provider or Provider’s Authorized Representative requested the State Fair Hearing
- Date forwarded to OAH
- Identification of the individual filing the request for a State Fair Hearing
- Identification of the individual recording the request
- Nature of the State Fair Hearing
- Resolution of the State Fair Hearing
- Corrective action required

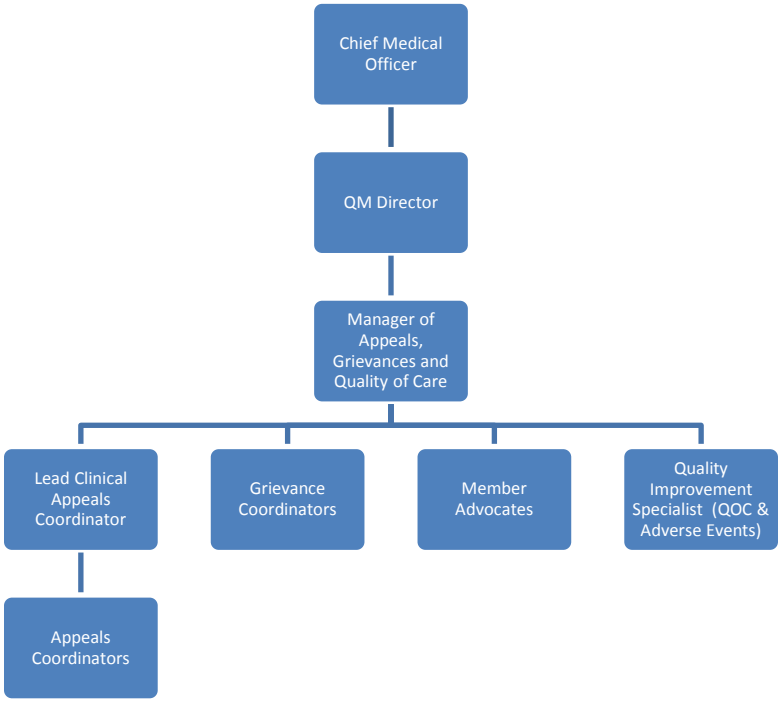
- Date resolved

Sunflower will often speak directly with provider office staff to resolve both member and provider issues. By continually reviewing the data in grievances, appeals, and State Fair Hearings, we can identify trends and supply provider education appropriately. QI identifies the root cause, implements a solution, often including additional provider education, with other Sunflower departments and evaluates if the problem is getting addressed. Sunflower does not take punitive action against a provider, or Authorized Representative, for filing a reconsideration, appeal or requesting a State Fair Hearing.

TRACKING AND STAFF TRAINING (ATT. D 5.5.3)

Sunflower's QI organization structure supports greivance and appeal excellence. Sunflower has dedicated staff who work appeals, grievances and state fair hearings. The QI department has oversight for appeals, grievances and state fair hearings which requires the dedicated staff to work with members, providers, and other health plan departments including, Provider Relations, Claims, and Medical Management, as necessary to resolve the grievances, appeals, and State Fair Hearing cases.

Figure 5.11.E_QI Staff Org Chart



Sunflower focuses on each particular member's individual situation and needs in these cases as they are resolved to ensure that the member needs are met utilizing collaboration with other departments and agencies. Sunflower will continue to provide training to new Sunflower staff on appeals, grievances and state fair hearings for both members and providers. Additionally, Sunflower QI will provide annual trainings for existing staff and ongoing trainings like the quarterly trainings for existing staff to ensure that when there are changes made to the processes the staff are knowledgeable and able to assist members and providers appropriately with regard to grievances, appeals and state fair hearings. Sunflower also provides quarterly Sunflower Business Orientation as well to provide the training updates to new and existing staff.

Sunflower in Action…

Our Grievance & Appeals Coordinator, a Sunflower team member of 5 years, relates the following:

I am excited to arrive to the office daily, knowing the likelihood is great that I will be able to help multiple members meet their needs, and as a result, gain better health outcomes. For example, upon receiving a grievance from a parent who felt our member had been unfairly removed from a residential facility, I coordinated a Sunflower team that assisted the parent in every way he requested and was successful at re-establishing services appropriate for the member's needs. I can honestly say that I felt that member and his family were in a better position as a result of having a dedicated team of Sunflower representatives who cared about the needs of our members.

SYSTEM TO CAPTURE, TRACK, AND REPORT GRIEVANCES, APPEALS, AND STATE FAIR HEARINGS

Sunflower uses a robust Customer Relationship Management (CRM) system that allows us to effectively capture all required data elements of each case on grievances, appeals, and State Fair Hearings, for tracking, trending and providing reports back to KDHE to fulfill reporting requirements. CRM enables Sunflower to maintain an internal database for tracking where grievances, appeals, and State Fair Hearings are routed for investigation. Sunflower's Grievance and Appeals Coordinator uses CRM to designate the deadline for each investigation summary.

USING GRIEVANCE, APPEALS, AND STATE FAIR HEARING DATA TO IMPROVE OPERATIONAL PERFORMANCE

QI routinely monitors trends in aggregated data captured in our CRM system for appeals, grievances and state fair hearings to identify opportunities for improvement, determine the root cause, and apply Rapid Cycle of Process Improvement steps utilizing the Plan-Do-Study-Act (PDSA) method. Categories in CRM include, but are not limited to:

- Quality of Care
- Clinical Criteria Not Met—Inpatient Admissions or Medical Procedure
- Accessibility of Office
- Attitude/Service of Staff
- Prior or Post Authorization

- Quality of Office Building
- Lack of Information from the Provider
- Timeliness
- Level of Care Dispute
- Benefit Limitations/Exclusions
- Pharmacy

Sunflower further defines these broad categories to delineate and trend issues while monitoring and tracking resolution timeframes. Sunflower QI provides ongoing training relating trends or opportunities identified through data analysis feedback, and as requested by our subcontractors.

Sunflower's Success Using Member Grievance Data to Improve Member Transportation Experience

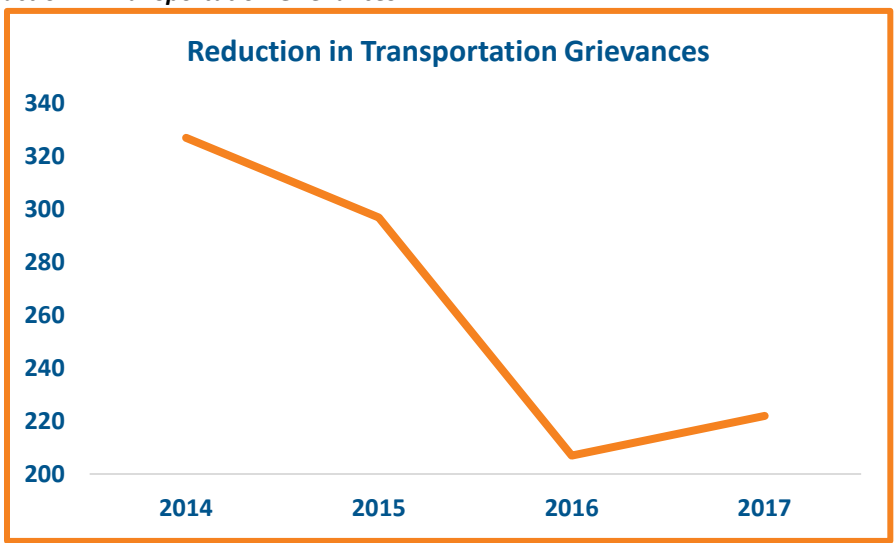
For example, Sunflower reviews member grievance data regularly to identify opportunities to improve member satisfaction and quality of care. From this data, Sunflower found that transportation services were consistently trending as our highest grievance category. In 2014, 52% of member grievances received were related to transportation. Based on this information, a member grievance trends analysis was completed and strategies were implemented in 2015 with the goal to reduce the transportation related member grievances by 5%. Interventions implemented include:

- QI and Medical Management participation in monthly transportation subcontractor operations meetings to provide feedback on trends encountered in real time. The Medical Management team works closely with members and was able to provide Sunflower's subcontractor with timely examples of service improvement opportunities and member impact. Additionally, the QI teams' assessment of grievance trends from the previous month and those pending resolution provided immediate feedback on how the subcontractor was impacting their performance from Sunflower's perspective.
- Interventions for members who were in a wheelchair and required transportation that would accommodate those needs adequately. As a result, our Medical Management, QI and Vendor Management (VM) teams collaborated with the transportation subcontractor to develop scripting to be used when scheduling transportation for members with wheelchair requirements. The scripting included asking whether the member's wheelchair was manual or electric and whether it would fit through a standard doorway. The scripting allowed the transportation subcontractor to ensure the vehicle provided met the member's mobility needs.

Sunflower also used the monthly and quarterly subcontractor oversight meetings to highlight provider trends related to no-shows, late arrivals and safety concerns. This consistent, scheduled and focused review encouraged our transportation subcontractor to address items with providers in a timely fashion and consider strategies to prevent further issues. The results

of these collaborative efforts are evident in the grievance numbers noted in ***Figure 5.11_Reduction in Transportation Grievances*** below:

Figure 5.11_Reduction in Transportation Grievances



We met our goal of a 5% reduction in transportation grievances in 2015. The absolute reduction in transportation related grievances was 30 grievances, a 9.2% reduction. Sunflower's Medical Management, QI and VM teams continue to collaborate very closely to ensure that member experience with transportation continues to improve. Transportation is important piece in ensuring members are able to get to their appointments with providers for their overall health and well-being.

Sunflower provides ongoing training to subcontractors. The goal of this training is to ensure that everyone who has contact, or potential contact with members or providers, understands the process of appeals, grievances and state fair hearings, as well as the processes for requesting these steps, understanding State/Federal policies, regulations, and requirements applicable to appeals, grievances and reconsiderations. The objective of Sunflower's ongoing training strategy is the proper application of the knowledge gained about appeals, grievances, reconsiderations and state fair hearings in the day to day business operations and interactions with members and providers. Sunflower continually trains staff and subcontractors in accordance with KDHE guidance.

Between 2014 and 2017, Sunflower had a 32% reduction in transportation grievances.

Sunflower provides written reports of the grievances and appeals to the State, as required, including quarterly Grievance and Appeal Reports (GAR)/Appeals Resolution Timeframe and Grievances-Transportation, as described in Attachment H.

5.12 Program Integrity

5.12. PROGRAM INTEGRITY

SUNFLOWER DEMONSTRATED SUCCESS

Sunflower Health Plan (Sunflower) has served Medicaid members in Kansas as a participant in the KanCare program since 2013. We work closely with KDHE to provide an accurate, and consistent Program Integrity Plan as part of our Compliance and Ethics Program, as well as partnering with the State to mitigate any fraud, waste, and abuse (FWA). Our success is demonstrated by:

- The effectiveness of our prepayment program with 2016 prepay savings of more than $5.5 million, and January-September 2017 prepay savings of over $3.5 million
- The effectiveness of our recovery program with 2016 payment recoveries of over $6.3 million, and January-September 2017 payment recoveries of more than $4 million

Compliance with Scope of Work

Sunflower is currently in compliance with all KanCare contracts and all KanCare 2.0 requirements described in Section 5.12 of the SOW. Below we describe in detail our Compliance Program and Program Integrity Plan, as well as our strategic approach to preventing, detecting, and correcting incidents and practices that do not comply with the law. We also outline how we train and educate staff, monitor and audit risk, and communicate and coordinate our efforts with the state, among other topics. For ease of review we have included Scope of Work (SOW) references in headers and within the narrative.

5.12.1. PROGRAM INTEGRITY AND DISCLOSURE REQUIREMENTS

As part of our Compliance and Ethics Program, Sunflower operates a robust and comprehensive Program Integrity Plan committed to the prevention, reduction, detection, and reporting of known or suspected fraud, waste, and abuse (FWA), while also preventing potential health risks to members, through compliance with all applicable federal and State standards. Our Compliance Program guides employees, Board members, agents, providers, and subcontractors to ensure compliance with the KanCare Scope of Work (SOW) and all applicable federal and state program integrity requirements as well as Sunflower's standards of conduct. Sunflower's Compliance Program and Program Integrity Plan is supported by our parent company, Centene Corporation (Centene)'s, Special Investigation Unit (SIU) who conducts investigations, systematic testing, and tracks investigations in close collaboration with our Compliance Officer and local Program Integrity Manager (described further below).

Built on Core Elements. Sunflower believes it is vital to our mission to protect the integrity of Medicaid healthcare funds through a vigorous and high-quality Compliance Program. Sunflower's Compliance Program is built on the following core elements as identified by the Department of Health & Human Services' Office of Inspector General:

- Written standards of conduct and P&Ps
- Designation of a Compliance Officer and a Compliance Committee
- Regular, effective education and training programs
- Maintenance of effective lines of communication

- Well-publicized dissemination of disciplinary guidelines and enforcement of appropriate disciplinary action
- Internal auditing, monitoring, and other evaluation techniques
- Prompt response to allegations of improper/illegal activities and detected offenses
- Comprehensive Program Integrity/Fraud and Abuse Plan

Our Compliance Program ensures effective lines of communication between the Compliance Officer and Board of Directors (BOD), the Compliance Committee, staff, providers and subcontractors through a variety of means and we fully participate in all KDHE and CMS audit activities. Sunflower's philosophy is that all employees, temporary employees, consultants, providers, members, and caregivers have the responsibility for program integrity including identification and reporting of potential FWA activities.

PROGRAM INTEGRITY PROCEDURES (5.12.1.A)

Sunflower's Compliance Program incorporates effective internal controls that promote adherence to applicable federal laws including 42 CFR 438.608 and state regulatory and contractual requirements. Our Program Integrity Plan focuses on the prevention, reduction, detection, correction, and reporting of FWA and erroneous payments among providers, members, and subcontractors. We ensure that these requirements are met through processes and procedures that are designed to support and protect coverage of services and payment of claims as listed in this Contract.

Policies and Procedures (5.12.1.A.1)

Sunflower's Compliance Program Description and Program Integrity Plan illustrates our organization's strategic plan to prevent, detect, and correct incidents and practices that do not comply with the law, establishes ethical standards for employees, and outlines the manner in which ethical conduct is promoted throughout the organization. To ensure successful implementation of our Program, Sunflower has established specific policies and procedures relevant to compliance components for all operational areas of our business.

Operational Policies and Procedures. Examples include but are not limited to:

- Federal and State False Claims Acts
- Fraud, Waste, and Abuse including making referrals to appropriate state or federal programs
- Claims Processing
- Kansas Medicaid program requirements and contract provisions
- Centers for Medicare and Medicaid Services (CMS) program requirements and contract provisions including the delivery of prescription drugs
- State and federal legislation affecting organizational business practices
- Department specific compliance
  - Finance
  - Human Resources
  - Quality Improvement & Utilization Management

- Credentialing
- Enrollment
- Marketing
- Information Systems and Technology

Standards of Conduct. This document outlines our Compliance Program explaining the mission, values and philosophy of the company. Our Standards of Conduct present the compliance policy, scope, employee rights and responsibilities, and the possible effect of violations of these. This document includes policies and procedures around financial records and controls, Fraud and Abuse, Inside Information, Trade Secrets and Confidential Information, Media Relations, Electronic Communications, Conflicts of Interest, Gifts and Bribes, Health Care Laws, Discrimination and Harassment, and Political Activities. The Standards of Conduct inform employees about our ethical standards and expectations of business conduct; our expectation and requirement to disclose or report suspected violations along with explaining how Sunflower and Centene handle reports of possible violations; and strictly prohibits retaliation against whistleblowers how to report concerns. The Code is distributed to all employees and Board members upon hire and annually thereafter, requiring attestation that he or she has read the Code and understands that he or she is bound by it.

Annual Review of Policies. All Sunflower policies and procedures are maintained in our electronic Compliance Management System allowing us to effectively administer and monitor our internal governance, as well as our contractual and regulatory oversight capabilities. Policies are reviewed and updated at least annually by our Compliance Officer and updated as needed to incorporate changes in state or federal requirements. Through the use of our Compliance Management System, and in accordance with Section 6032 of the Federal Deficit Reduction Act of 2005, all of Sunflower's P&Ps are published online and available to all employees via our company intranet site. In addition to the P&Ps, the intranet site also includes a copy of the Code of Conduct, Employee Handbook, published Compliance, Program Integrity, FWA hotline information and an optional form for reporting FWA. Sunflower directs employees to these documents during new hire and annual training.

Designated Compliance Officer (5.12.1.A.2)

Sunflower's Vice President of Compliance, Carmen Mills, serves as both the local Compliance Officer and as the liaison to KDHE and reports directly to Sunflower's President and CEO and the Board of Directors (BOD). Carmen is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of this Contract and for ensuring effective lines of communication between the Compliance Officer and Sunflower staff, as well as KDHE staff. She is also charged with the administration and management of the organization's compliance efforts including, but not limited to:

- Overseeing and monitoring the Compliance Program
- Periodically reviewing and revising the program to accommodate organizational needs, legislative and regulatory requirements, and policies and procedures of government and, when applicable, private health plans

- Ensuring coordination with Centene's Special Investigations Unit to fulfill the requirements of the Managed Care Contract with the KDHE
- Ensuring that service providers, subcontractors and independent contractors who furnish, or may furnish, services to Sunflower, are aware of and adhere to the requirements of Sunflower 's Compliance Program
- Maintaining communication and reporting channels that encourage managers and employees to report suspected FWA and other improprieties without fear of retaliation
- Overseeing compliance education and training that focuses on the elements of the Compliance Program
- Working with appropriate departments to develop standards of conduct and policies and procedures to promote compliance with our compliance program

Regulatory Compliance Committee (5.12.1.A.3)

To ensure effective governance, Sunflower's Board of Directors establishes committees to undertake and report on various functions. Our Compliance Committee, reporting directly to our BOD, serves as the senior management committee charged with overseeing our compliance program and compliance with the requirements under the Contract. The Committee is chaired by our Compliance Officer and consists of a cross-functional team of our senior management who have the authority to implement corrective actions. Participants include, but are not limited to: Plan President, Vice President of Operations, Senior Vice President of Finance, Vice President of Medical Management, Vice President of Contracting/Network, Vice President of Quality, Chief Medical Director, and Manager of Human Resources. Additional Committee participants are included in meetings or functions as needed. The Committee's functions include:

- Analyzing the organization's environment, the legal requirements with which it must comply, and specific risk areas
- Assessing existing policies and procedures that address these areas for possible updates
- Recommending and monitoring, in conjunction with relevant departments, the development of internal systems and controls to carry out the organization's standards, policies, and procedures as part of its daily operations
- Periodically meeting to review compliance issues related to fraud and abuse
- Oversight of Sunflower's compliance program
- Oversight of Contract requirements
- Review of Special Investigations Committee and Workgroup recommendations and final decisions

The Compliance Committee meets at least quarterly and on an ad hoc basis when needed. Minutes are taken during the meeting and reflect attendance and participant discussion. Minutes are approved and signed by the Committee Chair at the subsequent committee meeting and maintained in a secure area.

Staff Training and Education (5.12.1.A.4)

Every Sunflower employee and subcontractor is responsible for implementing and carrying out our Compliance Program and Program Integrity Plan and each employee has the responsibility

to report potential FWA issues. We educate all employees, from senior leadership to our claims and call center staff, on the processes for identifying and reporting issues outlined in our Compliance Program. Sunflower leverages Centene's national compliance training program supplemented by locally developed information specific to state laws and contract requirements to communicate our standards and procedures to all employees (including senior management, employees, and temporary employees), subcontractors, members of its Board of Directors, and other significant agents. Mandatory training occurs upon hire, annually and on an ad hoc basis when circumstances warrant (e.g., in response to identified risks; as required by legislative edict or other material changes in law, policy, or to the Compliance Program). Training is provided in person, through written publications and web-based modules that include information on Sunflower's Compliance Program, identifying FWA and mechanisms to report the same, the Business Ethics and Conduct policy and other compliance related policies, procedures, standards. The Compliance Officer, in conjunction with Sunflower's Human Resources Department, tracks attendance and retains adequate records of its training of all employees, including attendance logs and distributed materials.

Specialized Training. Our Compliance Officer, Program Integrity Manager (PIM), SIU and Compliance Department Staff, and senior management staff also receive special training on FWA topics such as current fraud schemes, common coding or billing errors, and CMS-focused audits. For example, all of our Compliance staff are members of the Health Care Compliance Association (HCCA) and regularly attend trainings offered by the organization. Our PIM also attends the annual conference of the National Association for Medicaid Program Integrity.

Effective Lines of Communication (5.12.1.A.5)

To facilitate detection of potential non-compliant conduct, it is necessary for all individuals affiliated with Sunflower to feel comfortable in reporting and communicating all suspected and confirmed incidents of fraud, waste, abuse, illegal acts, inappropriate disclosures, and/or other incidents that violate applicable law, regulations, or our Standards of Conduct. Sunflower has adopted Centene's "Speaking Up" policy that requires all employees to report concerns, policy violations, misconduct and issues of non-compliance. Our staff training includes instruction on the variety of resources employees can use to report a FWA issue or concern. These resources include the employee's supervisor, the Compliance Officer, the toll-free FWA Helpline available to all employees 24 hours a day, 7 days a week, 365 days a year that permits employees to report incidents and concerns anonymously, or Centene Compliance representatives. All reporting resources are listed in training materials and on our intranet site available to all employees. We stress during our training that the most important thing is to report any and all suspected instances of FWA or noncompliance without fear of retaliation. In addition, confidentiality and non-retaliation policies have been developed and are widely publicized to all employees to encourage open communication and reporting. While Sunflower strives to maintain the confidentiality of an employee's identity, we explicitly communicate that there may be a point where the individual's identity may become known or may have to be revealed in certain instances such as internal disciplinary actions or involvement by governmental authorities.

Well Publicized Disciplinary Guidelines (5.12.1.A.6)

Sunflower maintains well-publicized, disciplinary guidelines setting forth the degrees of disciplinary actions that will be imposed upon corporate officers, managers, employees, and independent contractors for failing to comply with the company's standards, policies and applicable statutes and regulations. These disciplinary guidelines are included as part of our compliance training program noted above. At the conclusion of our training sessions, we remind staff that there can be a wide range of consequences for employees who violate our policies and the applicable laws and regulations. Disciplinary action may be appropriate where a responsible employee's failure to detect a violation is attributable to his or her negligence or reckless conduct. This includes personal, civil and criminal consequences for people who engage in violations, or know about them and do not report them; as well as consequences under our disciplinary guidelines up to and including termination of employment. Sunflower's goal is to maintain transparency and continue to build on our reputation as an organization that strives for the highest ethics and compliance and proactively identifies and mitigates any potential instances of noncompliance or FWA.

System for Monitoring and Auditing Compliance Risk (5.12.1.A.7)

Sunflower's Compliance Officer, in conjunction with dedicated compliance support staff, audits Sunflower's operations and functional departments. These audits and reviews inquire into our compliance with specific contractual requirements, applicable federal and state laws, and includes, but is not limited to:

- Annual contract assessments
- State Reports
- HIPAA
- State Inquiries
- Member and provider grievance and appeals activities
- Ad-hoc functional area audits as necessary

Sunflower uses a Compliance Management System to monitor our internal governance, as well as our contractual/regulatory oversight capabilities in an auditable and transparent fashion. The software provides the following system capabilities:

- Workflow enabled policy/procedure formulation (with documentation and sign-offs)
- Distribution of documents to appropriate internal departments and subcontractors
- Systematic tracking of compliance activities and proactive assessment of risks
- Annual evaluation of policies/procedures to verify compliance

Sunflower's Compliance Officer produces a monthly risk report of all areas of operational non-compliance that is distributed and reviewed with Sunflower's senior management and Centene's Corporate Compliance department. When necessary, the Compliance Officer and other management staff take immediate steps to correct identified risks or violations and prevent them from reoccurring. In certain cases, ongoing monitoring or subsequent reviews are implemented to ensure corrective actions have been executed successfully.

Additionally, Sunflower Compliance oversees the response for the External Quality Review Organization (EQRO) and State Contract Compliance audits. The EQRO reviews to determine MCO compliance with federal Medicaid managed care regulations and State standards for access to care, structure and operations, and quality measurement and improvement. The Sunflower Compliance team:

- Develops and distributes an audit plan when received from the EQRO or KDHE
- Facilitates internal planning meetings in order to meet deadlines
- Monitors, compiles and submits audit documentation
- Coordinates audit report response and follow-up as well as monitors remediation, if any

COORDINATING PROGRAM INTEGRITY EFFORTS WITH THE STATE (5.12.B)

Sunflower works collaboratively with KDHE personnel, Kansas' MFCU and KDADS (for LTSS and behavioral health integrity issues) on an ongoing basis to enhance our Compliance Program, including our Program Integrity Plan. Our Compliance Officer, PIM, and other designated representatives attend all meetings set by KDHE/MFCU/KDADS to collaborate on FWA policies and operations, including procedural updates or training sessions.

Monthly Meetings with KDHE (5.12.1.B.1)

Sunflower currently meets monthly (or as required) with KDHE and MFCU staff to discuss and coordinate reporting of all instances of credible allegations of fraud, as well as all recoupment actions taken against providers.

Compliance with Documentation Requests (5.12.1.B.2)

Sunflower will provide any and all documentation or information upon request to KDHE, MFCU, CMS, and its contractors, or the U.S. Health and Human Services' (HHS) Office of the Inspector General (OIG) related to any aspect of this Contract, including but not limited to: policies, procedures, subcontracts, provider agreements, claims data, encounter data, and reports on recoupment actions and receivables.

Reporting Potential FWA by Providers (5.12.1.B.3)

A crucial part of our Compliance Program is to report to the state any provider (individual, group, clinic, hospital, pharmacy, agency) whose billing activity appears to be potentially fraudulent. Sunflower will report any evidence indicating the possibility of FWA by a provider to KDHE, MFCU and appropriate legal authorities within two business days of identification. Sunflower acknowledges that failure to report suspected FWA may result in penalties including but not limited to suspension of payment or termination of the contract as well as other legal or equitable remedies which may be available to KDHE or MFCU for noncompliance with this section.

Quarterly Updates of Investigative Activity (5.12.1.B.4)

Sunflower will provide KDHE with at least quarterly updates on investigative activities including corrective actions taken as they relate to any potential FWA by providers.

Annual Program Integrity Work Plan (5.12.1.B.5)

Sunflower sets goals and objectives at the beginning of each year, and outlines the Program Integrity activities that we will conduct to achieve these goals in an annual Program Integrity Work Plan. The focus of our activities is based on the following sources: the CMS Office of Inspector General proposed program integrity work plan; direction from KDHE, the Kansas Medicaid Fraud Control Unit, or KDADS; issues identified by Centene Corporate Compliance or affiliate health plans; Sunflower staff experience; and issues identified by the Sunflower Provider Relations staff in their interactions with providers. The general categories of these goals and objectives are:

- Prevent FWA by Sunflower, our members, providers, or subcontractors
- Provide a systematic method for identifying, investigating, and taking corrective action against any provider suspected of improperly billing for services
- Ensure that all Sunflower providers, subcontractors, officers, directors, managers, and employees understand the FWA Plan and their role in the process
- Ensure confidential reporting of FWA issues and prevent retaliation against providers, members, and staff for reporting incidents
- Provide a method for reporting suspected and/or investigated cases of FWA to the appropriate State authorities, with the right information at the right point in the process

Sunflower develops each goal, objective, and activity so that responsibility and accountability for the steps involved, the documentation required, and the oversight is clear. The Work Plan is reviewed and approved by our Compliance Committee. This SIU work plan, Includes:

- Planned fraud detection, prevention, and correction objectives
- Fraud awareness initiatives
- Required reporting to regulators/law enforcement
- Estimated timeframes to completion

Designated Program Integrity Manager (5.12.1.B.6)

Sunflower's Program Integrity Manager, located in our Lenexa, KS office, reports to Centene's SIU with a dotted line reporting structure to Sunflower's Compliance Officer thus ensuring at least 90% of her time is dedicated in the oversight and management of Sunflower's program integrity efforts. Sunflower's PIM has open and immediate access to all claims, claims processing data, and any other electronic or paper information required to ensure that our program integrity activity is sufficient to meet the requirements of the KDHE.
Duties of the PIM include, but are not be limited to:

- Oversight of the program integrity function
- Liaison with the State in all matters regarding program integrity
- Liaison with Kansas' MFCU
- Assure coordination of efforts with KDHE and other agencies concerning program integrity issues

The PIM facilitates Sunflowers monthly FWA Work Group with representation from several departments within the health plan who review, track and discuss FWA trends. The group includes members from the following departments: Compliance, Operations, Provider

Relations, Contracting, Finance, Medical Directors, Medical Management, Vendor Management, Pharmacy, Quality and Customer Service. The FWA Work Group reviews recommended actions to be taken and assists the SIU Investigator in collecting information and enforcing the recommended actions. The results of each FWA Work Group meeting are presented to the Compliance Committee for review and to assist in enforcing recommended actions.

Additional Qualified Staff (5.12.1.B.7)

Sunflower maintains adequate qualified staff to assist the PIM in conducting reviews/audits and investigations. For example, Sunflower's dedicated SIU Investigator is responsible for investigations/audits, conduct systematic testing, data mining, reviewing regulatory requirements, track investigations and work and reporting recommendations to the FWA Work Group, PIM and Compliance Officer.

ENSURING PARTICIPATING PROVIDERS ARE ENROLLED AS MEDICAID PROVIDERS (5.12.C)

Sunflower ensures all participating providers are enrolled with KDHE as Medicaid Providers consistent with the requirements of 42 CFR § Part 455, subparts B and E as incorporated in 42 CFR § 438.608(b) prior to executing a Provider Agreement. Our Credentialing Department assists in the prevention of FWA by ensuring that participating providers are appropriately credentialed and eligible to provide Medicaid services. As part of our credentialing primary source verification process, we cross-reference the provider's National Provider Identification (NPI) number with the most recent Kansas Medicaid Assistance Program (KMAP) provider file for confirmation of their enrollment as a Medicaid provider prior to executing a provider agreement/contract. Prior to paying claims to a non-participating provider, Sunflower, at a minimum, verifies licensure and performs all federal database checks as specified at 42 CFR § 455.436 on all owners and managing employees.

SAFEGUARDING AND INVESTIGATING SUSPECTED FRAUD AND ABUSE (5.12.D)

Preventing and Detecting FWA at the Member Level

Sunflower educates members on preventing and detecting FWA through our Member Handbook, on our website, in our newsletter, and through all member facing staff. We train all staff to be aware of "red flags" including treatments or medication provided by more than one doctor, a member receiving similar treatment from multiple doctors, excessive non-PCP doctor visits, and a high volume of ED visits. These "red flags" are not absolute proof of member fraud; they may be an indication that a member's PCP is billing inappropriately, their chronic condition is not controlled, or the member has a condition that has not been properly diagnosed and requires plan intervention. If a member is flagged for review, Sunflower analyzes member-specific or service-type claims reports and examines any existing case management files.

Preventing and Detecting FWA at the Provider Level

During orientation sessions, Sunflower educates providers, subcontractors, and consultants on our Compliance Plan, including FWA practices. Centene's Business Ethics and Conduct Policy includes federal and state laws and regulations governing FWA and erroneous payments as well as policies and procedures, and whistleblower rights and protections.

Claims Payment Tools to Identify Suspected FWA

We also help prevent, identify, and investigate potential provider FWA through a number of controls aligned with claim submission, adjudication, payment, and post payment review. We maintain an overall average of over 85% for auto adjudication of electronically submitted medical, behavioral and LTSS claims. This encourages providers to submit electronically, allowing us to apply thorough claims edits at the point of submission. Additionally, the EVV system can bring transparency to service delivery and help improve payment integrity.

Sunflower leverages Centene's proven two-pillar approach —proactive and retrospective— similar to that employed by the federal Centers for Medicare and Medicaid Services (CMS), to prevent and detect FWA. As described in the ***Table 5.12.D_FWA Payment Detection and Investigation Tools*** below, we use robust technology systems and industry leading proactive and retroactive fraud and abuse prevention tools to uncover inappropriate claims billing practices. For example, our innovative fraud and abuse detection software contains hundreds of edits and uses complex algorithms to identify suspicious billing trends; billing outliers, such as diagnoses or procedures incompatible with age/gender; mutually exclusive codes billed together; unbundling; upcoding; add-on codes without primary CPT codes; and non-emergency procedures billed on Sundays or holidays.

Table 5.12.D_FWA Payment Detection and Investigation Tools

Tool	Description
EDIFECS X Engine	HIPAA compliance checking software that validates claims data against required data structure rules and syntax; tests to ensure conditional rules requiring secondary fields are accurate and complete; and ensures all data is in compliance with HIPAA Transaction Companion Guides.
Verisk's HealthCare Insight	Through our strategic partnership with Verisk's HealthCare Insight (HCI) subsidiary, Sunflower incorporates processing against National Correct Coding Initiative (NCCI) edits that supplement our claim processing controls. HCI keeps these edits current with federal and state regulations, including of 42 CFR 433.116 and 45 CFR 95, subpart F; coding rules; and code sets to ensure accurate claims coding before we pay them.
PostShield	Contains powerful fraud rules and algorithms developed by industry experts who understand the essentials of fraud detection and prevention. Post-payment algorithms are applied after claims payment, which produce smarter results and less false positives with unique external data sources incorporated into PostShield's analytics.
CaseShield	Used by SIU to initiate, organize, track, and record current and historical FWA cases that SIU conducts. CaseShield electronically houses SIU investigation files and documents and links SIU cases to internal and external reference sources, including medical records. SIU also uses CaseShield to generate FWA case documents (such as seeking case information from providers and/or other sources). CaseShield's FWA case tracking, plus case and financial reporting capabilities align with the National Health Care Anti-Fraud Association financial reporting standards, and state and federal regulatory reporting requirements.
QueryShield	Ad-hoc querying tool that enables real-time queries and complex pattern reports from data loaded into PostShield and CaseShield. QueryShield completes customized reports to meet the reporting needs of state and federal regulatory agencies and industry associations, template reports that may be reused and are accessible by a single user or multiple users, aggregated summary reports, trending analysis reports, cross-claim querying capability, fraud alert impact analysis, and instantaneous results that may be uploaded to CaseShield and/or exported.

Investigating Suspected FWA

The SIU conducts investigations, systematic testing, reviews regulatory requirements, tracks investigations, and works with various state agencies/departments as necessary. Suspected FWA is identified through referrals that may be from a person or agency outside of the organization, an employee, and systematically through our technology solutions. Upon receipt of a complaint or other indication of potential FWA, Sunflower's PIM notifies the SIU Investigator who conducts a preliminary investigation reviewing background information and any stored data. The SIU Investigator conducts a review for suspicious indicators based on state and federal laws, regulations and the appropriate provider contracts, documenting the list of indicators, approximate error rate and the sources used for validation. The case file is reviewed at a minimum, by the PIM and presented during Sunflower's FWA Work Group meeting. MFCU and KDHE will be notified within two business days of identifying a potential credible case or allegation of abuse and fraud. As part of the investigation process, the SIU Investigator may request a random sample of medical records for review by the SIU clinical nurses. After receiving the clinical findings summary, the SIU Investigator will write a final investigation report that outlines the investigation steps, the findings and the recommended next steps which may include a recoupment figure and a potential savings figure. Final actions may include provider/member education, corrective action plans, state/federal referral, or provider placed on review necessitating submission of medical records with all claims submitted for payment.

COMPLYING WITH STATE AND FEDERAL LAWS AND REGULATIONS (5.12.E)

Sunflower's Compliance Department and Centene's Legal and IT Security Departments work closely together to monitor relevant announced federal mandates at large (e.g. published in the Federal Register), IT mandates related to security, and federal mandates relevant to our contract with KDHE. The Sunflower Compliance Team, along with the Executive Team, monitor State Laws and Regulations which affect the Plan's Operations. We use our Compliance Management System, risk management, and compliance system to organize, manage, and document our compliance with specific state and federal mandates.

Recent Pre- and Post-payment Successes

Pre-payment Savings:

- ***More than $5.5 million for 2016***
- ***Over $3.5 million from January through September, 2017***

Post-payment Recoveries:

- ***More than $6.3 million for 2016***
- ***Over $4 million from January through September, 2017***

(These numbers include Change Healthcare (CXT) savings, Verscend (HCI) savings, and savings from the Payment Policy Initiatives)

RIGHT TO REVIEW, AUDIT AND RECOVER FROM PROVIDERS (5.12.F)

Sunflower acknowledges the right of the State, or any agent including the State's Fiscal Agent or other Contractor to review, audit, and recover from participating providers. Sunflower and our subcontractors acknowledge and will comply with requests and fully cooperate with any reviews or audits.

PROMPT REPORTING CONCERNING CHANGE IN MEMBERS' CIRCUMSTANCES (5.12.G)

Sunflower complies with 42 CFR § 438.608(a)(3) by promptly reporting to KDHE any information received concerning changes in a member's information that may affect eligibility, such as a member's residence, the death of the member, or other information specified by KDHE. Our Customer Service Department sends a detailed report of member updates to the state every week through a clearinghouse. We gather those changes through internal emails, alerts, and any applicable data from our Program Integrity Manager, which is compiled into our MCO Change Spreadsheet and sent to the state. Changes sent include:

- Address changes (primarily these are updates made by Customer Service Reps when they speak to members)
- Date of deaths reported to the plan
- Level of care changes that Medical Management reports to me
- Name changes
- Date of birth corrections
- Gender corrections

NOTIFCATION OF ADVERSE ACTIONS TAKEN AGAINST PROVIDERS (5.12.H)

Sunflower's PIM reports adverse actions taken against a participating provider's participation in our network, including actions of our subcontractors, to KDHE on a monthly basis using the required Adverse Action Report. For example, if we identify a quality of care concern and take action to suspend or terminate the provider from our network, we would report this via the Adverse Action Report. Sunflower additionally complies with 42 CFR § 438.608(a)(4) by notifying KDHE when we receive information about a change in a participating provider's circumstances that may affect their edibility to participate in KanCare, including termination of the provider's agreement with Sunflower. For example, if we learn about the death of a provider or that a provider has retired, we would notify KDHE contact via secure email protocol.

TERMINATING PROVIDER AGREEMENTS (5.12.I)

Sunflower will terminate contracts with any participating provider whose Medicaid Provider Agreement has been terminated for cause by the State. Upon notification of a provider termination from the KDHE, Sunflower's PIM sends an email to our Provider Relations team who will notify the provider and our Provider Data Management team who will initiate the termination within our credentialing and claims payment systems. The provider's termination will be effectuated on the date as specified in the written notification from KDHE. The PIM also engages our Eligibility team who will send written notification to members assigned to the provider at least 10 calendar days prior to the effective date of termination. If the provider is a specialist, we notify members who have received services from the provider in the previous six months. Our Member Services staff will work to ensure any members assigned to that provider are satisfactorily reassigned and transitioned to a new participating provider.

Sunflower will not enter into a provider agreement or pay a non-participating provider terminated for cause by KDHE. Sunflower acknowledges that Federal Financial Participation (FFP) is not available for amounts expended for providers excluded by Medicare, Medicaid or CHIP, except for emergency services. In addition, Sunflower's subcontractors, and members of

Sunflower's or the subcontractor's participating providers are prohibited from employing or contracting with persons or entities that KDHE has terminated from participation in the Kansas Medicaid program.

INACTIVATED PROVIDERS (5.12.J)

Using the process described above, Sunflower will terminate a participating provider whose Medicaid Provider Agreement has been inactivated by the State. The termination will be effective on the date that KDHE inactivated the provider. Sunflower acknowledges that it is not prohibited from entering into a single case agreement or other arrangement for non-participating provider payment for such providers.

ANNUAL RISK ASSESSMENT (5.12.K)

On an annual basis, Sunflower conducts a Risk Assessment of our FWA/program integrity procedures. The Risk Assessment includes assessment of subcontractors that are delegated to adjudicate claims on behalf of Sunflower (i.e. dental, vision, pharmacy and transportation). Sunflower's Compliance Officer and PIM are responsible for developing the Risk Assessment and will meet with management throughout the organization to review the risk universe to help guide the audit work plan for the upcoming year. Sunflower's annual Risk Assessment includes a listing of the top five vulnerable areas and outlines action to mitigate risks in each area. The risks identified in our Risk Assessment, may include, but are not limited to:

- Priorities and/or potential risks identified by the Office of Inspector General (OIG)
- Priorities and/or potential risks identified by the Centers for Medicaid & Medicare Services (CMS)
- Other regulatory guidance and FWA alerts
- Priorities and/or potential risks identified by Legal and/or Compliance departments
- Process deficiencies identified as a result of an internal and/or external audit
- Past FWA referrals/cases, trends, and/or schemes
- Activities in high-risk counties, high risk providers, high-risk activities
- High profile deliverables to regulators and/or law enforcement, which if not completed in a timely manner, can lead to non-compliance

The Risk Assessment is reviewed by Sunflower's SIU Committee and our Compliance Committee and used to develop our Program Integrity Work Plan. Sunflower will submit the Risk Assessment to KDHE within 30 days of its completion each year.

RETAINING OVERPAYMENT RECOVERIES (5.12.L)

Sunflower acknowledges and will comply with the requirements outlined in Section 5.12.L of the Scope of Work related to recovering and retaining overpayments. Sunflower acknowledges, that as a Contractor, we are entitled to retain overpayment recoveries, including overpayments due to FWA that were first identified by Sunflower.

Recover Established Overpayments (5.12.L.1)

Sunflower will, when directed by KDHE, recover established overpayments made to a provider by the State for performance or non-performance of activities not governed by this Contract.

When funds are recovered, Sunflower will promptly notify KDHE of any amount recovered and, as directed by KDHE, Sunflower will immediately provide the amount recovered to KDHE, or KDHE will withhold the amount recovered from a payment otherwise owed to Sunflower. In the event the overpayment is not recoverable, Sunflower will promptly notify KDHE- DHCF and provide an explanation as to the reason the overpayment is not collectable.

Discovery of Overpayment (5.12.L.2)

Sunflower acknowledges that KDHE and any agent, including the State's Fiscal Agent or other Contractor not a KanCare MCO, may discover and identify an overpayment to be recovered from a participating or non-participating provider that was made by a Contactor(s), and the Contractor(s) is entitled to retain overpayment recoveries, including overpayments due to FWA, that were first identified by the Contractor(s). Sunflower further acknowledges that Contractor(s) are not entitled to any recovery under this section when KDHE and any agent, including the State's Fiscal Agent or other agent, identifies and pursues overpayments, false claims, or fraudulent claims paid by the Contractor(s) to a Provider.

Require Providers to Report Overpayment (5.12.L.3)

Sunflower will require participating providers and non-participating providers to report overpayments and specify the reason for the overpayment in writing. The overpayment shall be returned to the Contractor(s) within 60 calendar days after the date on which the payment was identified.

Reporting Excess Payments (5.12.L.4)

Sunflower will comply with 42 CFR § 438.608(c)(3) by reporting to KDHE, within 60 calendar days of identification, capitation payments or other payment in excess of amounts specified in the Contract.

Reporting Overpayments (5.12.L.5)

Sunflower will comply with 42 CFR § 438.608(a)(2) by promptly reporting all overpayments identified or recovered, specifying the overpayments due to potential Fraud, to KDHE.

Use of Recovery Information (5.12.L.6)

Sunflower acknowledges that the annual report on Sunflower's recoveries and any information or documentation related to recoveries that were retained by Sunflower or the state will be used by the state for purposes of developing Actuarially Sound Capitation Rates.

VERIFYING RECEIPT OF SERVICES (5.12.M)

Sunflower uses an Explanation of Benefit (EOB) process to verify, on a regular basis, whether services reimbursed by Sunflower were actually furnished to members as billed by participating providers. Using RAT-STATs sampling software (also used by the US Department of Health & Human Services Office of Inspector General), Sunflower sends EOB mailings to members to verify services provided. The sample size is enough to produce accurate results up to a 95% confidence interval with an anticipated error rate of 10%. Information provided in the EOB, includes the list of services provided and billed to the health plan; the name of the provider

who furnished the services; and the date on which the service was furnished. Members who receive an EOB, but believe they have not received the service, will be asked to call our Member Services Department or our FWA Hotline. Our Member Services staff will gather the appropriate information and forward validated concerns including identifying "high-risk" services to the PIM staff for further review and investigation.

SUSPENDING PAYMENT FOR CREDIBLE ALLEGATIONS OF FWA (5.12.N)

In compliance with 42 C.F.R. § 455.23, Sunflower and its subcontractors will suspend payment to a provider upon determination by KDHE of a credible allegation of fraud for which an investigation is pending under the Medicaid program, unless KDHE has identified in writing a good cause reason for not suspending payment or to suspend payments only in part.

Upon notification from KDHE to suspend a provider's payments, Sunflower sends written notification to the provider in accordance with the obligations set forth in 42 C.F.R. § 455.23(b) and maintains the suspension for the durational period set forth in 42 C.F.R. § 455.23(c). The notice of payment suspension states that any payments withheld will be done in accordance with 42 C.F.R. § 455.23(g).

Sunflower maintains all materials related to a payment suspensions for a minimum of 10 years in compliance with the obligations set forth in 42 C.F.R. § 455.23(g).

CONTRACTOR OWNERSHIP AND CONTROL INFORMATION (5.12.O)

Sunflower acknowledges and will disclose ownership and control information in accordance with 42 CFR 438.608(c)(2) to include:

- The name and address of any person (individual or corporation) with an ownership or control interest
- The date of birth and Social Security Number, if an individual
- Other tax identification number, if a corporation, with an ownership or control interest in or in any Subcontractor that has a five 5% or more interest
- Whether the person (individual or corporation) with an ownership or control interest in is related to another person with ownership or control interest
- The name of any other disclosing entity
- The name, address, date of birth, the Social Security Number of any managing employee of the disclosing entity (or Fiscal Agent or managed care entity).

Please see ***Attachment 5.12.O Sunflower Disclosure of Ownership and Control Interest Statement Form.***

Timeframe for Submitting Disclosures (5.12.N.2)

Sunflower will submit Disclosures to the State at the following times:

- As Sunflower submits the proposal in accordance with the State's procurement process
- Once Sunflower executes a Contract with the State
- If there is a renewal or extension of the Contract
- Within 35 calendar days after any change in Sunflower ownership

OWNERSHIP OR CONTROL INTEREST IN CONTRACTOR (5.12.P)

In accordance with 42 CFR § 455.106, Sunflower will disclose to KDHE, the identity of any person who:

- Has ownership or control interest in Sunflower, or is an agent or managing employee of Sunflower
- Has been convicted of a criminal offence related to that person's involvement in any program under Medicare, Medicaid or CHIP since inception of those programs.

Disclosure will be made at execution of the Contract, prior to renewal of the Contract, or upon request by KDHE.

PROVIDER OBLIGATION TO DISCLOSE OWNERSHIP OR CONTROL INTEREST (5.12.Q)

As part of our provider enrollment and credentialing process, Sunflower requires providers to disclose the identity of any person described in 42 CFR § 1001.1001(a)(1). Such disclosures are forwarded to KDHE. Sunflower will abide by any direction provided by KDHE, pursuant to 42 CFR § 1002.3, on whether or not to permit the applicant to be a participating provider. Specifically, Sunflower will not permit the provider to become a participating provider if KDHE or Sunflower determines that any person who has ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or CHIP, or if KDHE or Sunflower determine that the provider did not fully and accurately make any disclosure required pursuant to 42 CFR §1001.1001(a)(1).

PROHIBITED RELATIONSHIPS (5.12.R)

Prohibited Relationships and Affiliations (5.12.R.1 – 5.12.R.4)

Sunflower acknowledges and will comply with the requirements set forth in 42 CFR § 438.610 regarding prohibited relationships. Sunflower nor its subcontractors will knowingly have relationship with the following:

- Individuals or entities debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No.12549 or under guidelines implementing Executive Order No. 12549
- Individuals' or entities' affiliates, as defined in the Federal Acquisition Regulation, of an individual or entity described in Section 5.12.1.R.1.a.

Sunflower acknowledges that "relationship," for purposes of prohibited affiliations include:

- A director, officer, or partner, or subcontractor of Sunflower or a subcontractor of subcontractor
- A person with beneficial ownership of five percent or more of Sunflower or one of its subcontractor's equity
- A participating provider or person with an employment, consulting or other arrangement with Sunflower or subcontractor that provides items and/or services that are significant and material to our or our subcontractor's obligation under this Contract with the State

Sunflower nor its subcontractors will have a relationship with an individual or entity that is excluded from participation in any federal health care program under section 1128 or 1128A of the SSA.

Annual Payments Exceeding $5 Million (5.12.R.5)

Sunflower acknowledges that any participating provider, provider entity, Contractor, or subcontractor that receives or makes $5 million in annual payment from KDHE must comply with section 1902(a)(68) of the SSA and 42 CFR § 438.608(a)(6) as a condition of receiving payment. Sunflower understands that the $5 million amount will be based on paid claims, net of any adjustments to those claims and that it is the responsibility of the participating provider, provider entity, Contractor, or subcontractor to make the determination as to whether they meet the $5 million threshold.

To comply with Section 1902(a)(68) of the SSA and 42 CFR § 438.608(a)(6), Sunflower's Compliance and Ethics Program policies provide detailed information about the federal laws identified in Section 1902(a)(68) of the SSA and any state laws imposing civil or criminal penalties for false claims and statements, or providing whistleblower protections under such laws. In addition, our policies include detailed information regarding procedures to detect and prevent FWA in federal health care programs, including the Medicare and Medicare Advantage Programs. Sunflower provides comprehensive training on our Compliance and Ethics program and provides copies of these policies to all employees, contractors, and agents/vendors. Our Employee Handbook includes a specific discussion on the federal and state laws described in its written policies, Sunflower's policies and procedures for detecting and preventing FWA and the right of its employees to be protected from discharge, demotion, suspension, threat, harassment, discrimination, or retaliation in the event the employee files a claim pursuant to the Federal False Claims Act or otherwise makes a good faith report alleging FWA in a federal health care program, including the Medicare and KDHE Programs, to Sunflower or provider or to the appropriate authorities.

Cost Recovery and Cost Avoidance Tracking and Reporting (5.12.R.6)

Sunflower submits a quarterly payment integrity report to KDHE detailing, for the reporting period, the dollar amounts cost avoided through front end edits and other cost avoidance efforts, and the dollar amounts identified and recovered through FWA detection efforts.

Other Requirements (5.12.R.7)

Sunflower acknowledges and complies with all State requirements and safeguards, including:

- Using unique identifier provided by the State's Fiscal Agent for each individual participating provider.
- Reporting fraud and abuse information to KDHE quarterly in a report including all information indicated on the report template approved by KDHE
- Documenting that safeguards at least equal to federal safeguards (at 41 USC 423, section 27) are in place
- Conducting program integrity data analytics specific to Kansas data for both Sunflower and its subcontractors

- Denying or terminating the Contract:
  - KDHE may refuse to enter into or renew a Contract with Sunflower if any person who has an Ownership or control interest in Sunflower, or who is an agent or managing employee of the Sunflower, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid, or CHIP.
  - KDHE may refuse to enter into or may terminate the Contracts if it determines that Sunflower did not fully and accurately make any disclosure required under this section.

5.12.2. MEMBER FRAUD AND ABUSE

SUNFLOWER'S MEMBER FRAUD, WASTE, AND ABUSE

As part of our comprehensive Fraud Waste Abuse (FWA) program, Sunflower and our parent company, Centene Corporation (Centene), use a centralized Special Investigations Unit (SIU) to successfully provide oversight and guidance for the prevention, detection, and resolution of member FWA. Sunflower's Compliance Officer, the Program Integrity Manager (PIM), and the Sunflower Leadership Team, in collaboration with Centene's SIU, monitor, investigate and track member activity and utilization of services to identify any potential FWA. Sunflower identifies and investigates member FWA through numerous avenues, tools, and strategies. This program is a part of Centene's overall Anti-Abuse FWA program, and includes regular meetings between Sunflower's and Centene's SIUs to discuss new cases and the next steps of ongoing audits and investigations.

Partnering to Mitigate FWA

Through our regular State payment integrity meetings, Sunflower continues to work in partnership with KDHE, KDADS, and our partner Managed Care Organizations (MCOs) to identify opportunities to modify and strengthen HCBS service requirements intended to reduce or mitigate member FWA. For example, Sunflower has identified that Day Habilitation for persons with Intellectual and Developmental Disabilities (IDD), which is not required to go through Electronic Visit Verification (EVV), may be a service for which the waiver definition and billing requirements can be modified. Because of this, Providers are unable to bill for members who are independently participating in their community or work activities, as well as times during which staff are not directly assisting a member. Sunflower has shared this information and recommendation with the State during State/MCO payment integrity meetings and looks forward to striking a mutually supportive relationship with all concerned to continue to build out this effort. Additionally, Sunflower recommends, that providers enter member approved schedules into the State's EVV system so Sunflower and other MCOs would be able to compare actual time worked to the approved schedule and units of services. This would allow members to manage and change their schedule when they approve a worker to come at a different time. Through our regular meetings, we will continue partnering to reduce FWA as well as the cost associated with such activity.

STRATEGIES FOR IDENTIFYING MEMBER FRAUD, WASTE, AND ABUSE

Members engaging in FWA may be identified through a number of avenues, including utilization (UM) management, chart review, and referral by Sunflower employees, network providers, or someone who is aware of the behavior. Member FWA may also be identified using our data analytics tool *Healthcare Fraud Shield.* Using advanced analytics and data mining, Sunflower identifies duplicative, excessive, or contraindicated treatments, as well as irregularities in services provided and/or medications prescribed, the number of providers used concurrently by the member, and excessive emergency department (ED) use. Sunflower and Centene also perform specialized reviews on request or at the recommendation of the State's legal agency or KDHE for cause. Sunflower maintains systematic controls and oversight for identifying and preventing FWA throughout our claims lifecycle.

Specific reviews conducted by Sunflower and the SIU include:

- Reviewing member encounter data to detect services provided and/or medications prescribed by more than one provider of the same or similar specialty
- Identifying abnormal trends in a member's drug utilization history, such as:
  - Office visits or provider specialties that do not match or support the medications prescribed
  - Multiple prescriptions from the same therapeutic class of drugs prescribed by two or more physicians
  - Two or more drugs in the same therapeutic class prescribed several times on the same or subsequent day by the same or multiple providers
  - Using two or more pharmacies to obtain a quantity of drugs from the same therapeutic class which exceed the manufacturers maximum dose as approved by the FDA or benefit limits
  - Using forged prescriptions to obtain medications
- Analyzing claims history to identify members who have more than two ED visits with non-emergent diagnosis or visits on the same or subsequent days
- Identifying members receiving services from more than two providers with the same specialty
- Tracking reports of member using their medical cards to purchase drugs on a forged prescription
- Responding requests or recommendations of KDHE or other State agencies for cause
- Tracking member behavior of consistently seeking/obtaining medical services not supported by diagnosis or medical records/documentation

These reviews are accomplished using numerous programs, such as:

- **PostShield-**is a tool that contains powerful fraud rules and algorithms developed by industry experts who understand the essentials of fraud detection and prevention. These post-payment algorithms, applied after claim payment, produce smarter results and less false positives with unique external data sources incorporated into PostShield's analytics. PostShield results can be utilized by any members of our organization including staff in our

SIU, Medical Management, Provider Engagement, Quality Improvement, Compliance and Legal Departments.

- **CaseShield-**is used by SIU to initiate, organize, track, and record current and historical FWA cases that SIU conducts. CaseShield electronically houses SIU investigation files and documents, and links SIU cases to internal and external reference sources, including medical records. SIU also uses CaseShield to generate FWA case documents (e.g. seeking case information from providers and/or other sources). CaseShield's FWA case tracking, and case and financial reporting capabilities align with the National Health Care Anti-Fraud Association financial reporting standards, and State and federal reporting requirements.
- **QueryShield-**is an ad-hoc querying tool that enables a user to run real-time queries and complex pattern reports from data loaded into PostShield and CaseShield. QueryShield completes template reports that may be reused and are accessible by single and multiple users, aggregated summary reports, trending analysis reports, cross-claim querying capability, fraud alert impact analysis, and customized reports to meet the specific State, federal, and agency reporting needs. Instantaneous results that may be uploaded to CaseShield or exported.
- **RxShield-**empowers users with functionalities to help monitor pharmacy expenditures. By conducting cross-claim analysis between pharmacy and medical claims, RxShield can identify prescription drugs improperly billed, detect prescribers providing medications inappropriate for diagnoses or outside the standard of care, and demonstrate abusive member patterns of prescription use. This data can easily be compiled into detailed, customized reports for analysis. RxShield adds new member and prescriber alerts regularly, and enables users to conduct pharmacy peer comparisons to ensure users are up-to-date with new pharmacy trends.

Correcting Member Behavior

Sunflower provides member education in an attempt to correct abusive behavior. Abusive behavior may include, but is not limited to:

- Identifying members receiving services from more than two providers with the same specialty
- Analyzing claims history to identify members using two or more emergency facilities for non-emergent diagnosis or who have more than two Emergency Department visits with non-emergent diagnosis or visits on the same or subsequent days.
- Concurrently using two or more prescribing physicians to obtain drugs from the same therapeutic class of medication and identifying abnormal trends in a member's drug utilization history, such as:
  - Office visits or provider specialties that do not match or support the medications prescribed
  - Multiple prescriptions from the same therapeutic class of drugs prescribed by two or more physicians
- Two or more drugs in the same therapeutic class prescribed several times on the same or subsequent day by the same or multiple providers.

- Using two or more pharmacies to obtain a quantity of drugs from the same therapeutic class which exceed the manufacturers maximum dose as approved by the FDA or benefit limits
- Report of member using the medical card to purchase drugs on a forged prescription.
- Consistently seeking/obtaining medical services which are not supported by diagnosis or medical records/documentation.

Our ED Diversion Program reduced average member ED visits from 4,293 in 2014 to 3,870 in 2016—a 9.7% decrease.

We will also investigate all potential member fraud and abuse requests or recommendations made by the state's legal offices or KDHE for cause.

Programs for Preventing Member FWA

As noted above, Sunflower has embedded programs to identify, monitor, and reduce member FWA and to address issues listed above by working with the member through notifications and Case Management to curb potential abuse issues. This oversight also ensures that members are receiving necessary services. If a member is misusing or abusing health benefits and services, our Compliance Officer and PIM will collaborate with our Chief Medical Director and VP of Medical Management to conduct targeted member education and outreach. This may include a phone call by a Customer Service Representative or SC to further explain health benefits and to remind the member about the availability of our 24/7 Medical Triage; information on available nurse advice services; a referral to our service coordination program for health risk assessment, education, Disease Management (DM); a visit by a Community Health Worker to identify potential barriers to care; or in serious cases of abuse, member enrollment in a Pharmacy Lock-In Program. Other prevention programs include:

Member Education and Validation of Services. Sunflower informs members about potential fraud issues in our Member Handbook, New Member Orientation, and through other periodic communications, such as member newsletters or when talking to a Customer Service Representative or SC.

Utilization Management Programs. The Chief Medical Director and UM staff are responsible for prior authorizations and medical necessity determinations using established criteria. They annually review and update as necessary prior authorization requirements to protect against future over- or under-utilization of services. Our pharmacy benefits subcontractor, Envolve Pharmacy Solutions, works with us to maintain a Drug Utilization Review Program. This program alerts prescribers and dispensing pharmacists to potential FWA issues by identifying overuse, inappropriate or medically unnecessary care, and to address concerns associated with specific drugs, including the potential for drug-drug interactions. The Chief Medical Director and Pharmacy Director review pharmacy utilization to identify members for the Patient Review and Coordination (PRC) Program based on potential patterns of abuse and utilization guidelines for the PRC Program. If the member meets the criteria, the SC will refer the member for the Program.

Monitoring Over-Utilization. Our Medical Director and Vice President of Medical Management monitor and identify potential over-utilization of services by a specific member by reviewing routine reports through our Centelligence ® health informatics platform. During the review, staff look for key patterns of abuse, such as members who have more than two ED visits for non-emergent diagnosis, members obtaining services from two or more providers of the same specialty, or someone who is posing as the member and receiving services not consistent with historical treatments, services or diagnoses. If staff identify a member through any of these means, they enroll that member in our service coordination program.
Once the member is enrolled in this program, the SC will review the member's care plan, which may include performing an updated partial or full reassessment of the member's needs, barriers and planned services, including BH services. The SC also will reconcile the member's current medications with those on the care plan, and frequently monitor the member through personal contact and include any caregivers.

We may also identify members with polypharmacy involving therapeutic duplication, or a high use of controlled drugs from routine pharmacy utilization reports. Our UM Committee will review identified members and may make recommendations, such as discussion with the prescribing physician(s) or referral to other programs like the Pharmacy Lock-in program.

Managing Emergency Department Visits. Sunflower follows an ED Diversion Program work process to identify and reduce inappropriate member use of ED services, as well as educate members about the appropriate use of Primary PCP services. This work process identifies members with frequent ED utilization and how to redirect members to appropriate service levels, such as urgent or PCP care, using the nurse advice line, and helping members arrange for and keep primary care visits, which decreases the frequency of inappropriate ED use. Through this effort, our overall ED use decreased from 4,293 average monthly visits in the second quarter of 2014 to 3,876 average monthly visits in in the fourth quarter of 2016, a 9.7% decrease. Supplemental Security Income (SSI) population ER visits decreased 18.6%, from 2,608 average monthly visits to 2,123 average monthly visits.

Through our Medical Management staff, we encourage members to see their PCP rather than using the ED, and when continual abuse is identified, refer members to a SC or and/or our Administrative Lock-in program. Once members are identified and referred to case management, a Sunflower nurse reaches out to the member and works with them to evaluate and identify why the member is using the ED. Once the root cause is discovered, the nurse works with the member to develop a course of action to decrease ED use, up to and including, establishing a relationship with PCP and attending appointments with the member, if necessary. The SC will help members understand disease process, as well as aid in coordination of medical services, BH, pharmacy, DME, etc.

Designated managers provide oversight and outcome monitoring in an effort to ensure continued improvement, and employ an ED Report to identify members to refer members for service coordination or Lock-In. These managers will gather information on Sedgwick County, the highest ED using population and partner with Community Health Workers to educate

members on services available. This includes a partnership with our dental vendor so members receive letters encouraging them to see a dentist in their area.

Lock-In. Sunflower uses an Administrative Lock-In System, which complies with all state and federal regulations. We notify the State immediately when a member has been placed in Administrative Lock-In and if a member in Lock-In transfers to fee-for-service or another plan. Situations in which Sunflower may place a member in Administrative Lock-in include:

- Persistent non-compliance for members who persistently refuse to follow prescribed treatments or comply with the MCO's requirements
- Abusive or threatening conduct if a member engages in abusive or threatening conduct
- Fraud/Abuse if a member is found to be committing fraud or abuse of medical benefits
- Overutilization when a member uses Medicaid services at a frequency or amount that is not medically necessary

If the member has a substance use disorder, mental health diagnosis, or disability diagnosis related to the persistent non-compliant behavior, Sunflower works with BH and disability providers to help members modify their behavior prior to placing a member in administrative lock-in through member education and counseling. During this process we share with them information on exactly how they have may have misused their benefit. We ensure all attempts to educate and modify behavior are documented in our Compliance Management System by the staff working with the member. During the Lock-In period, the member may be required to use one pharmacy, one hospital, and/or one service provider. The member has the right to appeal their placement into Administrative Lock-In and will be given notice and the opportunity for a fair hearing before placement into Administrative Lock-In. We will ensure that the member has reasonable access (taking into account geographic location and reasonable travel time) to Medicaid services of adequate quality. Restrictions will not apply to emergency services furnished to the member.

Notifying the State of Members Suspected of Fraud or Abuse

Sunflower will continue to notify the State of any member who has been identified through UM activities, chart review, or by provider referral as participating in fraudulent or abusive activities. Sunflower will continue to provide the State with written notification and supporting documentation related to such suspected fraudulent activities.

This documentation includes a copy of Sunflower's preliminary investigation, including all supporting documentation and evidence. If a member's abusive or fraudulent activities involve drug-seeking behavior or drug abuse, Sunflower's PIM immediately refers the member to our Lock-In Program. Based on state or federal regulations and/or the seriousness of the violation, we also refer the case to other appropriate State or federal agencies. Our PIM also coordinates with SIU and other staff to provide any additional assistance needed by the State or federal agency.

Sunflower currently reports specific information about our FWA program via several reports to the State. These reports include:

- **Verification of Services Provided (VSP) Report** – Also monthly, Sunflower partners with Centene's Corporate SIU to verify whether services reimbursed by us are actually furnished to eligible persons as billed by providers. Centene's Information Systems team randomly selects the statistically valid sample of members for whom claims were processed. The policy for this process is CC.COMP.16.01 EOB Service Verification. This report and process follows all requirements outlined in Verification of Services Provided 42 CFR §455.20.
- **Fraud, Waste, Abuse, and Lock-In (FWA) Report** – On a quarterly basis, the PIM compiles a FWA report that includes an update of investigative activity, including corrective actions taken. The report follows all requirements as outlined in our current Contract, Coordination of Program Integrity Efforts and Other Requirements, and includes information on Specific FWA cases including: unique provider Name/NPI/TIN, provider type, referral allegations, potential monetary exposure and any identified recovery; education provided and summary of total recoveries by provider type. The report also includes the activities of the Lock-In program along with any identified overpayment based on Program Integrity projects.
- **FWA Annual Risk Assessment Report** – Annually, Sunflower and Centene conduct an annual risk assessment on both our and our vendors' fraud and abuse/program integrity procedures (for those subcontractors that are delegated to adjudicate claims on behalf of Sunflower Health, such as dental, vision, pharmacy, or transportation). The assessment includes a listing of the top five vulnerable areas and an outline of actions to be taken to mitigate risks in each area. In compliance with section 2.2.30.5 Program Integrity and Disclosure Requirements, the assessment will be provided to the State within 30 days of its completion each year. On an annual basis, we will submit to the State our policies for employees, Sunflower Health, and all of it agents/vendors that comply with Section 1902(a)(68) of the Social Security Act.

5.12 Attachments

Sunflower Health Plan’s response to this section is provided in our Proprietary Proposal.

5.13 Financial Management

5.13. FINANCIAL MANAGEMENT

SUNFLOWER DEMONSTRATED SUCCESS

Sunflower Health Plan (Sunflower) is currently and will continue to be in compliance with all State financial management and reporting requirements. As a trusted partner with KDHE, Sunflower has the capability and capacity to fulfill all current and future financial management requirements related to KanCare. Our success is demonstrated by:

- Providing accurate, continually updated information to KDHE
- Ensuring review and fulfillment at the direction of Sunflower's Senior Executive Finance Officer and submission in the State's format
- Timely completion of all financial reporting required and requested by KDHE

Compliance with Scope of Work

Sunflower understands and acknowledges all requirements set forth in section 5.13 and will comply.

5.13.1. DISCLOSURE OF FINANCIAL RECORDS

ACCOUNTING SYSTEM AND FINANCIAL RECORDS (5.13.1.A-B)

Sunflower uses PeopleSoft financial management software to record and report financial data related to the KanCare program. All financial transactions are auditable in accordance with Generally Accepted Accounting Principles (GAAP) guidelines, and data is readily ascertainable from PeopleSoft via online queries and reports. Sunflower is in compliance with all current financial disclosure requirements and will continue to provide updated, accurate, and complete information regarding any financial records relating to our capacity to bear the risk of potential financial losses, or to the services performed and amounts paid or payable, with all procedures, policies, and records available throughout the contract. All records will also be available after the contract and open to State and federal audit for a period of not less than 10 years.

FINANCIAL REPORTING (5.13.1.C-D, G, J)

Sunflower understands and agrees to continue filing all requested financial reports with the State in a format and frequency as specified by the State, signed and certified/attested to by Sunflower's Senior Executive Finance Officer or Chief Executive Officer attesting to each report's completion and accuracy. We currently submit and will continue to submit all financial reports in a format and frequency as specified by the state, with reporting requirements reflecting the results of the KanCare program.

In accordance with GAAP guidelines and as defined by the State, Sunflower will submit Medicaid-specific audited financial reports to the State annually.

PERFORMANCE BOND (5.13.1.E)

Sunflower complies with all currently existing performance bond requirements. Our continuing participation satisfies the 45-day requirement, and we will continue to comply with State

guidance regarding performance bond and restricted reserve account requirements as communicated by KDHE.

INSOLVENCY PLAN (5.13.1.F)

We will also continue to provide our insolvency plan to the State annually or as requested, and understand all members shall be held harmless in the event of insolvency. For additional detail, please see ***Attachment 5.13.1 Sunflower Insolvency Plan.***

LETTER OF CREDIT (5.13.1.H)

Should Sunflower obtain any Letters of Credit as directed by the State, we will provide copies of each Letter of Credit held to the State.

OWNERS WITH INTEREST OF 5% OR GREATER (5.13.1.I)

Sunflower is not currently owned by any person or corporation with a 5% or more ownership or controlling interest. Sunflower's Compliance Department annually completes and submits the 5% Ownership Report and will submit financial statements for all owners with a 5% or greater interest should that occur.

5.13.2. PAYMENT TO CONTRACTOR(S)

ACTUARIALLY SOUND CAPITATION RATES (5.13.2.A)

Since becoming operational in 2013, Sunflower understands the State and its actuaries have been following all federal and State regulations related to actuarially sound capitation rate payments in accordance with generally accepted actuarial principles and in conformance with 42 CFR § 438.3(c)(1)(ii), § 438.4, § 438.5, § 438.7, and Sunflower has been assisting with this process by completing Medicaid Reporting Templates (MRTs) as designed by the State.

Risk Adjustment and Amendment Process (5.13.2.B-C)

We understand these rates are subject to a risk adjustment methodology that is developed, documented, and approved in accordance with 42 CFR § 438.5(g) and 42 CFR § 438.7(b)(5), and that rates are set and adjusted annually by KDHE and their actuaries from the preceding year for inflation, trends, utilization, and policy changes and must be approved by CMS.

Annual Rate Development (5.13.2.D)

To support annual rate development, Sunflower submits and will continue to submit validated Encounter Data and audited financial reports in accordance with 42 CFR § 438.5(c), and completes a State-designed MRT as requested and in the format prescribed by KDHE.

Capitation Payments (5.13.2.E-F)

Sunflower will retain capitated payments only for Medicaid eligible members and will communicate overpayments and allow the State to recoup any discovered overpayment to the State within 60 days of discovery. Sunflower acknowledges that the specified capitation payments will constitute full and complete payment for all goods and services provided for the

covered time period. We also acknowledge the State's right to recover inappropriate capitation payments.

CASE AUDITS, DISPUTE, AND RECOVERY (5.13.2.G-I)

Sunflower acknowledges our right to audit and recommend adjustments to case mix information based upon documented processes. Any adjustment requests that may affect the case mix will be submitted to the State no later than 30 days prior to the rate effective date. Sunflower also agrees to yield to the State in the event of disputed membership enrollment. Any and all recoveries for withhold arrangements shall be subtracted from Sunflower's monthly PMPM payment or paid by check to KDHE.

MEDICAL LOSS RATIO (5.13.2.J)

Our monthly, quarterly and annual Medical Loss Ratio (MLR) reporting to the State complies with the current Contract. Sunflower currently calculates MLR consistent with the State's template reports which consider the requirements specified in 42 CFR § 438.8 for the MLR reporting year. At all times, we will use the State's MLR Reporting Template, such as our current monthly/quarterly reporting using the State's Kansas Reporting template including the MLR Report Long. We will continue to report Fraud/Waste/Abuse prevention activities to the State in accordance with their report templates so that they can be identified, and we understand the State will not include Fraud activities until CMS adopts a standard per 45 CFR Part 158. We also understand we may at some future date apply a credibility adjustment factor as specified by CMS. Sunflower understands the State may require the Sunflower to pay remittance to the State if the MLR under the contract for the MLR reporting year is less than 85%, and upon notification by the State, would pay a remittance to the State within 30 days if MLR for a reporting year is lower than 85%. Annual MLR Reporting is currently submitted and will be submitted within 8 months of the close of the MLR Reporting Year in accordance with Attachment H reporting requirements. We acknowledge that this requirement survives the Contract.

5.13 Attachments

sunflower health plan

POLICY AND PROCEDURE

DEPARTMENT: Finance	**DOCUMENT NAME:** Plan in the Event of Financial Insolvency
PAGE: 1 of 3	**REPLACES DOCUMENT:**
APPROVED DATE: 5/13	**RETIRED:**
EFFECTIVE DATE: 01/13	**REVIEWED/REVISED:** 4/14; 3/15; 1/16; 12/16; 9/17
PRODUCT TYPE: KanCare	**REFERENCE NUMBER:** KS.FINC.01

SCOPE:
Sunflower State Health Plan (Referred to as "Health Plan"), Centene Corporation, Kansas Insurance Department (KID) and KDHE-DHCF.

PURPOSE:
To provide requirements for Insolvency Protection for Health Plan's Contract with KDHE-DHCF.

POLICY:
Insolvency Protection shall meet or exceed requirements in the Medicaid Contract.

PROCEDURE:
Parental Guarantee

1. Centene Corp will serve as a parental guarantor to the Health Plan for the duration of the contract with KDHE-DHCF.

2. As part of the guarantee, Centene's Finance Department (Finance) will review the Health Plan's financial statements on a monthly basis.

3. In the event the Health Plan's Total Net Value is projected to fall below required thresholds defined by KID, Finance will transfer necessary funds into the Health Plan's account to ensure adequate funding through the next month.

4. In the event Finance is also insolvent, the Health Plan will follow the process outlined in the Insolvency Account section item 5.

Provider Agreements

1. All Health Plan agreements with providers will include language holding members harmless for any payments in the event the Health Plan is financial insolvent.

Performance Bond

1. In addition to Centene Corp's parental guarantee, the Health Plan shall establish a Performance Bond in the amount of $5,000,000 with a Surety Company licensed to do business in Kansas and payable to the State.

2. In the event that a determination is made by the KDHE-DHCF or Kansas Insurance Department that the Health Plan is insolvent, KDHE-DHCF may draw upon the amount solely with the two authorized signatures of

representatives of the KDHE-DHCF and funds may be disbursed to meet financial obligations incurred by the Health Plan under this Contract. A statement of account balance shall be provided by the Health Plan within 15 calendar days of request of the KDHE-DHCF.

3. If the Contract is terminated, expired, or not continued, the Performance Bond shall be released by KDHE-DHCF to the Health Plan upon receipt of proof of satisfaction of all outstanding obligations incurred under this Contract.

4. In the event the Contract is terminated or not renewed and the Health Plan is insolvent, KDHE-DHCF may draw upon the Performance Bond to pay any outstanding debts the Health Plan owes KDHE-DHCF including, but not limited to, overpayments made to the Health Plan, and fines imposed under the Contract or, for which a final order has been issued. In addition, if the Contract is terminated or not renewed and the Health Plan is unable to pay all of its outstanding debts to health care providers, KDHE-DHCF and the Health Plan agree to the court appointment of an impartial receiver for the purpose of administering and distributing the funds of the Performance Bond. An appointed receiver shall give outstanding debts owed to KDHE-DHCF priority over other claims.

REFERENCES:
Medicaid HMO Contract Section

ATTACHMENTS:

DEFINITIONS:

REVISION LOG

REVISION	DATE
Annual review – no change	4/25/14
Annual review – no change	3/16/15
Annual review – no change	1/19/16
Annual review – no change	12/5/16
Annual review – no change	9/18/17

POLICY AND PROCEDURE APPROVAL

POLICY AND PROCEDURE

DEPARTMENT: Finance	**DOCUMENT NAME:** Plan in the Event of Financial Insolvency
PAGE: 3 of 3	**REPLACES DOCUMENT:**
APPROVED DATE: 5/13	**RETIRED:**
EFFECTIVE DATE: 01/13	**REVIEWED/REVISED:** 4/14; 3/15; 1/16; 12/16; 9/17
PRODUCT TYPE: KanCare	**REFERENCE NUMBER:** KS.FINC.01

The electronic approval retained in Compliance 360, Centene's P&P management software, is considered equivalent to a physical signature.

Controller: Approval on File
V.P. of Finance: Approval on File

5.14 Claims Management

5.14. CLAIMS MANAGEMENT

SUNFLOWER DEMONSTRATED SUCCESS

Sunflower Health Plan (Sunflower) has served Medicaid members in Kansas as a participant in the KanCare program since 2013. We work closely with KDHE to provide timely, accurate, and consistent claims processing, coordination of benefits, and encounter submissions. We use a fully integrated Management Information System (MIS) to successfully process claims and submit encounters to the State.

- On average, Sunflower processes approximately 6 million medical, behavioral, and nursing facility claims a year with an average payment turnaround time of less than nine days.
- Sunflower consistently meets and exceeds timely claims processing and payment metrics.
- Through our systematic controls, Sunflower has realized over $125 million in third party liability saving from coordination of benefit, cost avoidance, and recovery activities.
- Sunflower submits approximately 5.4 million encounters per year with an accuracy rate of over 98%.

Compliance with Scope of Work

Sunflower is currently in compliance with all KanCare contracts and all KanCare 2.0 requirements described in Section 5.14 of the Scope of Work (SOW). Below we describe in detail our overall approach for timely claims processing; post-pay recovery, third party liability, and coordination of benefits; encounter data submission; and other data processes including accountability, oversight, and evaluation for complying with each element of the SOW. For ease of review we have included SOW references in headers and within the narrative.

5.14. CLAIMS MANAGEMENT

5.14.1. TIMELY CLAIMS PROCESSING

A History of Timely Claims Service

Sunflower has been successfully processing claims as a participant in the KanCare program since 2013. Sunflower views claims processing as a critical opportunity to offer superior service to our providers, ensuring a sound provider network. Sunflower takes pride in its exceptional track record of reimbursing providers in a timely manner, with an average payment turnaround of less than nine days. We view the claims process as a very important data gathering aspect of our operation, since it supports our quality and utilization monitoring efforts; informs in part our quality improvement initiatives, provider education, and outreach and incentive initiatives; and supplies KDHE with complete, accurate, and timely encounter reporting.

Experience Processing & Paying Claims:

- ***In 2017, Sunflower processed 100% (99.98%) of clean claims within 30 days, with an average turnaround time of less than nine days.***
- ***Sunflower maintains an overall average automatic adjudication rate above 85% for all claims, which means less than 15% of our claims require manual intervention.***
- ***In 2017, the average turnaround time for nursing facility claims is less than 10 days.***

Sunflower leverages claims processing and reporting capabilities developed over our parent company, Centene Corporation's (Centene's), 33 years of experience receiving, processing, and reporting claims data to our state partners, including KDHE. Through our integrated MIS and business processes, we ensure ongoing, timely, and accurate claims processing for electronic and paper claim submissions.

We support receipt of claims in HIPAA-compliant formats, and we auto-adjudicate over 85% of all claims thanks to the integration of our functional MIS components. Sunflower and our affiliated health plans have multi-year experience serving HCBS providers with claims support features, including electronic visit verification (EVV) interoperability and online long term care claims assists. Our MIS supports Medicare crossover claims processing, with controls to safeguard against balance billing. Our integrated Centelligence® health informatics platform allows us to identify and resolve claims issues through reports and interactive dashboards. We configure our MIS to process claims from non-traditional provider types by using HCPCS codes and affording these providers the training and support they need.

Fully Compliant with Key Health Care Transaction Standards. Sunflower complies with all federal mandated HIPAA-required formats and code sets for the 837 Institutional Claim and Encounter Transactions, the 837 Professional Services Claim and Encounter Transactions, the 837 Dental Services Claim and Encounter Transactions and National Council for Prescription Drug Programs (NCPDP) standards as specified in the Implementation Guides and Kansas Companion Guides.

Attestation to Meeting the Requirements in Attachment I. We have reviewed in detail all claims requirements stipulated in Attachment I of the Request for Proposal (RFP), Attachment H for Claims Reporting, and other requirements indirectly impacting claims processing such as those for Post Payment Recovery and Reporting. We currently support similar requirements for KDHE today and in all our affiliate health plans today. We are confident, based on our Kansas and nationwide experience with similar requirements, to meet KDHE needs.

Local Claims Operational Excellence. Our Sunflower Claims Team has five years of expertise in claims processing for KDHE programs, enabling us to process complex claims in an accurate and timely manner. Sunflower provides local oversight of claims payment operations through the Claims Research and Analysis staff and management team. Our Sunflower Claims Team is comprised of a dedicated claims operations staff of 13 Claims and Business Analysts that support all aspects of Sunflower claims operations such as claims processing, system configuration, claims audit, and encounter processing. Along with the review of frequent performance reports by the management team, the Claims team reviews daily pend reports to

Sunflower in Action…

Claim billers at Hutchinson Regional Medical Center recognized one of our team members on her attention to their questions and concerns; getting things corrected, or routing to the proper department for final resolution.

identify aging claims and conduct outreach to providers or take appropriate steps to facilitate the resolution and finalization of aging claims.

Our Operations Department collaborates with the State and our fellow MCOs on a number of activities, including claims processing and payment processes. Our Senior Manager of Operations communicates daily through email with KDHE and participates in biweekly meetings with KDHE to address any claims and data related issues.

Also, Sunflower is backed by a dedicated team of Centene Claims Processors trained on the KanCare benefits plan and KDHE-specific processing rules and requirements, providing support to Sunflower for electronic and paper claim receipt, claims quality monitoring, and other support services.

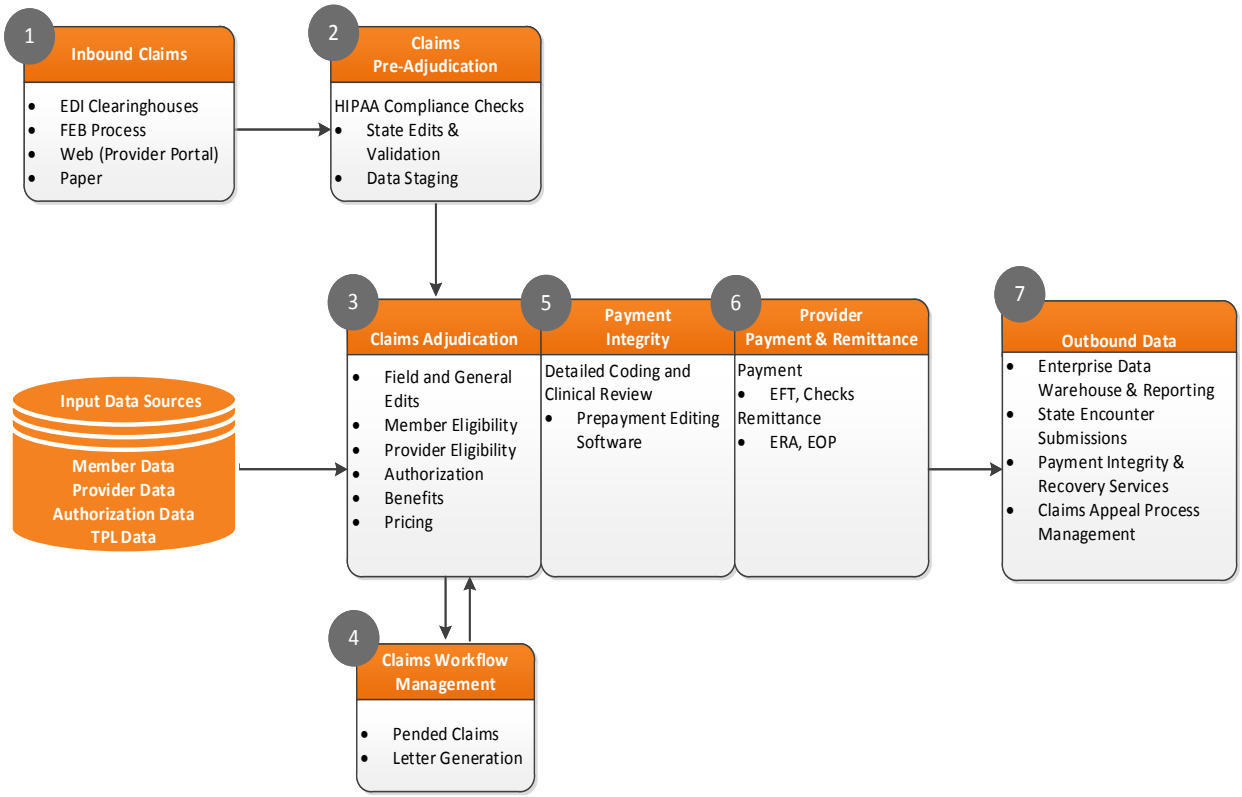
Integrated Claims Processing and Payment Systems. Successful claims payment requires integrated systems for member and provider data management, claims processing, and reporting. Our MIS has the following key integrated components to support accurate and timely claim adjudication processes:

- Unified Member View (UMV): processes and stores member enrollment data including eligibility, demographics, covered benefits, and third party liability (TPL) information.
- Provider Data Management (PDM): our system of record for provider information including network status, specialties, licensure, and fee schedules, and identifiers such as NPI, Medicaid ID, and service location code.
- Customer Relationship Management (CRM): Our CRM member and provider service inquiry platform enables our call center staff to identify, engage, and serve our providers and members in a coordinated fashion across the breadth of their wellness, clinical, claims inquiry and other administrative matters. CRM incorporates real time updates from our Centelligence® data integration system for information on claims processing and payment, enrollment, eligibility, and care gaps.
- AMISYS Advance (AMISYS): our best in class HIPAA-compliant claims processing module with configuration and editing capabilities for all claim transactions, which complies with the claims requirements and timeframes mandated by KDHE and federal regulations. Because AMISYS identifies the claim date of submission; admission and discharge dates; level-of-care information; and provider type (traditional or LTSS), it accurately applies KDHE fee schedules, program guidelines, and claims payment timeframes for claims.
- TruCare: supports our clinical service coordination processes housing member authorizations and level-of-care information. TruCare maintains medical and behavioral health member service authorization requests and electronically sends and updates authorization data every 15 minutes to AMISYS.

Claims Processing Functions to Process and Pay All Claims Timely and Accurately. Sunflower's public sector focused HIPAA and KDHE compliant claims adjudication process and systems are integrated end-to-end: from provider claim submission to provider payment. See ***Figure***

5.14.A_Claim Processing Workflow below for a flowchart that summarily illustrates the entire process.

Figure 5.14.A_Claim Processing Workflow



<u>Inbound Claims (Item [1]).</u> We accept provider inbound claims through many submission methods, including electronic data interfaces (EDI), KDHE Front End Billing (FEB) processes, web portal entry, and paper submissions. We support all HIPAA EDI required formats, including the 837 Health Care Claims (Institutional, Professional, and Dental) and NCPDP D.0 Pharmacy claims. For paper claims, we accept the UB-04, CMS 1500, and Dental ADA formats. All paper claims received are scanned and converted to electronic data. For all claims we receive, our MIS translates data from the claim, applying common formats to all claims. KDHE requirements are configured via the table-driven configuration utility within our claims processing system, AMISYS. AMISYS verifies that the claim complies with HIPAA, validating against ANSI Accredited Standards Committee X12N and KDHE's Systems Companion Guides for syntax and data structure. If a claim does not pass these rules, a notification is triggered to the trading partners and providers (via ANSI TA1/999 Functional Acknowledgment or rejection letter).

For all EDI claims, we provide an electronic acknowledgment of receipt of the claim to the provider within 24 hours using HIPAA standard electronic acknowledgments. For paper claim submissions, we provide a letter or explanation of payment (EOP) to the provider within 15 days after receipt of the claim indicating payment details on the EOP or additional information needed to process the claim.

Claims Pre-adjudication Edits (Item [2]). Submitted claims are mapped, translated, and validated by our MIS against common edits, including member identifiers, billing and rendering provider identifiers and other data elements against internal data, such as member eligibility in the member data management system (UMV). If a transaction is rejected for any of the specific reasons configured in our MIS, an ANSI 277 Unsolicited (277U) notification is systematically issued to the EDI trading partner or submitting provider, conveying the specific KDHE-approved edit that did not pass our upfront validation processing. Direct Data Entry (DDE) and LTSS Claims Wizard submitters receive a similar status message on our Portal. In the event a paper claim fails pre-adjudication edits, our MIS automatically generates and sends a letter to the submitting provider, rejecting the claim and citing the specific edit(s) responsible. Likewise, when a provider submits a paper claim that fails pre-adjudication edits, we automatically send a letter to the provider rejecting the claim and showing the specific reasons for the rejection. Examples of pre-adjudication edits include:

- ***Member Validation*;** confirms presence of member record in our systems.
- ***Validate Dates of Service;*** confirms that the claim date of service is valid and does not contain a date outside of the member's eligibility span.
- ***Diagnosis Code Validation;*** confirms the presence and accuracy of ICD-10 and procedure codes, and all HIPAA code sets and identifiers.

AMISYS Adjudication (Item [3]). Once a claim passes the pre-adjudication edits, it is loaded into AMISYS, our claims adjudication system. AMISYS performs six primary steps of adjudication that a claim must pass in logical succession to reach a "finalized" (paid or denied) status or internally pended status. These high level steps include:

- ***Field and general edits*** - the claim is checked for the presence and validity of common data fields, including CPT, ICD-10, age, gender, duplicate, and timely filing edits, and if they are consistent with the business rules outlined by KDHE and federal regulations.
- ***Member edits*** - the claim is checked for member eligibility during service date spans, coverage type, and existence of TPL.
- ***Provider data*** - the claim is checked for the submitting provider's eligibility during service date spans and network participation status.
- ***Prior-authorization*** - when applicable, the claim is checked for a prior-authorization and validates the presence of criteria during the service date spans.
- ***Covered Services*** - the claim is checked against our benefit management rules and validates whether the member is eligible for the services rendered during the service date spans.
- ***Pricing*** - the claim is then priced by applying any member TPL; coordination of benefits (COB) financial responsibilities; copayments or deductible amounts; and provider specific contractual and financial agreements.

Claims Workflow Management (Item [4]). Our integrated claims workflow capabilities manage the workflow of any pended claim in real time. If a claim pends in AMISYS, an electronic work item is routed to a staff person with the expertise to address the particular pend issue for

resolution. For example, we can route claims with specific pend codes to our licensed clinical staff for medical review, research and resolution. In addition, Claims Analysts have immediate access to paper claim images (including attachments) via the Centene Document Management System (CDMS) to support the communication and routing of information between departments. When the "pend issue" is addressed, we re-adjudicate the claim in real time using the process described above.

Payment Integrity (Item [5]). Before payment, claims are routed for assurances in payment integrity. Sunflower maintains systematic controls and oversight for identifying and preventing Fraud, Waste and Abuse (FWA) throughout our claims lifecycle. HIPAA compliance checking and pre-payment edits occur before we pay claims. AMISYS identifies incorrect billing and potentially fraudulent practices such as unbundling, mutually exclusive codes, procedure frequency-by-day, and age/gender discrepancies.

Verisk's HealthCare Insight (HCI). Through our strategic partnership with Verisk's HealthCare Insight (HCI) subsidiary, Sunflower incorporates processing against National Correct Coding Initiative (NCCI) edits that supplement our claim processing controls. HCI keeps these edits current with federal and state regulations, including of 42 CFR 433.116 and 45 CFR 95, subpart F; coding rules; and code sets to ensure accurate claims coding before we pay them.

Provider Payment & Remittance (Item [6]). AMISYS finalizes claims with a status of paid or denied for the next weekly payment cycle once the claim successfully passes all edits. AMISYS captures the date of payment and the check or transaction number with the claim. We offer providers Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) payment options. We also offer paper check and paper Explanations of Payment (EOP). Our ERAs/EOPs provide an itemized accounting of the individual claims included in the payment including, but not limited to, the member's name, date of service, procedure code, service units, the amount of reimbursement, and the identification of our Managed Care Plan. The provider will receive an ERA or EOP even if a claim is denied, clearly stating for the provider the reason(s) for claim denial, along with instructions for correction and resubmission, if applicable. Finally, we also offer providers a payment option through our free PaySpan comprehensive payment management solution. PaySpan supports online EFT enrollment and activation, including bank depository accounts and remittance preferences, enables providers to view detailed remittance information online. Providers can also download HIPAA 835 electronic remittance files directly to their financial system to manage their accounts receivables.

Outbound Data (Item [7]). AMISYS electronically sends processed claims data to the EDW, where that data is accessed by our Encounter Data System (EDS) to meet KDHE encounter data submission requirements. EDS is a highly customizable encounter reporting system which applies edits and mapping routines to claims data and translates encounter data into HIPAA 837 files for submission to KDHE. We also use processed claims data with specialized third-party liability (TPL) subcontractors to support post-payment recovery when TPL is unknown at the time we pay a claim, and for subrogation to parties with TPL.

APPROACH TO MEETING PAYMENT TIMELINESS STANDARDS (5.14.1.A-B)

Sunflower has the tools, experienced staff, processes and support systems in place to ensure claim timeliness, accuracy, and completeness of data submitted. We measure claims timeliness from submission date to payment date (paper check date or EFT notification date), or date of electronic or paper denial notice. We acknowledge KDHE's requirements for timely payment of claims as stated in the Statement of Work. Every quarter, our Senior Manager of Operations or designee submits to KDHE the claim reports as required in Attachment H.

Our MIS applies date and time stamps upon receipt of all claims (electronic or paper), allowing us to maintain metrics on the timeliness of our claims processing and payment. From claim receipt to provider payment, our MIS retains and displays a complete claim processing history, enabling us to focus on any claims that risk exceeding timeliness standards. Our MIS allows us to monitor adjudication results daily to ensure claims we pay are processed correctly without delaying payments.

We have complementary processes and metrics in place to monitor our claims processing for accuracy and quality. Our claims staff monitor our online Claim Status Dashboards (Dashboard) which display the volume of claims receipt, auto-adjudication rates, paid and denied claim statistics, pends, adjudication inventory, voids, and rejects. The Dashboard can be filtered to drill down to any issues that may be affecting claims accuracy and processing timeliness.

Claim Finalization (Paid/Denied) Metrics (5.14.1.B)

We have and continue to maintain an excellent record for timely claim finalization (payment, partial payment, or denial) for both in-network and out-of-network providers. The following table highlights our year to date metrics from our October 2017 Claims Metric Report which meets or exceed KDHE timeliness requirements. See ***Table 5.14.A_4_Claims Metrics***.

Table 5.14.A_4_Claims Metrics

	YTD 2017	YTD 2016
Clean Claims Processed within 30 days	100% (99.98%)	100% (99.93%)
Non-clean Claims Processed within 60 days	99.79%	99.9%
All Claims (including adjustment) Processed within 90 days	100%	100%

Monitoring Claims Inventory to Support Timeliness Standards. For claims inventory management, our Centelligence® dashboard reporting system provides day-to-day management and insight into claim transactions including all electronic and paper submitted claims, appeals, call center routed inquiries, correspondence, authorizations (both standard and expedited), and other forms received by Sunflower. We use dashboard reports to manage the aging of work in accordance with KDHE turnaround time (TAT) standards. Our claims dashboard reporting includes claim receipts, auto-adjudication rates, TAT, paid and denied claims, first-time claim pended inventory, adjustment inventory, voids, configuration, monthly interest, rejects of claims, and encounter processing.

Claims Audit Division to Support Accuracy and Quality Standards. Our Claims Audit Department (CAD) is responsible for the independent and objective evaluation of claims payment accuracy per our policies and procedures. CAD operates independently of the Claims Department and reports directly to the Senior Vice President, Internal Audit. CAD helps ensure that provider payment processing is in accordance with appropriate rates and that all State and Federal claim processing rules are followed including, but not limited to, prompt payment and interest calculations. CAD issues monthly and quarterly reports to the Sunflower Claims Team and management that summarize audit results.

CAD audits encompass claim entry, adjudication processes, as well as whether determinations on enrollment, benefit, and payment are accurate. CAD staff perform weekly and monthly, statistically valid audits based on a random sample of processed claims, to assess claims for processing, payment, and financial accuracy. CAD selects random samples from each check run, which includes paid, denied, appealed, and adjusted claims. The sample provides a 99% confidence level, plus or minus 2.5%. CAD assesses multiple attributes including, but not limited to, outliers/unusual practices, a trace of claim dollars in the audit sample to the specific underlying source documents (e.g., provider contracts, fee schedules, benefit grid), accuracy of claim data entry, other third party liability (TPL) insurance investigated for coordination of benefits, and verification that claims coding was consistent with provider credentials.

Tracking Claim Receipt Date for Timely Claims Processing (5.14.1.C.1)

Each claim is assigned a unique control number incorporating the Julian time stamp we affix to all claims upon receipt, indicating when the claim was received. This “date stamp” is part of the control number used to identify each unique claim, allowing us to track our adherence to claims processing timeliness standards, maintain inventory control, and audit our claims adjudication and payment processes. Throughout the claim lifecycle, from receipt to payment, AMISYS retains a comprehensive audit history of all claim transactions and data elements, including date span logic, historical claims tracking, operator ID stamping, enabling us to filter down to a specific parameter for targeted audits.

Identifying Claims and Transactions via an Internal Control Number (ICN) (5.14.1.C.2). As indicated above, AMISYS assigns a unique ICN to each claim and its attachments, adjustment, and financial transaction, as approved by KDHE. As indicated above, the date used in the ICN is the date when we receive the claim. The Sunflower ICN complies with the KHDE requirements of alphanumeric, maximum field length of sixteen (16) bytes and the date of claim receipt. Each of our claims paying subcontractors also maintain a unique internal control number to track claim receipt, maintain inventory control, validate claims for duplicate submission, verify member eligibility, and apply KDHE processing and payment requirements. We will notify KDHE in the rare event we, or our subcontractors, change the structure of the ICN.

Our current ICN, including each subcontractor, is detailed in the following table. See ***Table 5.14.B_Current ICN Structures.***

Table 5.14.B_Current ICN Structures

Current ICN Structures	
Sunflower	The AMISYS system assigns a unique ICN for submitted claims such as O161KAE#####. - Positions 1: A letter in the alphabet representing the year ▪ M = 2013 ▪ N = 2014 ▪ O = 2015 ▪ P = 2016 - Positions 2-4: Julian date - Positions 5-6: State Identifier (e.g., KS is Kansas) - Position 7: Either an "E", "P", 5, 6 or 7, where "E" indicates an electronic claim submission, "P" indicates a paper claim submission, 5 or 6 indicate an electronic corrected claim, and 7 indicates a paper corrected claim - Positions 8-12: Number incremented by 1
Envolve Pharmacy	As each claim is entered electronically in the NCPDP D.0 format, the ICN number is selected from a sequential number generator during the adjudication process. Numerical values automatically increment by 1 for every claim record. In 2018, Envolve Pharmacy will be updating the ICN to include the date of claim receipt as part of the ICN structure.
Envolve Vision	For vision claims, Envolve Vision assigns a unique ICN such as 201508211538. - Positions 1-4: YYYY or 4-digit year claim received - Positions 5-6: MM or 2-digit month claim received - Positions 7-8: DD or 2-digit day claim received - Position 9: Alphanumeric character. An alpha character indicates the claim is received via the secure provider website - Positions 10-12: Alphanumeric character in chronological system derived order
Envolve Dental	For dental claims, Envolve Dental assigns a unique ICN such as 20150513100555. - Positions 1-4: YYYY or 4-digit year claim received - Positions 5-6: MM or 2-digit month claim received - Positions 7-8: DD or 2-digit day claim received - Position 9: Either a 1 or 0, where 1 indicates an electronic claim submission and 0 indicates a paper claim submission - Positions 10-14: Sequential system assigned claim number
LogistiCare	For NEMT claims, LogistiCare assigns a unique ICN such as L012015090865737XA. - Position 1: The value of "L" as a placeholder - Positions 2-3: The value of CC as the 2-digit server ID for Sunflower - Positions 4-7: YYYY or 4-digit year the claim received - Positions 8-9: MM or 2-digit month claim received - Positions 10-11: DD or 2-digit day claim received - Positions 12-17: The trip ID which can be up to 6 digits - Position 18: The value of "X" as a placeholder - Position 19: The trip leg represented by a letter where "A" is the first leg, "B" is the return leg, and subsequent letters represent additional stops (e.g., adding a stop to the pharmacy after a doctor's appointment.) Sunflower will work with LogistiCare to limit the ICN to only 16 digits.

Tracking Payment Date for Provider Payments (5.14.1.C.3)

The AMISYS system assigns a payment date for each provider payment for both electronic funds transfer (EFT) and paper check payments. For payment purposes, we consider the payment date the same as the EFT or paper check date. For 835 electronic remittance, the ERA

is sent the same day as the EFT payment. For paper checks, the EOP is sent with the check. AMISYS retains the assigned payment date for tracking, reporting, and auditing purposes.

Provider Payment System (PPS). Our integrated PPS helps ensure that the claims we pay weekly are processed correctly. Using the assigned payment date, we conduct a payment review prior to the releasing the final provider payment. PPS helps assure claims are reviewed in a timely manner, preventing any bottlenecks of claims issues that would otherwise hold up our weekly payment cycle.

Supporting Providers with Technical Assistance for Claims Submission (5.14.1.D)
Sunflower prides itself on meeting the provider where they are and has therefore adapted communication and outreach strategies based on the provider's schedule and preferred communication preference (e.g., phone, in-person, and email). Sunflower has a comprehensive approach to train, support, and disseminate resources to ensure that providers have the tools to file timely, complete, and accurate claim submissions.

Provider Technical Assistance. In addition to our Provider Relations staff who continuously work and coordinate support with our providers regarding claims and all other areas regarding provider relations with Sunflower, Centene offers an EDI Help Desk to communicate directly with providers or clearinghouses who may experience issues or have questions about electronic submissions. EDI Help Desk technicians also reach out and work directly with providers who have high rejection rates to help resolve any issues that cause claim rejections, and they offer training or technical expertise to encourage EDI submissions from those providers not yet submitting claims electronically. Beyond claim and remittance transactions, providers connecting directly with Sunflower also receive direct assistance from our EDI Help Desk to implement the broader HIPAA transaction set, including 270/271, 276/277, and 278.

View Claim Adjudication Logic. The secure Provider Portal will also provide access to Sunflower claims adjudication logic using our Clear Claim Connection software. This software allows our providers to understand our administrative and clinical claim edits at a detailed coding level, to offer claim processing transparency and ensure claim coding accuracy.

Enlisting, Training, and Supporting Providers. Sunflower supplements our technology options with active provider education, one-on-one assistance, and other training methods to ensure provider awareness and understanding of how these technologies can streamline their processes. Below we list some of the methods that have helped us to achieve high rates of EDI claim submission and that we use in Kansas to encourage our providers to move to EDI.

- As mentioned above, Centene offers an EDI Help Desk to communicate directly with providers or clearinghouses for both operational issues for providers filing claims electronically, as well as outreach to providers to encourage EDI.
- Our Sunflower Provider Relations Staff is trained in our electronic submission offerings and works with the provider community directly to facilitate enrollment; walk them through the

Sunflower Portal submission options, in training sessions or through web meeting enabled type sessions.

- We send EOP stuffers containing the benefits of filing electronically and EFT payment.
- Quarterly Provider Newsletters are sent to specialist and PCP office locations geared toward billing and coding staff within a practice or facility and emphasizing EDI and EFT.
- E-Newsletters are posted under the Provider News section on our public website as needed, covering claims related topics. We also post KMAP Bulletins under Provider News to further educate our providers on billing related items from KDHE.
- We routinely evaluate the need to host workshops to assist provider staff in understanding the benefits of EDI and EFT, to discuss new policies and procedures regarding claims submission.

Monthly Tracking and Reporting Submitted, Paid, Denied, and Adjustments (5.14.1.E)

Using Centelligence®, we currently report claims processing standards to KDHE, including the number of claims submitted, paid and denied, in accordance with the RFP requirements. Our Claims Report submitted to KDHE contains monthly information for the following claims metrics:

- Number of claims received
- Number of clean claims processed within 30 days
- Number of non-cleam claims processed withing 60 days
- Total number of all claims received and processed within 90 days
- Number and value of claims denied by service type
- Average claim turn around time by service type
- Number and value of claim adjustments by claim type

We currently also provide to KDHE the claims reports outlined in Attachment H – Reports, and will support any new reports required by KDHE.

Supporting Nursing Facilities Timely Claims Processing (5.14.1.F)

Sunflower processes and pays over 95% of nursing facility claims within 21 calendar days with an average turnaround time of less than 10 days.

Sunflower has the experience in Kansas supporting timely processing and paying nursing facilities. Since 2013, Sunflower has supported the unique requirements to process and pay claims from nursing facilities in an efficient and timely manner, including payment of the FFS rate and the application of patient liability deductions to the claims payment. Through our provider support offerings and flexible claim submission options customized for LTSS providers, meet and exceed KDHE nursing facility processing requirements.

Claims Systems and Edits for Nursing Facility Claims (5.14.1.F.1.b). Our experiential data shows that when providers submit claims electronically, the period from date of service to payment is less than half compared with paper submissions. Electronically submitted claims are also more

complete because our MIS validates data elements at the earliest stage of submission. We encourage nursing facilities to submit claims electronically by offering web portal claims submission capabilities. For example, our LTSS Claims Wizard is designed specifically to allow LTSS providers with recurring claims billing and limited claims coding experience to efficiently submit accurate, complete HIPAA compliant claims through a step-by-step claim entry process, with validation assists and online help, decreasing billing errors during claim preparation and ensuring providers receive more timely payment for their services. The LTSS Claims Wizard allows providers to submit new claims for their member residents by starting with prior submissions for those members, effectively creating a template with member and service information pre-populated and easily updated by the provider for new submissions.

Successful nursing facility claims payment, to include the applicable patient liability deductions and FFS payment rate requires integrated systems for member and provider data management, claims processing, and reporting. As discussed above, our MIS has the following key integrated components to support accurate and timely nursing facility claim adjudication processes:

- Unified Member View (UMV): processes and stores member enrollment data including eligibility, demographics, covered benefits, and third party liability information. The level of care is also a component of the 834-enrollment file processing which is used to edit claims to ensure nursing facility claims are not paid unless the level of care is applicable to pay the claim.
- Provider Data Management (PDM): our system of record for provider information including network status, specialties, licensure, and fee schedules, and identifiers such as NPI, Medicaid ID, and service location code.
- TruCare: supports our clinical service coordination processes housing member authorizations and level-of-care information.
- AMISYS: our HIPAA-compliant claims processing module with configuration and editing capabilities for nursing facility claims, which comply with the claims requirements and timeframes mandated by KDHE and federal regulations. Because AMISYS identifies the claim date of submission; admission and discharge dates; level-of-care information; and provider type (traditional or LTSS), it accurately applies KDHE nursing facility FFS fee schedules, program guidelines, and payment timeframes for nursing facility claims.

Recovery and Recoupment of Claims for Quality Care Delinquencies (5.14.1.F.1.c). Sunflower maintains policies and procedures for recovery and recoupment of nursing facility claims for care assessment delinquencies. We establish an internal project to track and monitor the recovery process from the nursing facility. The project is placed into a queue with our work management tracking module of our MIS and sent to the Recovery Team. Once a project is received by the Recovery Team, they review and research the request and obtain the appropriate approvals to process the recovery of the overpayment. Then they send a letter to the nursing facility detailing the recoupment amount, the reason for the recoupment, methods to submit the overpayment amount to Sunflower, and any additional or resolution dispute protocols. For example, the nursing facility may submit additional documentation to support that the payment is correct. We give the nursing facility 60 days to respond to the letter. Once a

final determination is made, we process the recovery amount. The nursing facility has the option to submit a refund check directly to Sunflower. All refund checks are submitted to a Lock Box and tracked in the project notes. The nursing facility may also opt to have the refund posted against their EFT payment. These refunds are also tracked in the project notes and the ERA back to the nursing facility. Our Recovery Team has reconciliation processes in place to make sure all refund payments are posted for the nursing facility. We will provide the amount recovered to KDHE.

Timely Payment for Nursing Facilities (5.14.1.F.1.d). Our MIS tracks and measures claim timeliness from the time we receive a claim to the time we pay it, as well as the timing of all the processing steps along the way. We also capture and track the timing of any subsequent claim adjustments. Using our Centelligence® reporting dashboard platform, Sunflower monitors claims throughput, and our Claims Team monitors pends to identify any potentially problematic trends (including timeliness issues) and effectively address them. In 2017, Sunflower paid over 90% of nursing facility clean claims within 14 calendar days, and over 99.5% of nursing facility clean claims within 21 calendar days.

Providing Assistance to Nursing Facilities for Claim Submissions (5.14.1.F.1.d). Sunflower believes that issues relating to claims submission and payment are best resolved through proactive identification of potential delays in claims processing, analysis and research of any issues to identify the root cause, and collaborative provider outreach and education. Our Claims Management and Provider Relations teams understand the nuances of nursing facility provider billing practices. These groups have expertise in the complexities of reimbursement related to nursing facility services, and unique reimbursement elements such as Medicare coordination, patient liability amounts, and facility-specific fee schedules. These teams help nursing facilities work through any problems they may have with claim submissions and resolution, including initiation of immediate claim adjustments. In addition, our Provider Call Center Representatives are able to respond to claim submission questions from nursing facilities.

Supporting Alternative Payment Schedules for Nursing Facilities (5.14.1.F.2). Sunflower has the processes, capabilities, and systems to support alternate payment schedules. Any negotiated alternate payment schedules will be included in the provider contract. We currently support alternative payment arrangements with the 27 Community Health Medical Centers (CMHC) in Kansas, and can support similar arrangements with our nursing facility providers as required.

As provider contracts are received, payment schedules and arrangements are configured in the provider data management component of our MIS. This module has both contract simulation capabilities and allows us to configure and systematically load complex contract fee schedules which are integrated with AMISYS, the claims processing system. The table-driven parameters in AMISYS allow us to process claims according to the configured fee and payment schedules.

Supporting Claims Payment Reporting (5.14.1.G)

Through our Enterprise Data Warehouse (EDW) and Centelligence® health informatics and reporting platform, Sunflower currently supports claims payment reporting within the specified timeframes as required in Attachment H – Reporting Requirements, including reports and notifications. See Section 5.16 Reporting and Data Collection for additional information on our reporting to KDHE.

Generating Reports. Our EDW and Centelligence® platform, enables our reporting and analytics capabilities needed to report on claims payments. Our Chief Data Analytics Coordinator maintains overall responsibility for reporting, with support from all functional areas (such as Claims, Service Coordination, and Finance). Centelligence® allows Sunflower to generate standard and ad-hoc reports from a single data repository to manage and develop report design, testing, scheduled production, and transmission. The foundation of Centelligence® is our Enterprise Data Warehouse (EDW), powered by high performance relational database technology. EDW systematically receives, validates, integrates, and stores data from both internal (e.g., service authorizations, member information, etc.), and external sources (e.g., claims data from subcontractors, providers, KDHE, etc.). EDW supplies the data needed for Centelligence® analytic and reporting applications while orchestrating data interfaces among our core applications for the exchange of near real-time data.

KDHE Department Portal. Through our interoperable MIS, we can also offer the State (at the State's option) a secure portal for access by authorized State personnel, to retrieve reports and enhance the State's ability for oversight and compliance monitoring and collaboration with Sunflower, with expanded secure communication capabilities. (Attachment I: 4.3.8)

Practices to Simplify Claims Submissions and Ease Provider Administrative Burdens (5.14.1.H)

Supporting Multiple Methods for Claims Submission. Sunflower offers providers multiple on-line claim submission methods to provide a consistent, "no wrong door" approach to claims submission. Sunflower focuses on being available and engaged as local experts with our billing providers. We proactively encourage providers to file claims as soon as possible after the date of service, not only to ensure timely claims payment to them, but so we can use that information in service of our members.

Today, over 97.5% of Sunflower claims are submitted through EDI, FEB, and Web processes.

For timely and accurate claims processing, we continue to promote electronic submission for our providers through provider training and education via outreach calls, targeted emails and fax blasts, in-person meetings, and webinars. Today over 97.5% of Sunflower claims are submitted through electronic methods such as EDI, the KanCare FEB solution, and secure web entry.

Providers currently have the following options to submit claims. See ***Table 5.14.C_Flexible Claim Submission Methods.***

Table 5.14.C_Flexible Claim Submission Methods

Flexible Claim Submission Methods	
Direct submission via Sunflower secure Provider Portal	Providers can directly submit HIPAA EDI 837 Institutional and Professional batch files through our secure Provider Portal.
FEB Submission	We continue to support the FEB process to assist in reducing provider administrative overhead and allowing providers to continue to bill in the same manner as they submit Kansas Medicaid claims. We receive claims from the KDHE supported AuthentiCare EVV system, allowing our HCBS providers a seamless claim submission process.
Clearinghouse Facilities	We support submission of HIPAA 837 EDI claims via over 80 clearinghouses, including Availity, Change Healthcare (formerly Emdeon), and others.
HIPAA-compliant Direct Data Entry (DDE)	Online entry of claims directly through the HIPAA-compliant DDE feature (also available through the Provider Portal). Our DDE feature provides interactive assists to walk the submitting provider through the claim submission process, with look up and validation assists for codes (e.g., CPT, ICD-10); cross-field logical checks (e.g. if one form field is populated, checks that other fields are populated); validation of member and provider data; and online help. This results in instant feedback to the provider on any submission issues to maximize clean claim data entry. Claims with Attachments. We allow electronic submission of claims with attachments (e.g., for claims that require written documentation to justify payment) when a provider submits a claim using our DDE functionality.
Multi-Payer Portal	In alignment with our no wrong door approach, a provider can also submit claims through a multi-payer portal, whichever is most convenient to the provider's existing workflow. The multi-payer portal allows providers to use a single portal and single login to interact with multiple payers for checking member eligibility and benefits and claims submission. This service is completely free of charge to providers.
LTSS Claims Wizard	We offer the LTSS Claims Wizard, a specialized version of our online Direct Data Entry (DDE) feature on the Provider Portal, designed specifically for LTSS providers with no coding experience to submit accurate and complete claims through a step-by-step claim entry process, with validation assists and online help, driving down errors and ensuring providers receive more timely payment for their services.
Paper Claims – converted into machine readable data	In addition to our electronic claim capabilities, we receive submission of paper claims sent to our claims processing centers. Using Optical Character Recognition technology, paper claims are scanned and converted into machine readable data through our CDMS. Once processed, paper claims, like EDI claims, are edited through identical business edits as electronically submitted claims.

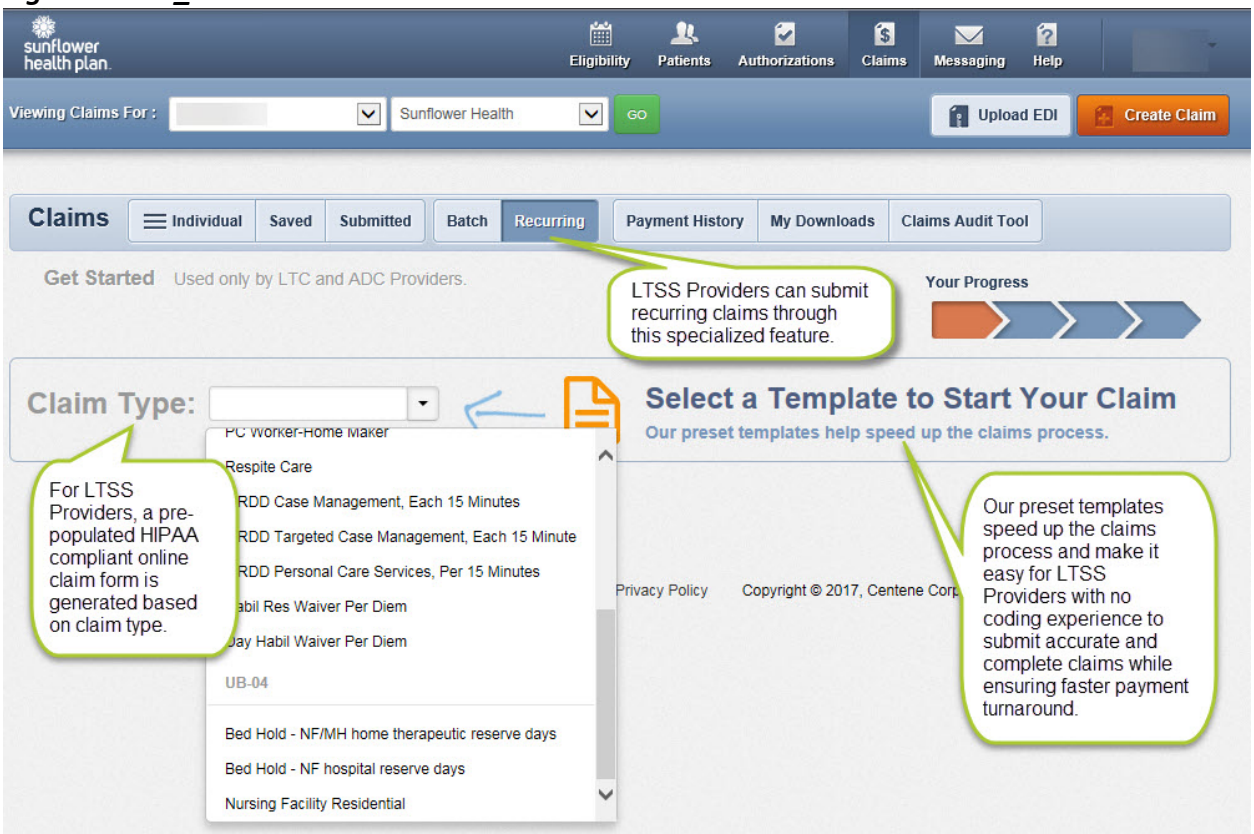
Supporting the FEB Process for Claims Submission. Sunflower has supported the FEB requirements since the start of the initial contract with KDHE. This allows providers to continue to submit claims to Kansas Medicaid if they choose. KS waiver service claims come through the FEB interface. Our HIPAA compliant, interoperable MIS supports the State's FEB system, including the daily receipt and processing of HIPAA 837 claims from FEB using Web Services Description Language (WSDL) technology for interfacing per State requirements. When Sunflower receives the HIPAA compliant (SNIP Level 4) claims from the FEB Fiscal Agent, they send a 999 file acknowledgment and 277CA response within 24 hours of receipt. In the event there are any pending files after 24 hours, our EDI team notifies the Fiscal Agent (FA) via email or phone. As part of the FEB requirements, Sunflower also submits claim copies to the Fiscal Agent (FA) for all electronic and paper claims submitted directly to Sunflower, the same day the claim was received. For pharmacy and non-emergent transportation claims (NEMT), we submit the claim copies to the FA the day before the encounters are submitted.

Sunflower currently receives and processes approximately 38% of all our electronic claims from the KanCare FEB process.

Supporting LTSS Providers with the LTSS Claims Wizard. For Sunflower's long-term services and supports (LTSS) providers, (e.g. Nursing Facilities, Assisted Living Facilities) who have recurring billing needs for members in their care, we offer our LTSS Claims Wizard, a specialized version of the online Direct Data Entry (DDE) claim submission feature on our secure Provider Portal. The LTSS Claims Wizard is designed for LTSS providers with little or no claims coding experience, and helps them efficiently submit accurate, complete HIPAA-compliant claims. The LTSS Claims Wizard walks LTSS providers through an online, step-by-step claim entry process, with validation assists and online help, driving down errors and increasing timely provider payment.

Additionally, the LTSS Claims Wizard allows providers to submit new claims by starting with prior submissions for those members, effectively creating a template with member and service information that is pre-populated and easily updated for new submissions. See ***Figure 5.14.1_LTSS Claims Wizard*** for a screenshot of these capabilities through the Provider Portal.

Figure 5.14.1_LTSS Claims Wizard



Supporting the COBA Process and Medicare Crossover Claims. Our enterprise MIS currently supports the Coordination of Benefits Agreement (COBA) claims crossover process for several of our affiliates so that providers need to file their claims only once for dually eligible members. Sunflower currently has an established connection with CMS Benefits Coordination & Recovery Center (BCRC), test files, and a scheduled go-live of January 1, 2018, to accept and process Medicare crossover claims. We participate in regular touch base meetings with KDHE and the BCRC in preparation for go-live. Our MIS has passed all the HIPAA compliance validation checks in place by the BCRC, so it is ready to accept and process HIPAA compliant 837 claims.

Supporting the Spenddown Process. Our MIS also supports Web Services Definition Language (WSDL) web service technology to support the State's Spend Down processes, allowing our claims system to connect to the State's Medicaid Management Information System (MMIS) – to receive a member's current spenddown information while adjudicating claims.

Pharmacy Spenddown Claims. We have worked closely with KDHE over the past five years on the spenddown process for pharmacy claims to ensure timely and accurate processing of spenddown amounts. Currently, claims adjudicated through the Pharmacy Benefit Manager (PBM) system indicate to our pharmacy providers the amount submitted to Spenddown Web Service and applied to spenddown. Our PBM systems currently connects to the KDHE system hourly for submission and receipt to the Spenddown Web Service Response File to obtain the

most current spenddown amount in a timely manner for our members and providers. We will continue to work with KDHE to further develop these processes.

Claims Reprocessing Related to System Issues (5.14.1.H.1). In the event of system issues, Sunflower has the capability to resubmit to AMISYS any claims incorrectly processed. If we determine that a claims processing issue is due to system configuration, or CAD informs us of a potential configuration issue based on their audits, we create a Change Request (CR) to have the configuration changed accordingly. All CRs go through testing and validation to ensure achievement of the correct outcome. Our testing also includes regression testing and User Acceptance Testing (UAT). Upon successful completion of these steps, changes are reviewed and approved by claims management and promoted to production.

Case Study: Working with KDHE on Fee Schedule Changes. In 2016, we had to make significant changed in our payment structures to support the required Kansas 4% deficit reductions. We were the first MCO to have the fee schedule changes implemented in our claims processing system. KDHE then had to make changes to the way the fee schedules were written. Our responsiveness to the KDHE request required Sunflower to remove the changes, rewrite, re-implement, and reprocess the claims impacted by the changes. Using our structured change management and claim resubmission processes, we successfully implemented and reprocessed the impacted provider claims.

As our MIS retains a copy of all submitted claims, we do not require that the provider resubmit the claim. Our Claims Management teams also have the ability to resubmit a claim, or batch of claims, impacted by system issues such as configuration. In these situations, our Claims team creates an internal Claim Project to document, track, and monitor the reprocessing of these claims. Each project is recorded on the KDHE Unified Log and submitted to KDHE on a weekly basis. The log report contains our weekly status update on the claim reprocessing, until the issue is successfully completed.

Sunflower in Action…

Phoenix Home Care & Hospice sent a note of thanks for the assistance and support our teams provided on getting claims corrected and reprocessed for their agency. They noted that our team members were extremely helpful and professional.

Standardized Timely Filing Requirements (5.14.1.H.2). Sunflower supports KDHE standardized timely filing requirements, applying a 180-calendar day filing limit for all claims for all services, and a 365-day limit for any correction or rebilling of a timely filed claim. During initial provider orientation, our Provider Service Representatives educate the provider on our timely filing requirements. In addition, our Provider Manual available on our website contains detailed information on timely filing of first-time claims, retroactive eligibility, secondary claims for both in-network and out-of-network providers, and corrected claims. The Provider Manual also outlines the qualifying circumstances in which Sunflower will evaluate the timely filing requirements such as catastrophic events that interfere with normal business operations, mechanical or administrative delays or errors by Sunflower or KDHE, or if the member was

eligible and the provider was unaware of eligibility in specific circumstances. Claims received outside the time frames will be denied for untimely submission.

Processing Claim Adjustments and Corrected Claims (5.14.1.H.3). The AMISYS system applies the same processing and editing logic for corrected claims and claims adjustments consistent with all other claims, including first-time claim submissions. If a claim is denied for incomplete or inaccurate information, or for any reason, the provider will receive an Explanation of Payment (EOP). The EOP, or Electronic Remittance Advice (ERA) for Electronic Funds Transfer (EFT), clearly outlines KDHE's approved reason(s) for claim denial, along with instructions for correction and resubmission, if applicable. Sunflower systematically examines membership data across multiple products to identify if a member is enrolled in another plan. When we learn of "dual enrollment," we provide that information to KDHE and update enrollment. We process retroactive eligibility if claims were processed during a period of Third Party Liability (TPL), and we recover payment from the primary payer.

Routing Claims to Subcontractors for Timely Claims Processing (5.14.1.H.4). Sunflower has established procedures to route EDI and paper claims received by us on behalf of our claims paying subcontractors. The data and file exchange components of our MIS are configured to receive, transmit, and validate secure file exchanges between Sunflower and our trading partners using a service-oriented architecture. In 2018, we will be enhancing our routing capabilities for subcontractor claims received through the FEB solution and other provider claim submission methods. Through our parent company, Centene, we have subcontractor oversight and monitoring, including claims submission, processing and reporting to ensure our subcontractors adhering to all KHDE requirements. Sunflower's Manager, Vendor Management is responsible for local subcontractor oversight by conducting regular meetings with each subcontractor to discuss and review any questions or operational issues and by maintaining monthly and quarterly key performance indicator reports.

Recovering Overpayments Made to a Provider (5.14.1.I)

Sunflower maintains policies and procedures to recover established overpayments to a provider when directed by KDHE for performance or non-performance of activities according to the State's guidelines and policies. Under KDHE direction, we establish an internal project to track and monitor the recovery process. The project is placed into a queue with our work management tracking module of our MIS and sent to the Recovery Team. Once a project is received by the Recovery Team, they review and research the request and obtain the appropriate approvals to process the recovery of the overpayment. Then they send a letter to the provider detailing the recoupment amount, the reason for the recoupment, methods to submit the overpayment amount to Sunflower, and any additional or resolution dispute protocols. For example, the provider may submit additional documentation to support that the payment is correct.

We give the provider 60 days to respond to the letter. If the provider disputes the original recovery request, provides additional documentation, and our Recovery Team determines the

initial recovery is correct, we give the provider another 30 days to submit the refund. Once a final determination is made, we process the recovery amount. The provider has the option to submit a refund check directly to Sunflower. All refund checks are submitted to a Lock Box and tracked in the project notes. The provider may also opt to have the refund posted against their EFT payment. These refunds are also tracked in the project notes and the ERA.

Our Recovery Team has reconciliation processes in place to make sure all refund payments are posted for the provider. Any recovered amount will be reported to KDHE in the format and manner requested by the State. In the rare event we are unable to recover an overpayment, we notify KDHE with an explanation of the reason the overpayment is not collectible.

Supporting KDHE Overpayment Recoveries (5.14.1.J)

Sunflower currently supports KDHE's supplemental recovery program in place with the fiscal agent subcontract with Health Management Systems (HMS). We provide encounter files containing any TPL information to KDHE which are used by HMS® to identify paid claims meeting the State criteria. We have a data authorization agreement in place, which allows HMS® to use Sunflower encounter data containing billing and payment data. HMS® uses the data within the encounter files to match claims identified for recovery by Sunflower.

Sunflower will continue to work with KDHE on any recovery programs established by KDHE; any KDHE agents, including the State's fiscal agent; or other KDHE contractors not a KanCare MCO. We acknowledge any funds recovered for overpayments by these entities are the property of the State. We also acknowledge that we do not get any of the recovery when KDHE gets overpayments, false claims, or fraudulent claims paid by the Sunflower.

Providing Outpatient Drug Claims Information (5.14.1.K)

Sunflower currently provides all claims information to KDHE on outpatient drugs administered to our members for which are responsible for the coverage according to the requirements of 42 CFR § 438.3(s)(2) and (3). Our comprehensive Centelligence® reporting system receives, integrates, and maintains medical and pharmacy claims data, allowing us to generate this reporting data to KDHE. We provide this information within 45 days calendar days after the end of each quarterly rebate period to the State in the encounter claim files per State requirements. Through Centelligence®, which receives processed pharmacy claims data every 24 hours electronically from our affiliated PBM, we receive and also securely transmit to the State with data needed for their reporting of drug utilization information in the quarterly utilization reports to CMS and quarterly rebate invoices to drug manufacturers according to 42 CFR § 447.511(c).

Supporting 340B Claims Reporting. Sunflower and our affiliated PBM partner will have the appropriate claims system edits in place to support the KMAP MCO 340B Policy effective April 1, 2018. Currently, our claims and encounter processing systems verify the provider NPI KMAP ID, and NDC codes for submissions to the State. As part of the implementation for the 340B policy, we will validate that the Submission Clarification Code claim identifier is included in the

claims for Covered Entity pharmacies and our Encounter Claim data submissions to the State. The Provider News section of our website contains the KMAP Bulletin: MCO 340B Policy posted on November 14, 2017, for additional information on this policy and requirements.

5.14.2. POST-PAY RECOVERY, THIRD PARTY LIABILITY, AND COORDINATION OF BENEFITS

INTRODUCTION AND EXPERIENCE

Sunflower, along with our parent company Centene, has successfully coordinated benefits and carried out Third Party Liability (TPL) activities according to federal and KDHE standards since 2013. As a trusted administrator of public sector programs, Centene has designed Third Party Liability (TPL) claims processes and data interfaces based on a Medicaid as a payer of last resort principle in line with KDHE coordination of benefit policies outlined in this contract. Our processes are supported through claims automation, training for providers, edit controls in internal systems, and data exchange with leading TPL subcontractors who specialize in TPL identification and post-payment recovery in the public sector. We make every reasonable effort to determine the liability of third parties to pay for services provided to our members and have comprehensive policies and procedures for identifying existing TPL resources, undertaking cost avoidance, and recovering liability from the third party.

Between January and November 2017, our systematic controls resulted in over $125 million TPL savings through coordination of benefit, cost avoidance, and recovery activities.

Post-Pay Recovery and TPL (5.14.2.A)

We comply with all federal regulations including Section 1902(a) (25) of the Social Security Act and Title XIX of the Social Security Act and comply with State of Kansas statutes and regulations for TPL, medical Subrogation and estate recovery for all Sunflower members. Our Vice President, Compliance oversees our adherence to all state and federal statutes and regulations, using our Compliance Management System automated workflow capabilities, as well as via our TPL related policies and procedures, available to all our staff via our secure intranet system.

Post-Pay Recovery. Sunflower works closely with a third-party subcontractor, HMS® to recover funds post-payment in cases where we were not aware of TPL at the time services were paid, and to identify and pursue all potential TPL payments. On a weekly basis, we provide HMS® with a claims detail report of claims processed the previous week. If HMS® determines that a claim is related to TPL for a member with other insurance, HMS® initiates steps to recover the overpaid TPL dollars from the insurance carrier on behalf of Sunflower, and requests reimbursement to Sunflower for the amount of payment. Our recovery efforts ease provider's administrative and financial burden, as there is no need for the provider to attempt to obtain payment from the primary carrier.

Subrogation Recoveries. For subrogation recoveries, Sunflower has partnered with a recognized leader in healthcare subrogation services. Sunflower uses our partner's experience to provide post-pay recovery for subrogation, malpractice claims, and product liability. For

subrogation claims, the subcontractor negotiates a settlement with the third party. Sunflower's affiliate health plans across the country have found success in using this partner to provide superior services for subrogation recoveries.

A Comprehensive Approach to Capturing and Verifying Third Party Liability (5.14.2.B)
Sunflower's preference is to identify and pursue TPL where possible for our members. Our experience has shown that the best approach to cost avoidance is to minimize the need to recover costs in the first place and we employ several methods to support our "pre-emptive" strategy for members in the Sunflower program. This strategy is integrated throughout our claims automation, provider training, internal system configuration, and data exchange with our business partners, affiliate subcontractors, and TPL partners. Inquiring about sources of potential TPL is an ongoing process, taking place through multiple activities. Identifying sources of TPL occurs through processing of the proprietary TPL and HIPAA 834 eligibility files from KDHE; claim processing activities; TPL subcontractor partner practices; provider education and training; use of the secure Provider Portal; Sunflower point of service investigations; and member validation activities. We use all these methods to identify members newly eligible for Medicare or other payers.

Reconciling the Proprietary TPL and HIPAA 834 Eligibility Files. Upon receipt of the proprietary TPL and 834 Eligibility files from KDHE, coordination of benefits (COB) data is automatically loaded to the member data management (MDM) component of our integrated MIS. In 2018, we are enhancing our MDM component with features and functionality currently in place at several of our affiliate plans. This Unified Member View (UMV) functionality provides the single source of truth for all informational aspects of our members' relationship with Sunflower, including member demographics, current and historical benefit plan eligibility across all our products (Medicaid and Medicare), alternate contact information, member communication options, and more. UMV employs a master data management approach to collecting, matching, quality-assuring, storing, and distributing member enrollment data we receive from our State partners to our MIS system components needing that information (e.g., AMISYS Advance for claims processing). UMV automatically links individual member identifiers to a unique master member index, enhancing our ability to maintain historical member data and resulting in a unified view of a member's enrollment history across all Sunflower programs and eligibility spans. UMV systematically promulgates updated eligibility data, including COB data obtained from the 834 and the proprietary TPL file, to our other applications requiring that data, including the eligibility subsystems of all subcontractors.

This is the first step in our approach to ensure the eligibility subsystem contains current information necessary to identify members who might have third-party coverage with Medicare, any other group insurance, trustee, union, welfare, or employer organization. If at any time, the TPL data we receive from KDHE differs from the information we have received from any other source, we will continue to ensure that KDHE receives the updated information to ensure synchronization of data between Sunflower and KDHE.

Claim Processing Activities. Our claims processing system, AMISYS, enforces TPL cost avoidance when a third party pays a benefit through prompt suspension of claims submitted without required Explanation of Benefits (EOB) or payment information from a primary payer. AMISYS has the following system edit, configuration, and support tools:

- ***Systematic Edits.*** During the claims adjudication process, our claims processing system checks for other coverage and pends the claim based on the information contained within the record. Our AMISYS system is configured with the TPL bypass codes outlined by the State to ensure we do not deny claims for other insurance which are noted as a TPL exception. For pended claims, a dedicated team of resources within Sunflower's Claims Operations Team processes TPL claims to determine any additional liability as the secondary payer. To enable accurate automated cost avoidance, claims for members with other coverage that are submitted without required EOBs or payment information from a primary payer, are denied. Further, we also validate TPL whenever we receive an adjustment request from a provider.
- ***Decision Support Tools.*** Our claims team examines claims submissions for patterns of billing errors from providers, including those related to TPL, using decision support tools within our Centelligence® health informatics and reporting system. We use this information to educate providers if needed on appropriate billing for members with TPL. We also utilize industry leading recovery subcontractors (see below) to identify claim overpayments and to recoup payments from third parties on our behalf.
- ***Diagnosis Code Edits***. We load potential accident and trauma-related ICD-10 diagnosis codes into AMISYS, allowing us to identify potential subrogation. If a claim is received that triggers these edits or the claim contains a trauma indicator of "Y", we will pay the claim and send this information to our subrogation subcontractor to pursue recoveries. Sunflower continually works to ascertain the legal liability of third parties to pay for care and services available under the KanCare program, and actively pursues recovery from the responsible carrier.
- ***Sunflower Claims Analyst Oversight.*** Sunflower's Claims Analysts will review operations reports focused on first-time claims with EOB attachments or claim adjustments. The Claims Analyst will route any TPL information (member contact information, plus other information from the EOB or adjustment request) to Centene Claims Department's TPL Team. A TPL Analyst will then verify enrollment with the third party and the member and update the member record accordingly to ensure we are coordinating benefits appropriately.

TPL Subcontractor Partner Practices. We augment our TPL identification processes with established national recovery subcontractors through our partnership with HMS® our partner for TPL identification and post-payment recovery services. Each month, we send Member demographic data to HMS® to be matched to HMS®' database of national insurance eligibility information to identify other available insurance coverage. HMS® reviews access coverage information it receives from over 1,000 different sources, mainly other insurance carriers. When a match is found, HMS® verifies coverage directly with the carrier through a combination of online tools and telephone contact and sends the resulting data back to Sunflower. We then load this "member level" TPL information into member data management component and from

there the data automatically, and electronically, feeds our claims system. We validate TPL data we receive from HMS® by systematically matching member identifiers in the TPL files received from HMS® with the corresponding identifiers we have on members in our MIS.

Provider Education and Training. Through our regular provider orientations, ongoing training meetings, and our online Provider Manual, we educate our providers on the importance of identifying TPL information at the time the member receives services. We inform and educate providers about the importance and process for submitting denial notices from third parties, accident details, any medical records corroborating no other liable parties, or explanation of benefit (EOB) or payment information from a third party where member liability exists in the TPL and other payer segments of their HIPAA 837 EDI claim submissions, or their paper claim submissions. E-Newsletters are posted under the Provider News section on our public website as needed, covering claims related topics. We also post KMAP Bulletins under Provider News to further educate our providers on third party liability related topics from KDHE. Our Provider Relations team offers targeted provider education when we identify provider trends or issues related to billing primary payers.

Secure Provider Portal. Our secure Provider Portal allows authorized provider users to see any current TPL information we have on record for a member, affording them a means to check for TPL as part of their routine member eligibility verification process before claim creation and submittal. The secure Provider Portal also allows providers to submit TPL documentation by uploading images, PDFs, Microsoft Word documents, or other digitally formatted TPL related documents. This information is accessible to our claims processors to expedite finalizing claims with TPL. Also, a provider may enter a claim directly via our HIPAA compliant Direct Data Entry (DDE) online claim entry facility available through our secure Provider Portal. Our online claim entry application has logical field checks so that, for example, if a provider indicates that the member has other insurance, and there is no third-party payment information, the application alerts the user to the missing information while they are entering the claim.

Point of Service Investigation. Sunflower staff may become aware of TPL information through processes such as authorization, concurrent review, provider outreach, or service coordination. Therefore, we train staff to use every member and provider interactions, chart reviews, etc. as an opportunity to identify TPL and to submit a notification to a TPL Analyst, requesting that the member record is updated accordingly. Our Customer Relationship Management (CRM) system allows Customer Service Representatives to collect any TPL information from a member. The claims note indicates the name of the insurer, the policy and group number, the name of the member, and the effective date. This information is then transferred to the COB/TPL Analyst for updating in UMV, and subsequently our claims system, our other applications, and transmitted to subcontractors dependent on this information.

Validation Activities for Members with Identified TPL. We understand the importance of validation activities for verifying TPL information and ensuring that members identified on State

agency data matches are indeed the actual persons referenced. Through various strategies, we are able to validate members and their identified TPL by:

- Validating TPL with members during our welcome call
- Creating outbound campaigns in our Customer Relationship Management (CRM) module
  - Sending letters to members indicating TPL and requesting a verification form to return
  - Creating call queues in CRM for member verification outreach
- Creating inbound campaigns in our CRM
  - During inbound member calls, verifying accuracy of TPL information (after immediate need is addressed first)

Educating Members Regarding Medicare Eligibility and Referring to Appropriate Resources.
We understand the importance of educating and assisting our members eligible for Medicare to proactively identify which services are covered, or not covered by Medicare. Our Service Coordination and Customer Service teams work with members to provide education about Medicare covered and non-covered benefits via face to face and telephonic contact. Our Customer Service Representatives are trained to answer member questions relating to Medicare eligibility and appropriate resources. Monthly, KDHE provides to Sunflower a list of Medicare non-covered codes. AMISYS is configured with these non-covered codes for claims adjudication. Our Claims Management teams use this up to date list of codes for review, research, and education.
We also educate members through our digital communication strategies which include:

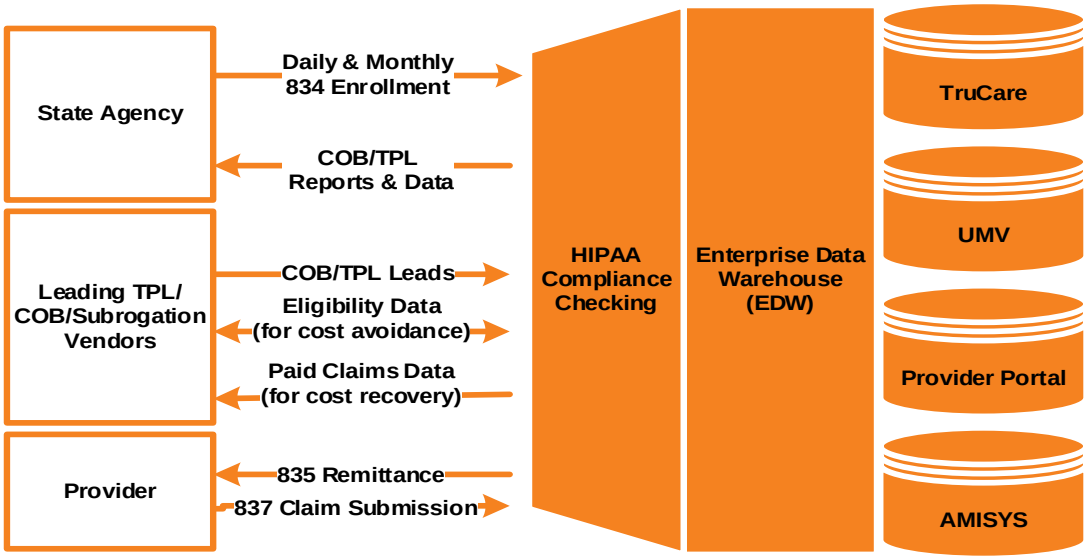
- Our Member Handbook which contains a summary grid detailing covered benefits as well as information about who, when, and how to contact us for assistance.
- Our mobile-friendly member website which contains information about benefits and services as well as a link to the Member Handbook, member resources, and program benefits.
- Our member mobile application which contains an overview of benefits and services as well as access to our provider directory, Find-a-Provider, and how to contact us for assistance.

We supplement our member focused communication efforts with provider education and outreach so providers can assist in helping members understand their coverage and benefits. For LTSS members, information on their benefits and services are covered in detail during the New Member Orientation in the member's home and documented in the person-centered service plan (PCSP) in TruCare and available to members and their caregivers through our secure Member and Caregiver Portals.

Coordinating Benefits and Provider Payments with Identified Other Party Liability (5.14.2.C)
Sunflower understands that Medicaid is the payer of last resort (except in those cases where this rule may not apply), and we will adjudicate claims according to Federal and State requirements for COB and TPL, including those related to Medicare dual eligible Members and

timely filing rules. As mentioned above, we capture any identified other party liability at the member level within the member data management component of our MIS.
AMISYS, our claims processing system, uses table driven parameters configured to coordinate benefits in accordance with KDHE processing rules. During claims adjudication, AMISYS checks for other insurance; processes the claim according to COB rules; pend or denies the claim based on the information contained within the record; and notifies the provider of the adjudication and processing. For pended claims, dedicated Sunflower claims staff process TPL claims, determining additional secondary payer liability. We deny pended claims submitted without required Explanation of Benefits documentation or primary payment information. We also validate TPL whenever we receive adjustment requests from a provider. See ***Figure 5.14.A_Coordination of Benefit***s for an illustration of our COB processes.

Figure 5.14.A_ Coordination of Benefits



Coordination with Third Parties (5.14.2.C.1). Sunflower pays as secondary to all third parties except for members eligible and enrolled for benefits from the Specialty Health Services, Vocational Rehabilitation, Indian Health Services, and the Crime Victim's Compensation Funds programs. Sunflower processes claims as primary for members enrolled in these three programs through configuration and claim adjudication policies set in AMISYS.

In those cases where the member has received services that were paid by a third party, but the member has coinsurance, deductibles, co-payments, or other cost-sharing expenses, Sunflower will pay those expenses on behalf of the member, not to exceed the lowest allowable amount by the primary payer. We use the following methodologies for coordination with third parties:

- ***Commercial Payors.*** We review the commercial payor's EOB, determines the allowed amount for the claim and then compare to the Medicaid allowed amount. The lessor of the two amounts becomes the allowed amount for the claim.

- Once the allowed amount is determined, the commercial payment is deducted and we pay any difference between the allowed amount and the commercial paid amount up to the patient responsibility.

- **Medicare.** We compare the Medicare allowed amount to the Medicaid allowed amount. The lessor of the two amounts becomes the allowed amount for the claim.
  - Once allowed amount is determined, the Medicare payment is deducted and we pay any difference between the allowed amount and the Medicare paid amount up to the patient responsibility.
- **Medicare Part A exhausted and Medicare Part B pays.** This applies only to inpatient claims. The allowed amount is calculated, with no comparison with Medicare allowed amount. We deduct the Medicare B payment from the allowed amount and pay the remaining balance.

Coordination of Benefits Agreement (COBA). Our enterprise MIS currently supports the COBA claims crossover process for several of our affiliates. If a provider submits claims for a Sunflower dually eligible member to Medicare or a COBA-participating Medicare Advantage plan for processing, we will coordinate with the CMS Benefits Coordination & Recovery Center (BCRC) for Medicaid so that the provider needs to file their claim only once. When we receive a HIPAA 837 claim file from the BCRC, our claims processing system will identify members with Medicare as the primary payer, validate COB identification claim information, and adjudicate for remaining benefits using the 837 COB segment information. We coordinate benefits under both programs and issue payment and the remittance advice explaining the payment to the provider for each segment of processing, first for Medicare benefits and then for the Medicaid portion, even if the Medicaid portion is for a $0 payment. If third party liability cannot be established or third-party benefits are not available, we will process the claim.

State Adjusted Capitation Payments (5.14.2.C.2). Sunflower understands and acknowledges that the State has adjusted our capitation payment equal to the State's TPL recoveries for members and that we will retain our TPL recoveries.

Participation in Data Match Programs (5.14.2.C.3). Centene and Sunflower are dedicated to cost avoidance and recovery and protecting the valuable and limited resources available to KDHE for the KanCare Medicaid program. As described above, we have multiple approaches for identifying TPL and then recording this information in our systems so that we can use this to process claims with COB. Sunflower has worked closely with KDHE to match data for TPL with the Defense Eligibility Enrollment Reporting System (DEERS). Our AMISYS system is updated with KDHE published TPL carrier exceptions to ensure we do not deny claims for services not covered by the specific insurance carrier. We have also established with KDHE and the Department of Health and Human Service's Administration for Children and Families (ACF) the necessary protocol and business processes to exchange information with the Public Assistance Reporting Information System (PARIS) for purposes of TPL identification and subsequent COB processes.

Tracking and Reporting TPL Cost Avoidance and Recovery (5.14.2.C.4). Sunflower's ability to collect, manage, analyze, and report data through one production and reporting system allows us to offer an all-encompassing holistic view of the programs and benefits we administer. Our MIS stores and processes data in all areas necessary to support our operations, including but not limited to, claims, third party liability data, member and provider services, authorizations, and eligibility. Sunflower data is housed in our Enterprise Data Warehouse (EDW) and available for reporting and analysis through our Centelligence® platform, in full compliance with KDHE and federal guidelines and regulations. We track TPL cost avoidance and recovery for all Members including savings when we did not pay a claim due to known TPL / Medicare coverage. Sunflower will continue to comply with any KDHE requirements and federal regulations for the distribution of TPL recoveries, and we will report to KDHE any recoveries collected and accounted for, outside of AMISYS, as offsets to medical expenses. We report information to KDHE in the format specified in the Payment Integrity Report and according to the schedule established by KDHE.

Data Transfer of TPL Information (5.14.2.C.5 and .6). As mentioned above, we receive from KDHE information regarding member TPL information in the proprietary TPL and HIPAA compliant 834 Eligibility files. Upon receipt of these files, TPL data is automatically loaded into the member data management component of our MIS. Once loaded, the system promulgates updated eligibility data, including TPL/COB data, to our other applications requiring that data, including the eligibility subsystem of AMISYS. If at any time, the TPL data we receive from KDHE differs from the information we have received from any other source, we will ensure that KDHE receives that updated information to ensure synchronization of data between Sunflower and KDHE.

Coordinating with the State for Child Support Birth Expenses Information Requests (5.14.2.C.7). Sunflower will coordinate with KDHE to provide on request and within ten (10) business days, child support birth expenses paid by Sunflower. Any information requests are will be tracked in our Compliance Management System which allows us to effectively administer and monitor any requests from KDHE.

Claims for EPSDT, Pregnancy Care and Prenatal Care (5.14.2.C.8). Sunflower complies with all KDHE and federal regulations related to labor, delivery, and postpartum care; prenatal care for pregnant women; preventive pediatric services (including early and periodic screening, diagnosis and treatment services); and instances when a child support enforcement order is in effect, as specified in 42 CFR Part 433, Subpart D – Third Party Liability and 42 CFR 433.139 – Payment of Claims. For these services, we will pay the provider and pursue recovery from a liable third party, if one exists. We enforce this "pay and chase" rule for pregnant women and children through identification of appropriate procedure codes on the inbound claim and member information housed in AMISYS (sourced from UMV). We will continue to ensure medically necessary procedures are never denied due to billing issues.

Provider Portal Offers Member TPL Information (5.14.2.C.9). Our secure Provider Portal is a web-based platform supporting provider administrative "self-service" capabilities including eligibility inquiry, authorization submission and status, claim submission, claim status inquiry, claim payment history, and all TPL information on file for members. This coordination of benefit information includes the member ID, member last name, member first name, member middle initial, carrier name, policy number, group policy number, and coverage type. Through the eligibility inquiry function on the Provider Portal, the provider is also able to see the member effective and end dates of the policy and member demographics such as gender, date of birth, date of death (if applicable) and other policy related information.

Following Other Insurance and Medicare Pricing Rules (5.14.2.C.10). We use AMISYS's table driven parameters to configure the system to coordinate benefits and adjudicate claims as established by Kansas Medicaid policy for Other Insurance and Medicare pricing rules. For inpatient claims where the TPL paid amount is less than the Medicaid allowed amount and there is member liability, we will pay up to member liability, not to exceed our allowed amount. As required by KDHE, for inpatient claims where the TPL paid amount is more than the Medicaid allowed amount, no additional payment will be made. Also, for Federally Qualified Health Centers, Indian Health Centers, and Rural Health Clinic encounter paid claims, the Sunflower payment amount is equal to the encounter rate minus the other insurance carrier (OIC) payment per Kansas Medicaid policy.

Transferring New TPL Lead Information to the State (5.14.2.C.11). Sunflower is currently working on a new file layout at the State's request to submit any verified new TPL lead information for our members in the form, frequency, and manner prescribed. Currently several of our affiliate plans provide this information to their State partners.

Participation in the Coordination of Benefits (COBA) Medicare Process (5.14.2.D)

Our enterprise MIS currently supports the Coordination of Benefits Agreement (COBA) claims crossover process for several of our affiliates so that providers need to file their claims only once for dually eligible members. Through the State COBA process, Sunflower will accept and process Medicare crossover claims for all our assigned members. We maintain HIPAA compliance and will follow state COBA policy and process. Sunflower currently has an established connection with CMS Benefits Coordination & Recovery Center (BCRC), test files, and a scheduled go-live of January 1, 2018, to accept and process Medicare crossover claims. We participate in regular touch base meetings with KDHE and the BCRC in preparation for go-live. Our MIS has passed all the HIPAA compliance validation checks in place by the BCRC, so it is ready to accept and process HIPAA compliant 837 claims.

We will use AMISYS for claims processing, configured to meet all Medicare crossover claims requirements. When we receive a HIPAA 837 claim file from the BCRC, AMISYS will identify dually eligible members, where Medicare is the primary payer and will validate COB identification information on the claim. Further, AMISYS will adjudicate the claim for remaining Sunflower benefits using COB information and Medicare adjudication results found in the 837

claims file. We will process payment for all Medicare providers seeing our dual members, including those not part of our network.

Supporting KDHE Supplemental Recovery Program (5.14.2.E)

Sunflower currently supports KDHE's supplemental recovery program in place with the fiscal agent subcontract with HMS®. We provide encounter files containing any TPL information to KDHE which are used by HMS® to identify paid claims meeting the State criteria. We have a data authorization agreement in place which allows HMS® to use Sunflower encounter data containing billing and payment data. HMS® uses the data within the encounter files to match claims that have been identified for recovery by Sunflower. We acknowledge that any TPL identified and recovered by the State more than six months after the date of payment of a claim will be retained by the state.

5.14.3. ENCOUNTER DATA AND OTHER DATA REQUIREMENTS

INTRODUCTION AND EXPERIENCE

Since 2013, Sunflower has worked closely with KDHE and KDHE's Fiscal Agent (FA) to collect, validate, and submit service information, data, and documents to the State, including encounter data, enrollment information, and member and provider characteristics in accordance with 42 CFR § 438.242. Sunflower will continue to work closely with KDHE to provide timely, accurate, complete, and consistent data that meets and exceeds KanCare 2.0 program requirements, including our subcontractor encounter data. We submit an average of over 450,000 encounters per month to KDHE's FA for all services rendered under our existing KanCare contract, and Sunflower achieved an average encounter accuracy rate of 98.87% for the 2016 contract year. We attribute our success to our close partnership with the State where we communicate daily to cultivate proactive, bi-directional feedback between Sunflower and KDHE. Sunflower understands the importance of working closely with the State, and when appropriate, we partner with KDHE on resolution of data issues. For example, Sunflower proactively reviews all claim copy errors and performs outreach to the State only when we have determined we do not have enough information to correct the errors independently or if there is an issue regarding the claim copy file submission.

Sunflower achieved an average encounter accuracy rate of 98.87% for the 2016 contract year.

Ensuring Quality Encounter Data through People, Processes, and Technology (5.14.3.A)

Sunflower's interoperable MIS operates and manages the two-way data exchange (e.g., claims, encounters, enrollment) and processing requirements supporting the KanCare program, and will continue to do so for KanCare 2.0. In addition to Section 5.14.3, we have reviewed the Contract's Attachment J requirements, KDHE's 837 Institutional and Professional Claim and Encounter Transactions Companion Guides, the KanCare Guide, and HIPAA NCPDP standards. Our systems and processes are fully compliant with KDHE's data transaction and encounter submission processes needed to support KanCare 2.0, and we will continue to make necessary changes when updates are made, including updates to the KanCare Guide (e.g., program changes, periodic updates to schedules). Today, our Senior Executive/Project Director- Plan

President and CEO and Information Systems Director/Manager- VP of Operations (who has delegated authority) provide attestation to the truthfulness, accuracy, and completeness of Sunflower data submitted to KDHE and KDHE's Fiscal Agent (FA), and will continue to do so for KanCare 2.0.

Sunflower complies with all HIPAA and government regulations as well as the contractual agreements, RFP, companion guide, and KanCare Guide specifications related to encounters to ensure accurate, complete, and timely submissions to meet or exceed KDHE requirements. Prior to submission to KDHE and KDHE's FA, Sunflower tests encounter data for accuracy, completeness, logic and consistency, including that of our subcontractors. Sunflower submits encounters to KDHE for every paid, denied, and adjusted service rendered to an enrolled member, inclusive of, but not limited to, information such as procedure codes, diagnoses, service location, coordination of benefits information, and amounts remitted to providers, including capitated services for which claims have been adjudicated.

Excellence and Experience of Local Sunflower Team. Since 2013, Sunflower has maintained our encounter data submission policies and processes to support KDHE and the KanCare program, and we will ensure we meet and exceed encounter performance requirements for KanCare 2.0 through our experienced Kansas-based teams.

- ***Information Systems Director/Manager: Dr. Jonalan Smith, VP - Operations.*** Dr. Smith brings over 15 years of health care experience and 4 years of experience at Sunflower to work closely with KDHE overseeing Sunflower's encounter data submission processes to ensure successful encounter performance.
- ***Claims/Operations Manager: Michelle Boller, Senior Manager - Operations.*** Michelle brings 22 years of health care experience and 5 years of experience at Sunflower to maintain the relationship with KDHE and overall communications with the State for encounter data. Michelle works collaboratively with the State in handling encounter maintenance work and will ensure Sunflower meets and exceeds KanCare 2.0 encounter data requirements.
- ***Senior Executive Finance Officer: Terry Weathers, Senior VP - Finance.*** Terry brings 33 years of health care experience and 5 years of experience at Sunflower. Terry is responsible for assisting KDHE in reconciliation of paid claims to submitted encounters.
- ***Provider Relations Team.*** Our Provider Relations team has 58 years of combined experience at Sunflower and through our parent company. Sunflower's Provider Relations team supports provider communication and education, including working directly with our providers, as needed, to deliver training and resolve issues related to claims submission.
- ***Claims Liaisons.*** Our dedicated Claims Liaisons have over 75 years of combined experience at Sunflower and through our parent company. Our Claims Liaisons provide critical feedback to claims processing and configuration staff, as well as the Provider Relations team. This allows us to provide KDHE with accurate encounter data, as well as prompt claims resolution for identified discrepancies and provider education related to claims issues.

Excellence and Experience of Encounters Business Operation Team. Sunflower is supported by our parent company's Encounters Business Operations (EBO) team, which was created over 10 years ago to manage all encounters preparation and submission related processes. The EBO team is dedicated to encounter excellence, and has been recognized by our State and CMS partners as leaders in the industry. Our centralized EBO team is strategically built to include resources with expertise in all aspects of a claim's lifecycle, including provider data, eligibility, claims processing and configuration, and capitalizes on that knowledge to ensure compliance with all KanCare contractual measures.

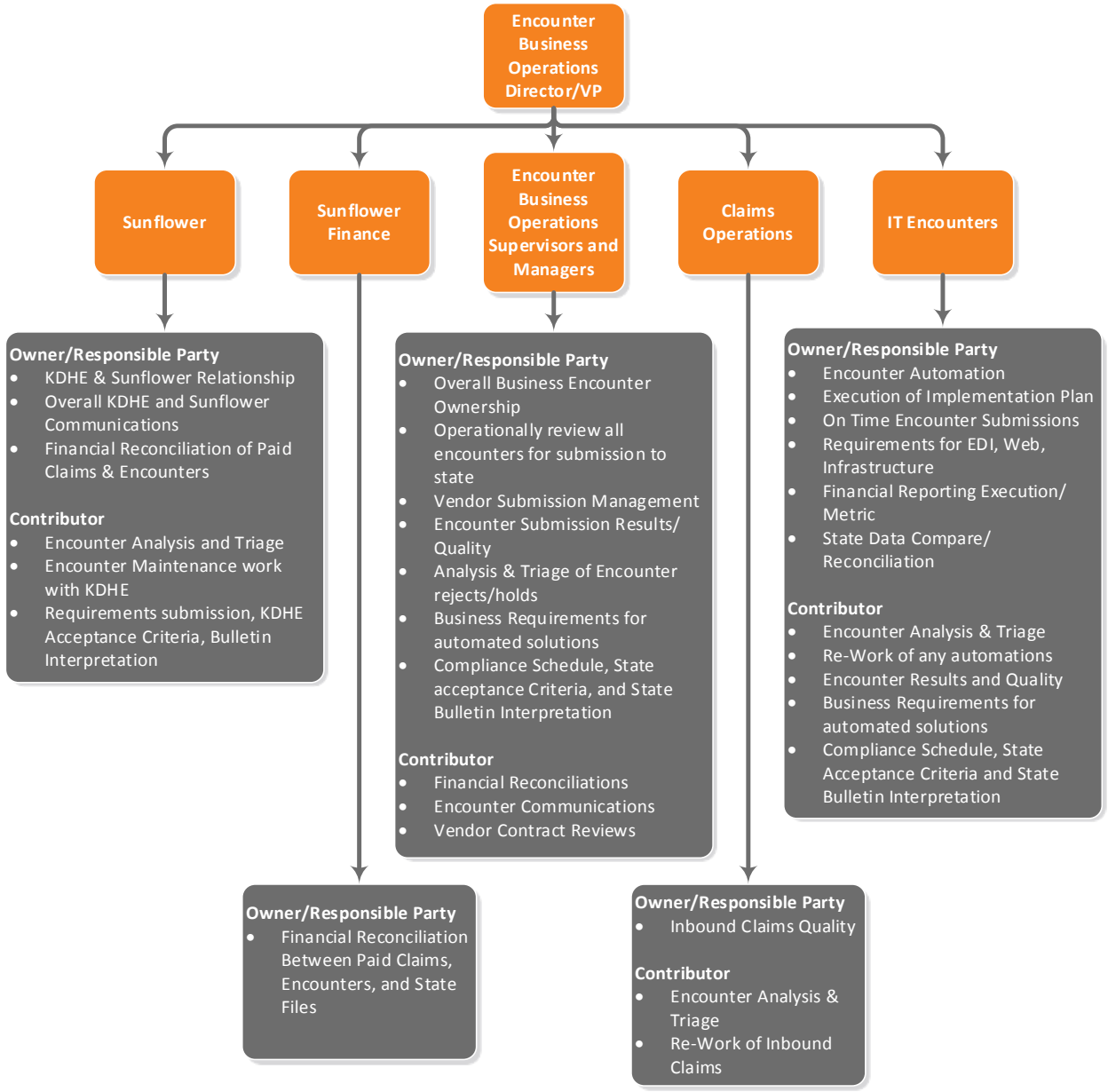
- ***EBO Director/VP of Encounters and Coding Analytics- Jessica Silver.*** Jessica brings over 10 years' experience supporting encounter processes. Jessica oversees our EBO team and supports Sunflower's encounter data operations. Sunflower will continue to leverage this national experience to submit high-quality encounter data to KDHE.
- ***EBO Encounter Specialists.*** The EBO team is staffed with dedicated EBO Encounter Specialists to support Sunflower operations. The EBO Encounter Specialists leverage EBO's nationwide expertise and bring best practices from Sunflower's affiliate health plans to support our encounter data performance.

The EBO team partners with our centralized IT Encounters team and subcontractors to ensure successful encounter delivery. For example, the EBO team documents and implements encounter business requirements, monitors file processing and delivery, collaborates externally to foster partnerships, and analyzes encounter holds and rejects. This includes working with our centralized EDI, Web, and Claims teams to ensure billing edits are in place to support Sunflower's partnership with KDHE to meet and exceed encounter requirements.

Coordinated Team Approach. The EBO team coordinates the expertise of multiple areas through regular meetings with the IT Encounters team, subcontractors, and local Sunflower staff, including Claims Liaisons, Finance, Compliance, and Provider Relations teams. This coordinated team approach ensures encounter processes and performance requirements are consistently met. For example, we collaborate to develop performance improvement solutions around topics such as overall encounter status including pass rates; paid claims to encounters reconciliation; outstanding and upcoming business concerns; underlying claims issues; and subcontractor encounter reporting status.

The EBO team partners with Sunflower Claims Liaisons who have local expertise and in-depth understanding of KDHE claims processing rules and provide critical feedback to our centralized claims processing and configuration staff. The Sunflower Provider Relations team supports provider communication and education, and works directly with our providers, as needed, to resolve issues related to claim submissions. ***See Figure 5.14.3.A_Encounter Business Operations: Roles and Responsibilities.***

Figure 5.14.3.A_Encounter Business Operations: Roles and Responsibilities



Encouraging Electronic Claims Submission. Today, over 97.5% of claims submitted to Sunflower are submitted electronically or entered online on our secure Provider Portal via the HIPAA-compliant Direct Data Entry (DDE) feature and LTSS Claims Wizard (a version of our DDE feature designed specifically for the billing needs of our LTSS providers). Our electronic submission process uses data validation edits as part of our quality control strategy on the "front end" of the encounter production process for ensuring key fields are accurate and complete. As a result, we are able to prevent instances of missing or incorrect key data fields in the initial claim submission. Our experiential data shows that electronic claims are usually filed at least 50% closer to the date of service than paper claims and with significantly less submission errors. Thus, we aggressively promote electronic submissions from all providers. We offer multiple

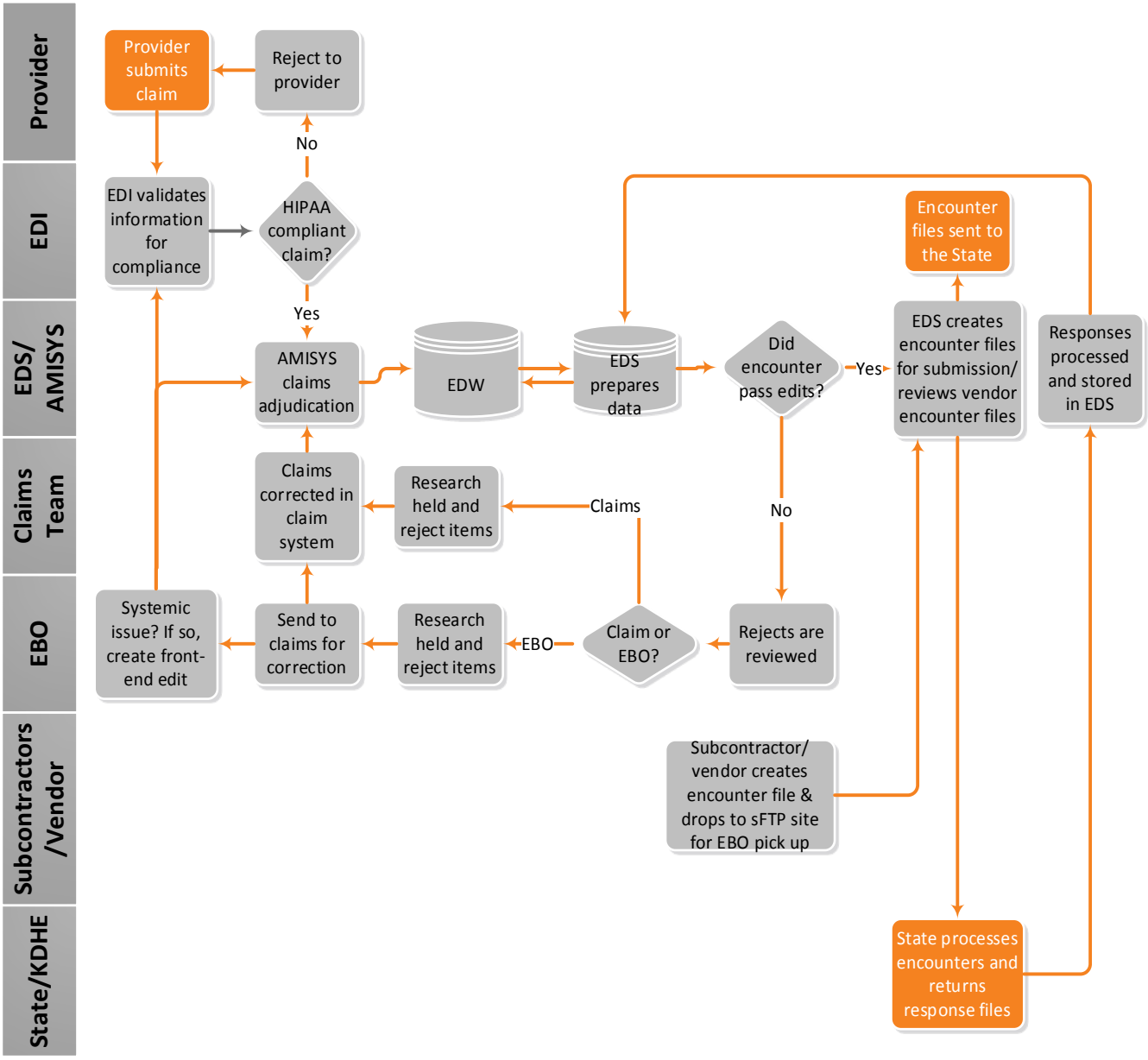
supports for electronic claim submission including in person and online training, telephone support, an EDI onboarding platform, complete documentation on our website, and other interactive tools on our Provider Portal.

Converting Paper Claims to Electronic Data. We accept paper claims from providers and require all paper submitters to use CMS 1500 and UB04 paper formats. We use the CDMS component of our MIS to convert paper or fax claim submissions into machine readable data. CDMS is our automated content management system, expressly designed to efficiently manage inbound and outbound paper and fax document traffic to/from Sunflower. CDMS automates and accelerates the processing of paper and faxed claims and related paper based correspondence. CDMS' integrated architecture incorporates a full featured, secure inbound/outbound fax communications system with enterprise level document scanning, Optical Character Recognition (OCR), indexing, and routing workflow capabilities to streamline and automate the capture and processing of paper claims and conversion into machine readable data.

Once converted into data, paper claims are processed through the same validation and code set edit checks that we perform on electronically submitted claims. Our EDS also treats claims data derived from paper submissions no different than claims submitted electronically, and all encounter records we prepare and submit to KDHE (from paper or electronic claim submissions), are sent as HIPAA-compliant transactions.

From Claims to Encounters: Sunflower's End-to-End Approach. Our front-end controls help ensure accurate, timely, and complete claims submissions from providers to support back-end encounter data submission to KDHE. We do this by complying with industry-accepted clean claim standards, including sub-capitated claims. This accurate data supports proper adjudication. Upon claim receipt, our compliance software validates data against ASC X12 HIPAA Version 5010 syntax, for data structure, tests for conditional rules requiring secondary fields, and helps ensure data is in compliance with KDHE companion guides as we process the claim. This helps assure that the downstream encounter data we produce meets and/or exceeds KDHE standards. Our subcontractors also employ similar EDI quality control measures. ***See Figure 5.14.3.B_End-to-End Claims to Encounter***.

Figure 5.14.3.B_End-to-End Claims to Encounter



<u>Ensuring Encounter Data Quality during Claims Adjudication.</u> Once our MIS checks submitted claims for HIPAA compliance, completion, and valid information, those claims are loaded into AMISYS Advance (AMISYS), the claims processing component of our MIS, for adjudication. AMISYS applies Sunflower rules for covered services, verification of member eligibility for dates of service, matching of claim to service authorizations (if applicable), provider network status, provider eligibility to render the services on the claim, determining if the provider is not excluded from providing Medicaid services, and application of appropriate fee schedule. AMISYS also performs edit checks for TPL and automated clinical and FWA edits and processes,

until the claim is finalized to a paid or denied status. The system also reviews adjudicated claims prior to payment for duplicate claims. After claim adjudication, all data elements from the claim as well as adjudication results are stored in the Centelligence® Enterprise Data Warehouse (EDW) component of our MIS, and accessible by our EDS, enabling us to create HIPAA-compliant encounters.

Encounter Data System (EDS). Encounter data submission and operations are supported by the EDS component of our MIS, a comprehensive encounters workflow system, which edits and validates claims data, creates encounter submissions files, loads inbound response files, and tracks and reports encounter data status. Encounter rules and edits are set up in our EDS to ensure encounters are HIPAA-compliant 837 transactions that conform to KDHE-specific content, format, and transmission specifications.

Ensuring Encounter Data Accuracy. In addition to various levels of edits occurring during the inbound claims process, EDS applies KDHE custom edits both pre- and post-payment to claims processed in our AMISYS claims processing system to ensure all critical data elements are present and accurate, including claim type, place of service, revenue code, diagnosis codes, amount paid, and procedure code. We also capture and submit all valid provider data elements as billed on the claim including, but not limited to NPI, taxonomy and Medicaid ID. Our automated EDS encounter submission scheduler ensures we perform these edits in time to meet KDHE's submission timeframe of 30 days within claim payment for both paid and denied claims. Held data is triaged to identify and resolve any issues identified through the edits.

EDS creates Medical 837 Professional and 837 Institutional encounter submission files for those encounters which pass the quality checks discussed above. All 837 files are run through EDIFECS, our HIPAA compliance checking tool to confirm no compliance errors exist. The EBO team and Encounters IT team will review any issues to determine root cause and resolution.

After receipt and loading of the response files, any encounter errors/rejects received are reviewed by the EBO team and Encounters IT team. Root cause analysis is performed to ensure necessary changes are implemented for any pended/rejected encounter. The EBO team works with various teams to ensure errors/rejects are resolved. This includes our centralized Claims Department for any claims related issues, Sunflower staff for member or provider related issues, or our IT Encounters teams for issues such as 837 formatting. When appropriate, we correct errors at their source. For example, we may initiate the CR process to resolve claims issues at the source in our claims processing system as a

Sunflower in Action…

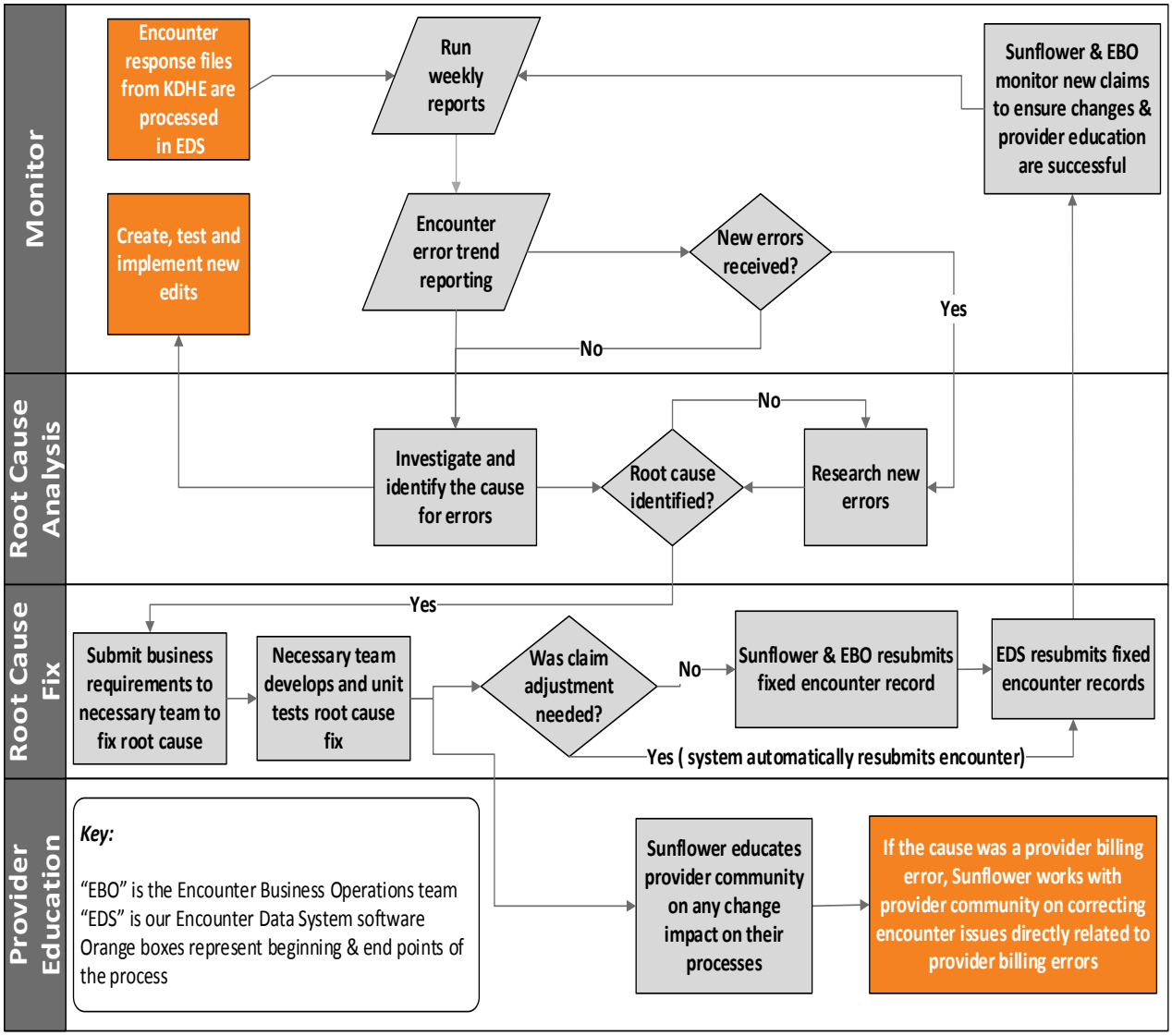
Sunflower regularly partners with the State on reviewing the applicable encounter rejects to ensure these are reviewed and applied correctly. Historically, Sunflower has worked with the State on various occasions to modify the edit logic within the State's system to ensure it is consistent with CMS guidelines. Through this collaboration, Sunflower was able to resubmit and have these encounters processed by the State with no disruption to the providers (e.g., 526 edit – Statement vs Admit Date).

result of working on provider billing updates. The EBO team will submit requests for any errors in encounter data or data submission attributable to applicable program logic within the EDS.

The EBO team regularly examines the highest encounter "scrub" reasons as reported in the encounter solution. Wherever possible, the encounter edits that occur frequently on the "back end" (in the EDS) are moved to the "front end," at the point of claim submission, including our EDI subsystem and AMISYS claims processing system, to enforce those edits and reject or deny inaccurate claims as early as possible in the process so that the claim can be corrected and submitted accurately by the provider. Sunflower and the EBO team will participate in KDHE-sponsored workgroups directed at continuous improvements in encounter data quality and operations.

Timely Error Resolution. EDS enables the EBO team to research errors in a timely fashion in accordance with KDHE's requirement to remediate all encounters within 30 calendar days after notice for those failing X 12 EDI compliance edits and repairable compliance edits. Through our EDW, we can identify any encounters that must be reprocessed, view encounter issues from the batch level down to the individual service line detail level, and view the processing history of any given encounter record. We manage timely error resolution by performing root cause analysis of any errors from an encounter submission, and route the encounter record to the appropriate EBO, IT, Claims, or subcontractor teams for resolution. If an erred encounter record requires the claim to be reprocessed, corrections are made at the source and the encounter is then resubmitted through EDS to KDHE within the agreed upon timeframe. ***See Figure 5.14.3.C_Encounter Root Cause Analysis.***

Figure 5.14.3.C_Encounter Root Cause Analysis



Ensuring Encounter Data Completeness. Sunflower collaborates with our centralized Encounters teams to maintain processes for tracking encounter submission, error correction, resubmission, and compliance with targets for accuracy, timeliness and completeness. Together, we generate, review, and act on multiple reports specifically developed for this process. Monthly, a reconciliation is completed by the EBO team, IT Encounters, and the Encounters Analytics team to tie adjudicated (paid/denied) claims to their current encounter status. This reconciliation is based on paid dollars by date of service month. This process has proven successful in providing the ability to reconcile every claim to a submitted encounter, and understand where the encounter is within the processing cycle. In 2016, 98.9% of our claims paid matched to our submitted encounters to KDHE, exceeding the 98% KanCare encounter completeness requirement. If discrepancies arise in these reconciliations, it is the responsibility of the EBO team and IT Encounters team to reconcile and resolve these issues to ensure all encounters are submitted to KDHE in an accurate, complete and timely manner.

Ensuring Encounter Data Timeliness. Sunflower submits encounter files within 30 days of claims payment in accordance with KDHE submission timeframes, and we have demonstrated our ability to exceed KanCare 2.0's encounter timeliness standards. In the 2016 contract year, Sunflower submitted 98.99% of encounters within 30 days of the claims paid date. The finalized encounter submission files are submitted via Secure FTP (SFTP) to KDHE. Our Coviant Transaction Manager handles our automated, scheduled file exchanges between Sunflower and KDHE to ensure delivery of encounter submissions. To confirm successful transmission, the EBO team and Encounters IT team will monitor EDI acknowledgments returned by KDHE for each encounter file submission, including subcontractor encounter file submissions.

Continuous Process Improvement. Sunflower leverages operational feedback as a method to continuously improve each step of the encounter process. The guiding approach to our encounter data preparation is our end-to-end framework, where we identify and resolve issues at the root cause. Our EBO team uses our Centelligence reporting functionality to identify encounter trends in order to monitor that we're meeting KanCare program requirements and to proactively identify and correct issues with KDHE. We are expanding our Centelligence capabilities to include more robust encounters quality and monitoring dashboards to more easily identify performance anomalies (e.g., timeliness) and drive operational improvement.

In the 2016 contract year, Sunflower submitted 98.99% of encounters within 30 days of the claims paid date.

Subcontractor Encounter Submission. In addition to encounter data we produce, Sunflower and the EBO team also monitor and facilitate encounter submissions to KDHE from our affiliated subcontractors. All subcontractors who receive claims submissions from providers on behalf of the KanCare program are contractually obligated to submit encounter data to Sunflower in accordance with KDHE requirements. If documented service level agreements related to encounter submissions to Sunflower are not met, we enforce financial sanctions and corrective action plans, as applicable.

Subcontractor Oversight. Encounter submission errors of our subcontractors are monitored and corrected in collaboration with the EBO team. This enables the EBO team to oversee the subcontractor's encounter accuracy and completeness and identify issues that could possibly impact encounter data quality. Our subcontractors submit their encounter data to us in HIPAA-compliant formats per a required schedule. We will then load subcontractor encounter data into our MIS for validation prior to submission to KDHE. Files that pass KDHE-specific processing rules will be submitted to KDHE. When an issue is identified, the EBO team will meet with Sunflower and subcontractors to address and resolve the issue. Any records not meeting KDHE edits and rules will be systematically returned to the subcontractor for correction and resubmission within KDHE-specified timeframes. All teams meet regularly until the issue is addressed and new processes are consistently maintained. Sunflower monitors subcontractor encounter submissions via quarterly Joint Operating Committee reviews with each subcontractor.

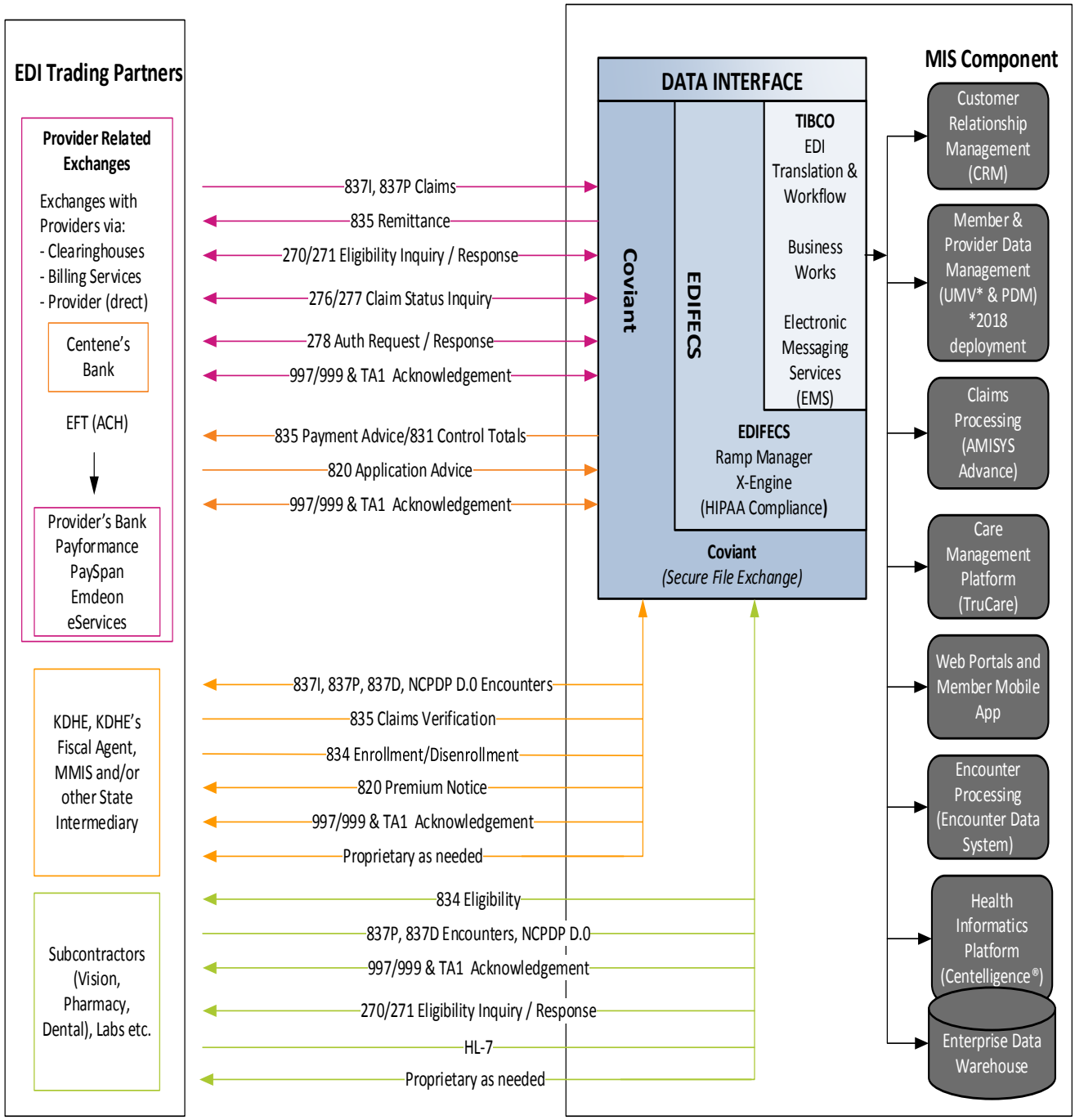
An MIS Ready to Meet and Exceed KanCare 2.0 Data Requirements (Attachment J)

Through the EDI capabilities of Sunflower's MIS, we successfully receive, process, acknowledge, update, and transmit formatted data to and from our Kansas trading partners (e.g., KDHE, KDHE's FA, providers, subcontractors) through SFTP, and we support interoperability with virtually every type of industry standard. Sunflower's MIS currently supports HIPAA and non-HIPAA compliant code sets, and state proprietary formats for file and data exchanges. Our MIS supports hundreds of secure data exchanges and data interactions on schedules ranging from daily to annually, or on an event-driven (real-time) basis, depending on the specific information and data product required by KDHE, providers, or other trading partner. Through our MIS, we also have secure access to state agency online applications, such as the AuthentiCare EVV system from First Data. And we support secure electronic data exchanges through an expanded use of web and mobile technologies, including our secure web portals and Sunflower member mobile app. See ***Figure 5.14.3.D_Electronic Data Interfaces: EDI Architecture***.

Today, we support all HIPAA transaction formats, including:

- The HIPAA 820 Premium Payment transaction
- The HIPAA 834 - both for receiving enrollment and eligibility data and for issuing demographic member updates back to KDHE
- The HIPAA 835 for encounter adjudication result reporting
- The HIPAA 837 Institutional, Professional, and Dental (837I, 837P, 837D) transaction for provider claim and encounter submissions to KDHE and KDHE's FA
- NCPDP D.0 Pharmacy Claim/Encounter Transaction
- The HIPAA 270/271 Eligibility/Benefit Inquiry/Response
- The HIPAA 274 Healthcare Provider Information
- The HIPAA 276 Claims Status Inquiry
- The HIPAA 277U (Unsolicited 277) and 277CA (Claims Acknowledgement) claim/encounter status transaction
- The HIPAA 278 Utilization Review Inquiry/Response

Figure 5.14.3.D_Electronic Data Interfaces: EDI Architecture



We also exchange the required data as specified in the Contract's Attachment J, in the formats and methods as agreed upon with KDHE including:

- Provider network data
- Case management fees, if applicable
- Member and services data
- Pharmaceutical Report

- Mental Health Outcomes Data
- Daily claims data file submission
- Substance Use Disorder (SUD) Data

Enterprise MIS Ensures Availability and Timely Recovery (Att. J 1.6). Our MIS is engineered with the hardware, software, communications, and processes to ensure that our applications are available for our Sunflower staff, providers, members, KDHE, and other state partners, with the least possible disruption. We maintain and continually enhance the availability of our MIS through the design of redundancy we factor into the hardware, software, and networking components of our MIS architecture. Our MIS is based on these principle design points:

- ***High Availability*** is achieved through effective risk mitigation strategies and by maintaining extensive redundancy in our entire computing infrastructure and network features. For example, our use of virtualization provides an optimal solution to deploy and manage applications while also maximizing application availability and integrity.
- ***Utilizing Industry Standard and Best in Class*** operating systems, virtualization platforms, application software, and hardware components. Our use of blade servers, virtualization, clustering, Storage Area Network, and hardware redundancy affords us the availability and performance to power the three broad tiers of our systems architecture, which are presentation, application, and data storage.
- ***Scalability and Flexibility*** to maintain agility in our MIS, allowing for quick changes based on business imperatives. From a hardware perspective, we realize these principles through a "computing utility" approach, which is the ability to expand the capacity of our operations without affecting the availability of current business operations and deliver computing power and reliable data storage any time, to any application and in any amount.
- ***Monitoring and Service*** to achieve and maintain high availability; monitoring our environment to anticipate problems; service our members, providers, KDHE, and our Sunflower staff; and address situations before there are issues.

All of the MIS infrastructure technologies, MIS service management strategies, incident management, Business Continuity and Disaster Recovery policies, procedures, and processes are in place today currently supporting Sunflower and the KanCare program, and will continue to support KanCare 2.0.

- Today our Telephony and Voice Portal Platform's Interactive Voice Response (IVR) functionality and our Sunflower public website, secure web portals, and Sunflower member mobile app are available 24/7. We maintain this level of service for Sunflower's programs.
- Outside of our IVR, web, and mobile functions, our other MIS functions are available for online use from 7 a.m. to 7 p.m., Central Time, Monday through Friday. In fact, availability is typically well beyond these hours depending on system loads and system maintenance. All of our production systems, ***including our systems supporting data exchanges with KDHE and KDHE's FA***, as well as local Sunflower offices are monitored 24/7/365 for service

availability, system performance, and capacity utilization. For unscheduled system unavailability due to the failure of our systems, we restore services within 48 hours of the official declaration of system unavailability.

- We ***notify*** designated KDHE staff via phone, fax, and/or electronic mail within one hour upon discovery of a problem that results in delays in report distribution or problems in online access to critical systems functions and information during a business day, in order for the applicable work activities to be rescheduled or handled based on our MIS unavailability protocol.
- Sunflower's ***Business Continuity Plan/Disaster Recovery Plan*** is formulated and tested in coordination with our corporate Business Continuity Department. From a data protection perspective, Sunflower's data availability, integrity, confidentiality, and security is protected and enforced by IT fault tolerant architecture, safeguards, controls, policies, as well as ongoing testing, and employee training and certification. See Section 5.15.2 Use and Safeguarding Data for more information.

5.15 Information Systems

5.15. INFORMATION SYSTEMS

SUNFLOWER DEMONSTRATED SUCCESS

Sunflower Health Plan (Sunflower) has served KanCare members since 2013, and we remain fully committed to supporting the State's vision to move HIT and HIE forward in Kansas. We continue to work closely with the State and its partners, most notably the State's MMIS and EVV system contractors. We look forward to positively impacting the State's implementation of its Kansas Modular Medicaid System (KMMS), particularly since our own HIT is grounded in the same Medicaid Information Technology (MITA) architecture. In the pages that follow, please find details on Sunflower's demonstrable successes including (among others) our:

- Accelerating investments in impactful HIT/HIE capabilities since 2013, reflected graphically in ***Figure 5.15.A_Accelerating Our Investment in Health Information Technology*** below.
- Continued expansion of information sharing and valuable functionality in our Provider Portal, resulting in an increase in Provider Portal users from 700 in December 2012 to over 13,800 registered users as of December 2017.
- Introduction of new online capabilities for providers, including member panel level quality and cost interactive analytics to support providers as we phase in alternative payment methods (APM) with providers through our Value Based Purchasing (VBP) programs.
- Embrace of existing and new standards for interoperability, security and quality, including the International Standards Organization (ISO) 27001 certification of our information security program, the URAC accreditation of our Pharmacy Benefits Manager, and new support for Health Level 7 (HL7) clinical transactions.
- Ability to maintain business continuity with no delays in meeting State requirements, thanks to the redundant, resilient nature of our HIT architecture, and proven processes and organization. This is the same business continuity base which was most dramatically demonstrated in 2017 at our Texas and Louisiana (Hurricane Harvey) and Florida and Georgia (Hurricane Irma) affiliates, with no disruption in service during these major weather emergencies.
- Annual updates to the State of the HIT/HIE plan we submitted in 2013

Compliance With Scope of Work (SOW)

Sunflower currently complies with all KanCare contract requirements, and all KanCare 2.0 requirements described in the RFP Section 5.15 and RFP Attachment J. In addition, we have reviewed all RFP Amendments, including RFP Round One and Two Questions and Answers, as well as the 2017 State Medicaid Health Information Technology Plan (SMHP) Addendum, the State's existing EVV System Contract and all Amendments (as referred to in RFP Amendment Four, Round One Question and Answer #247) and applicable documentation included with the RFP. In the discussion that follows in this Section 5.15, we outline our information systems; overall approach to and plans for HIT and HIE; prior authorization (PA) capabilities; web-based portal functionalities; experience with electronic visit verification systems; administrative, physical, procedural, and technical security safeguards; confidentiality policies and procedures; system change management processes; and business continuity (BC) and disaster recovery

planning (DR). For ease of review, we have included explicit RFP/SOW references in headers and within the narrative.

5.15.1. HEALTH INFORMATION TECHNOLOGY AND HEALTH INFORMATION EXCHANGE

OUR COMMITMENT TO HIT AND HIE FOR CARE DELIVERY AND QUALITY (5.15.1.A)

HIT Defined

Sunflower, along with our parent company, Centene Corporation (Centene), shares the State's expansive definition of HIT as not only the "digitization" of medical records but the appropriate sharing of health information across all stakeholders in the health care continuum, including providers, members, caregivers, the State, MCOs, and supporting subcontractors. This is why our HIT, also referred to in this section as our enterprise Management Information System (MIS), is designed on an interoperable, standards based service oriented architecture. Our modular approach to HIT design has allowed us to adopt and deploy an accelerating number of new applications, connectivity features, and information based analytics and services over Sunflower's operating history. Please see Figure 5.15.A_Accelerating Our Investment in Health Information Technology for a graphical depiction of this trend, displaying new functions we have deployed year after year, each function building on the last to improve functionality and our ability to send and receive health data.

Sunflower's HIT, supplied to us by our parent Centene, is a scalable platform serving over 7 million Managed Medicaid members in 24 states.

Expansive Data Sharing Capabilities. In addition to the newer functions of our own HIT, such as increasingly complex and accurate predictive analytics, expanded uses of our Provider Portal, and mobile applications for members, we have continued to enhance our health data sharing capabilities with our Centelligence® Gateway system, allowing us to go beyond support for all HIPAA transactions, and State proprietary formats, to expanded and meaningful use of HL7 Admission, Discharge, Transfer (ADT) data, Continuity of Care Documents (CCD-A), and the rapidly emerging HL7 Fast Health Information Resources (FHIR) data standards for clinical information exchange. Please see Section 5.15.1.E for more details.

Figure 5.15.A_Accelerating Our Investment in Health Information Technology

ACCELERATING OUR INVESTMENT IN HEALTH INFORMATION TECHNOLOGY

As technology matures, Sunflower and our parent company, Centene, have capitalized on IT developments with an accelerating rate of innovation, building new functions upon proven enterprise integrated Health Information Technology. Our centralized team of over 1,300 IT professionals work closely with Sunflower and our affiliate health plans serving publicly funded health programs in 29 states to engineer solutions for the unique needs of our State partners, providers, and members.

2013	2014	2015	2016	2017 - 2018
				Enterprise Provider Analytics
				Community Resource Database
				Appointment Wizard™
				Service Coordinator Portal
				Centelligence® Clinical Gateway
			Member Mobile Application	Member Mobile Application
			Caregiver Portal	Caregiver Portal
		TruCare Integrated Care Management	TruCare Integrated Care Management	TruCare Integrated Care Management
		Health Info Exchange & EMR Support	Health Info Exchange & EMR Support	Health Info Exchange & EMR Support
	Online Member Health Record	Online Member Health Record	Online Member Health Record	Online Member Health Record
	Member & Provider Relationship Management	Member & Provider Relationship Management	Member & Provider Relationship Management	Member & Provider Relationship Management
Member & Provider Call Campaigns	Member & Provider Call Campaigns	Member & Provider Call Campaigns	Member & Provider Call Campaigns	Member & Provider Call Campaigns
Executive Ops Dashboard	Executive Ops Dashboard	Executive Ops Dashboard	Executive Ops Dashboard	Executive Ops Dashboard
Predictive Modeling	Predictive Modeling	Predictive Modeling	Predictive Modeling	Predictive Modeling
Electronic Remit Advice	Electronic Remit Advice	Electronic Remit Advice	Electronic Remit Advice	Electronic Remit Advice
Provider Data Management	Provider Data Management	Provider Data Management	Provider Data Management	Provider Data Management
Member Portal	Member Portal	Member Portal	Member Portal	Member Portal
Centelligence® Platform	Centelligence® Platform	Centelligence® Platform	Centelligence® Platform	Centelligence® Platform
EDW-Based Reporting	EDW-Based Reporting	EDW-Based Reporting	EDW-Based Reporting	EDW-Based Reporting
Cent Account	Cent Account	Cent Account	Cent Account	Cent Account
Online Health Risk Assessment	Online Health Risk Assessment	Online Health Risk Assessment	Online Health Risk Assessment	Online Health Risk Assessment
Provider Portal	Provider Portal	Provider Portal	Provider Portal	Provider Portal

TRANSFORMING HEALTH CARE THROUGH HIT AND HIE (5.15.1.B)

We are eager to build upon our KanCare experience to further State strategies in leveraging HIT support for KanCare 2.0, promoting health care quality and system wide efficiencies through expanded health information sharing. An important part of the State's HIT strategy is reflected in the 2017 State Medicaid Health Information Technology Plan (SMHP) Addendum which we have reviewed. We will continue to promote with our providers the State's Medicaid EHR Incentive Payment Program and the State's Medical Assistance Provider Incentive Repository (MAPIR) as reflected in the SMHP, to help foster growth in EHR meaningful use in Kansas, including the use of EHR technology in alignment with Modified Stage 2 and Stage 3 requirements as detailed by CMS' Final Rule of October 6th, 2015. We continue to offer web and other connectivity options for providers that encourage Stage 2 and 3 meaningful use, including support for e-prescribing, the use of care gap alerts, applications for ED admission notifications, and more (see Section 5.15.1.E below). We believe the best way to drive EHR meaningful use is to offer impactful applications and information sharing.

STRATEGIC PARTNERSHIPS WITH HEALTH INFORMATION ORGANIZATIONS (5.15.1.C)

Sunflower continues to participate in organizations dedicated to the exchange of health information in Kansas. We are a participant of the Kansas Health Information Network (KHIN) health information exchange (HIE), which maintains data connectivity to the Lewis and Clark Health Information Exchange (LACIE). In addition, Sunflower's Vice President of Operations/Systems Director continues to serve on the Advisory Council of KanHIT (KDHE Office of Health Information Technology). We remain committed to collaborating with Kansas providers to foster new ways of securely exchanging health data to improve health care delivery and quality. For example, we are working with the Kansas Association for the Medically Underserved (KAMU) for the use of Social Determinant of Health and Independence (SDOHI) data collected through KAMU's administration of the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) form. Please see Section 5.15.1.E.1 below for more information.

PLAN TO IMPROVE CARE, WELLNESS AND QUALITY THROUGH HIT AND HIE (5.15.1.D)

We will submit our HIT and HIE plan after Contract award, in compliance with Section 5.15.1.D above. In 2013, we submitted our HIT and HIE plan to the State, and submitted annual updates on March 30th of each year since then, with our latest HIT HIE plan update dated March 30th, 2017. Since 2013, CMS has announced and begun implementation of the Merit-based Incentive Payment System (MIPS), and we will include in our plan how we will expand (in a manner consistent with the State's SMHP Addendum) our promotion of meaningful use to include the MIPS Advancing Care Information (ACI) standards, with ACI's emphasis on promoting patient engagement and the electronic exchange of information using certified EHR technology. Today, Sunflower uses a blend of web and mobile platforms, and standards based data exchanges to promote and foster patient engagement and electronic information exchange, including online tools for providers and members, as well as Community Service Coordinators. Please see Section 5.15.1.E below for our preliminary HIE/HIT plan for KanCare 2.0.

PRELIMINARY PLAN TO IMPROVE CARE, WELLNESS AND QUALITY THROUGH HIT (5.15.1.E)

Architecture for Interoperability with Providers and State Framework (5.15.1.E.1)

Sunflower's HIT is an enterprise Management Information System (MIS) designed for efficient electronic health information exchange with providers and the State via a standards based Service Oriented Architecture (SOA) with microservices accessible via open Application Programming Interfaces (APIs) to service user and application functions in a scalable manner. As is the case with the Kansas Modular Medicaid System (KMMS, RFP Section 5.16.3), our design is also informed by CMS' Medicaid Information Technology Architecture (MITA) Version 3 with integrated components and industry-standard application, data, and communication interfaces. Our MIS features table-driven, configuration utilities that eliminate the need for

custom development while giving us flexibility to support a wide variety of health information exchange needs. Our adherence to open industry standards including HIPAA transaction and codeset standards, RESTful web application service designs, HL7 clinical data exchange formats, and HIPAA compliant security controls affords Sunflower maximum latitude in working within the KDHE-DHCF framework to facilitate the exchange of health information among Sunflower, the State, providers, Community Service Workers and members.

Like the Kansas Modular Medicaid System, our MIS is based on a Service Oriented Architecture, using a data service bus, and informed by MITA design principles, with compliance to open standards.

Ready to Support the KDHE-DHCF's KMMS Framework. We have a successful history of working with the two key contractors the State has procured for KMMS: DXC and Cerner Corporation. We continue to work with DXC in Kansas for KanCare operations, and our affiliates work with DXC in several states for Managed Medicaid administration. Our affiliate in Texas undertook a major development and deployment effort successfully with Cerner to support that state's foster care health plan program. As the State continues to develop and phase in implementation of KMMS, we are confident that our MIS, grounded in very similar design strategies as KMMS, will allow Sunflower and the State to leverage next generation health exchange capabilities.

Working together with Cerner, our Texas affiliate health plan successfully developed, deployed, and operates a secure web based Electronic Health Record system in the service of children in the Texas Foster Care health plan.

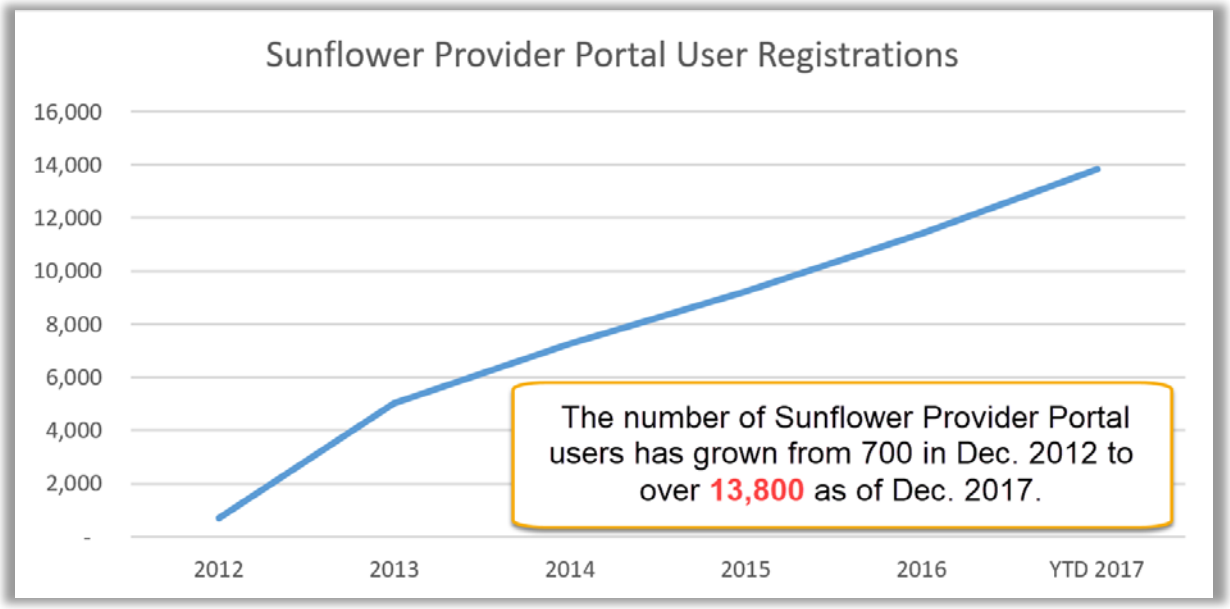
Active in the Health Connectivity Community. Sunflower continues to participate in organizations dedicated to the exchange of health information in Kansas. We are a participant of the Kansas Health Information Network (KHIN) health information exchange (HIE). In addition, Sunflower's Vice President of Operations/Systems Director continues to serve on the Advisory Council of KanHIT (KDHE Office of Health Information Technology). We remain committed to collaborating with Kansas stakeholders to foster new ways of securely exchanging health data to improve health care delivery and quality outcomes.

Exchange of Health Information between Providers and Sunflower (5.15.1.E.1, continued)
Today, Sunflower supports the exchange of health information with providers in several ways, including an expanding set of online services and information delivered through our web-based, secure **Provider Portal**, as well as via a growing family of HIPAA EDI and HL7 compliant administrative and **clinical data exchanges**.

Provider Portal. Our web based Provider Portal is an enterprise scalable, standards based platform that is fully HIPAA security and HIPAA transaction compliant and available 24 hours a day, seven days a week. Sunflower's Provider Portal offers administrative "self-service" capabilities including eligibility inquiry, authorization submission and status, claim submission,

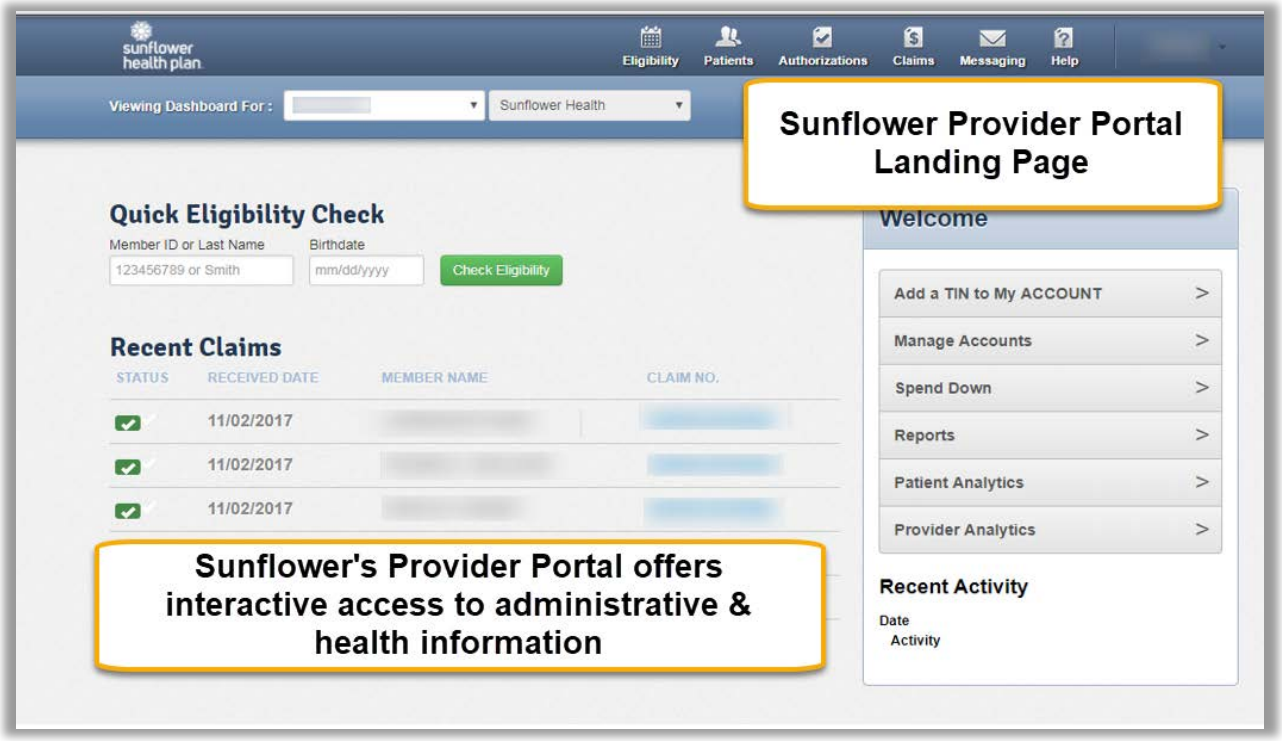
claim status inquiry, and claim payment history. As we have continued investing in our Provider Portal with new interactive functions and targeted analytics for our providers, we have seen significant growth in the number of users of our Provider Portal. See ***Figure 5.15.B_Sunflower Provider Portal User Registrations*** below.

Figure 5.15.B_Sunflower Provider Portal User Registrations



Much of the growth in our Provider Portal's user base is due to a growing number of *clinical* applications with health information presented in a meaningful, impactful manner. These clinical functions include: online care gap notifications (alerting providers to health alerts and care gaps), emergency room high utilizer flag (alerting providers if a member has had three or more emergency room visits in 90 days), and an online Member Health Record (MHR) delivering advanced capabilities for clinical service coordination (see further discussion in Section 5.15.1.E.2 below). The Provider Portal also supports online care and disease management (DM) referral (allowing the provider to refer her patient to one of our programs), practice-level clinical quality and cost reports, patient analytics, provider analytics (see discussion further below) and clinical practice guidelines. See ***Figure 5.15.C_Provider Portal Landing Page*** immediately below for a snapshot of the screen presented to providers upon login. For more information about our provider website and technological tools to support providers, please see Section 5.6.

Figure 5.15.C_Provider Portal Landing Page

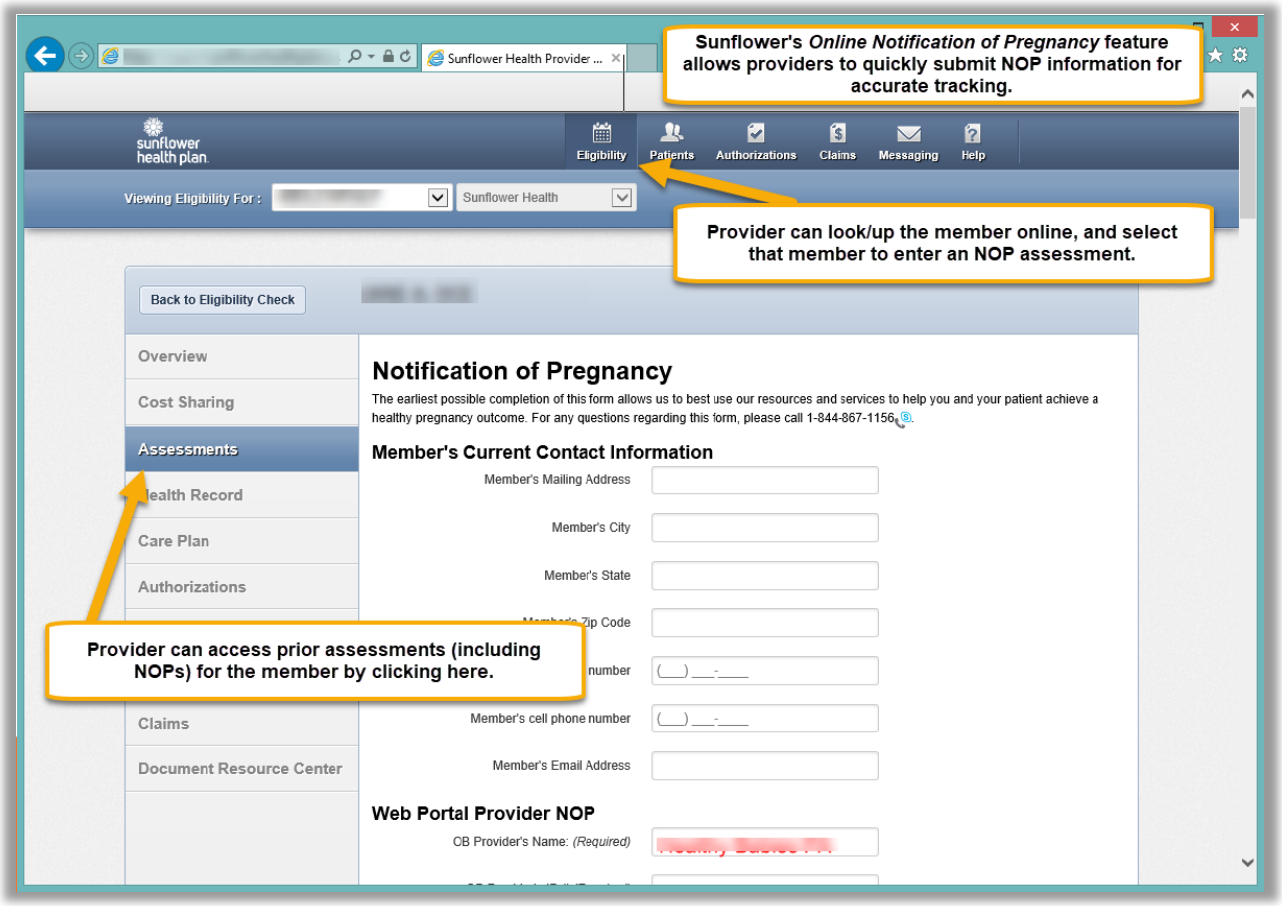


In 2018, we are enhancing our Provider Portal to include all **physical and behavioral health (BH) functions on one secure platform** – further enabling BH and physical health care coordination, and expanding the health information we exchange with all providers via this online presence.

Online Notification of Pregnancy Submissions. We continue to deploy new and innovative ways for providers to exchange health information with us. We also integrate whenever possible provider electronic health information exchange with our growing family of Pay for Performance (P4P) and other Value Based Purchasing (VBP) alternative payment methods. An illustration of this strategy is our recently launched **Timeliness of Prenatal Care Incentive Program (Prenatal Program)**. The goal of our Prenatal Program is to increase the percentage of members entering prenatal care in timely fashion through incentives tied to appointment access, in line with NCQA's Prenatal and Postpartum Care (PPC) HEDIS measure.

A *critical part* of this HEDIS measure is receiving an accurately completed Notification of Pregnancy (NOP). To enhance accurate and timely collection of NOP data, we expanded the functionality of our Provider Portal to allow providers to efficiently enter NOP data. Once the provider completes and submits the NOP form, that data is stored in our HIT for online access by our Service Coordinators, providers (via the Provider Portal), and for subsequent operational and HEDIS reporting. Please see ***Figure 5.15.D_Online Notification of Pregnancy*** below (Protected Health Information removed). Note that our providers must enter the NOP online to qualify for our Prenatal Program incentive.

Figure 5.15.D_Online Notification of Pregnancy



Supporting Providers with Online Analytics. As noted above, we continue to expand the range of Value Based Purchasing (VBP) programs we offer providers, with alternative payment models to support payments tied to performance, gain and risk sharing. A critical success factor in the deployment of any VBP program is the ability for the MCO to offer clear, accurate, and timely information so that providers can understand their status at any time relative to their VBP program quality and cost goals. This is why we offer today, through our Provider Portal, a family of well-organized interactive reporting dashboards, supported by data, information, and analytics from our Centelligence® health informatics platform. Centelligence® integrates physical and behavioral health (BH) claims data, pharmacy claims data, lab test results, assessments, and other demographic, administrative and clinical data to deliver information to Sunflower staff, members, and providers. Please see ***Figure 5.15.E_Online Utilization Dashboard Example*** and ***Figure 5.15.F_Online Value Based Contract Dashboard Example*** below for just two examples of the type of information we make available to providers via our Provider Analytics capability (no Protected Health Information is in these summary level snapshots).

Figure 5.15.E_Online Utilization Dashboard Example

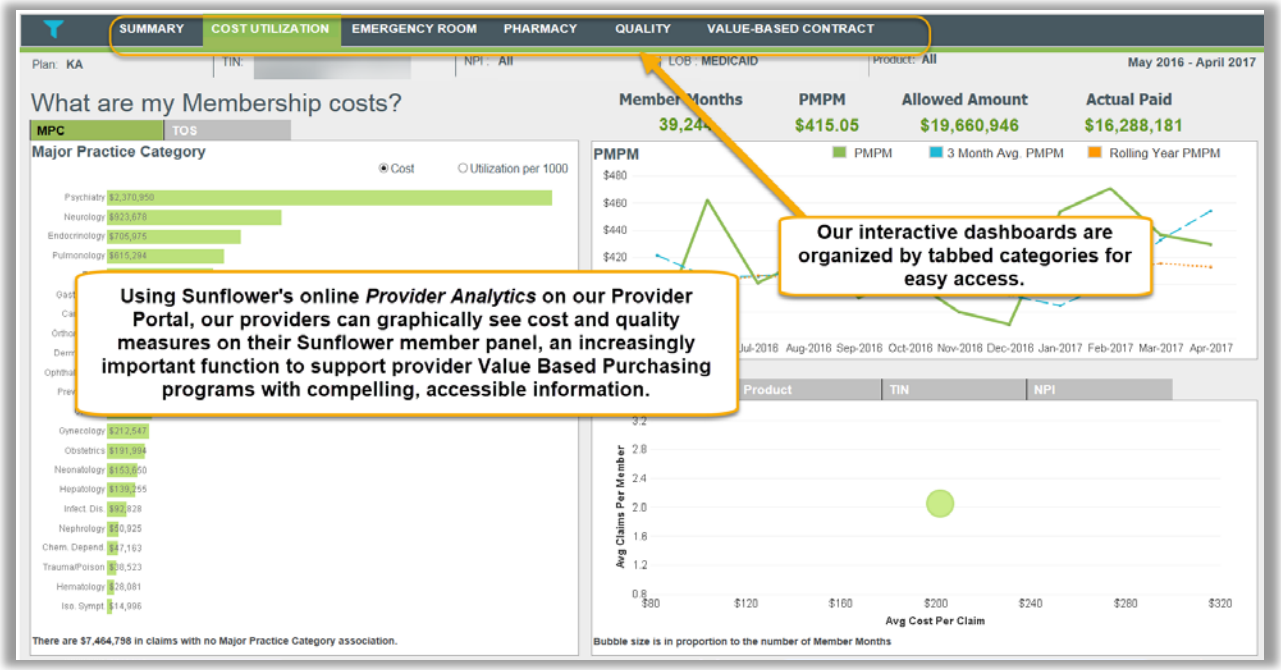
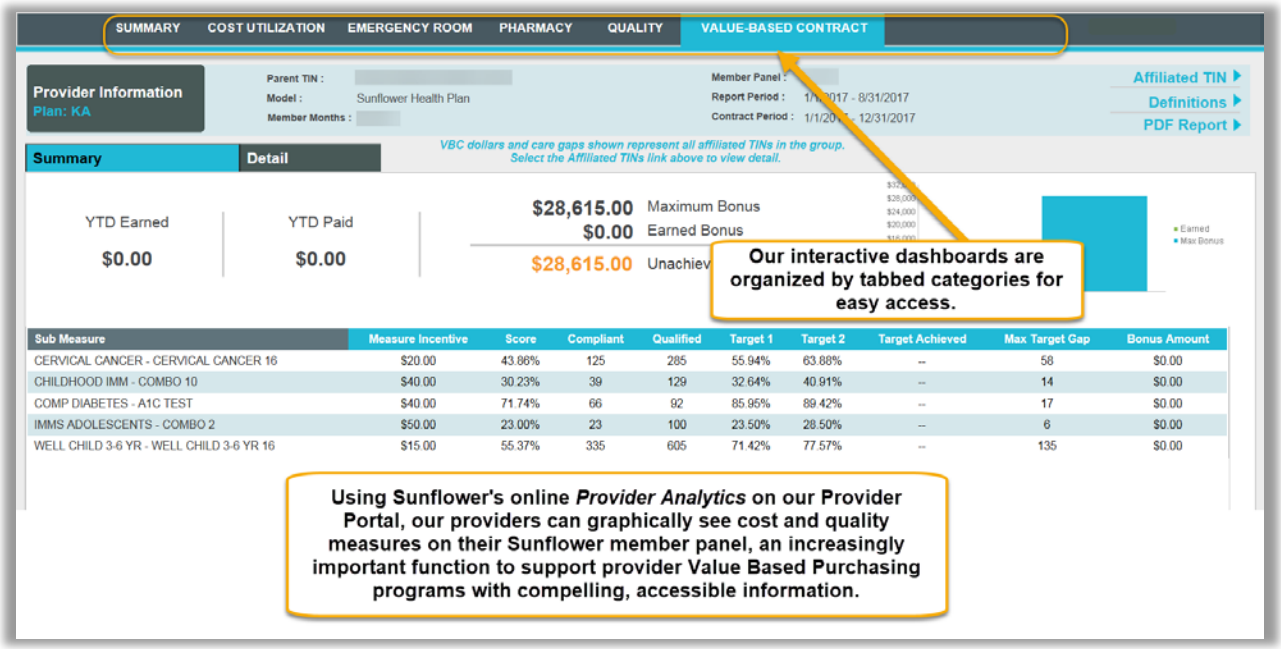


Figure 5.15.F_Online Value Based Contract Dashboard Example



Electronic Appointment Scheduling. An important informational exchange need for providers, members and MCOs is the capability to create and track member appointments with their providers, to enhance and promote wellness, monitor any emerging member health issues, and to improve overall access to care.

In 2019, Sunflower will offer providers and members' real-time appointment scheduling through our **Appointment Wizard™** scheduling system, which will allow Sunflower Customer Service Representatives (CSRs) and Service Coordinators to schedule appointments with participating providers. Appointment Wizard™ also supports text and/or email reminders for members. Sunflower staff will have secure access to Appointment Wizard™'s online appointment-scheduling portal, and can set-up appointments while on the phone or while meeting with members, without the need for multiple calls to-and-from provider offices. In addition, Sunflower staff can securely attach documentation to the member appointment for specific care gaps (e.g., EPSDT needs) to ensure a thorough, efficient member office visit.

Appointment Wizard's™ secure cloud based technology, allows us to lower provider administrative burdens while ensuring access to care for our members. For example, Sunflower's affiliate health plan successfully piloted Appointment Wizard™, which resulted in care gap closures, an over 85% member appointment completion rate, and improved operational efficiencies for over 200 FQHCs.

Using Telehealth to Share Clinical Information. We are expanding our use of innovative telehealth strategies (including the use of telemedicine and telemonitoring technologies) for clinical information sharing with providers to enhance care access and delivery. Successful telehealth projects require a close working relationship with community efforts as well as national and local telehealth experts, and we will collaborate with Kansas' existing telehealth initiatives such as the Heartland Telehealth Resource Center to implement our proposed telehealth models.

Example: Virtual Visits. As an example of one telehealth initiative we are undertaking: we will deploy virtual video visits for members to be connected to a board certified physician. If a member calls us or our 24/7 Nurse Advice Line, and the member's PCP cannot be reached, we will stay on the line with the member while connecting them to a telemedicine vendor. This interactive provider-to-member virtual visit will include medical history and telephonic consultation for stress/anxiety, depression, addiction, domestic abuse and grief counseling as well as dermatology, sexual health and general health symptoms and complaints and can include prescription of medication, if necessary.

Our Arizona affiliate will be the first managed care health plan in the country to host their own Project ECHO and we will apply our Arizona affiliate's experience to develop similar Project ECHO programs.

Telementoring. In addition to above, we will equip providers and Community Service Coordinators with training and resources through provider-to-provider consultations via our own Sunflower Project ECHO initiative. Project ECHO is a hub-and-spoke knowledge-sharing network, led by expert teams who use multi-point videoconferencing to conduct virtual clinics with community providers. In this way, primary care doctors, nurses, and other clinicians learn to

provide excellent specialty care to patients in their own community. Sunflower's parent company recently executed a national contract with Project ECHO, allowing us to access the database of training and programs currently offered through Project ECHO's worldwide network. In addition to offering our providers access to Project ECHO's comprehensive mentoring curricula, we will implement two Sunflower customized Project ECHO initiatives in Kansas: a program for Chronic Pain Management and an ECHO offering expressly for our Community Service Coordinators. Please see Section 5.5 and 5.7 for more information on our Project ECHO and other Telehealth initiatives for KanCare 2.0.

Telemonitoring. In collaboration with Community Living Opportunities (CLO), Neighborhood Network and HomeLink Support Technologies, Sunflower will partner with CLO to help fund a pilot which will include a model of housing, telehealth and supervision support, and networked onsite living supports for members in LTSS. The Neighborhood Network creates a support system for neighborhoods by using smart home technology, remote coaches and clinicians, and professional neighbors or roommates to deliver individualized care on demand or as scheduled. CLO utilizes a combination of onsite and remote caregivers, and HomeLink Support Technologies to provide needed services to members in the most independent living arrangement possible. CLO offers HomeLink Support Technologies to both members in the Neighborhood Network and members who live within their own homes. HomeLink includes a team of 24/7 caregivers, remotely located, who are trained on and monitor individual member needs through a system of individualized sensors and individually tailored responses.

Sunflower in Action…

Austin, a Sunflower member with I/DD, previously lived at home with his parents and siblings. He says it was "always my dream to live in a college town… Rock Chalk!" He now lives in his own apartment in Lawrence within CLO's Neighborhood Network. Austin utilizes HomeLink technology which allows him to push a button to access caregiver support, and allows his staff to also detect when he may need them. Austin has a job at a local convenient store. He says his favorite part about his living arrangement is, "Having a lot of independence. Doing anything I want without being told."

Tele-Care Monitoring. Sunflower continues to explore innovative ways to utilize technology to support our members. Our Tele-Care Monitoring Program will provide real time monitoring of biometric data using web-based technology combined with telephonic disease management coaching for high risk members. Through this program, Sunflower aims to reduce preventable health care utilizations, promote member adherence to treatment guidelines and improve self-management skills. The program objective for pregnant members is to improve glycemic control to promote positive birth outcomes. Conditions covered include COPD, Diabetes, Heart Disease (Heart Failure and Coronary Artery Disease) and Hypertension.

Information through Provider Communications. We offer targeted online communications with our providers to exchange information via regular webinars on topics such as using our web tools, how to update their provider information for our files, medical and case management,

grievance and appeals, quality programs and more. We maintain a regularly updated set of documentation and training resources for providers on our public website, including cultural competency, topical disease alerts, and more. We issue provider news frequently and offer an e-mail provider notification service with frequent, but topically focused news items of importance to the provider's participation in our KanCare program. See ***Figure 5.15.G_Example of Recent Sunflower Provider e-Mail News Bulletin*** below.

Sharing Information with Community Service Coordinators. Our Service Coordinator Portal is a secure, role-based system designed specifically for the use of our Community Service Coordinators, offering them the interactive online access CSCs need to support Sunflower members, with HIPAA compliant bi-directional information sharing of service plans and supporting documentation, notifications, contact information, and member clinical and service history. The SC Portal will allow CSCs to update and access service plans, notes, and more, and coordinate with Sunflower staff and providers.

Figure 5.15.G_Example of Recent Sunflower Provider e-Mail News Bulletin

Data Exchanges with Providers. We support all HIPAA transaction data exchanges with providers, including HIPAA 837 EDI claims via submission through the State's Front End Billing (FEB) system, direct HIPAA EDI submissions to us via our Provider Portal, or via any of almost 80 national claims clearinghouses. We also support HIPAA 835 payment and remittance transactions, as well as Electronic Funds Transfer (EFT) payments to providers. Our affiliated pharmacy benefit manager (PBM), Envolve Pharmacy Solutions, supports the HIPAA compliant NCPDP D0 pharmacy point of sale transaction. In addition, we are planning new clinical HL7 based data exchanges with providers (see discussion below in 5.15.1.E.3).

Exchange of Health Information between Sunflower and the State (5.15.1.E.1, continued)
We exchange health information with the State today for a growing number of KanCare administrative and clinical purposes, all in compliance with State and Federal standards, through our interoperable MIS.

HIPAA and Industry Standard EDI Transaction Support. The configurable EDI subsystem component of our integrated MIS continues to fully comply and exchange health care administrative transactions with the State's Medicaid Management Information System (MMIS), including the HIPAA 834 enrollment/disenrollment, 837 claims, 835 remittance advice, 820 premium payment details, NCPDP D0 pharmacy claim, and all other HIPAA transactions and codesets. We support the 837 claim formats for both the receipt of claims from the State's Front End Billing (FEB) system, as well as for submission of encounter data back to the MMIS. Our MIS also supports all proprietary data formats required by the State's MMIS, such as the TPL/COB file.

Support for State Front End Billing. Our HIPAA compliant, interoperable MIS has supported the State's Front End Billing system (FEB) since 2013, including receipt of HIPAA 837 claims from FEB per State requirements. Our support for FEB allows providers to continue to submit claims directly to Kansas Medicaid if they choose. When Sunflower receives HIPAA compliant (SNIP Level 4) claims from FEB, we issue HIPAA compliant Functional Acknowledgment and 277CA Claims Acknowledgement response, per FEB standards. Sunflower also submits claim copies to the Fiscal Agent for all electronic and paper claims submitted directly to Sunflower, the same day the claim we receive those claims.

Support for Spend Down Processing. Our MIS also supports Web Services Definition Language (WSDL) web service technology to support the State's Spend Down processes, allowing our claims system to connect to the State's Medicaid Management Information System (MMIS) – to receive a member's current spenddown information while adjudicating claims.

Secure Connectivity with K-TRACS. Authorized Sunflower users of our MIS can access the State's K-TRACS system, allowing our clinical professionals to review member pharmacy utilization that was not paid for by Sunflower. We use K-TRACS after our own retrospective Drug Utilization Review (DUR) reporting indicates that a Member has potentially inappropriate utilization (e.g. multiple prescribers for controlled substances) or if we receive concerns from the State, providers, or our case managers concerning the Member. In these situations, K-TRACS helps us refine our view of the member's needs and allows us to determine the best interventions if needed.

State Portal Option. Through our interoperable MIS, we can also offer the State (at the State's option) a secure portal for access by authorized State personnel, to retrieve reports and enhance the State's ability for oversight and compliance monitoring and collaboration with Sunflower, with expanded secure communication capabilities.

Exchange of Health Information between Sunflower and our Members (5.15.1.E.1, continued)
In addition to enabling standards based connectivity with the State, providers, and Community Service Coordinators, we also focus on engaging electronically with our **members** to empower them with health information to promote wellness, prevention and wellness.

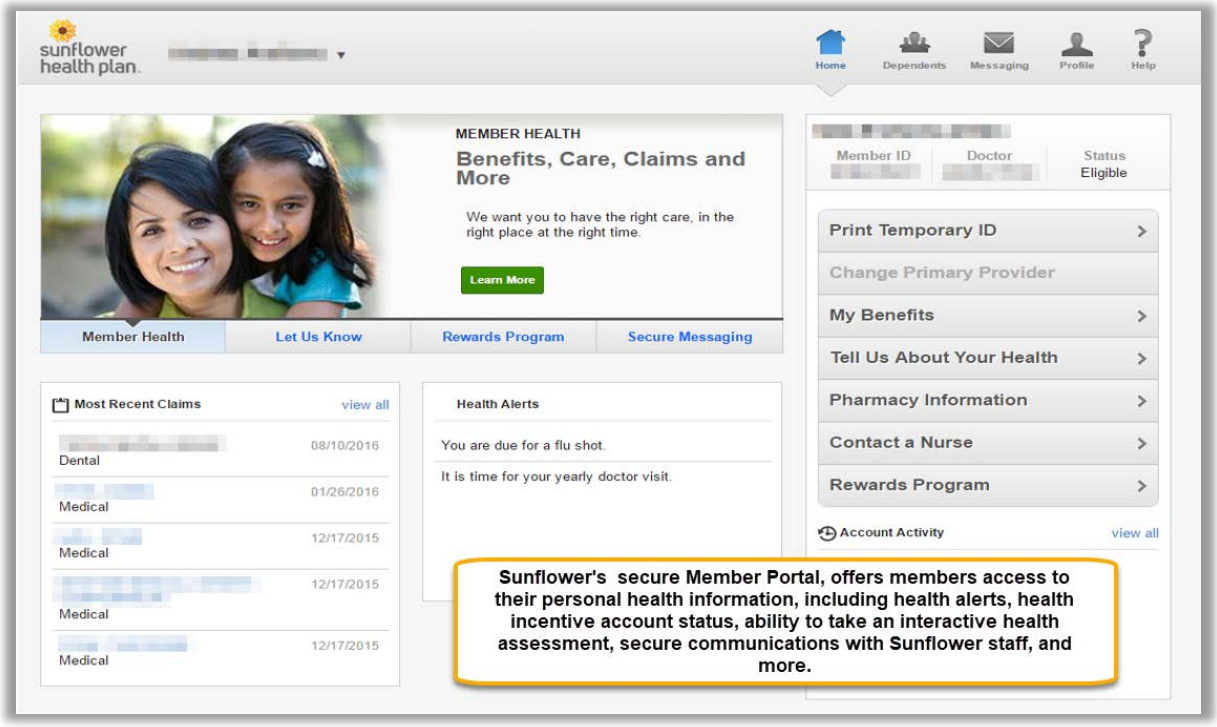
Our secure, web-based **Member Portal** offers members online access to their Sunflower personal health information and a number of supporting self-service functions, such as the ability to:

- View their clinical service and medication history
- Change Primary Care Providers
- Update their contact information
- Take an online Health Risk Screening
- View a health alert, gap-in-care, or member-centric care plan
- Communicate with Sunflower staff

Members can also check the status of their CentAccount® rewards program balance. Sunflower's CentAccount® rewards program actively promotes personal health care responsibility and ownership by offering our members financial incentives for certain healthy behaviors and adherence to their care plan regimens. In addition, we offer support for Microsoft HealthVault Personal Health Record (PHR) for our members who wish to maintain their own electronic PHR, using Microsoft's industry leading PHR platform. The PHR is the member's record to keep and stays with the member, even if they leave Sunflower.

Please see ***Figure 5.15.H_Sunflower Member Portal*** below for a snapshot of the landing page our members experience upon login to the Member Portal. In addition, Sunflower's member mobile application, **MySunflower**, is available on both iOS and Android operating systems. Our member mobile application is uniformly branded for Sunflower, so users will know where to turn to for any assistance. Keeping in mind the needs of our members, our member mobile application can also be made accessible to parents or legal guardians, and is available in English and Spanish. See Section 5.10 for more information on our member engagement technologies.

Figure 5.15.H_Sunflower Member Portal



Promoting Member Wellness: Healthy Behavior Activity Tracker. To promote wellness and keep Sunflower members engaged in their health we will offer our members access to an interactive application for fitness and activity tracking, accessible through their PC, smartphone, or tablet device. Though this application, members can track their health-related behaviors, including steps, activity, nutrition, and sleep. In addition, our application is Integrated with more than 100 leading health and fitness apps and devices available on the market (including dozens that are free or low-cost), allowing members to have a holistic view of their health, and inform their next best, data-driven health action.

Helping Providers Acquire and Use EHR Technology (5.15.1.E.2)

Making EHRs More Useful for Providers. Since 2013, we have encouraged our providers via meetings and online newsletters to adopt certified EHR technology and enlist in the KDHE Medicaid EHR Incentive Program, and guided them to the Kansas Foundation for Medical Care (KFMC), which was the Kansas Regional Extension Center (REC) for provider EHR support. The REC funding grant expired on April 7, 2016, and KFMC can no longer support the REC function. However, Sunflower remains committed to assisting providers in acquiring and using certified EHR technology. We will continue to promote the State's Medicaid EHR Incentive Payment Program and use of the State's Medical Assistance Provider Incentive Repository (MAPIR), to help foster growth in EHR meaningful use in Kansas by our providers, including the use of EHR technology in alignment with Modified Stage 2 and Stage 3 requirements as detailed by CMS Final Rule of October 6th, 2015. One way we encourage adoption of certified EHR systems is by

supporting processes and applications which add to the usefulness of EHRs for providers and are in alignment with Modified Stage 2 and Stage 3 requirements. Here are two examples:

Online Pharmacy Prior Authorization Interface to EHRs. Our affiliated PBM offers web based online submission of pharmacy PAs, through Cover My Meds (CMM). CMM is an online PA platform used by over 700,000 providers nationwide across multiple MCOs and health insurers, offering providers a consistent user interface for PA entry and tracking, while allowing PBM to customize PA criteria per Sunflower and State requirements. Using the CMM Portal, our providers can also view PA requests sent to PBM with status, as well as in process PA requests (those PA requests not yet completed by the provider). CMM also integrates with over 500 EHR systems, including major vendors popular with Kansas providers such as Cerner and Epic. This integration capability allows providers to prepare an online PA request directly from their EHR system, further enhancing workflow and the utility of their EHR, and assisting providers meet Modified Stage 2 EHR incentive requirements related to medication ordering.

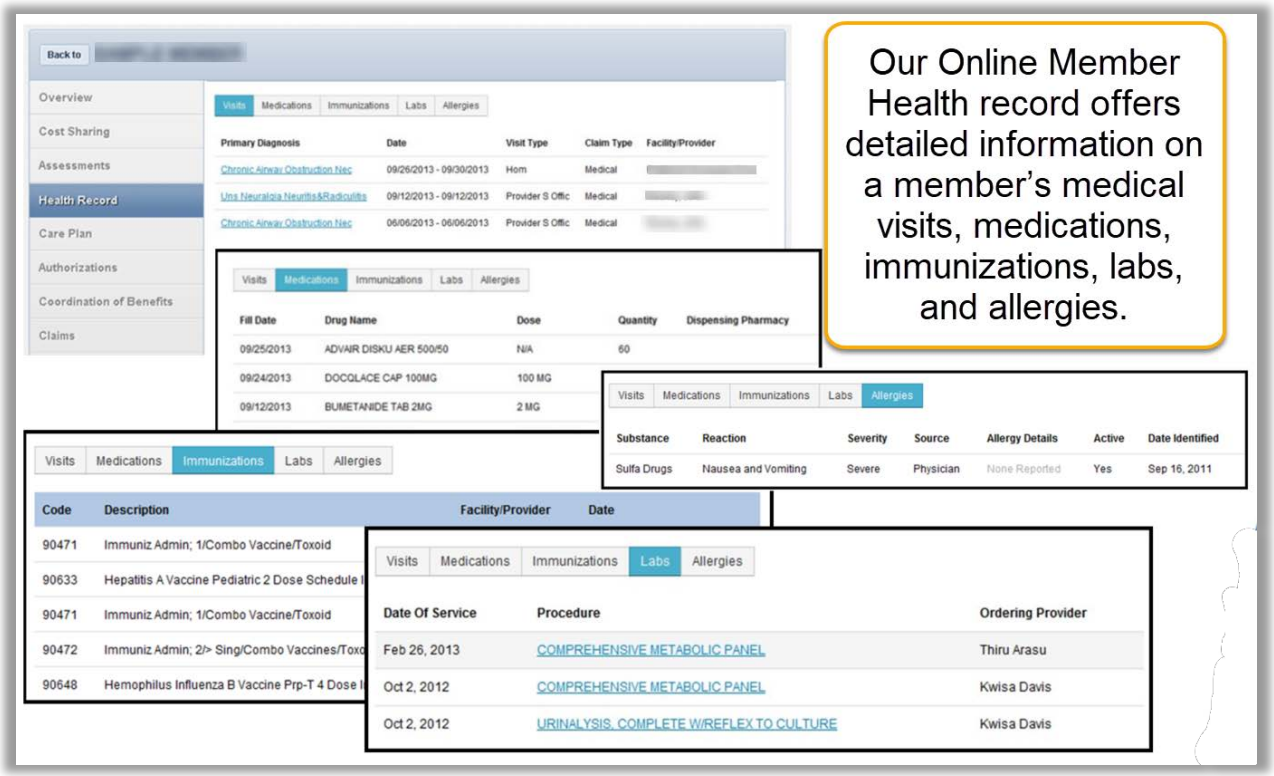
Supporting e-Prescribing. Our PBM also supports real time information for our "e-Prescribing" providers at the point of prescribing – through our contractual relationship with the Surescripts network. Surescripts is the industry's dominant pharmacy information exchange and it operates the country's largest e-prescribing network. Available during emergencies or routine care, the Surescripts network is used every day by thousands of prescribers, across all 50 states, to electronically access prescription information and route prescriptions. Over 1,500 EHR and e-Prescribing vendor systems have interface support to Surescripts. Through the PBM connection to Surescripts, our providers using an e-prescribing application have access to Sunflower member eligibility, potential drug-drug interactions, and Sunflower pharmacy network information. The result: our e-Prescriber providers can instantly be aware of important information specific to our member at the point of prescription writing, further adding to the usefulness of their EHR, and helping providers meet Stage 3 EHR incentive requirements related to e-prescribing.

Supporting Providers Not Yet Using EHRs through the Online Member Health Record.
According to KFMC, approximately 50% of eligible providers registered with CMS for the EHR incentive program, and approximately $120 million in EHR incentives has been paid to Kansas providers. Although this is an impressive effort, there are still a sizable number of Kansas providers who do not use EHRs in their practices. The reasons for this are varied, ranging from a lack of capital to not having the requisite EHR expertise. For these providers, we offer free and secure access to our online **Member Health Record (MHR)**.

The **MHR**, available on our secure Provider Portal, offers actionable information in a manner and format that allows providers to view clinical history and current interventions on their members. Providers can view member contacts, utilization history (derived directly from physical, behavioral, and pharmacy claims data), lab test results, care plans (when applicable), allergies, eligibility history, participation in Sunflower Service Coordination programs, and more to assist providers in their practice of coordinated care delivery. The clinical data provided on

the MHR is supplied through our Centelligence® platform, which integrates administrative, demographic, and clinical data from multiple sources, making our MHR a secure, web-based clinical data home. In 2018, we are enhancing our MHR with additional tools to support our 5,500 members in Foster Care and other child members with features such as contact information of the member's Integrated Care Team (e.g., caregiver, caseworker, PCP), completed EPSDT assessments, immunization schedules, and growth charts. Please see ***Figure 5.15.I_ Member Health Record*** (Protected Health Information removed). For providers with no access to an HHS Office of National Coordinator (ONC), certified EHR system, our MHR, accessible to all providers supporting the member (including behavioral health providers) as well as authorized Sunflower clinical staff, is another way we encourage the use of electronic information among providers.

Figure 5.15.I_ Member Health Record



Expanding Meaningful Use of Data from Certified EHR Technology (5.15.1.E.3)

Strategic Approach: Meet Providers Where They Are Technologically. An underlying tenet of our Sunflower EHR connectivity plan is our ongoing incorporation of multiple "channels" to ensure that we can provide flexible options for providers with certified EHR technology to exchange clinical data with us, no matter the data communications capability of the provider. For example, we remain a participant in the Kansas Health Information Network (KHIN) and can enlist the use of that HIE for KHIN connected providers, and our Centelligence® Gateway interface system (discussion immediately below) which allows for HIE or direct connections to

providers using Health Level 7 (HL7) interfaces such as Admission, Discharge, Transfer (ADT), CCD-A, and Observation Result (ORU) transactions.

As noted in Section 5.15.1.E.1 above, we also offer providers access to electronic health records and two-way notifications through our own Provider Portal for those providers who have not yet acquired EHR technology of their own. For example, our Provider Portal allows providers to alert our clinical staff when a member is present in an emergency room. When ED staff verify member eligibility, they are presented with an ED indicator on the eligibility inquiry screen, as an optional check box. If ED staff check this box, an automated alert is generated via TruCare to notify our Service Coordinators.

Architected for Clinical Data Exchange. A key component of our interoperable MIS that allows us to use data from certified EHR technology is our **Centelligence® Gateway** clinical data interface engine. Centelligence® Gateway allows us to establish a high-performance information link closer to the point of care, via connectivity to providers, hospitals and hospital based health systems, health information exchanges (HIEs), and the State. Centelligence® Gateway supports HHS Office of National Coordinator, standards-based data interchanges, including ADT, CCD-A, ORU lab test results, and soon the new and rapidly growing HL7 Fast Health Care Interoperability Resources (FHIR) protocol. Several of our affiliates use Centelligence® Gateway for Medicaid programs in their respective states, including Texas, Florida, Arizona, Michigan, Illinois, Georgia, and Washington State, for a variety of coordinated care and quality improvement applications. For KanCare 2.0, we will employ Centelligence® Gateway for both ADT and C-CDA exchanges with our key providers (see discussion further below).

Using Data Today from Certified EHR Technology. Shortly after beginning operations in 2013, we worked with our strategic and highest volume hospital providers on innovative ways we could jointly leverage the investment these providers were making in their certified EHR systems. Our original focus was on enhancing the administrative efficiency and data collection process for inpatient (IP) admission authorizations. We outlined our project goals with each provider, the requisite EHR data we would need to access and Sunflower functional job roles needing hospital EHR access to support our goal of efficient IP authorization processing. After a HIPAA compliant system access procedure, our provider partners then provisioned "read only" access to their EHRs for authorized Sunflower utilization review (UR) staff following HIPAA Minimum Necessary guidelines. When a Sunflower member is admitted to one of the hospitals where we have EHR access, the hospital

Today, Sunflower UR staff access the EHRs today at eight of our hospital providers to support inpatient authorization review, helping to alleviate hospital administrative burden and speeding our own UR process.

The eight health systems where we have online access to EHR's provided care for over 45% of Sunflower's KanCare members in 2017.

simply notifies us of the admission, and Sunflower Service Coordinators can then securely look/up the member's record securely and online via the hospital's EHR system, and enter information directly into our own enterprise HIT system for authorization review and approval. In addition, authorized Sunflower Concurrent Review nurses have access to these EHR systems to support their reviews during a member's inpatient stay. Today we have grown this program to eight hospitals, meaning that authorized Sunflower clinical staff can access any of the eight provider's hospital EMRs when needed.

Receiving Social Determinants of Health Assessment Data from Providers. The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) is a national effort to help providers collect the data needed to better understand and act on patients' Social Determinants of Health and Independence (SDOHI). The PRAPARE assessment tool consists of a set of national core measures as well as optional measures for community priorities. The PRAPARE tool aligns with national initiatives prioritizing social determinants (e.g., Healthy People 2020), measures proposed under the next stage of EHR Meaningful Use, clinical coding under ICD-10, and health centers' Uniform Data System (UDS), and several ONC certified EHR vendors offer PRAPARE form templates in their system. For example, the most prevalent EHR in use by Kansas Association for the Medically Underserved (KAMU) member clinics is the eClinicalWorks system, and eClinicalWorks offers a PRAPARE template, allowing KAMU clinics the opportunity to further leverage their EHR investment in a meaningful, impactful manner.

KAMU's member FQHCs have, over the past year, begun implementing the administration and collection of PRAPARE assessments to screen and identify those SDOHI that may lead to barriers to health care. Sunflower will begin piloting with our partner CHC, CMHC, and FQHC providers at KAMU the collection of PRAPARE assessment data for incorporation into our Centelligence® data warehousing, reporting, and analytics platform. Using our Centelligence® informatics platform, we will identify opportunities to integrate PRAPARE data with physical, behavioral health and pharmacy claims data to identify high-cost, high-need patients for customized interventions to address SDOHI factors. We will also use PRAPARE data in the aggregate by geography to identify systemic service shortages such as transportation, and the need for focused interventions. We will pilot the use of PRAPARE SDOHI data to inform our existing Centelligence® risk stratification process. In addition, we will index PRAPARE data to our members' clinical records in our HIT for viewing by our Medical Management and authorized SC staff (via our TruCare platform), and access by Community Service Coordinators via our secure Service Coordinator Portal (SC Portal). Our SC Portal is a secure, role-based system designed specifically for CSCs, offering them the interactive online tools needed to support Sunflower members, with HIPAA compliant bi-directional information sharing of service plans and supporting documentation, notifications, contact information, and member clinical and service history.

Finally, Sunflower will explore linking the use of the PRAPARE tool with our **Life Ally program** which will give providers, service coordinators, and community service coordinators a community resource database to support members in accessing services related to SDOHI.

Through Life Ally, all members of the Integrated Care Team, such as Service Coordinators, Community Service Coordinators, Community Health Workers, members, and providers will have access to a **Community Resource Database** to identify, refer, and follow up with local social services and community organizations to **"close the referral loop"** and ensure members receive the services they need. Sunflower's Community Resource Database is a comprehensive online social utility for access to local social services and community resources, such as, food, housing, transportation, and education services that best fit members needs and can impact their health and wellbeing. The Community Resource Database includes features such as:

- Search capability by both keyword and filters
- Graphical resource mapping display and directions from as a little as a mile up to 50+miles
- Favorites and save functionality

Through Life Ally, Sunflower staff will have the capability to track, trend, and report on membership needs (e.g., assistance with utilities) and utilization by geographic area and resolution of life barriers. Through our population health based SDOHI approach, we leverage innovative technology to effectively and efficiently engage and support members.

Using ADT Transactions to Drive Coordination and Administrative Efficiencies. During the course of our contract, we will implement Admission, Discharge, and Transfer (ADT) hospital connectivity with our strategic hospital health system provider partners, building upon:

- Our existing access to the EHR systems of these providers (see discussion above),
- The standards based clinical data interface capabilities we have with Centelligence® Gateway, and
- Informed by the growing body of experience with ADT processing and meaningful use by our affiliates nationwide.

Our ADT initiative will enhance Sunflower's ability to rapidly identify and engage members when they are most at-risk for adverse outcomes and inappropriate utilization. By receiving, processing and distributing ADT information, we can:

- More quickly identify and engage emergency room frequent flyers and implement early identification of members in need of discharge planning and post-discharge outreach
- Provide timely care coordination, such as, Service Coordinator or Community Service Coordinator assignment, risk level identification, and outreach
- Streamline our PA process through elimination of manual steps for both the hospital and Sunflower

<u>ADT Use for Care Coordination and Risk Identification</u>. Early in our support for KanCare 2.0, and using our Centelligence® Gateway as a number of our affiliates do now, we will receive ADT transactions daily for Sunflower members from our ADT transmitting hospital certified EHR systems. We will use that information to securely notify our Service Coordinators and Community Service Coordinators assigned to a member represented on an ADT, as well as the

PCP (including KAMU clinic) or other provider assigned to that member, to help drive follow/up contact and intervention from the Service Coordinator, Community Service Coordinator, and/or PCP per the member's Individual Service Plan.

In addition, we will explore with our providers the use of ADT data to identify newborns of our Sunflower members, giving us an additional (and more timely) notification of birth than that from claims data alone, and allowing us to notify the State in quicker fashion and well within the sixty (60) calendar days required (per Section 5.2.1.A.1.d in the RFP). We will also use the ADT data we receive as additional information for our Centelligence® predictive analytics system to use in the identification of care gaps, and risk stratification.

ADT Use for Inpatient Prior Authorization Automation. For our KanCare 2.0 program we will also pilot the use of inbound ADT data we receive to automatically construct Inpatient Admission Prior Authorization (IP Auth) records in our TruCare care and UR platform, and, if appropriate medical necessity criteria are met, to systematically issue an IP Auth approval to the admitting hospital. Upon successful pilot completion, we will deploy this capability for all of our hospital providers, further incenting hospitals to provide us with ADT transactional data. Our automated IP Auth solution will ultimately lead to lower administrative costs for our hospitals and more provider time to focus on our member's needs.

Informed by Growing Experience of our Affiliates

Through our interoperable HIT and our affiliates nationwide, Sunflower enjoys the benefit of rapidly growing expertise in the receipt, processing, workflow enabling, reporting, and distribution of targeted ADT data. The operational ADT processing experience of our affiliates, along with the input of our Kansas providers will continue to inform our plans for the expanded meaningful use of data from certified EHR systems. ***Table 5.15.A_ADT Experience*** below highlights the experiences and outcomes from our affiliates, allowing us to learn from affiliate expertise, as well as target meaningful goals for impactful outcomes from our ADT efforts in Kansas.

Table 5.15.A_ADT Experience

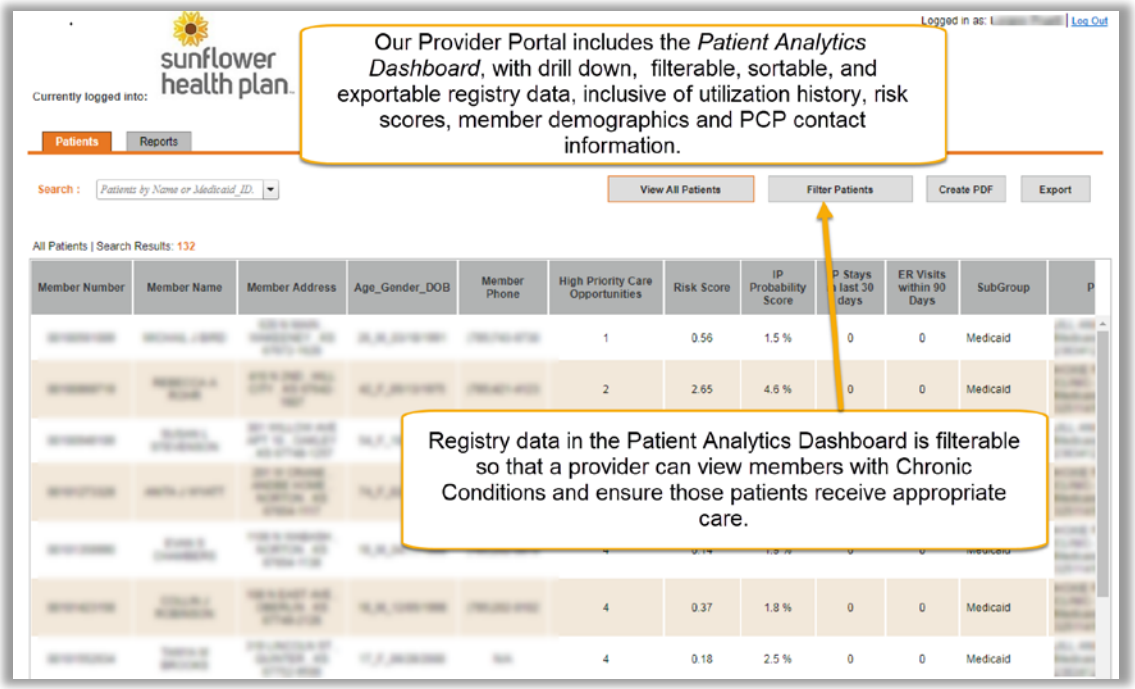
Sunflower Affiliate	ADT Initiative	Outcomes
Florida	Our Florida affiliate's emergency room Diversion Program uses a combination of ADT transactions, received twice a day for participating hospitals, integrated with claims data, and information from care managers to systematically stratify members who have been to the ER into intervention groups. Based on the members' conditions and number of ER visits, an algorithm assigns members into different tiers for prompt follow up via a letter, automated call, additional assessment, or care management referral. Through this outreach, our affiliate addresses any barriers to care including transportation, PCP change, provider	• 64% reduction in cost for ED visits when comparing the use/cost in the three-month period before intervention

Sunflower Affiliate	ADT Initiative	Outcomes
	education, and member education on accessing the appropriate level of care.	
Washington State	Our Washington State affiliate receives ADT admission notifications when members enter acute facilities and they provide these notifications to their care managers and providers. Their program utilizes both cohorts and daily driver reports to identify at-risk members for outreach, community engagement, and all levels of care management. In addition to the near real-time notification at admission into an ED, our affiliate's teams use the updated demographic fields from ADTs to track hard-to-reach members and set care guidelines within a member's record to notify facility staff for enhanced care coordination.	• 40% improvement in reaching hard-to-reach members which increased number of referrals into care management programs
Texas	Our Texas affiliate recently implemented connectivity with the Health care Access San Antonio HIE for enhanced care coordination with our providers through receipt of inpatient ADT data. Our affiliate also receives ADT data directly from some network hospital providers via secure FTP, expanding the range of our membership for which our affiliate's care coordinators can be notified of ED admissions and other critical hospital events. Upon ADT receipt, our HIT automatically issues secure emails directed at PCPs and FQHCs who have opted in to receive this information. These secure emails contain key ADT information on members in a PCP/FQHC's panel, including diagnosis, hospital location, Medicaid ID, name, and a super-utilizer flag.	• Enhanced ability to monitor ED admissions of over 168,000 members and the full member panels of 84 of our PCP groups. • FQHCs report marked improvement in patient engagement (up to 50%) after the FQHC contacts patients listed on ADTs, enabling targeted patient education to improve care and lower ED visits.
Arizona	In Arizona, our BH affiliate participates in the Arizona Health Current HIE. Health Current is a statewide clinical data sharing initiative processes approximately 85 million ADT transactions per year, along with a full complement of other standardized data exchanges, such as lab test results, radiology results, alerts, and notifications on behalf of eight million unique patients. Our affiliate receives ADT messages securely within an average of 4 hours of the actual admission, discharge, or transfer clinical event affecting their most vulnerable members with severe mental illnesses and physical comorbidities. This information enables care management staff to coordinate care, target interventions, and collaborate with members and providers on updated care plans.	• 98% of our Arizona affiliate's network hospitals send ADT data to AzHeC • 76% of their outpatient providers use AzHeC for a variety of data sharing uses
Illinois	In March 2017, our Illinois affiliate successfully implemented an electronic ADT system with a key hospital health system providing a bi-directional, real-time notification alerts system to allow our affiliate's Medical Management team to receive hospital ED and ADT information.	• Recently implemented in 2017, with the goal of timely care coordination, reduction in unnecessary ED visits, and other objectives, including reduction in administrative burden.

Using CCD-A Information to Enhance Quality Data Collection. For KanCare 2.0, we plan to pilot the receipt of CCD-A information from select strategic providers to automate the collection of HEDIS related information directly from the provider's certified EHR system. Through our Centelligence® Gateway system, our HIT will query provider EHR systems for members in our files who have outstanding care gaps, requesting CCD-A data to indicate if these gaps have been addressed. Provider EHR systems will then send CCD-A documents to our Centelligence® Gateway system, which will then electronically make that data available to our HEDIS reporting system (an integrated component of our Centelligence® analytics and data warehousing platform). This approach will make the HEDIS data collection process less invasive to the provider, enhancing their efficiencies. Depending on the outcome of our CCD-A HEDIS data collection pilot, we will expand the program to any of our network providers with the prerequisite certified EHR systems. Our CCD-A connectivity initiative and our HEDIS Value Based Purchasing (VBP) programs are mutually reinforcing, in that providers will be naturally incented to report HEDIS care gap closure information to us quickly to meet their HEDIS measure objectives in their VBP arrangements with Sunflower. Please see Section 5.7 for more information on our Sunflower Alternative Payment Methods and Value Based Purchasing programs.

Supporting Provider Registry Development – Members with Chronic Conditions (5.15.1.E.4)
Sunflower's Provider Portal offers powerful member registry capabilities online through our Patient Analytics dashboard, powered by our Centelligence® data integration and predictive analytic platform. The Patient Analytics dashboard allows individual providers to access their patient disease registries (at the PCP or practice level) to view critical information including evidence-based care gaps, identify quality improvement opportunities, and improve their service coordination functions. The patient analytics dashboard offers providers physical and behavioral health diagnoses, and medication, lab, and care team data on a member level, as well as easy to build reports, allowing providers and their care team to view care gaps and status for patients. In addition, the data in our Patient Analytics dashboard is exportable in PDF, text, comma separated value (CSV) or Microsoft Excel formats for optional import by providers into their own registry system. Please see ***Figure 5.15.J_Patient Analytics Registry*** below (with Protected Health Information removed).

Figure 5.15.J_Patient Analytics Registry



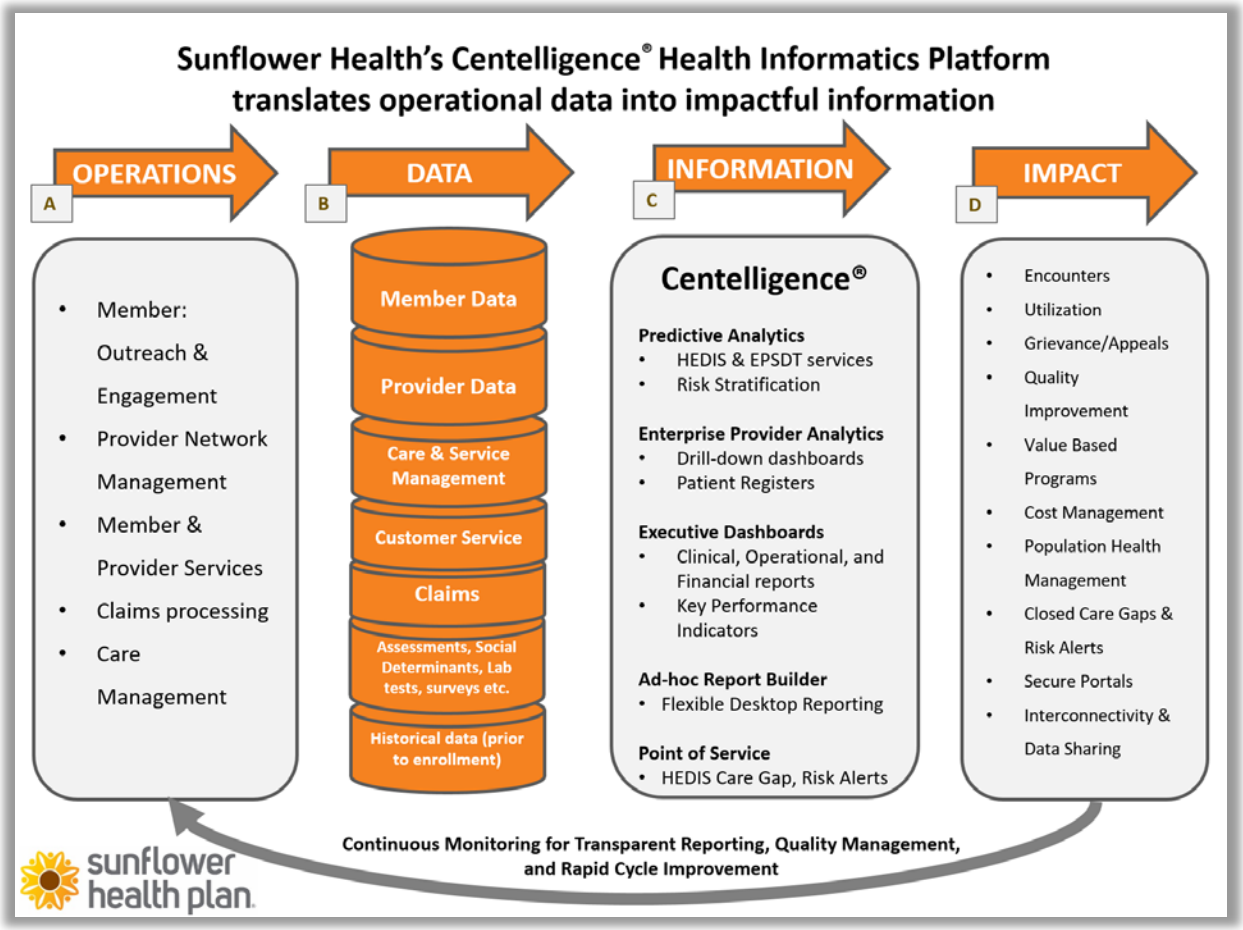
Integrated Systems to Provide Integrated Data (5.15.1.E.5)

Today, we provide timely, accurate, auditable, quality information to all our KanCare stakeholders using our **Centelligence®** data integration, decision support, comprehensive reporting and informatics platform, integrated via our **Service Oriented Architecture (SOA)** with all of our best of breed ***functional systems***. This SOA design allows us to provide administrative, operational, clinical and service information using accurate, integrated and timely data.

Please see the ***Figure 5.15.K_Information Flow*** below for a summary graphic of how our HIT transforms data from our KanCare operations into information. The left column of ***Figure 5.15.K_Information Flow*** (**A**) depicts our core operational functions, which uses and generates data from our integrated functional systems including our TruCare clinical care management platform, our Customer Relationship Management (CRM) member and provider service and data management system, our AMISYS claims processing platform, our Encounter Data System, external data sources (e.g. the State's MMIS contractor, lab test vendors) and secure web portals. The operational data from these functional HIT components (represented in column **B**) is integrated in Centelligence (**C**) for analytic and information and data delivery via reports and online dashboards. Column **C** in ***Figure 5.15.K_Information Flow*** summarizes the types of information we use for operational and care quality monitoring and action. We use and share these information and reports with providers, Community Service Coordinators and the State as appropriate for compliance and transparency reporting to the State and for informing our continuous monitoring of our KanCare operations and quality, symbolized by the information and information sharing methods we supply in item **D** in ***Figure 5.15.K_Information Flow***. Our

HIT uses a HIPAA compliant role based access control (RBAC) approach to security to ensure that Sunflower internal and external users of information have access appropriate for their job responsibilities, in line with HIPAA minimum necessary rules. Our approach to RBAC is one component of our overall HIT Security Program, which has ***International Standards Organization*** (ISO 270001) certification, recognizing our adherence to security best practices and demonstrating that we have successfully adopted the globally recognized information security framework.

Figure 5.15.K_Information Flow



MIS Core Components. ***Table 5.15.B_Sunflower MIS Core Components*** below offers a summation of the KanCare information that our HIT system (MIS) systematically collects, collates, organizes, displays and distributes – and the integrated source component (e.g. TruCare, CRM) of our MIS which is the master source of that information type.

Table 5.15.B_Sunflower MIS Core Components

Information Type	Integrated Component Within Sunflower's MIS[1]
Member demographics and eligibility, enrollment and disenrollment	*Member Data Management (MDM)*

Information Type	Integrated Component Within Sunflower's MIS[1]
Provider demographics, specialties, directory information, credentialing, affiliations	*Provider Data Management (PDM)*
Member and provider service inquiries, grievances, and inquiries, communication preferences	*Customer Relationship Management (CRM)*
Clinical Care Management plans, care authorizations, appeals	*TruCare*
Claims and claims processing results and history, claims payments	*AMISYS Advance*
Encounter data (for submission to State via State's MMIS contractor)	*Encounter Data System*
Online assessments, demographic updates, PCP updates	*Secure, web based Member Portal*
Online claims entry and claims adjustment requests, authorization requests	*Secure, web based Provider Portal*
Integration of above data for reporting and analytics, including physical, behavioral health, and pharmacy utilization, assessments, lab test results, and more. Analytics for identification, display and reporting of health and care gap alerts, population risk stratification, and more.	*Centelligence®*
Footnotes	
[1] Our use of the phrase "HIT" is synonymous with "MIS".	

Utilization Information. Centelligence® integrates physical, behavioral health, and pharmacy claims data and produces a full range of aggregate and member level utilization information that is used by Sunflower management and staff, and shared with providers as appropriate (see discussion above in Section 5.15.1.1 on our Provider Portal) to inform overall KanCare cost and quality monitoring.

Support for Appeals Management. Among other clinical management functions, our TruCare integrated care management platform features a totally integrated appeals function for the capture, assignment, workflow, tracking, and resolution and reporting needs of appeals management. TruCare functionality allows appropriate and authorized users to:

- Create/Edit an appeal request
- Complete an appeal review (e.g. by peer advisors)
- Complete an appeal outcome
- Generate and communicate an appeal decision notification

Because TruCare is integrated with our Centelligence® reporting platform, we can monitor and report on our appeals activity and ability to meet appeal determination turnaround times.

Grievance Information: Captured Through CRM Technology. Our Customer Relationship Management (CRM) member and provider service inquiry and tracking platform can efficiently and thoroughly capture grievance information, with supporting workflow routing, tracking, management and Centelligence® powered reporting capabilities.

Disenrollment for any Reason Other than a loss of Medicaid Eligibility. If a Member contacts Sunflower to initiate disenrollment from our KanCare program our Customer Service Representatives (CSR) records this as a work item in our CRM system, and our Eligibility Specialist (ES) contacts the State to process the disenrollment. Our CRM receives affirmation of that disenrollment from the State via the HIPAA 834 file process and we can track and report on the disenrollment request (and status) via our CRM system.

Collecting, Processing and Updating Data (5.15.1.E.6)

As part of our normal business support capabilities, our MIS successfully receives, processes, acknowledges, updates, and transmits formatted data (including member and provider demographic and other characteristics germane to KanCare administration, and including service utilization and related encounter data) to and from a wide variety of Trading Partners (the State, the State's MMIS contractor, medical test labs, providers, claims clearinghouses, etc.) through all industry standard methods (VPN, Secure FTP, https, etc.) and using, wherever mandated and/or possible HIPAA and HL7 formats, and in all cases with HIPAA Security safeguards and controls.

Member Characteristics Collected and Harmonized Through Multiple Sources.

Member Data through EDI. Today we process inbound HIPAA 834 transactions on a daily and monthly basis from the State's MMIS contractor, and in accordance with State companion guide specifications.

We receive and transmit (for our subcontractors' use) HIPAA 834 transaction files via our secure EDI data communications sub-system. Our job scheduling software manages member data load processes for overall process integrity. Inbound 834 files from the State's MMIS contractor are automatically processed through our EDI system for HIPAA 5010 compliance validation and translation. Our system also edits for duplicate member records, and we also edit for date criteria validity, field data integrity, and valid date spans. Any member records that trigger edits default into an Exception Report where they are systematically corrected by our Eligibility Specialist using data correction routines prior to subsequent processing.

We load the processed member records through Add, Delete, and Modify transactions with accurate begin and end dates - all within 24 hours of receiving the HIPAA 834 from the State's MMIS contractor. Once member data is loaded into our member data management system (MDM), it is systematically promulgated to our other MIS components including AMISYS Advance, our core claims processing system, our TruCare integrated health services management platform; our Centene Document Management System (CDMS), and our Centelligence™ Enterprise Data Warehouse (EDW) data integration engine via near real-time Extract, Transport, and Load (ETL) middleware. Through EDW, we also make member eligibility data securely accessible to our providers online via our Provider Portal and to members via our Member Portal. We securely transmit member eligibility data to our subcontractors including, Sunflower's affiliated subcontractors for vision benefits (Envolve Vision), PBM, dental benefits

(Envolve Benefit Options), DM, and 24/7 nurse advice line (Envolve PeopleCare). Our member database system can maintain Sunflower's member historical data indefinitely, subject to State retention requirements.

Member Data through Member Services and Secure Web. Today, we collect member data changes initiated by the Member (or their parent or legal guardian) via our CRM as well as our secure, web based Member Portal (e.g. for demographic changes, PCP changes, member communication preferences). We also support the ability to transmit these member demographic changes, such as changes in address or telephone number, to any of our state clients who request this information. To capture member "self-reported" changes, we efficiently capture member demographic changes via our CRM system. Our Customer Service Representatives (CSRs) can enter new member contact information in fields that do not overwrite the information we receive from the State's MMIS contractor so that we can maintain **data integrity** - keeping data issued to us by the State separate from self-reported information from the member. Members can also provide demographic changes to us via our secure web based Member Portal.

For the 2016 KanCare contract year, Sunflower achieved an average encounter accuracy rate of over of over 98.87%, submitting 98.99% of encounters within 30 days of the claims paid date.

Provider Characteristics. The **Provider Data Management (PDM)** component of our HIT includes a single relational repository for all of Sunflower's core provider functions including: provider prospecting and recruiting; contracting; enrollment; credentialing; financial affiliation configuration; data administration; and provider directory management. Our PDM Department enters and updates provider data in PDM, ensuring that all provider data comes from one governing source for complete data integrity. PDM stores and indexes multiple providers' numbers including Tax ID, the HIPAA National Provider ID (NPI), provider's language information, locations, office hours, ADA accessibility, etc. PDM is completely integrated with our CRM platform, enabling enterprise level call center support for provider inquiries, outbound campaigns and targeted outreach, and unified provider contact management and communications across all the venues in which providers interact with Sunflower (phone, fax, email, mobile platforms or web).

Encounter Data. Sunflower uses an industry-leading encounter workflow system specifically designed for managed care Medicaid encounter processing. Fully integrated with our HIT (including our AMISYS Advance claims processing system), our **Encounter Data System (EDS)** is configured to meet specific program requirements as defined by the State. For every clean claim, our encounter data displays the same line item detail as received on the claim, regardless of claim type, and disposition (e.g. paid, denied, adjusted, voided). Our encounter data submissions include State-required HIPAA-compliant codesets including HCPCS, CPT-4, ICD-10, NDC, CDT, Place of Service (POS), Claim Adjustment Reason Codes (CARC), Remittance Advice Reason Codes (RARC), and NCPDP D0 transactions. Through our encounter submission process, we submit all rendered services and billed amounts as well as an indication of whether the claim is original, adjusted, voided, denied, a replacement, or from capitated services. We also

capture and submit to the State all valid provider data elements as billed on the claim including, but not limited to NPI, taxonomy and Medicaid ID.

Today, over 97.5% of claims Sunflower receives are electronically submitted, allowing us to provide subsequent encounter data with consistently high accuracy and timeliness.

We design our front-end claims receipt processes to validate inbound claims data from providers with checks on member and provider data, HIPAA compliance tests, duplicate claim checks, clinical coding, and tests for potential fraud, waste or abuse, to minimize downstream issues with the resulting encounter data we send to the State. We also continuously promote and support the use by our providers of electronic claim submissions, by offering multiple methods for providers to submit to us (including via the State's Front End Billing (FEB) system), and by offering regular webinars on claim submission topics. Electronic claim submissions enhance our KanCare encounter data submissions to the State by applying Sunflower and State required claim and encounter data edit and validation rules wherever possible on the "front end" claim submission process, ultimately leading to more timely and accurate encounter data for the State. In addition, our automated EDS encounter submission scheduler insures we perform these edits in time to meet KDHE's submission timeframe of 30 days within claim payment for both paid and denied claims.

MOVING HIT AND EHR FORWARD IN KANSAS (5.15.1.F)

Sunflower will collaborate with the State to develop a joint plan to move HIT and EHR forward in Kansas. We will also continue to work with any entities (including our fellow KanCare MCO Contractors) that the State directs us to work with (e.g. KanHIT), along with Sunflower's parent company (Centene), Sunflower's affiliate sub-contractors for KanCare and, our strategic provider partners, including KAMU.

A Heritage of Collaborating with the State to Move Forward

Since beginning KanCare operations in 2013, Sunflower has worked on a consistent basis with the State on several HIT and information sharing fronts, collaborating as well with the State's MMIS Contractor (DXC) and our fellow KanCare MCOs.

In 2015, Sunflower's Analytics Team proposed a regular monthly in-person meeting with the State, with attendees including State users of Sunflower reports, for the express purpose of adjusting our existing reports to fit State needs, formulating new reports to meet evolving State needs, and eliminating reports the State no longer found necessary. The State accepted our proposal and continues to find substantive value in these monthly meetings, augmented with increased e-mail and telephone communications between our monthly

Sunflower's Analytics Team uses its combined 82 years' experience in health related informatics to collaborate with the State. Sunflower's team brings credentials such as: MS in Bioinformatics, MPH concentrating in Clinical Informatics, MS in Mathematics, MBA in Information Sciences, and MBA in Health Care Administration.

forums. Our monthly reporting meeting with the State has led to a number of impactful enhancements. For example, in support of Kansas' legislative mandate requiring Step Therapy for the use of less expensive medications prior to more expensive alternatives, we formulated and tested an algorithm with the State to assess the impact of Step Therapy on KanCare. This algorithm, which eventually became a shared algorithm to produce the Step Therapy Pharmacy Report for all three KanCare MCOs, was the product of several meetings with the State and Sunflower, and has helped the State to determine the impact of Step Therapy.

In addition, our Operations Department collaborates with the State and our fellow MCOs on a number of activities. Our Senior Manager of Operations participates in biweekly meetings with the State and our fellow MCOs to review ongoing operations, and identify and formulate plans to address any emerging data related issues. Our Operations Department is also actively engaged with the State to support the Provider Enrollment Project (in compliance with CMS Managed Care Rule 2390), as well as the State's TPL Automation Project.

During 2017, we also identified and facilitated discussion with the State, DXC, and our fellow MCOs on challenges in the existing EVV authorization file transmission process. Sunflower analyzed the issue, and formulated alternative solutions for the State and key stakeholders (including DXC and our fellow MCOs) to consider. Please see Section 5.15.1.I.1 below for details.

Looking Ahead

We look forward to building on the examples above and expanding our working relationship with the State to develop a joint plan to move HIT and EHR forward in Kansas. In our preliminary plan, we have outlined a number of projects to enhance and expand the meaningful use of clinical data, including the increased utilization of Admission, Discharge, and Transfer (ADT) transactions and Clinical Continuity Documents (CCD-A) to improve care coordination, improve administrative processes, and help produce impactful information for overall KanCare 2.0 quality and cost effectiveness. Through our affiliates, and our clinical data sharing, interoperable HIT, we bring the experience and capability to not only work with the State in its HIT/EHR plan, but to help the State realize those plans for KanCare 2.0. Please see Section 5.15.1.E above for more information.

PHARMACY SERVICES (5.15.1.G)

Through our PBM, Sunflower will continue to supply fully functional and integrated PA systems for our KanCare pharmacy services. Sunflower and PBM's Management Information System (MIS) are integrated to a degree not possible with independent medical, behavioral health (BH), and pharmacy benefits management entities. As with all the application components of our enterprise MIS and supporting Health Information Technology (HIT), our PA systems are each functionally rich for the application at hand (Medical and Behavioral Health (BH) authorizations, Pharmacy PA), yet integrated where they need to be to assure whole person and coordinated care delivery, accurate and timely claims adjudication, and reliable reporting. Our Medical/BH PA and our Pharmacy PA systems support automated authorizations (no manual intervention) where appropriate - as well as manual PA determination support.

Pharmacy PA Functionality (5.15.1.G.1)

PBM system for eligibility and PA is built on one architected platform and is developed and operated internally by experienced PBM professionals. PBM's system supports a number of secure, internal data interfaces with Sunflower's Medical and BH MIS (supplied to us by our parent Centene), including eligibility, pharmacy claims, pharmacy network and other operational information. Through integration with our nationwide, highly available Pharmacy Point of Sale network supplier (POS Network), PBM's system supports NCPDP based automated PA determinations at the Pharmacy, for such uses as Step Therapy and other DUR applications as appropriate, as well as manual PA determination functionality for use by PBM staff supporting Sunflower.

Patient Information and Related History Integrated into Pharmacy PA System (5.15.1.G.1.a). Our PBM PA system is integrated with our POS Network. PBM PAs, whether automated or manual are facilitated and informed by access to all prior member specific medication history that we have on the member with supporting access to historical administrative data including diagnoses and prior health care utilization (including historical FFS data if made available to us by the State).

Envolve Pharmacy was one of the first PBMs to receive Pharmacy Benefit Management accreditation from URAC. This accreditation was achieved by demonstrating and meeting industry practice standards in organizational quality, customer service, communications and disclosure; pharmacy distribution channels, DUR, and formulary development.

In addition to above, our PA system and PBM team of review pharmacists take into consideration several other factors to determine whether to approve or not approve a PA request. These factors include, but are not limited to:

- FDA approved indications with dose and age specifications
- Evidence-based medicine supported in peer-reviewed journal articles
- Published National or Professional Societies' standards of practice
- FDA alerts, market withdrawals or news that provides updated information on market availability, treatment of a condition/disease or adverse events of medications
- National Institute of Health and/or Centers for Disease Control recommendations or guidelines
- Clinical judgment based on the clinical information available to the prescriber during the time of the review

Automated PA Processing at Point-of-Sale (5.15.1.G.1.b). PBM's system supports several categories of automated PA approval today that are applied in real time at the point of dispensing (the "Point of Sale", or POS). PBM's electronic claim adjudication process has the capability to compare the prescribed medication against a member's previous drug history for

step therapy auto-approval or member's diagnoses from claims to auto-approve based on diagnosis:

Step Therapy Auto Approval Logic. These are PA rules implemented to steer members toward the use of a clinically recognized first-line drug before approval of a more complex and often more expensive medication where the safety, effectiveness and value has not been well established, before a second-line drug is authorized. For step therapy medications, our POS Network uses automated adjudication logic that reviews in real-time a member's past prescription claims history for a first-line drug to qualify a patient for coverage at the point-of-sale without requiring the prescriber to complete the administrative PA review process. If patients have the first-line drug in their claims history, they may automatically qualify for coverage of a second-line therapy without triggering a review for coverage. Utilization of this logic allows Sunflower to manage the KanCare benefit without requiring unnecessary member or prescriber disruption. Examples of drugs with step therapy include branded metformin extended-release and hepatitis C agents.

Diagnoses Based Auto Approval Logic. Our PBM PA system can be configured to exempt PA requirement for a specific drug or drug class based on member's disease state. We send members' disease state information from physical and behavioral health claims data electronically to PBM as ICD-10 diagnoses codes. The PBM system is configured to then exempt medication limits for member with the diagnosis in real time at the pharmacy point of sale (through our POS Network) as well as indicating the exemption to PBM staff using the PA system (e.g. when serving a prescriber who is calling in for a PA approval). In addition, our POS Network supports the entry of a member's diagnoses at the pharmacy (e.g. from a provider's prescription), and our POS Network can automatically apply any germane diagnoses based auto approval logic. An example of this diagnosis auto-approval logic is the medication Lyrica.

In addition to the above, our POS Network applies several other automated rules at the pharmacy point of sale, including drug-to-drug interactions, ingredient duplication, therapeutic duplication, and high dose situations. POS messaging may either stop the claim when a PA is required or request pharmacist oversight. This real-time processing logic is based on FDA recommendations and promotes safe and effective medication utilization by our members. In addition, our POS Network applies these edits at the point of sale:

- **Quantity Limits** (claim's quantity per day) implemented to prevent doses above or below the FDA approved guidelines for a drug.
- **Lower Age Limits** implemented to prevent children below the FDA approved age from receiving medications off-label. Examples of drugs classes with lower age limit include, but are not limited, to dementia medications, sedative hypnotics.
- **Upper Age Limits** implemented to prevent adults from receiving medications commonly indicated for pediatric use only (without proper documentation of diagnosis). Examples of drug classes with upper age limits include, but are not limited, to long-acting ADHD medications (stimulants and non-stimulants) and short-acting ADHD medications (stimulants).

- **Dose Consolidation Edits** implemented to prevent members from receiving multiple strengths of the same medications. Examples of drug classes with dose consolidation edits include, but are not limited, to long-acting ADHD medications (stimulants and non-stimulants).

Online PA Submissions for Prescribers. We support online entry of PA's through our partnership with Cover My Meds (CMM). CMM is an online PA platform used by over 700,000 providers nationwide across multiple MCOs and health insurers, offering providers a consistent user interface for PA entry and tracking, while allowing PBM to customize PA criteria per Sunflower and State requirements. Once logged into the secure CMM Portal, our prescribing providers can check member eligibility, and the member's demographic information immediately pre-populates a new PA request with the information returned from our HIT by the eligibility inquiry. The provider then enters the medication and quantity required (aided by drop down lists), whether this is an initial or renewal PA request, and other information related to specific KanCare criteria. The provider can also securely upload any documentation she feels is important for the PA. Once the provider submits the PA, the data is electronically and securely routed to PBM's system, where it is available for manual online review by a PBM pharmacist reviewer and our PBM PA reviewer applies criteria (see section 5.15.1.G.1.a above).

Using the CMM Portal, our providers can also view "in process" PA requests (those PAs not yet completed and submitted by the provider), as well as PA requests the provider has sent to PBM with status of those PA submissions.

CMM integrates with over 500 Electronic Health Record (EHR) systems, including major vendors popular with Kansas providers such as Cerner and Epic. This integration capability allows Providers to prepare an online PA request directly from their EHR system, further enhancing workflow.

PA Requests from Prescribers via Phone or Fax. Through our provider manual (available on our provider Portal), as well as our provider training and ongoing communications, we educate our providers on prescription drug PA requirements. In addition to the use of CMM, our providers can fax or phone in PA requests and these are processed promptly by PBM staff supporting Sunflower.

Nationwide System Supporting NCPDP Standards (5.15.1.G.1.c). Sunflower's enterprise HIT is securely integrated with PBM's systems will continue to support Sunflower with their nationwide POS Network that is available to adjudicate claims with all contracted pharmacies 365 days a year, 24 hours a day – in real time. PBM receives over 50 million Medicaid pharmacy claims a year and 99.9% of these claims are electronically submitted.

PBM's POS Network processes claims using the National Council for Prescription Drug Programs (NCPDP) D.0 standard (HIPAA 5010). Once the PBM system has determined a member is eligible for benefits, the system applies prospective DUR editing to ensure the medication is safe for

the member. Prospective DUR edits include drug interactions, duplicate prescription, refill too soon, proper dosage, proper days' supply, duplicate therapy, etc. PA edits, including step therapy edits, are also applied; along with, quantity limits, age limits and plan-specific benefit restrictions. If all conditions are met, the claim is approved and information returned to the pharmacy indicating payment amounts. If the claim is denied, the claim denial code(s) and specific reasons are returned to the pharmacy. PBM's average POS Network system transaction response time is less than one second.

Standard NCPDP Support for PA (5.15.1.G.1.d). PBM's integrated PA and pharmacy claims system currently supports the HIPAA 5010 (the NCPDP D.0 transaction), at no additional charge to Sunflower, pharmacies, or providers.

Integrated Informatics and Reporting Produces Actionable Information (5.15.1.G.1.e). At the heart of Sunflower's reporting information capabilities is our Centelligence™ platform. Centelligence™ is fully integrated with our production HIT enrollment and eligibility, clinical care management, EDI, claims and encounter processing, member and provider service and data management applications and PBM. The Centelligence™ family includes several modules for multiple information based needs with web-based reporting and management Key Performance Indicator (KPI) Dashboards capability, powered by an industry leading suite of analytic systems. Our Centelligence® EDW receives pharmacy claims data from PBM every 24 hours. EDW integrates medical, BH, and pharmacy claims data to support a number of predictive analytics (risk stratification, care gap alerts, and other informatics), reporting and online dashboard applications. PBM also supports Sunflower with regular reports including Monthly claim data, Step Therapy report, PA report, Weekly Rejections report, and more.

In addition, PBM supports Sunflower through a team of professionals dedicated to pharmacy services reporting. This team assists Sunflower with analytic support and ad hoc reporting requests.

Customized and Timely PA Denial Letters (5.15.1.G.1.f). PBM's system fully supports the generation and distribution of PA Denial Letters to members and Providers in support of Sunflower's KanCare program. In addition, Sunflower is NCQA accredited and, as such, we follow NCQA UM standards for the production and issuance of PA Denial Notices.

PA Notifications (5.15.1.G.1.g). A provider may fax us a PA request, call in a PA request or use our CoverMyMeds (CMM) Portal to submit a PA request. If the provider submits the PA online via our CMM Portal, the data is electronically and securely routed to PBM's system. In all cases, the PA is reviewed by a PBM pharmacist reviewer, who applies criteria (see section 5.15.1.G.1.a above) and contacts the provider with a decision within State required timeframes. The same review process applies to PAs received via fax and phone. Approved PAs are electronically sent to our POS Network for prescription dispensing at the pharmacy. If the PA is denied, the provider is notified of that status via a denial letter (see Section 5.15.1.G.1.f above).

Communicating PA Decisions. Our Sunflower providers are also able to check on PA status by calling our Sunflower call center, choose the option for pharmacy PAs, and talk with a member of the PBM team.

PA Data Integrated with Claims Records (5.15.1.G.1.h). Real time integration of PA data with claims adjudication is also inherent in PBM's system – enabling PBM system to have applicable PA request data immediately on hand when a pharmacy claim is ready for adjudication. When a PA request is approved or denied, the PA result is electronically sent to PBM's POS Network for accurate pharmacy claim adjudication at the point of sale. In addition, the PA status updates the PBM call tracking system, and this information (as well as claims adjudication information from the POS Network) is available online to PBM PA reviewers, in secure HIPAA compliant fashion and in compliance with HIPAA Minimum Necessary rules.

Systematic PA Flexibility (5.15.1.G.1.i). PBM's system can be configured to allow or disallow for existing PA's to expire on their originally issued expiration date based on State policies or requirements. For example, we can authorize continuation of existing prescriptions for new members, especially those with special needs such as those taking insulin, seizure medications or prescriptions for mental health conditions. We can also honor State-approved pharmacy PAs in place at the time a member transitions from fee-for-service to our plan for an interim period (e.g. 90 days).

Accommodating Members with Specific Disease States (5.15.1.G.1.j). Our PBM PA system can be configured to exempt some or all PA requirements for a specific member depending on that member's disease state. As described above in Section 5.15.1.G.b, our PBM PA system is configured to exempt some or all PA requirements for a specific member depending on that member's disease state. We send this disease state information from physical and behavioral health claims data electronically to PBM as ICD-10 diagnoses codes. The PBM system is configured to then exempt medication limits for that specific member in real time at the pharmacy Point of Sale (through our POS Network) as well as indicating the exemption to PBM staff using the PA system (e.g. when serving a prescriber who is calling in for a PA approval). In addition, our POS Network supports the entry of a member's diagnoses at the pharmacy (e.g. from a Provider's prescription), and our POS Network will automatically apply any germane diagnoses based auto-approval logic.

Edits for Prescriber Specialty (5.15.1.G.1.k). Our PBM system has full configuration support that allows us – at the benefit plan level – to configure edits on a provider's specialty to drive subsequent automated PA determination – or other action as needed (e.g. pend the PA request for subsequent review because the prescriber does not have the requisite specialty for the prescription approval he/she is seeking).

For example, PBM's system can be configured to allow auto-approval for authorized physicians whose specialty is psychiatry, to support prescribing of antipsychotics for children. However, in this configuration a prescription for this same therapy written by a physician with a disallowed

specialty (e.g. family practice) is not allowed to receive an automated PA approval, but would be directed (via messaging to the pharmacist at the point of dispensing) to submit a PA to PBM via CMM, phone, or fax.

Table Driven Configuration Utilities (5.15.1.G.2)

PBM's system uses table driven utilities and a relational database design that allow our business analysts to configure required changes to the State's specific PDL and PA criteria requirements - all without the need for programming or implementing "hard coded" entries. The system also maintains a full history of all PDL and PA criteria changes for quality assurance and audit purposes. For example, each week we receive a PDL file from the State. The PBM system loads and automatically identifies any changes in the PDL by comparing the input file to the State PDL data we have on record. We then file an electronic change request to our POS Network, recording the changes in the PBM system. We then thoroughly test the changes in our POS Network. Similarly, we receive PA criteria updates from the State, which we electronically send to PBM, who loads those PA criteria into their system. As with PDL data, PBM keeps complete history of PA criteria changes. Our change process for PDL and PA updates from the State will allow us to implement mandated changes for KanCare 2.0 within required timeframes.

In general, for all of Sunflower and PBM's operational systems, we "abstract" the benefit plans, eligibility processing, reporting criteria, claims processing rules, and provider and member data processing rules – from our core applications: we do not "hard code" health plan criteria into our HIT system, rather we configure KanCare administrative rules via table entries and configurable parameters. This not only allows for us to responsibly introduce changes quickly that the State may need during our contract operations, it also allows for greater transparency, auditability, and quality control over our health plan configurations. Managed Medicaid Experience (5.15.1.G.3)

Sunflower is part of a nationwide team of affiliates with 33 years' experience in Managed Medicaid program operations now serving Medicaid and CHIP programs in 24 states, including five years supporting KanCare. Along with Sunflower itself, our affiliates administer Managed Medicaid supporting TANF, Aged Blind and Disabled, LTSS, Foster Care, and I/DD plans, with supporting PBM operations across these programs.

Throughout our operational history, we have found repeatedly that no one State approaches Medicaid and CHIP based managed care programs in the same manner. From a PA perspective, we thus have a rather expansive library of proven criteria across the medical, behavioral, and pharmacy spectrum. Sunflower can access and share the comprehensive library of PA criteria and expertise from PBM with the KDHE Pharmacy Program.

<u>Expertise in Formulating Effective PA Criteria.</u> PBM's Drug Information (DI) Department creates and maintains hundreds of PA policies for consideration and use by Sunflower and our affiliated Medicaid health plans nationwide. The DI Department is comprised of pharmacists dedicated to using evidenced based medicine principles to create and maintain PA policies for Medicaid

programs across 24 states. The team of 9 pharmacists is led by a Board Certified Pharmacotherapy Specialist and 8 of the 9 with pharmacists have completed a residency or fellowship. Each time a new drug for outpatient use is approved by the FDA, the DI Department creates new PA policy using the available primary, secondary, tertiary literature and clinical guidelines. The draft policy is sent to two external physicians with expertise in the drug for review and feedback. After the feedback has been received and any changes are applied, the new policies are brought to the Clinical Pharmacy Advisory Committee which is a subcommittee of our P&T Committee, composed of pharmacists including those experienced with Medicaid for additional review and approval. The new drugs' efficacy, adverse effects, drug-drug interaction and long-term outcomes are evaluated and compared against other drugs as well as clinical practice guidelines to determine the new drugs' place in therapy. This same process is completed when a drug gets a new indication and the PA policy must be modified. New proposed or revised PA policies go to our P&T Committee for review and feedback and then the health plan feedback and policies are presented at the quarterly corporate P&T Committee for final approval. Sunflower Heath fully complies with the State's KanCare PDL and PA rules, and we introduce no PA criteria without the express direction of the State, however, we are always available to offer new PA criteria for the State to consider for KanCare 2.0, based on the expansive, nationwide pharmacy data and analytic expertise that our DI Department and Sunflower possess.

Administrative and Drug Savings (5.15.1.G.4)

Impacting Drug Costs for KanCare through Step Therapy. Sunflower shares its monthly step therapy savings with the State to track and monitor effectiveness of our step therapy management. Currently, we monitor 22 step therapies and, as of October 2017, our Step Therapy program has saved $1.2 million since October 2016.

Impact of Medication Therapy Management (MTM) Program. Our MTM Program seeks to decrease gaps in care, use of high risk medications, improper adherence, inappropriate dosing and other medication-related issues through medication therapy reviews and targeted interventions by pharmacists. Sunflower partners with OutcomesMTM to provide MTM to members through local Kansas pharmacies. OutcomesMTM uses the independently validated Actuarial Investment Model (AIM®) to quantify drug and medical savings based on the severity rating of the MTM claim from Level 1 adherence support to Level 10 life-threatening.

Based on OutcomesMTM's evaluation, our KanCare MTM program saved $1.4 million based on 2017 interventions.

Capturing and Documenting Savings Through Centelligence®. One component of our integrated HIT is our proprietary Centelligence® data integration, informatics, decision support and reporting system. Among other capabilities, Centelligence® integrates PA, member and provider data, medical, behavioral, pharmacy and dental claims data into one relational, high performance, Enterprise Data Warehouse (EDW). Using our Centelligence® analytic and reporting toolset, we can then document the efficacy (including the administrative and drug

savings) of our pharmacy program, including the Step Therapy cost impact analysis mentioned above.

Collaborating with the State. We look forward to discussing and providing similar cost impact analyses to the State upon request. Our Centelligence® platform gives us the latitude to support the state's drug cost analytic needs.

Providing Measurable Outcome Information (5.15.1.G.5)

Our Centelligence® platform provides desktop and provider profile reporting in addition to internal management Key Performance Indicator (KPI) Dashboards and HEDIS reporting. Using Centelligence®, Sunflower was able to identify initiatives that led to measured year over year improvements in the HEDIS Annual Monitoring for Patients on Persistent Medications (MPM) measure from 84% in HEDIS measurement year 2013, to 90% for HEDIS measurement year 2016. MPM assesses adults who receive at least one therapeutic monitoring for select therapeutic agents. For patients on persistent medications, appropriate monitoring is important to assess for side-effects and adjust drug dosage/therapeutic decisions accordingly.

Using Centelligence®, Sunflower was able to identify initiatives that led to measured year over year improvements in the HEDIS Annual Monitoring for Patients on Persistent Medications (MPM) measure from 84% in HEDIS measurement year 2013, to 90% for HEDIS measurement year 2016.

We evaluate monthly and quarterly Centelligence® reporting on retrospective DUR programs to assess therapeutic appropriateness, cost-effectiveness, quality of care, fraud and abuse, over/underutilization, adverse drug events, and manage outcomes. Based on these reports, we develop targeted interventions to prevent recurrence of inappropriate medication use or abuse. Examples of our retrospective DUR interventions include provider outreaches regarding potential inappropriate use of medication or patient drug non-adherence to aid prescribers in improving the care of their patients. In addition, we monitor potential overutilization or inappropriate prescribing and, when necessary, we intervene through our Lock-In Committee and Quality of Care Committee.

Sunflower is also able to create reporting that support and inform State pharmacy quality improvement initiatives. For example, for the Mental Health Medication Advisory Committee (MHMAC), Sunflower provided data including behavioral health related HEDIS measure rates by prescriber specialty.

In addition, we are currently working with the State on the State's Opioids Policy. After the Policy is completed, we will continue working with the State to define measurable quality outcomes related to the Policy and use our Centelligence platform to compare "before and after impacts" on quality outcomes related to the Opioids Policy.

An HIT Engineered for Highly Available Access to Information (5.15.1.G.6)

Both Sunflower and PBM's secure enterprise information systems are engineered for full redundancy, high availability, and business continuity through our annually refreshed systems architecture. This means all our medical and behavioral health and pharmacy service applications have the following features to assure system redundancy and business continuity:

- All operational data (PAs, member and provider data (including service data), claims data, etc.) is stored on our multi-path, fully redundant Storage Area Network (SAN). Our SAN storage arrays use RAID-5 and/or RAID-6 for optimum availability, user responsiveness, and data redundancy.
- We run our applications in either clustering or (in the case of our Windows/Intel applications) a fully virtualized server environment, allowing on-demand processing and further levels of secure server redundancy.
- Our HIT delivers functionality to our end users through virtual desktop and remote application support using industry leading Citrix technology. This architectural HIT approach means that information access is not impacted by a failure at the PC workstation level and all data is securely and centrally housed in HIPAA compliant, regularly audited fashion.
- Our software applications are delivered to our end users via Centene's nationwide multi-path Wide Area Network (WAN) – and we use redundant networking hardware and software- and dual, independent data communication vendors - to supply WAN services.

These redundant back-up features assure the maximum possible system availability and minimum possible unscheduled availability. In addition, our secure, web based member and provider Portals (which supports the HIPAA compliant entry of medical and behavioral health PA's and claims, as well as eligibility inquiry support and other transactions for our providers) has scheduled availability of 24 hours a day, 7 days a week, 365 days a year for the use of our providers. PBM's POS Network is available 365 days a year, 24 hours a day and uses the National Council for Prescription Drug Programs (NCPDP) D.0 standard (HIPAA 5010).

Both Sunflower and PBM are supported with a comprehensive, customized, fully documented, thoroughly communicated, annually tested Business Continuity Plan (BCP). Our BCP incorporates a Disaster Recovery Plan (DRP) that covers all reasonably anticipated contingencies and recovery strategies, customized for the particular site or system disabling risks that may be present at any Sunflower or PBM operating location.

Please see Section 5.15.2 (Use of and Safeguarding Data) for more information on the HIPAA compliant security, availability, and BCP aspects of our MIS.

Sunflower's Technology Platform (5.15.1.G.7)

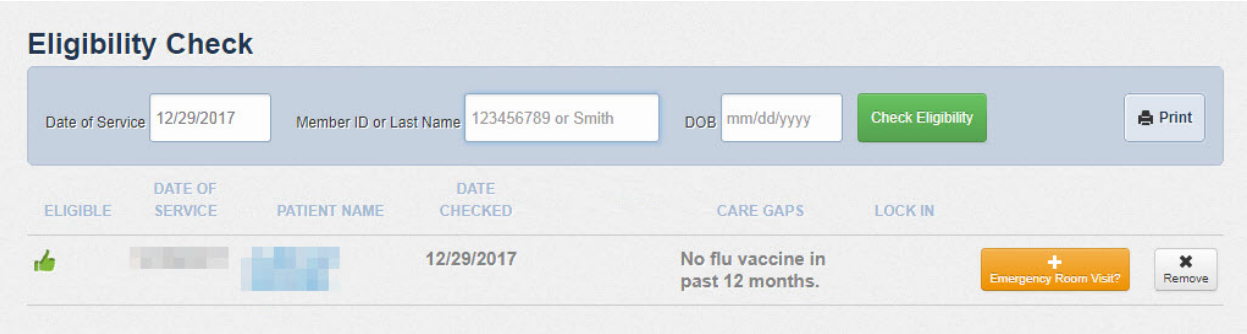
An HIT Focused on Publicly-Funded Programs. Both Sunflower and PBM use proven, established, integrated technology platforms supporting over 12.3 million members in 29 states primarily through publicly-funded programs such as Medicaid, Medicare, TRICARE and Health Insurance Marketplace including 330,000 physicians and 6,695 hospitals. We build our MIS on

principles of reliability, scalability, data integration, and interoperability, allowing us to deliver computing power as needed to support our operations.

Internet. We design our websites and portals for seamless integration of content, with navigation attuned to, and authorized for, specific user types, including providers and members. Our mobile-optimized member website has online access to searchable provider directories with the ability to search by location, name, distance, language spoken, gender, provider type, specialty, affiliations, whether the provider is accepting new patients, and more. We provide clearly organized resources including: plan benefits, caregiver resources, member tips on health and wellness, forms and links on member resources. We also feature comprehensive and current member handbooks.

Provider Web Resources. Our secure Provider Portal is a role-based system offering a comprehensive array of convenient self-service functions including the ability for providers to verify member eligibility, submit claims for services rendered, and view claims status (paid, denied, pended). See ***Figure 5.15.L_Provider Portal Eligibility Check*** below.

Figure 5.15.L_Provider Portal Eligibility Check



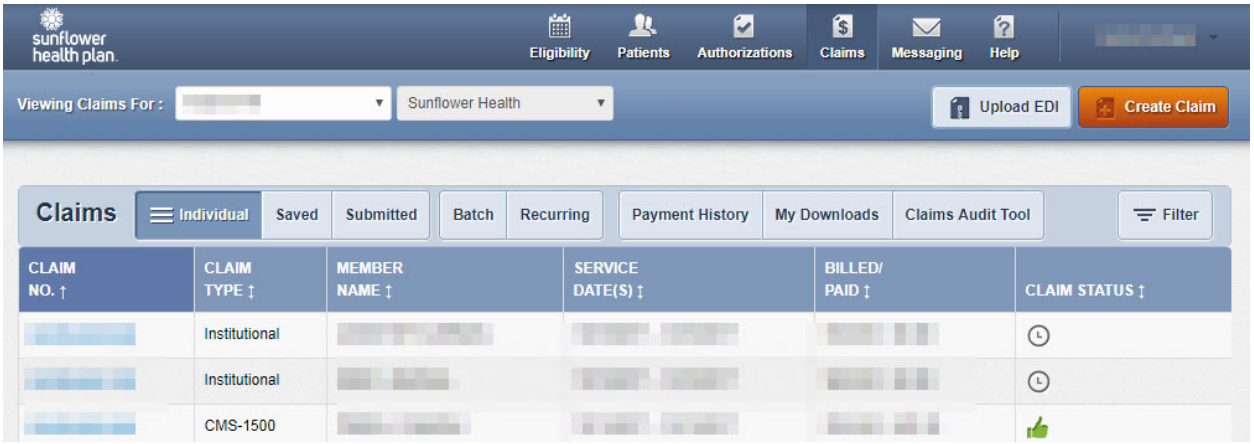
Providers have the following options to submit claims via our Provider Portal (see ***Figure 5.15.M_Provider Portal Claims Submission*** below):

- ***Direct Claim Submission.*** Providers can directly submit HIPAA EDI 837 Institutional and Professional batch files through our secure Provider Portal.
- ***HIPAA-compliant Direct Data Entry (DDE).*** Online entry of claims directly through the HIPAA-compliant DDE feature (also available through the Provider Portal). Our DDE feature provides interactive assists to walk the submitting provider through the claim submission process, with look up and validation assists for codes (e.g., CPT, ICD-10); cross-field logical checks (e.g. if one form field is populated, checks that other fields are populated); validation of member and provider data; and online help. This results in instant feedback to the provider on any submission issues to maximize clean claim data entry. Claims with Attachments. We allow electronic submission of claims with attachments (e.g., for claims that require written documentation to justify payment) when a provider submits a claim using our DDE functionality.

- ***LTSS Claims Wizard.*** We offer the LTSS Claims Wizard, a specialized version of our online Direct Data Entry (DDE) feature on the Provider Portal, designed specifically for LTSS providers with no coding experience to submit accurate and complete claims through a step-by-step claim entry process, with validation assists and online help, driving down errors and ensuring providers receive more timely payment for their services.

View Claim Adjudication Logic. We also offer providers our Clear Claim Connection feature, which allows providers to understand our claim coding requirements via an interactive web interface, as well as our interactive authorization utility, which allows providers to determine when a PA is required.

Figure 5.15.M_Provider Portal Claims Submission



Additional Provider Portal Features. In addition, providers can upload supporting clinical documentation for authorization requests or clinical quality measures, in one easily navigable, user friendly interface. Providers have access to member care gaps, health risk alerts, or special needs identified by Centelligence®'s predictive modeling analytics. These are presented to providers through eligibility inquiry search results, and on the online member Panel Roster, which displays all members assigned to the provider.

Member/Caregiver Web and Mobile Resources. As discussed above, our secure Member Portal includes member specific information on benefits and eligibility; the ability to change PCP; print and request ID cards; access health summary information including recent medical and pharmacy usage; and view referrals, authorization requests and approvals. The member portal also provides information on the member's CentAccount® rewards program account status. Our CentAccount® program promotes personal health care responsibility by offering members incentives for performing healthy behaviors through limited use reward cards. In addition to our mobile optimized websites, members can access our MySunflower member mobile application to search for a provider, view their member ID Card, and other interactive features.

Please see Section 5.15.1.E above for more information on the interactive features in both our Member and Provider Portals.

Datacenters. A central component of our proven technology platform are our redundant, secure datacenters. Centene operates two datacenters housing the systems of both Sunflower and PBM, with our primary datacenter located in Missouri and our disaster recovery back-up site located in California. Our two datacenters operate in contingency mode for essential business functions. The primary datacenter (MO) is a LEED certified, Tier 3 site with capacity for 384 IT racks, and over 18,000 square feet of datacenter floor. Both facilities employ redundant environmental, power, networking systems, and backup capability, and are hardened to withstand natural disasters (e.g., tornado, earthquake, fire). If a site-disabling event does occur in our primary datacenter, critical voice and networking processes will be redirected to the secondary datacenter in near real-time. The secondary datacenter can resume essential business and IT functions including those related to key member care and provider payment services within 24 hours from the time the disaster is declared. In addition, the datacenters are connected by a fully redundant WAN to ensure that an outage by our telecommunication providers will not result in system unavailability. Data backups are performed using IBM Tivoli Storage Manager, our automated hierarchical storage management system.

Centene's Security Program is International Standards Organization (ISO 270001) certified, demonstrating that we have successfully adopted this globally recognized information security framework.

Security Features. We use policies, safeguards, and monitoring tools to ensure adherence to HIPAA, HITECH, and subsequent rules. Our Information Technology (IT) staff employ safeguards through the coordination of our Security Project Management Office and under the supervision of our Security Steering Committee oversees our Security Program and is made up of interdisciplinary departments including our Chief Information Security Officer and Risk Officer with 20+ years' experience in military grade cybersecurity. We perform regular risk assessments to assess identifiable security risks, identify controls to reduce risk likelihood and impact, and ensure our HIT is kept secure from new security risks. We engage an external auditor to conduct an SSAE 16 SOC 1 Type II audit to verify the operating effectiveness of our controls.

Please see Section 5.15.2 below for additional information on our information security features and program.

HIPAA COMPLIANT WEB BASED PA APPLICATIONS FOR PROVIDERS (5.15.1.H).

Today, Sunflower provides secure, HIPAA-compliant, web based Provider Portal functionality with comprehensive automated functionality – including HIPAA Direct Data Entry (DDE) compliant support for:

- Eligibility inquiry and response, including the ability to search by KanCare Member Medicaid ID and Date of Birth
- PA request, acknowledgement, and response with:

- 24 months of historical PA data available, and all statuses except "voided" PA's are on the portal (approved, partial approve, partial deny, denied, and pended). Providers can search by confirmation number or the authorization number
- Rich filtering functionality including filters by date range, member ID, member last name or first name, confirmation number, authorization number, status, and authorization type (inpatient or outpatient)
- PA updates every 24 hours with options for real time PA status in development

- Assisted claim entry and acknowledgment, claim adjustment, and claims status request and response
- And several online assists in support of above; such as
  - An authorization requirement look-up at the procedure code level (allowing the Provider Portal user to easily query whether a physical or behavioral health service requires a Sunflower authorization request)
  - Link directly to KanCare Preferred Drug List (PDL) for pharmacy PA information per State requirements
  - Support for online submission of supporting documentation (e.g. for PA's and claims),
  - An interactive provider directory
  - Secure messaging with Sunflower staff
  - And other supporting resources

Clinical Functionality and Support for Alternative Payment Models

In addition, our Provider Portal supports both our medical and behavioral providers and offers **clinical applications** to assist providers in their practice of medicine and wellness, as well as quality and cost information providers need to meet their Value Based Purchasing (VBP) objectives. These additional functions include online care gap notifications and health alerts (driven by Centelligence®), online Member Health Record and TruCare Service Plan, Clinical Practice Guidelines, and other features. TruCare is our Member-centric health management platform for collaborative whole person care coordination, and case, BH, DM, and PA review. Centelligence® is our comprehensive family of integrated decision support and health care informatics solutions, including predictive analytics for the identification of health risks and care gap alerts. The Centelligence® platform integrates data from multiple sources, and provides actionable population and member level information, with the goal of improving clinical, operational, and financial outcomes.

Our online Centelligence® Provider Analytics suite, available to providers through our Provider Portal, offers drill down dashboards to prevent Provider quality and cost information to our VBP Providers in compelling fashion, allowing the Provider to focus on performance objectives. Please see Section 5.15.1.E above for more information.

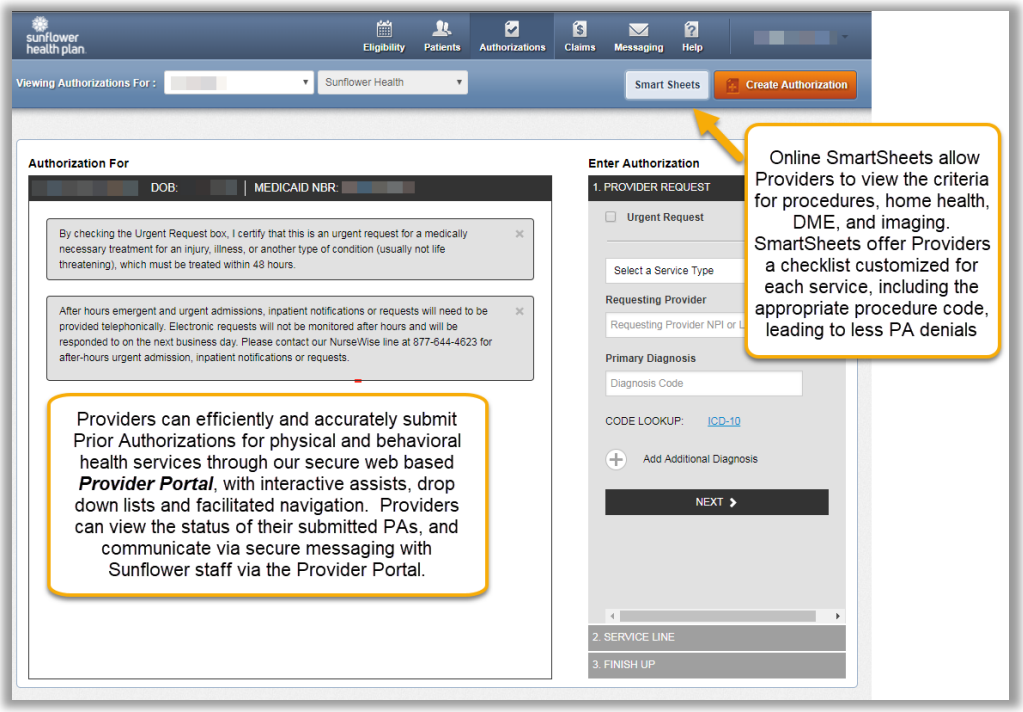
Online Entry of Pharmacy PAs

Through PBM, we also offer prescribing providers secure online access to our CoverMyMeds (CMM) Portal, for efficient entry and management of pharmacy PAs (see discussion below as well as Section 5.1.15.1.G).

Efficient, Yet Thorough PA Support (5.15.1.H.1)

Physical and Behavioral Health. The PA support in our Provider Portal allows authorized provider users to enter and submit authorizations online in a user friendly, facilitated HIPAA compliant fashion, with edits and codeset lookups to help the provider. The provider receives an immediate acknowledgement of receipt, and can monitor at the provider's convenience the status of their PA requests. Please see ***Figure 5.15.N_Sunflower Provider Portal PA*** the screenshot below from our Provider Portal for an example:

Figure 5.15.N_Sunflower Provider Portal PA

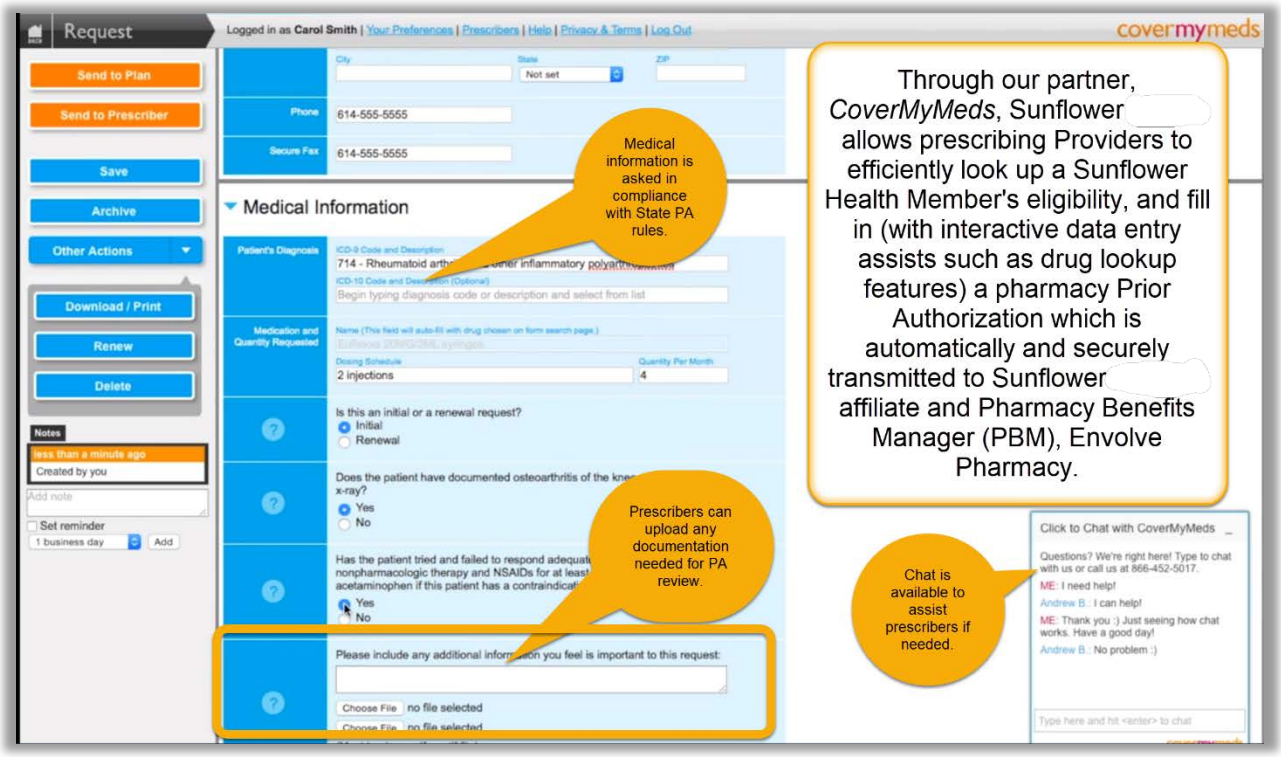


In 2018, we are enhancing our web-based authorization capability through the implementation of our comprehensive automated point-of-care solution. Our new auto authorization solution integrated with TruCare, is a fully automated, interactive workflow that supports real-time medical appropriateness review and determination for key services. This interactive workflow uses auto-determination rules to quickly approve PAs and provide a timely response to providers via our secure Provider Portal.

Pharmacy. As discussed in Section 5.15.1.G, Sunflower's PBM securely integrates with the nationwide CoverMyMeds (CMM) online pharmacy PA network. Prescribing Providers access CMM, lookup the Sunflower Member, and fill in a PA online, with assistance of pre-populated

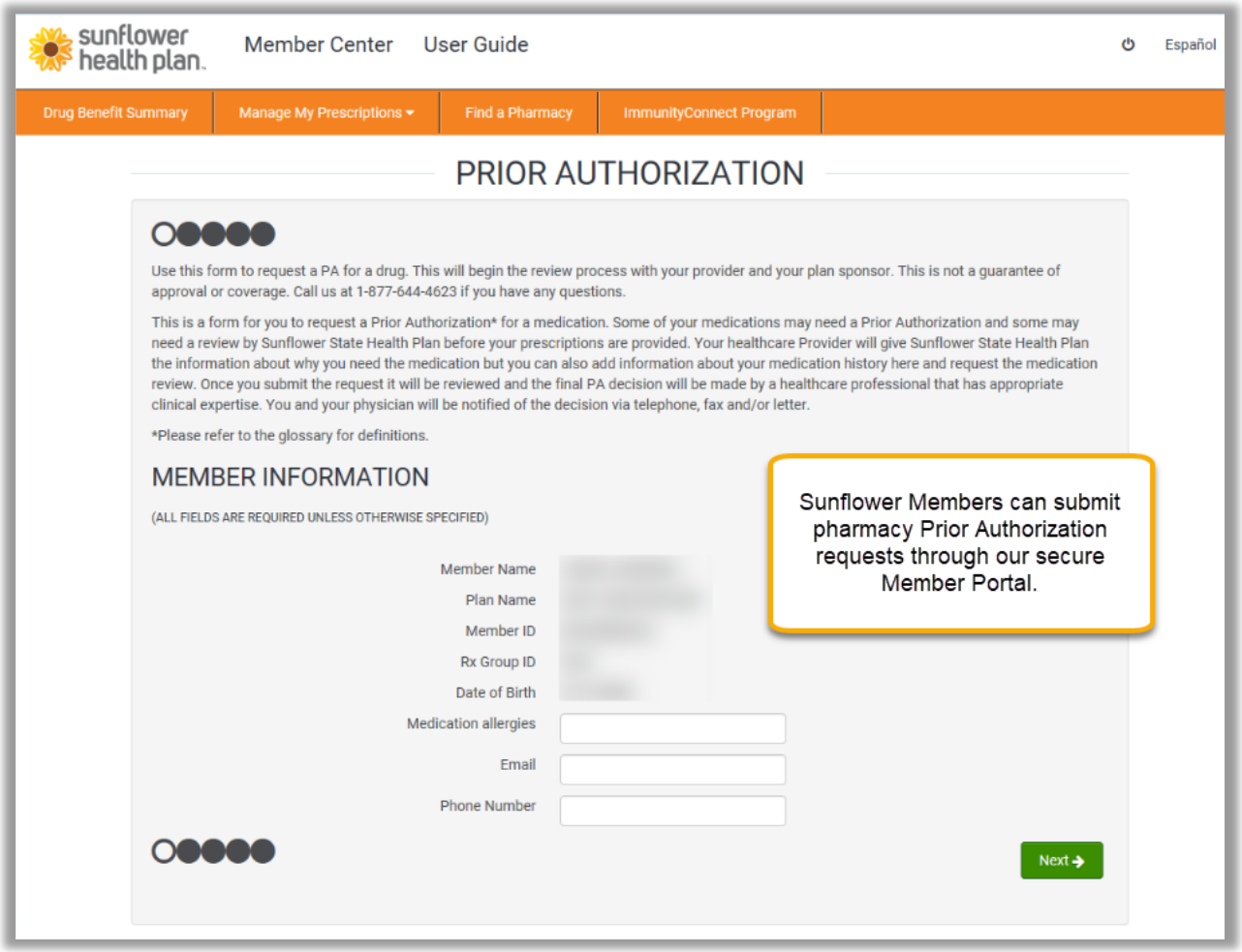
fields, drop down lists, checkboxes, and easy navigation, and submit their PA online. This PA data is immediately transmitted to PBM for either auto authorization or manual review if needed by a PBM specialist supporting Sunflower. See ***Figure 5.15.O_CoverMyMeds PA*** immediately below.

Figure 5.15.O_CoverMyMeds PA



Member Portal Pharmacy PA Submission Support. In addition to above, our Member Portal allows **members** to initiate a pharmacy medication PA process electronically. Sunflower's Member Portal is a secure, web based Portal allowing easy access to a member's eligibility and benefits information, prior medical, BH and pharmacy claims information (in consumer friendly format), health incentive program status, secure communications with Sunflower staff, and a variety of self-service online features including PCP change requests, ordering a new ID card and more. If a Member submits a PA request through the Member Portal, our PBM pharmacists review the PA, and contact the Member and their Provider with the PA review decision. See ***Figure 5.15.P_Sunflower Member Portal Pharmacy PA*** immediately below.

Figure 5.15.P_Sunflower Member Portal Pharmacy PA

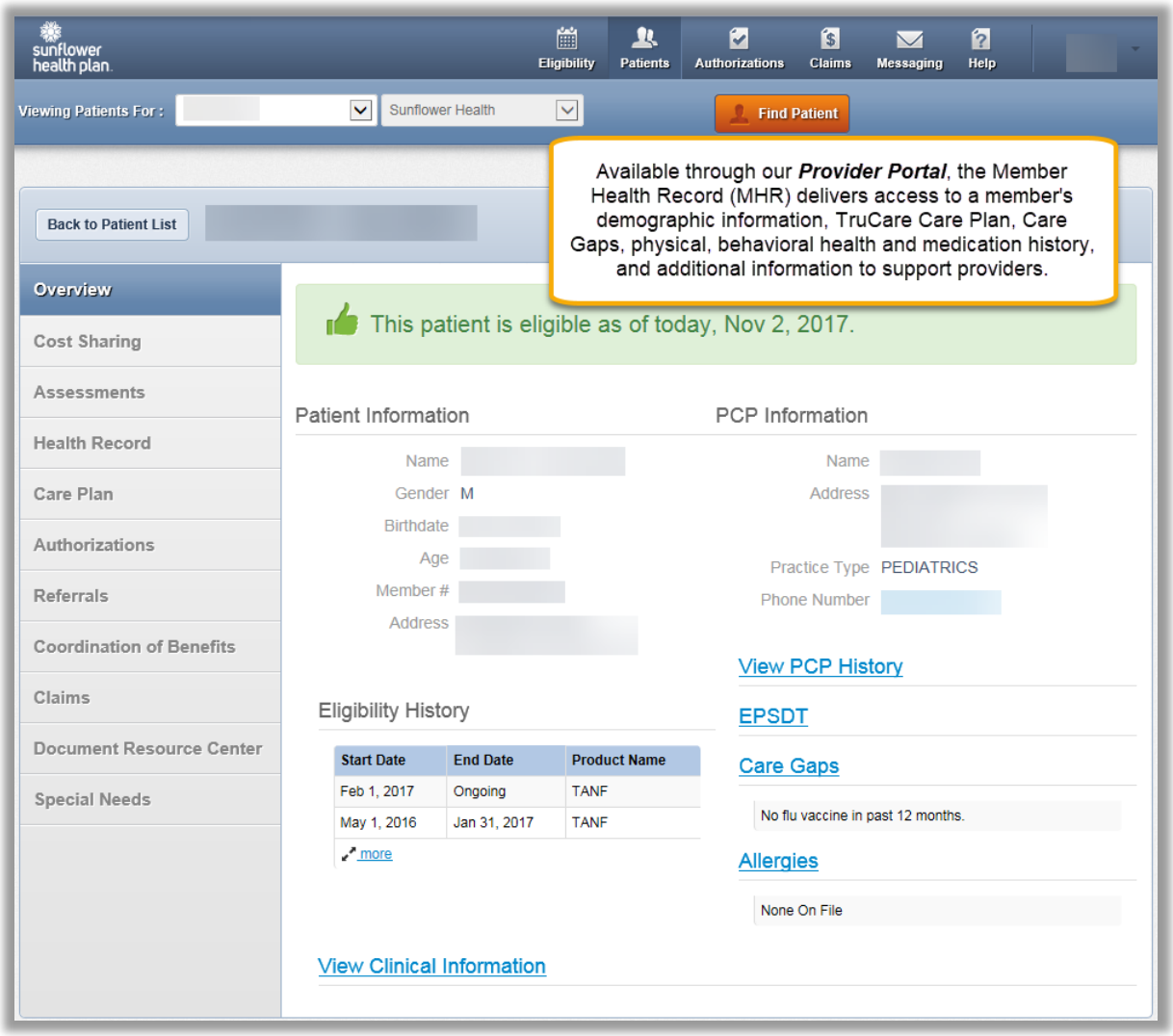


Secure Electronic Health Record Access for Providers (5.15.1.H.2)

Our Provider Portal delivers a comprehensive, secure and detailed online Member Health Record, an online Member Panel Roster and expanded clinical cost and quality reporting.

Our online summary Member Health Record (MHR) is a well-organized view of a member's care gaps (as identified by Centelligence® – our predictive modeling system) as well as a cursory clinical "face sheet" for each member for whom we have supporting data. Information in the online MHR is based on current and historic medical and pharmacy claims information, lab test results, Health Risk Assessments, and other information systematically received, processed, and integrated in our Centelligence® Enterprise Data Warehouse (EDW) for use by not only authorized providers but Sunflower's own authorized clinical staff. Please see example screen shot ***Figure 5.15.Q_Provider Portal Summary Member Health Record*** below.

Figure 5.15.Q_Provider Portal Summary Member Health Record



Electronic, Secure PA Review Requests (5.15.1.H.3)

Both our TruCare (physical and behavioral health PA support) and the PBM integrated PA and Pharmacy POS claims system support online access to up to 24 months (or further back if we have the information) of online, integrated administrative data for manual and automated review, accessible through our integrated Centelligence® platform. TruCare (medical and behavioral PA support) supports automated authorization support – for appropriate combinations of member, provider, and services requested. Further, Sunflower's TruCare users (including our Integrated Care Teams and Medical Management personnel) have full online access to historical physical, behavioral health, and pharmacy utilization data through TruCare's integration with our Centelligence® EDW – allowing our clinical staff to examine the member's utilization profile in its entirety, and apply appropriate evidence-based Medical Necessity Criteria (MNC) informed by that holistic picture. As mentioned in Section 5.15.1.H.1 above, we are significantly expanding the range of PA automation in 2018.

In addition, our UR clinical staff apply the Kansas Client Placement Criteria (KCPC) when reviewing authorization requests for Substance Use Disorder (SUD) services from our providers. Our UR staff document their application of KCPC in TruCare for purposes of ensuring that we consistently apply KCPC, and for any State auditing or reporting purposes.

Through integration with a nationwide Point of Sale (POS) pharmacy network, and using diagnoses and utilization history sourced from Centelligence®, PBM's PA system offers several automated PA review edits for Pharmacy POS processing including the use of Step Therapy Auto-approval (which accesses the member's prior medication history to check for use of a first-line drug prior to approval of second-line drug), diagnosis auto-approval (which access member diagnosis from claim data or a POS pharmacy entry), and other edits that access administrative data to inform the automated PA process.

Member Information Provided to Authorized Users (5.15.1.H.4)

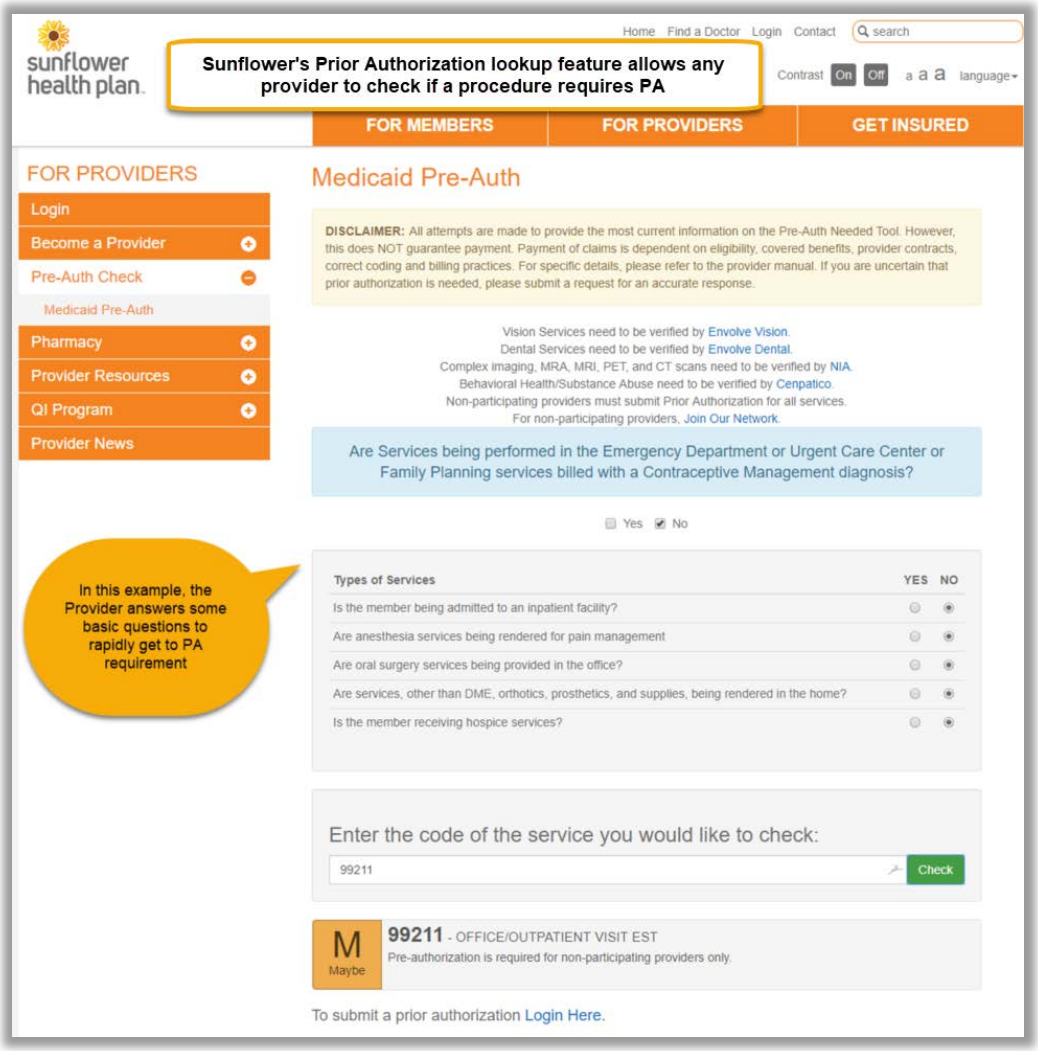
Member Profile Information (5.15.1.H.4.a). Our Provider Portal users can securely view, via our online Eligibility Inquiry function, our member's demographic and eligibility data online, as well as information on the member's PCP and whether the member is in one of our Care Management programs. Providers can also view clinical profile information including Care Gap Notifications (alerting providers to health alerts as well as gaps in care), emergency room high utilizer flag (alerting providers if a member has had three or more emergency room visits in the past 90 days), the online Member Health Record delivering advanced capabilities for clinical care management and the TruCare Care Plan if the member is in one of our case management programs (see Section 5.15.1.H.2 above).

Prescriber Information (5.15.1.H.4.b). Provider Portal users can view prior prescription drug utilization information, inclusive of the corresponding prescriber(s). In addition, any visitor to our Sunflower public website (optimized for mobile use) can use our interactive Find a Provider directory. This online provider directory offers multiple search options, including location or name; type; specialty; gender; language spoken; whether accepting new patients; and medical and hospital affiliations. The directory also includes our network pharmacy information.

PA History (5.15.1.H.4.c). Providers may view all PAs, along with the status of those PAs that they have submitted to Sunflower, including the date of submission and approval, for physical, behavioral health, and pharmacy PAs (the latter via our CMM Portal).

PA Questions (5.15.1.H.4.d). To help providers determine if a PA is required for any particular service, we offer our PA requirement inquiry feature. Please see ***Figure 5.15.R_PA Requirement Inquiry*** below for an example:

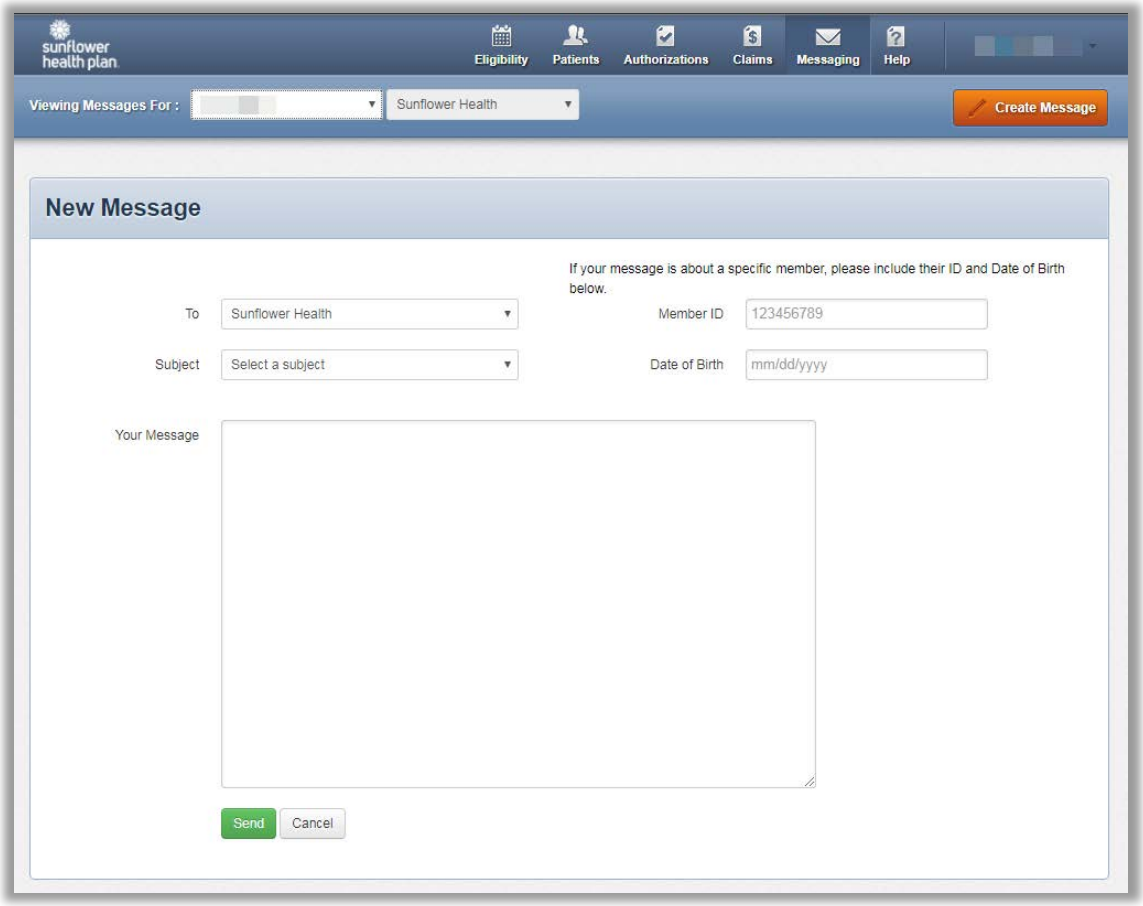
Figure 5.15.R_PA Requirement Inquiry



The above feature is available on the public portion of our Provider Portal – allowing any Provider (or any visitor to our site) to use the feature. We make this feature publicly available to support situations where non-network Providers are seeking to provide care to our Members. Providers can also quickly access pharmacy PA requirements from the above web page by clicking on Pharmacy which links to the KDHE Pharmacy webpage for PA forms and criteria.

In addition to the above, our Provider Portal also allows users to send targeted and secure messages to our staff, and to be notified by e-mail when the provider's query has been answered by Sunflower staff. Please see the sample screenshot ***Figure 5.15.S_Provider Portal Secure Messaging*** immediately below:

Figure 5.15.S_Provider Portal Secure Messaging



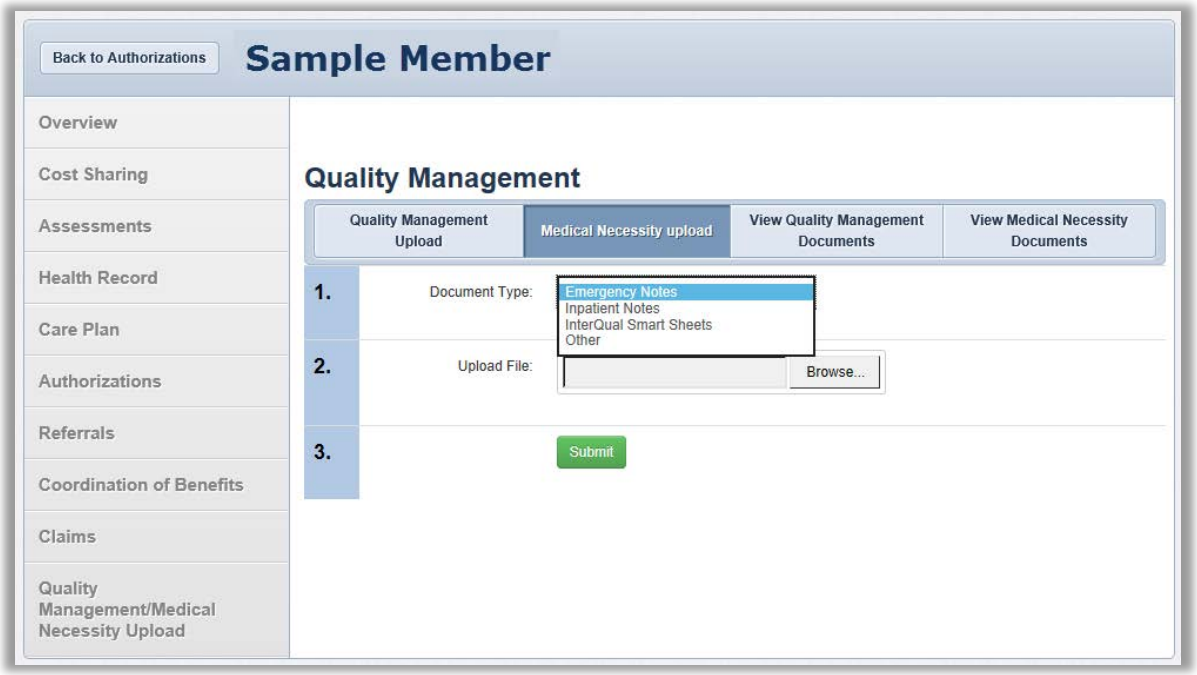
Of course, Providers can also call our Customer Service line at any time and be connected to Sunflower or PBM (for medication PA questions), and a knowledgeable staff person will assist the Provider.

Automated Criteria Check (5.15.1.H.4.e). When providers enter authorizations via the Provider Portal, our TruCare PA system systematically checks to see if the authorization request can be automatically authorized. The provider need not indicate they are requesting "auto authorization" – if the services requested can be automatically authorized, TruCare will instantly issue the approval to the provider. As mentioned in Section 5.15.1.H.1 above, we are significantly expanding the range of PA automation in TruCare in 2018.

Approval and Denial Outcomes (5.15.1.H.4.f). Our Provider Portal allows users to view the status and history of all the PA requests they submitted to Sunflower. Similarly, our Providers can check the status and history of all pharmacy PA requests they have made through our CMM Portal.

Ability to Attach Applicable Medical Record Data to PA Submissions (5.15.1.H.4.g). Provider Portal users can attach (via a secure file upload capability in the Portal) supporting medical or behavioral health data (e.g. attestation, lab test result, behavioral health assessment) in any industry standard format (e.g. Word Document, PDF, Image) in support of their PA request. The uploaded document is indexed to the PA request in TruCare, efficiently allowing Sunflower users to quickly access the attachment from TruCare, when reviewing the PA request from the provider. As a point of interest, this same document upload feature is also available in our online claim entry facility in the Provider Portal. See ***Figure 5.15.T_Provider Portal Document Upload*** immediately below.

Figure 5.15.T_Provider Portal Document Upload



Similarly, Providers filing a pharmacy PA may electronically attach a document(s) in any format via our CMM Portal (see discussion and CMM Portal snapshot in Section 5.15.1.H.4.d above).

Ability to Request Reconsideration of Denial Outcomes Electronically (5.15.1.H.4.H). Our Provider Portal (physical and behavioral health PAs) and our CMM Portal (pharmacy PA portal) allows users to electronically request a reconsideration of a PA denial, and to communicate with us via secured messaging.

OVERVIEW: SUPPORT FOR EVV (5.15.1.I)

Sunflower's HIT is compatible with all EVV systems that adhere to State and Federal standards. The standards based interoperability of our HIT allows us to use EVV technology to manage Home and Community Based Services (HCBS) utilization, pay HCBS claims, and collaborate with HCBS providers to ensure the delivery of authorized, timely, and appropriate HCBS for our members.

Since we began supporting the KanCare program in 2013, we have supported the State's requirements for operating and maintaining secure data interfaces with the State's existing AuthentiCare EVV system, including the HIPAA compliant transmission of PA files from our HIT to AuthentiCare (via the State's MMIS Contractor), receipt of HIPAA EDI claims, issuance of HIPAA EDI remittance advices, and receipt of reporting information from the AuthentiCare system. In addition, we support the use of the State's EVV system for all personal care services regardless of whether those services are directed by a home health agency or self-directed by the member. For example, 75% of our members participating in the State's Physical Disability Waiver have chosen self-direction for their services, and we support the use of EVV for all these self-directed members.

Through our interoperable, enterprise HIT we support usage of any EVV system that adheres to HIPAA based standards for transaction formats, and Federal and State standards for security safeguards, data integrity controls, and audit transparency.

We currently support our EVV operations with a dedicated Sunflower EVV Coordinator, who serves as our single point of contact for EVV related authorization and service plan issues. In addition, by the third quarter of 2018, and in line with our emphasis on increased EVV functionality and growing importance to the State (e.g. in light of the EVV provisions in the 21st Century Cures Act), we are expanding the role of our EVV Coordinator to include management of regular EVV training for internal Sunflower staff and our providers, as well as support for all EVV operational aspects (including data interfaces with the EVV system) of KanCare and KanCare 2.0, in coordination with the State and the State's EVV contractor.

Complying with EVV System Procurement (5.15.1.I.1)

Since beginning KanCare operations in 2013, we have complied with all terms of the State's current Contract procuring an EVV system. In preparation of our response to this RFP Section 5.15.1.I, we have reviewed the RFP requirements related to EVV use by Contractors, as well as the State's RFP Amendment Four, Round One Question and Answer #247, and the latest version of the State's existing EVV contract, including all six Amendments and Statements of Work, and we will continue to comply with all Contractor related requirements in the State's EVV procurement contract. We realize that the State's existing EVV contract is due to expire on 12/31/17, and Sunflower will comply with subsequent EVV contracts as those contracts pertain to Contractor operations.

Nationwide Experience supporting EVV to Inform Alternatives (5.15.1.I.2)

Through Centene and our affiliates, Sunflower has access to expertise supporting virtually all standard types of EVV interfaces and operational models, including the use of EVV for advanced communication capabilities such as online alerts for missed services and/or changes in condition. Through our affiliates and Centene, we also have growing expertise in EVV "aggregation capabilities", allowing us to support multiple EVV systems should the State decide upon such a strategy. We have examined the State's existing EVV Contract (per RFP Round One

Question and Answer #247) and realize that the State may soon consider changing EVV systems. Today our standards-based HIT operates with several leading EVV systems (including AuthentiCare for KanCare), and we are well positioned to support the State's EVV decision for 2018 and beyond.

Our interoperable HIT supports multiple EVV systems today and our organizational experience with leading EVV subcontractors means we can and will support any solution the State chooses, including retainment of the existing EVV Contractor.

EVV Alerts Help Assure Care Quality. We recommend that the State strongly consider EVV systems that support the entry or upload by HCBS providers of in-home worker schedules, and the ability for these EVV systems to issue electronic "missed appointment" alerts not only to the providers of services, but to the affected MCO (and thus Community Service Coordinators) as well. We have found through our affiliates that EVV missed appointment alerts are invaluable to enabling our Service Coordinators to ensure authorized and planned services are consistently delivered and that member back-up plans are mobilized if a home worker misses an appointment.

An EVV Partner. Should the State's chosen EVV system not have missed appointment alert capability, we will continue to fully support and work within any EVV system or deployment constraints. Sunflower and our affiliates actively engage with our State clients, HCBS providers, and our fellow MCOs to work together and assure smooth, cost efficient EVV deployments. See the discussion immediately below for an example.

Sunflower Case Study: Authorization Data Flow

Issue Identification. Over the course of supporting the existing EVV implementation, we identified a problematic operational issue with the daily data feed of authorization files from the three KanCare MCOs (including Sunflower) to the EVV system. In the existing arrangement, each day the MCOs transmit their authorization files to the State's Medicaid Management Information System (MMIS) Contractor, who consolidates those files into one transmission to the State's EVV vendor for access by authorized HCBS providers. This well-intended but circuitous process delays the population of accurate authorization data into the EVV system by up to two days.

In addition, there is no visibility for MCOs to see in timely fashion if there are any data issues with the authorizations the MCOs send to the MMIS Contractor. Rather, these issues do not manifest themselves to the MCO until the "downstream process" when the State's AuthentiCare EVV system attempts to load the MCO's authorization data submitted by the MMIS Contractor. The result is that MCO authorization data can take even longer to accurately load into the EVV.

The ultimate result of delays is that HCBS workers may not be able to check in with the EVV and deliver services to members because no authorization exists in the EVV, resulting in service gaps or onerous and confusing workarounds.

Formulating a Solution. In the spring of 2017, Sunflower, in concert with the Information Technology (IT) department of our parent, Centene, analyzed the existing EVV operational flow, documented the problematic areas in the flow, and formulated three alternative approaches to address the issue of delayed input of MCO authorization data into the EVV. Nationwide, Centene supports virtually all possible approaches of EVV support, including data interfaces with multiple EVV systems mandated in some states, interfaces with EVV systems our health plan affiliates directly procure, and hybrids of both these models. Thus, our Centene IT staff is deeply conversant in the logistical challenges of all these general approaches, and could quickly assess and recommend strategies for us to table with the State and our fellow KanCare MCOs.

In May of this year, we submitted our analysis and potential solutions to the State, our fellow MCOs and the MMIS Contractor, via the standing KanCare Operations workgroup meeting. All stakeholders (including the State's MMIS Contractor) were quite supportive of addressing the "authorization data flow" problem, and we continue to move forward with the State and our fellow MCO's on addressing the "auth data flow" issue.

Looking Ahead. We continue to believe the best approach for KanCare EVV operations is to allow KanCare MCOs to send authorization data directly to the EVV system, and remove the MMIS Contractor from the critical path between authorizations and HCBS workers accessing authorization data in the EVV. There are several ways to accomplish this "direct path" of authorization flow (all of which the MMIS Contractor supports) while still maintaining data integrity, auditability, and in fact improving operational monitoring and cost effectiveness. We look forward to helping all stakeholders (the State, MMIS Contractor, MCOs and the EVV vendor) achieve this optimum solution.

Planning for Success. In addition to the above, Sunflower will continue to collaborate with the State, the State's EVV systems supplier, the State's MMIS Contractor, and our fellow KanCare MCOs as the State's EVV needs evolve. Our ability to interface with EVV systems can support this collaboration in that we are able to interoperate with any industry standard EVV system if there are EVV vendor changes at the State or new EVV related requirements from either KDHE or KDADS.

Planning for New Regulatory Requirements. Section 12006 of the recently enacted 21st Century Cures Act prescribes federal payment matching incentives for states to require EVV use for certain personal care or home health care services. We wish to ensure the State is well-positioned for these incentives, which phase in beginning January 1, 2019, by continuing our operational and strategic support of the State's EVV system. In addition, on January 9th of 2017, CMS finalized new Medicaid Home Health Care Rules (Rules) for protection of beneficiaries receiving services from home health agencies. Among other requirements, the Rules prescribe integrated communication systems for care coordination, which we believe can be facilitated through the continued and expanded use of EVV technology and supporting applications.

Supporting Claim Submission Files from EVV System (5.15.1.I.3)
Our HIPAA compliant claims system supports all HIPAA 837 formats, and we can accept electronic claims from an EVV system at any frequency, including support for daily submissions. We continue to accept claims from the State's existing EVV system, via the State's Front End Billing (FEB) system, in HIPAA 837 format, and we issue HIPAA standard functional acknowledgement upon receipt of claim submission back to the submitting EVV system. Our TruCare care and UM system sends HIPAA compliant authorization files to the EVV system via the State's MMIS contractor (see Section 5.15.1.I.1 above), as well as electronically feeding these same authorizations to our claims system. When our claims system receives EVV claims, it automatically matches those claims to the authorizations sent, supporting both claim adjudication as well as allowing us to ensure that we receive claims from the EVV system for HCBS services we have authorized. Because our claims and authorization systems are integrated, this allows us to also support resolved claims exceptions, including claims that do not meet KanCare business rules (such as no authorization for the service on the claim), and our systems keep fully auditable detailed history of all resolved exceptions applied during the claims process.

EVV Monitoring Capabilities (5.15.1.I.4)
Verifying Services Provided per PCSP and Plan of Service. Through our HIT, with its integrated authorization and claim system components, we currently review weekly reports designed specifically to monitor that services billed on HCBS claims match units of service authorized on the member's PCSP and Plan of Service.

Systems Integration is the Key. We build a KanCare member's PCSP and Plan of Service in our TruCare system, which, as a component of our HIT, is integrated with our claims, customer service, reporting systems and, for KanCare 2.0 will be available on our provider, member and Service Coordinator web portals. TruCare is our member-centric health management platform for collaborative care coordination including LTSS/HCBS, case management, DM, and PA. TruCare transmits authorizations to the State's EVV system via the State's MMIS Contractor (see Section 5.15.1.I.2 above) for those services in the member's PCSP and Plan of Service requiring PAs. This authorization data conveys the amount, frequency, duration, and scope of each authorized service, and is used by our claims system to adjudicate the corresponding EVV claims. Both authorization data and processed claims information is electronically loaded in the Enterprise Data Warehouse component (EDW) of our HIT, where our Centelligence® analytics and reporting system enables us to report on authorizations and corresponding claims for HCBS service monitoring purposes. Centelligence® is our data integration, health analytics and reporting platform, delivering actionable information via standard, ad-hoc, and interactive dashboard reports.

The EVV Coordinator. As introduced above, today our EVV Coordinator serves as our single point of contact for EVV related authorization and service plan issues. As the State decides on an EVV system for 2018 and beyond, our EVV Coordinator will perform analyses using reports

from the State's EVV system to help monitor operations as well as identify potential indications of fraud, waste, or abuse (FWA) in our HCBS program.

Late and Missed Visits. We have the capability to receive late and missed visit alerts, should the State's chosen EVV system support that function, a capability we recommend the State consider for its EVV system (see Section 5.15.1.I.2 above). To support late and missed visit alerts, an EVV system must have the capability to allow home health agencies to upload worker visit schedules or to be able to enter those schedules into the EVV system, so that the EVV system can compare worker check-in and check-out times against the visit schedule. If the EVV system does not receive a visit check-in from the home worker (e.g. personal attendant) within a specified time range of a scheduled visit, the type of EVV system we recommend the State consider generally supports notifications via e-mail or via access by the MCO to an EVV system portal. We can support any of these notification capabilities (e-mail or portal), allowing our Service Coordinators to identify visit issues and ensure that members receive the services they need (e.g. by invoking the member's back-up plan if necessary). In addition, notifications received outside normal business hours will be received by Sunflower and our Community Service Coordinators, who can intervene as needed. Sunflower members are supported by our on-call, after hours Nurse Advice line supports which include Sunflower managers on call to help with issues of absent caregivers, utilities being turned off, and other in-home needs.

Making EVV Information Available to Service Coordinators. In addition to the above, we will continue to access the reports (e.g. visit activity by worker) produced from the EVV system that the State selects for KanCare 2.0 and make those reports available for our internal Sunflower Service Coordinators and Community Service Coordinators. Depending on the interface capabilities of the State's chosen EVV system, we will implement the most efficient method for secure report distribution. As mentioned above, and in addition, we recommend that the State's chosen EVV system have the capability for online notifications of home worker missed appointments, and our interoperable HIT can support this EVV capability if present.

5.15.2. USE OF AND SAFEGUARDING DATA

OVERVIEW (5.15.2.A)

Sunflower and our parent Centene safeguard Protected Health Information (PHI) and other confidential data through a continually updated, enterprise-wide Security Program, based on HIPAA mandates, rules, and standards per HIPAA Transaction and Code Set (TCS) regulations; HIPAA Security and Privacy; the Health Information Technology for Economic and Clinical Health Act (HITECH); all rules and regulations of our state Medicaid partners; and all provisions in Section 5.15.2 and Attachment J of the Scope of Work. All elements of our Security Program are currently implemented across our affiliate subcontractors and health plans. Through Centene, Sunflower has over 30 years of experience implementing and operating our security systems in 28 different states nationwide. Our Security Steering Committee oversees our Security Program and is made up of interdisciplinary departments including our Chief Information Security Officer and Risk Officer with 20+ years' experience in military grade

cybersecurity. Sunflower promotes a culture of Information Security, meaning that all employees, consultants, and business partners of the organization must exhibit security diligence through their day-to-day actions and behaviors. We also have processes and policies in place to ensure all subcontractors comply with PHI, HIPAA, and HITECH requirements. Our diligence is supported by a comprehensive array of best practice information security technical controls.

Protection of ePHI and Sensitive Data (5.15.2.A)

We safeguard electronic Protected Health Information (ePHI) through a layered approach to system hardening via complementary, mutually reinforcing access controls, intrusion detection, and data loss prevention technologies, informed by National Institute of Standards and Technology (NIST) guidelines, HITECH, industry best practices, and HIPAA mandates. We currently use HIPAA compliant methods for ePHI transmission, including Secure File Transfer Protocol (SFTP) for file transfers and VPNs, and Transport Layer Security (TLS) for secure e-mail exchanges. Unstructured data such as e-mail containing ePHI will be protected by our Digital Rights Management technology which ensures that transmitted ePHI is accessible by the intended recipient and cannot be forwarded to unauthorized recipients.

In 2016, we received International Standards Organization (ISO) 27001 certification for our Security Program. ISO 27001 is an internationally recognized gold standard in information security management.

Secure Transmission of ePHI and Sensitive Data through EDI. Our currently implemented EDI subsystem protects file exchanges with access control, authentication, and data integrity protection. We use EDI functional acknowledgements as a further control for assured delivery, data integrity, and record balancing. We support the use of Public Key Infrastructure security for both encryption and sender authentication, which ensures that data files are transmitted un-tampered.

Protecting Against Information Security Risks. To ensure the data housed in our systems and backup systems is protected against intrusion and malicious acts, we currently employ safeguards including:

- Anti-virus and host-based intrusion software on both PCs and servers for malware protection
- Intrusion Prevention Systems (IPS) for advanced network monitoring and defense
- A vulnerability management system that continuously assesses our MIS against a library of existing and new exploits and addresses risks by using firewall rules, administrative controls, and other mitigating safeguards.

Our firewall rules, IPS, and vulnerability management system have been implemented for over six years and all are regularly reviewed and updated to mitigate newly identified risks. Written system process and procedure manuals detailing system procedures for our information management processes and information systems will be made available to KDHE upon request

and our Security Risk Assessments will be updated regularly. We support all HIPAA compliant encryption techniques for external data communications (e.g. SSL, SFTP), implemented across our interoperable MIS, graphically depicted in ***Figure 5.15.U_Internet Encryption***, immediately below.

Figure 5.15.U_Internet Encryption

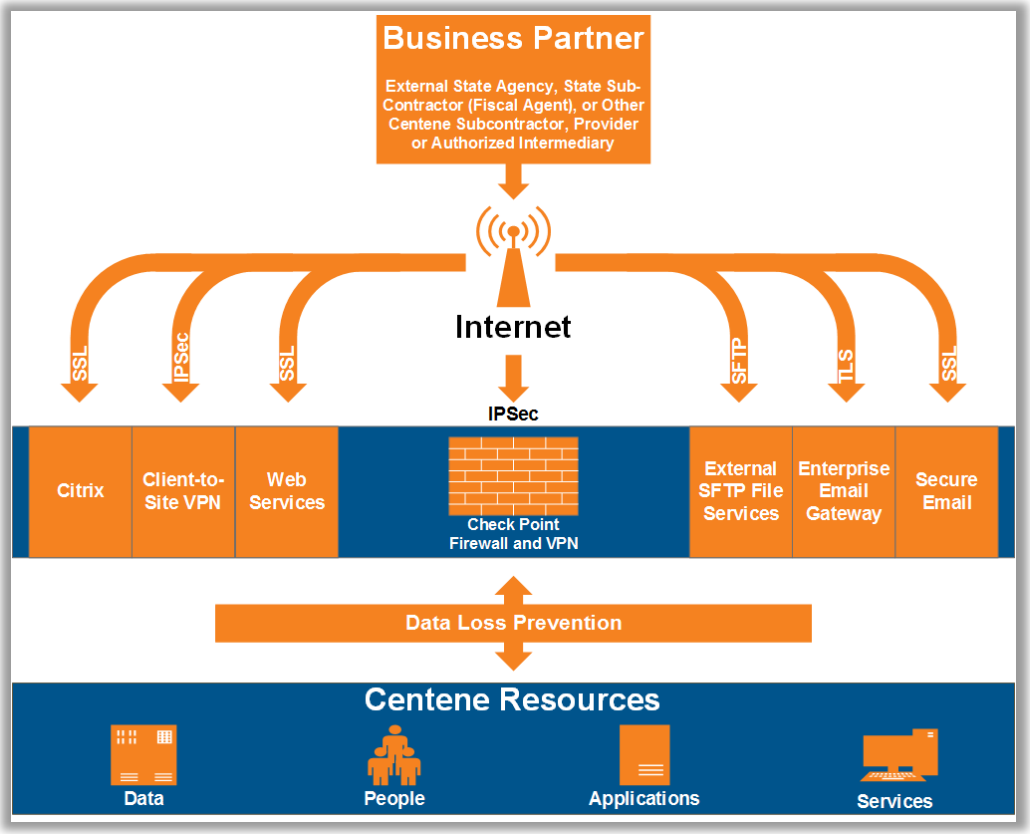


Table 5.15.C_Internet Encryption Components lists corresponding details on the components depicted in ***Figure 5.15.U_Internet Encryption*** above.

Table 5.15.C_Internet Encryption Components

Method	Description
CITRIX	Standard method of client access to the Centene environment. All Citrix protocols are encapsulated within SSL and passed through an additional firewall before access to the environment.
VIRTUAL PRIVATE NETWORK (VPN)	***Client-to-Site VPN:*** IPSec client-to-site VPN used for client access beyond Citrix protocols. ***Site-to-Site VPN:*** Established through Check Point boundary firewalls and IPSec encryption protocols using industry best practices to ensure protection of all communications.
WEB SERVICES	Our internet-facing web applications require use of Secure Socket Layer (SSL) encryption.
EXTERNAL SFTP FILE SERVICES	Centene provides an enterprise-class Secure File Transfer Protocol (SFTP) service for the encrypted transfer of privileged data, including PHI.
ENTERPRISE EMAIL	Centene uses Transport Layer Security (TLS) to encrypt the transmission of Simple Mail Transfer Protocol (SMTP) with any host. Any electronic mail transactions containing unencrypted privileged data (e.g. ePHI) is identified by our Data Loss Prevention (DLP) suite.
SECURE EMAIL	Centene uses Secure Email Gateway to encrypt and transmit email for partners unable to transmit secure email.
DATA LOSS PREVENTION	We use best-in-class Data Loss Prevention (DLP) solutions to safeguard PHI from inappropriate transmission in any information exchange.
DATA AT REST	All confidential data (including PHI) at rest in our MIS servers is secured via our data tokenization system.
MULTI-FACTOR AUTHENTICATION	We recently deployed multi-factor authentication (a second authenticator in addition to a network user ID and password) across our organization as an additional method of verifying a user's identity before allowing access to internal systems, data, and information.

DATA FILE UTILIZATION (5.15.2.B)

Sunflower is the steward of confidential data that belongs to the State and our members. We will continue to only use this confidential information as it relates to the care of our membership and rendering service to the State within the context of our contract with the State. We will not sell, disclose, assign, lease or otherwise dispose to third parties the data entrusted to us without specific prior written approval from the appropriate parties/individuals at the State.

Sunflower will either return to the State or return and destroy all PHI received by Sunflower from the State, or created or received by Sunflower on behalf of the State at expiration, termination or cancellation of our contract with the State.

SAFEGUARDING DATA (5.15.2.C)

Datacenters Ensure Backup of Program Data and Production Systems

Sunflower data is maintained in Centene's two enterprise datacenters that securely house all of Sunflower's core applications and data. Both facilities employ redundant environmental, power, and networking systems, and backup capability, and are hardened to withstand natural disasters. For example, our datacenters have a seismic importance factor of 1.5, and can withstand winds up to 165 MPH. If a site-disabling event were to occur in our primary datacenter, critical voice and networking processes would be redirected to the secondary datacenter within an hour. In addition, the datacenters are connected by a fully redundant WAN to ensure that an outage by either of our telecommunication providers (AT&T and Verizon Communications) will not result in system unavailability.

Core data, including data from systems supporting eligibility/enrollment, provider data management, claims and encounter processing, member and provider services, care, DM and UM is incrementally replicated every four hours from our primary datacenter to our secondary datacenter for the purposes of ensuring we have backed up data offsite that is never more than four hours old. We also perform a full replication of core data to our secondary site weekly. In addition, all database transactions are logged and written to high-speed media daily in our primary datacenter for data and master file backup. We also perform a backup of all application and subsystem software weekly in our primary datacenter. Data, master file, and software backups are performed using IBM's Tivoli Storage Manager, if needed.

Our datacenters, Management Information System (MIS) architecture, and frequent data replication and daily backups allow Sunflower to be prepared for scenarios such as system interruptions or failures that could compromise transaction and/or data integrity in a live or archival system; or other interruptions not threatening to transaction or data integrity, but which could limit access to Sunflower's MIS.

In addition, Sunflower's incident management process classifies unscheduled system interruptions in four severity classifications. These classifications address situations ranging from central computer installation and resident software destruction to system inaccessibility. Each severity classification defines detailed communication plans and clear responsibilities.

HIPAA Standards for Security and Privacy

Our Security Program employs a comprehensive set of reasonable safeguards against the destruction, loss or alteration of all data necessary to the operations performance to help assure that all user access to our systems is appropriate and follows the HIPAA Minimum Necessary Requirement for information accessibility on a "least privilege basis."

Auditing System Access and Usage

Our IT administrators check system log files to identify unauthorized login attempts. We use Rapid7 Nexpose to record the regular recertification by our managers of subordinate access to systems. Our IT Security staff use Spector software for data loss prevention and to audit the appropriate use by personnel of systems, email, and the Internet. Access to critical applications, databases, and operating systems are reviewed by system owners regularly to ensure that employees have access to resources they need for their jobs. Audit trails are currently incorporated into all software components in our MIS and we use Splunk security software, along with master data management methodologies and controls with common "cross application" primary and foreign keys to maintain audit logs and associated transaction reports on user login activity, records viewed/created/modified/deleted, as well as the movement of data from source to processed results. Our structured log management process has been implemented for over five years. Splunk allows for the auditing of individual and batch auditing, and all our core business applications prevent the alteration of finalized records. For example, no AMISYS Advance user can alter finalized claims data. Adjustments and voids against finalized

claims are possible, but no alteration is possible on the original, finalized claim record itself. Similarly, our TruCare system does not allow chronological clinical notes to be edited once those notes are written to the TruCare database. A TruCare user can add to historical notes (and these additions are time stamped and ID stamped), but no TruCare user can edit previously entered notes.

CONFIDENTIALITY OF DATA AND RECORDS (5.15.2.D.1, 5.15.2.D.2)

Sunflower conducts all operations under policies regarding the protection, use and disclosure of member health and enrollment information in accordance with federal and state requirements, specifically those set forth in the 45 CFR, and related laws such as 45 CFR 205.50, CFR 42 Part 2, and the Civil Rights Act of 1964, in addition to all state laws as required. We maintain and annually update these record confidentiality policies and procedures, and make them available online to employees via our enterprise Compliance Management System.

As deemed necessary, we will make this data available for duly authorized representations of KDHE and other state and federal agencies to evaluate the services Sunflower performs. This is accomplished through site visits to Sunflower offices or Centene's corporate datacenters; secure WebEx; Secure File Transfer Protocol (SFTP); or secure remote access for authorized KDHE personnel, as needed. To further support transparency with KDHE, Sunflower can deploy a secure portal for access by authorized KDHE personnel (KDHE Portal), to retrieve information and reports and enhance KDHE's ability for oversight and compliance monitoring, workflow and collaboration with Sunflower, and expanded secure communication capabilities.

Sunflower receives support and guidance from our Corporate Compliance Department partners to ensure we remain adherent to any updates to applicable state and federal regulations. This support comes in the form of research and written guidance, formal training presentations, corporate policies and procedure documents, and carefully drafted business associate agreement templates that Sunflower will be able to personalize for use with our subcontractors and consultants.

Sunflower understands it is necessary that data and information received and maintained in our MIS be utilized only for health policy decisions and research for operational purposes and to ensure the highest quality service to our members. Additionally, any person, agency or other entity requesting access to KDHE data or related information from Sunflower will be directed to KDHE.

PROTECTING CONFIDENTIALITY OF DATA AND PREVENTING UNAUTHORIZED ACCESS (5.15.2.D.3)

Sunflower is a trustee of valuable and confidential information that belongs to our members and state clients, and we rigorously employ the most thorough administrative, technical, procedural and physical security safeguards and processes. We recognize that KDHE reserves the right to approve or disapprove of Sunflower and Centene security procedures and we will adjust these accordingly, as may be required.

Ensuring Confidentiality of Member Information

We currently ensure the confidentiality of all member information by requiring all staff to sign a confidentiality agreement and by only allowing staff and providers to request, access or disclose confidential information as necessary to fulfill assigned duties and responsibilities. We require staff to mark any clinical information sent by mail or fax as “personal and confidential,” and only use secure email to send confidential information. Sunflower’s email system is based on Microsoft Exchange, and has a secure gateway connection to the Internet for email correspondence with any external party and supports industry standard email encryption methods for secure communications, all of which are compliant with HIPAA and Sarbanes Oxley (SOX) rules and regulations. We secure all physical access to clinical information under lock and key and limit access to essential personnel. Staff are currently instructed to destroy all unnecessary confidential information as part of required annual training on HIPAA compliance, and our Compliance Department performs quarterly HIPAA desk audits. All remote access users currently access systems through a Virtual Private Network (VPN) with required two-factor authentication.

Additionally, Sunflower and Centene currently implement enterprise-wide HIPAA Privacy and Security policies and procedures (P&P). These policies and procedures are reviewed annually, but can be edited as necessary to reflect applicable changes in regulations or contractual obligations.

Access Management

We currently implement tiered Role-Based Access Controls (RBAC) for all applications that process PHI. RBAC address security risks by defining employee access rights based on the employee's job responsibilities and security clearance, including whether that employee has inquiry only capabilities. These protections prohibit unauthorized access to the provider and member service components of our MIS and provide auditing support. Global access to all functions is limited to key staff. We have Business Associate Agreements in place for all subcontractors and vendors we employ who have access to PHI.

SECURITY OF FACILITIES (5.15.2.D.4)

Sunflower’s Datacenters

Our MIS is housed in two enterprise datacenter facilities owned by Centene which house our data and voice communications systems, and are securely connected to Sunflower via our internal WAN. Centene datacenter staff follows documented policies and procedures related to requesting, obtaining, monitoring, and auditing access to the datacenter. Our datacenters, and all Sunflower facilities, are currently secured via proximity card access on all external doors, elevators, and internal entry doors on each floor. Our card key system records all access attempts/card swipes whether successful or not. Security guards at our datacenters require that all visitors sign in and out at the front desk, utilize a temporary badge, and are accompanied by an employee when visiting. We also use digital security cameras, smoke and

electrical alarms, security guards who are on duty at all times, and panic switches installed at each reception desk.

Sunflower Offices

Similar to our datacenters, we use proximity card access for entry to all Sunflower field offices, and all filing cabinets or other storage areas where confidential information is stored are locked. Desktop machines are physically locked to fixed structures in our offices. Users who are authorized to have laptops must attach these laptops to docking stations with cable locks or lock those laptops in filing cabinets in their offices when not in use. Sunflower Compliance regularly checks that this policy is followed. To prevent disclosure of PHI, if a device is lost or stolen, access to that device (laptop, iPad, etc.) is automatically revoked and data is deleted remotely by authorized IT staff. In addition, we ensure the security and confidentiality of member information with our staff in the field by issuing lock bags to all who transport documents, requiring home security attestations, and confirming all physical information and relevant equipment is stored under lock and key.

Sunflower management and personnel will continue to comply with the rules of the State regarding access to State offices, data files and data.

RIGHTS IN DATA AND DISCLOSURE OF INFORMATION (5.15.2.D.5)

Sunflower understands, complies with, and will continue to comply with all requirements within section 5.15.2.D.5 Rights in Data and Disclosure of Information, the State Open Records Act, and all applicable State information disclosure regulations and requirements.

SYSTEM CHANGE MANAGEMENT (5.15.2.D.6)

A Best Practice Approach to System Change Management

Our MIS is designed for efficient and accurate system changes via a Service Oriented Architecture (SOA) incorporating microservices accessible via open Application Programming Interfaces (APIs) to service user and application functions in a scalable manner, while enabling rapid deployment of service changes. Our design is also informed by CMS' Medicaid Information Technology Architecture (MITA) with integrated components and open, well-documented, industry-standard application, data, and communication interfaces. All our MIS components feature table-driven, parameter-based configuration utilities, eliminating the need for custom software development and associated implementation risk. As a result, our system change efforts can focus on detailed analysis and precise definition of business rules, ensuring reliable, prompt system changes. Sunflower, backed by Centene, employs a best-practice Scaled Agile Framework (SAFe) approach for MIS system changes. SAFe is a proven implementation of the Lean-Agile methodology to rapid, reliable system changes in large enterprises with complex system needs. Centene's Agile Center of Excellence (ACE) implement SAFe throughout our enterprise to implement changes reliably with minimum time from request to deployment. We use Jira, a best of breed project communication system, to help power our collaborative SAFe change management approach. We also incorporate the Information Technology Infrastructure Library (ITIL) framework for implementation of tested

and approved changes into our production environment. All Centene IT management undergo training in ITIL, which includes best practices for IT service delivery, including change management.

System Change Management

Sunflower is supported by our centralized Organization Change Management (OCM) department. OCM assists Sunflower staff through change processes and proactively identifies and addresses potential concerns through impacted stakeholder analysis, communication, training, and adoption strategies. In addition, all system changes are controlled by our centralized Change Advisory Board, a multi-disciplinary team of IT operations, development and security professionals who meet twice weekly and serves as the primary gateway of a system change and move into production. Sunflower uses ServiceNow, an ITIL-based workflow application for integrating multiple aspects of MIS service delivery to ensure IT change processes are effectively managed and communicated in an auditable manner, whether internally initiated, requested by KDHE, or federally or otherwise mandated.

State Requested or Mandated Changes. State requests are received by Sunflower's Compliance Officer and/or Systems Director, who will record requests in our Compliance Management System for tracking of State commitments. Our Compliance Department notifies affected Sunflower departments of the change request, who examine requests and implement changes. For instance, Sunflower receives regular requests for new and modified reports, and follows the above process to successfully implement and adhere to these reporting changes. Additionally, we continue to successfully receive, implement, validate and deploy any changes to the PDLs and PAs issued by the State, in conjunction with our PBM, and their formal change process (see Section 5.15.1.G above). We receive PDL and/or PA changes at a minimum monthly from the State, and our change process will allow us to implement these mandated changes for KanCare 2.0 within required timeframes.

Tracking Federally or Otherwise Mandated Modifications. Our Compliance Department and centralized Legal and IT Security Departments monitor relevant federal mandates at large (e.g. published in the Federal Register), IT mandates related to security, and federal mandates relevant to our contracts with the State. We use our Compliance Management System to organize, manage, and document our compliance with specific federal mandates.

Communication (5.15.2.D.6.A). We communicate system changes to staff via ServiceNow, email, and our company Intranet site. When a change affects members and providers, we use appropriate combinations of direct mail, fax, outbound automated call campaigns, Interactive Voice Response (IVR) messaging, call scripting for inbound calls, Explanation of Payment (EOP) notices, email distribution lists, and public website notices. We communicate changes to the State through our Compliance Officer or Systems Director who engages the assigned change PM to offer the State any information needed. Our Compliance Officer, Systems Director or his authorized delegate will notify the State at least 90 days before the projected date of any

change impacting KDHE or any material software release updates to our core transaction systems, conversions of our core transaction systems, or new system implementations.

Should KDHE report a problem not resulting in system unavailability, our Compliance Officer and/or Systems Director will document the issue, respond in writing to KDHE within seven calendar days of KDHE's notice to us with our resolution plan, and we will either resolve the identified deficiency or supply KDHE with a requirements analysis and specifications document within 20 calendar days. Through our change management system, we will track our correction of the problem by an effective date to be determined by KDHE.

Initial Planning Process. Identifying Changes. Our SAFe process establishes roles and responsibilities necessary to identify, document, and deploy changes. We identify changes to:

- Implement new capabilities that enhance services in an innovative fashion
- Enhance or reengineer an existing process to improve overall efficiency and service
- Implement new contractual requirements from KDHE

As part of our annual Technology Refresh process, we review all computing related equipment and assess our current IT deployment compared with the latest product versions from our vendors and the projected business needs for the following year. A plan is then developed aligning architecture with need. Through our IT Systems Refresh process, we also introduce a controlled process of test and deployment routine system maintenance and capacity updates that are planned and introduced well before performance issues might arise. For any new MIS assets that we need to acquire (hardware, software, or services), we follow a disciplined procurement process following our audit standards. This further assures that updates and functional enhancements blend into our overall MIS architecture in a cost-effective manner and operate as intended with no adverse impact on our operations.

Valid Window for System Changes. As part of our best practice approach to low risk implementation of system changes, neither we, nor our subcontractors, schedule system unavailability (e.g. to perform system maintenance, repair, or upgrades) during hours that could compromise or prevent critical business operations. We will continue to follow this policy, unless otherwise agreed to in advance by KDHE.

Testing. We use SAFe change methodology and ITIL-based production controls to test upgrades from the software suppliers of our core MIS applications (e.g. claims, eligibility) before release. This approach is employed for software development, configuration changes and functionality testing of individual system components. We perform system integration, regression and user acceptance/quality assurance testing in test environments to determine how changes in one component impact others. If needed, we also perform stress tests using NeoLoad load simulation software to model the effect of user, network and batch process loads on the overall system.

Testing Process. Testing is completed by our IT Quality Assurance Team, developers, and other stakeholders, and is completed iteratively in rapid cycle fashion with development and configuration changes to ensure that desired functionality works accurately and as expected based on change requirements. The process requires peer review by our software development professionals to ensure consistency with ITIL-based principles of software design and security compliance. Progress is tracked in ServiceNow, which includes auditable record of changes and approvals. Once changes are thoroughly tested and approved by the Change Advisory Board, and Sunflower and Centene management as needed, changes are moved into our production environment.

Sunflower will support any KDHE required testing initiatives when needed, including systems integration testing for future KDHE initiatives. We have the capacity to provide test environment details, including provisioning specific test accounts (e.g. SFTP directories) required for integrated testing with KDHE upon authorized written request.

Production Control Operations. Our HIT uses Event Monitoring Architecture (EMA) technology to help ensure availability and reliability of our production control operations. Our EMA technology includes system availability monitors and dashboards, incident management tools, and software agents that monitor subsystems, applications, data and voice network, capacity, and end user response time. We undergo several regular internal and external audits, including our annual SSAE-16 and Sarbanes-Oxley Section 404 Management Controls audits, to continually test the effectiveness of our production controls.

Monitoring. On behalf of Sunflower, Centene also continuously monitors all infrastructure components for system performance and availability. If we experience a system failure or interruption, a notice is automatically sent to our centralized Incident Response Operation Center (IROC), which takes appropriate action, including resolution and recovery, root cause analysis, and corrective action plans if needed. Upon notification of an incident from any source, our Systems Help Desk classifies incidents by severity incident level to manage and restore disrupted services as soon as possible.

An Iterative Capability and Capacity Assessment Process. When new technologies, or significant changes to existing technologies, are needed, our IT Department leverages the Service Design process. New technology requests in the Service Design queue are evaluated and assigned to an architect and design lead. At weekly Service Innovation Meetings with leads from each technology area, design leads outline their request and gather feedback, ensuring all aspects of the enterprise are considered. If approved, additional technology evaluations (research, demos, completing scorecards, etc.) occur to find the preferred solution. Findings are presented at weekly Service Review Meetings and if granted approval, the request proceeds to Technology Design. Once a final design is approved by all members of the Design Team, it is presented at the next Service Review Meeting. Upon final approval of the design, the request is closed, and technology implementation begins.

The Service Design process provides a unified, consistent approach for technology selection and design; drives costs down by offering visibility to existing technology to increase reuse; identifies new technical and business integration points; and confirms that technology supports organizational standards and best practices. By leveraging Service Design, IT can provide industry leading technology solutions that are reliable, secure, supportable, scalable and feature-rich.

In addition to Service Design, our IT Security staff perform Information System Capability Assessments (ISCAs) to assess Sunflower's performance and capabilities according to ISCA guidelines.

A System Designed to Nimbly Respond to Change Requests. Sunflower's systems are specifically designed to efficiently accommodate changing expectations surrounding our programs and technology. We introduce system changes using the SAFe approach, ensuring quality-control processes are in place to prioritize and implement changes efficiently. We follow a defined Change Request (CR) Process for resolution with our in-house Centene Systems Group (CSG). For instance, if a coding issue causes claims to be erroneously denied, we work with the CSG Claims Configuration Team for resolution. The Claims Team conducts several levels of testing to confirm the accuracy of the CR, with changes moving into claims system testing and production accounts. On average, this type of project is complete within 45 days of the CR submission. Program changes, such as implementing a minor change to benefit payment, also follow the CR Process, as these typically involve technology updates to adhere to program changes.

Business Continuity-Disaster Recovery Planning

Sunflower will use our HIPAA compliant enterprise MIS to meet the provisions surrounding system availability, problem notification, business continuity, risk management and disaster recovery in Attachment J of the Scope of Work. Our integrated BC-DR plan includes comprehensive and clearly articulated policies and procedures; is compliant with HIPAA, State, and federal regulations; and meets all requirements described in Attachment J of the Scope of Work.

Our BC-DR processes are designed to handle the complete spectrum of disruptive events, including a worst-case disaster, such as work site destruction, or office inaccessibility requiring recovery at alternate locations. Our BC-DR plan provides detailed information on the specific activities needed to respond to the disruptive event and restore business functions, units, processes and operations in a safe, effective, and rapid manner. Our BC-DR plan includes call lists, risk and impact analysis, contingency plans, alternate location instructions, key vendor listings, and necessary supplies and information for recovery staff.

Information System Architecture. Our highly available architecture is comprised of widely available industry standard, best in class hardware, software, and networking technologies for:

- Virtualization platforms (e.g., VMWare, Citrix)

- Operating systems (e.g., Windows, Linus, HP-UX)
- Application software (e.g., AMISYS Advance – claims processing)
- Hardware components (e.g., Cisco, Hewlett-Packard, Avaya).

Our architecture includes blade servers, virtualization, clustering, SAN technology, and hardware redundancy including near real-time failover for critical applications. As discussed above, our parent Centene owns and operates two enterprise datacenters that securely house all core Sunflower applications and data. This allows all our critical systems function available to members and providers (eligibility/enrollment, claims processing systems, etc.) to be available twenty-four hours a day, seven days a week (24/7), except during periods of scheduled system unavailability agreed upon by the State and Sunflower. All other system functions and information is available to the applicable system users Monday through Friday, 7 am to 7 pm. Additionally, Sunflower will ensure that the systems and processes associated with our data exchanges with the State and/or its agent(s) are available according to specifications and the data exchange schedule.

Limiting Service Interruption. If a site-disabling event were to occur in our primary datacenter, in which the datacenter is destroyed or damaged, critical voice and networking processes would be redirected to the secondary datacenter within an hour, with total restoration of services implemented within forty-eight (48) hours of the official declaration of system unavailability. In addition, our datacenters are connected by a fully redundant WAN to ensure that an outage by either of our telecommunication providers (AT&T and Verizon Communications) will not result in system unavailability.

Our secondary datacenter can recover telecommunications operations and restore critical member care and provider payment services well within 48 hours of the failure's or disaster's occurrence.

Sunflower supports continuously available call services through telephony networking redundancy and available back-up staffing from our Topeka and Wichita office locations, as well as our Regional Service Center (RSC) in Atlanta, Georgia, further ensuring member and provider access to services and supports. Sunflower's key employee functions are backed up by staff trained to take on responsibilities at the RSCs. In the event of a natural disaster or pandemic, business functions relying on our telecommunications system have top priority, specifically our customer service call center. We have engineered several levels of redundancy in our phone system hardware, software, and networking, with automated rerouting of inbound calls to RSCs if the Sunflower call center experiences a communications failure.

Continuity of Claims Processing Operations. Centene supports Sunflower's claims operations from Great Falls, Montana, which has its own BC-DR plan refreshed annually. The claims center in Montana is securely networked for voice and data connectivity with both datacenters, as well as Sunflower offices and our RSC. Our automated claims workflow system can instantly route Sunflower claims workload to this center, with staff trained to handle Sunflower claims, if needed.

Problem Notification. Our BC-DR plan has a structured communication process used to update Sunflower staff, subcontractors, and the State in the event of a disaster. Designated coordinators reach out to staff and subcontractors via email. For instance, we have a dedicated Local Response Team (LRT) that takes part in our Crisis Management conference calls and directly reaches out to vendors during emergencies. All impacted Sunflower and Centene staff are notified using our emergency notification service upon declaration of a disaster/crisis. The notification system can send voice, SMS – text messaging, and email messages to all work contacts, including identified personal emails, as well as provided personal and emergency contacts of employees. We also utilize SnapComms internal communication channels to push desktop alerts and tickers directly to specified staff members.

As part of the notification process, Sunflower will promptly notify State staff of problems jeopardizing systems availability and performance. Sunflower staff will remain in contact with the State via email within one (1) hour of discovery, and provide hourly status updates on problem resolution. Additionally, Sunflower has consistently demonstrated its dedication to notifying the State of any problems through the MCO Problem Notification Form. At the request of the State, Sunflower will formulate Corrective Action Plan (CAP) if needed within five (5) business days of a problem's occurrence.

During emergency situations, Sunflower also can update our member website to provide emergency-appropriate information, including tips for preparation, alerts and updates, and service outage notifications.

A Thoroughly Documented Plan. BC-DR plans are available to our staff on our secure internal Intranet, as well as through our BC-DR planning software. Our BC-DR software enables us to make the BC-DR plan readily available at any time, with high availability thanks to secure cloud based storage. In addition, each member of the Sunflower Business Continuity LRT and department managers keeps a hard copy of the BC-DR plan offsite to ensure accessibility.

Performance Monitoring Process. Sunflower's centralized Incident Response Operations Center (IROC), a team of systems analysts, engineers and management, continuously monitors all production systems, including claims and encounter processing, as well as any remote offices 24/7/365 for system performance, service availability, and capacity utilization to anticipate and address situations before problems arise. If we experience a system failure or interruption, the IROC immediately invokes response and restoration procedures, and activates a temporary Command Center with a pre-designated Crisis Management (CM) team, inclusive of Sunflower management, that ensures critical business functions are recovered and restored. Our Systems Help Desk responds with a well-defined incidence management process with the primary objective of managing and restoring unexpectedly disrupted/degraded services.

Event Monitoring System Testing.

Continual Testing of System Performance. As discussed above we use event monitoring architecture (EMA) tools to continually identify and test system performance problems, including system monitors, incident management tools, and software agents from leading suppliers that monitor subsystems, applications, data and voice network, capacity, and end user experience. Strategically placed SolarWinds probes, for example, emulate user access to critical applications (claims/encounter processing), providing metrics that assist in the prediction, isolation, and diagnosis of application events, and provides data that aid in capacity planning, performance measurement, and service level reporting activities. Our System Performance Dashboard provides performance metrics like system defects, average transaction response times, and error tracking for core processing systems to identify trends in performance problems.

Corporate IT Disaster Recovery (DR) Plan Tests. Sunflower and Centene conduct annual full-scale testing of our HIT recovery capabilities. As part of this exercise, we perform a "hot-site" information technology test, also known as a Disaster Recovery (DR) Exercise. The last annual Information Technology DR Exercise was conducted successfully in September 2017. Validation of recovered applications assured IT staff that our HIT could deliver our systems in an emergency and validate confidence in our datacenters' capabilities. We will make the results of our DR exercise available to the State upon request, and will deliver a CAP within ten (10) business days of test conclusion should our results indicate failure.

Sunflower and Centene's last annual IT Disaster Recovery Exercise was conducted successfully in September 2017 – further validating our systems recovery capabilities.

Mock Exercises. We perform multiple mock scenario tests throughout the year to test specific situations, including the actual restoration of IT operations, systems, and data recovery, errors surrounding network, operating hardware, software, or operations that compromise transaction integrity, as well as our ability to restore local operations. Mock exercises are also opportunities to retrain staff regarding responsibilities during a crisis. Exercises change each year to ensure alertness to reasonably anticipated situations in Kansas that may impact delivery of care.

Table Top Plan Review. Sunflower's comprehensive BC-DR plan will continue to be formulated, maintained, and refreshed on an annual basis. Each year the BC Department, Sunflower's leadership team, key departments, and BC liaisons will participate in a formal table top review of the entire BC program, which includes a read through of the current plan and an update of all materials. We then will conduct a scenario-based exercise to assure we address all factors related to both short and long-term business interruptions that could cause a disruption in operations.

5.16 Reporting and Data Collection

5.16. REPORTING AND DATA COLLECTION

SUNFLOWER DEMONSTRATED SUCCESS

Sunflower Health Plan (Sunflower) is committed to supporting KDHE's reporting and data collection strategy, focused on data integration, analytic capabilities, and data centricity. Between 2015 and 2017, Sunflower successfully submitted over 1,400 reports to KDHE.

- Since 2015, Sunflower's timely submission has improved from five to six days prior to the State's due date, on average.
- In 2017, the number of KDHE-accepted reports increased to from 89% to 95%.
- Sunflower has helped the State to develop innovative reporting solutions, such as through our collaborative work on both the Customer Service and Step Therapy Reports.

Compliance with Scope of Work (SOW)

As incumbents, Sunflower is currently in compliance with all KanCare Contract requirements, and all KanCare 2.0 requirements described in Section 5.16 and Attachment H of the SOW. Below, we describe our targeted and refined systems, processes, and controls for ensuring timely, accurate, and complete data collection and reporting, for all standard and ad hoc report requests by KDHE. Sunflower also affirms our support of the Kansas Medicaid Modular System (KMMS) planning and implementation, and we are deeply committed to assisting KDHE to achieve its goals for the modular MMIS. Moreover, for ease of review, we have included SOW references in headers, and within the narrative, where applicable.

OVERVIEW

LOCAL EXPERTISE IN DATA COLLECTION AND REPORT PRODUCTION (5.16, 5.16.A, 5.16.B)

Since 2013, Sunflower has developed and maintained streamlined reporting processes, driven by Kansas-based staff, and has successfully met all KanCare reporting requirements in the timeframes and formats set forth by the State. Sunflower will continue to meet all KanCare 2.0 Contract requirements, and affirms our commitment to KDHE's internal reporting efforts to project and mitigate risk and care gaps, assess inefficiencies, promote quality, and reduce costs.

Between 2015 and 2017, Sunflower submitted over 1,400 reports to KDHE.

Providing Data Elements and Reports in KDHE Formats and Frequencies (5.16.A, 5.16.B)

Given Sunflower's demonstrated success, we are fully prepared to meet KanCare 2.0 Contract requirements, including those outlined in Attachment H. We will do so by performing standard and ad hoc reporting in the timeframes prescribed by KDHE, and will provide data elements and reports, including from subcontractors, in KDHE-defined formats, methodologies, and frequencies. We will continue to affirm, in writing, our understanding of State reporting requests, methodologies, and required submission timelines. Sunflower also ensures that data elements contained in our Enterprise Data Warehouse (EDW) map appropriately to the data elements defined by KDHE, for inclusion in KDHE's data warehouse.

SUNFLOWER'S TECHNICAL EXPERTISE AND STAFFING MODEL (5.16.C, 5.16.F.4)

Since the start of the KanCare Contract, Sunflower has worked to build the capacity of our Reporting Staffing Model, to better support our reporting and data collection processes, exceed reporting requirements, and support the State and our members effectively. Sunflower allocates the majority of reporting responsibilities to two teams: **Analytics and Compliance**.

Sunflower Analytics Team (5.16.C)

The Sunflower Analytics team is responsible for the development and execution of all standard and ad hoc reports for KDHE, including quality controls to meet reporting requirements, and innovative clinical informatics solutions. Within the Analytics team, staff either focus their efforts on reporting and data Analytics, by working on operational reporting initiatives, or clinical informatics, by working on impacting health outcomes for Sunflower's members.

Technical Expertise and Job Titles (5.16.C, 5.16.F.4). Led by our Chief Data Analytics Coordinator, Sunflower's Analytics team is made up of a Supervisor, Manager of Clinical Informatics, and a team of Data Analysts. These 10 Analytics staff have 82 cumulative years of experience working in the field of data collection, reporting, and analysis, and have a diverse set of educational credentials including: MS in Bioinformatics, MPH concentrating in Clinical Informatics, MS in Mathematics, MBA concentrating in Information Sciences, and MBA concentrating in Health Care Administration. Below, we outline the job description of our Chief Data Analytics Coordinator in more detail.

Sunflower's Analytics team of 10 have 82 cumulative years of experience working in the field of data collection, reporting, and analysis.

- **Chief Data Analytics Coordinator.** Responsible for ensuring accurate, timely, and efficient reporting, and input of data related to all core business functions: provider data, clinical data, member data, and other data types. The Chief Data Analytics Coordinator reports directly to Sunflower's Vice President of Operations/Systems Director.

Sunflower Compliance Team (5.16.C)

The Compliance team, who has three staff dedicated to providing oversight of reporting, is responsible for final quality checks and submission of all reports to KDHE. In addition to Sunflower reporting operations, the Compliance team is also charged with the administration and management of Sunflower's compliance efforts.

Technical Expertise and Job Titles (5.16.C, 5.16.F.4). Led by our Compliance Officer (CO), Sunflower's Compliance staff, who are dedicated to supporting Sunflower reporting, include a ***Supervisor of Compliance***, and a ***Senior Compliance Analyst***. These three staff have 35 cumulative years of experience working in the field of Compliance, and have a diverse set of educational credentials including: MA in Sociology, BS in Marketing, and MPH in Administration. Two of these staff have also obtained a Certification in Health Care Compliance (CHC) from the Compliance Certification Board, while one of these staff has an additional Certification in Health Care Privacy Compliance (CHPC) from the same organization. Below, we outline the job description of Sunflower's CO in more detail.

Sunflower's three Compliance staff who support reporting functions, have 35 cumulative years of experience working in the field of Compliance.

- **Compliance Officer:** Sunflower's CO serves as the local Privacy Officer, and as the liaison to KDHE. The CO is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the KanCare Contract, including reporting requirements. The CO is also responsible for ensuring Sunflower's policies establish effective lines of communication between the CO, Sunflower staff, and KDHE staff, and that all internal policies are followed. The CO reports directly to Sunflower's CEO/Senior Executive, and the Board of Directors.

DATA SYSTEMS, PROCESSES, AND QUALITY CONTROLS (5.16.D, 5.16.E, 5.16.F.1-3, 5.16.G, 5.16.J.3)

Ensuring Quality Subcontractor Data (5.16.D)

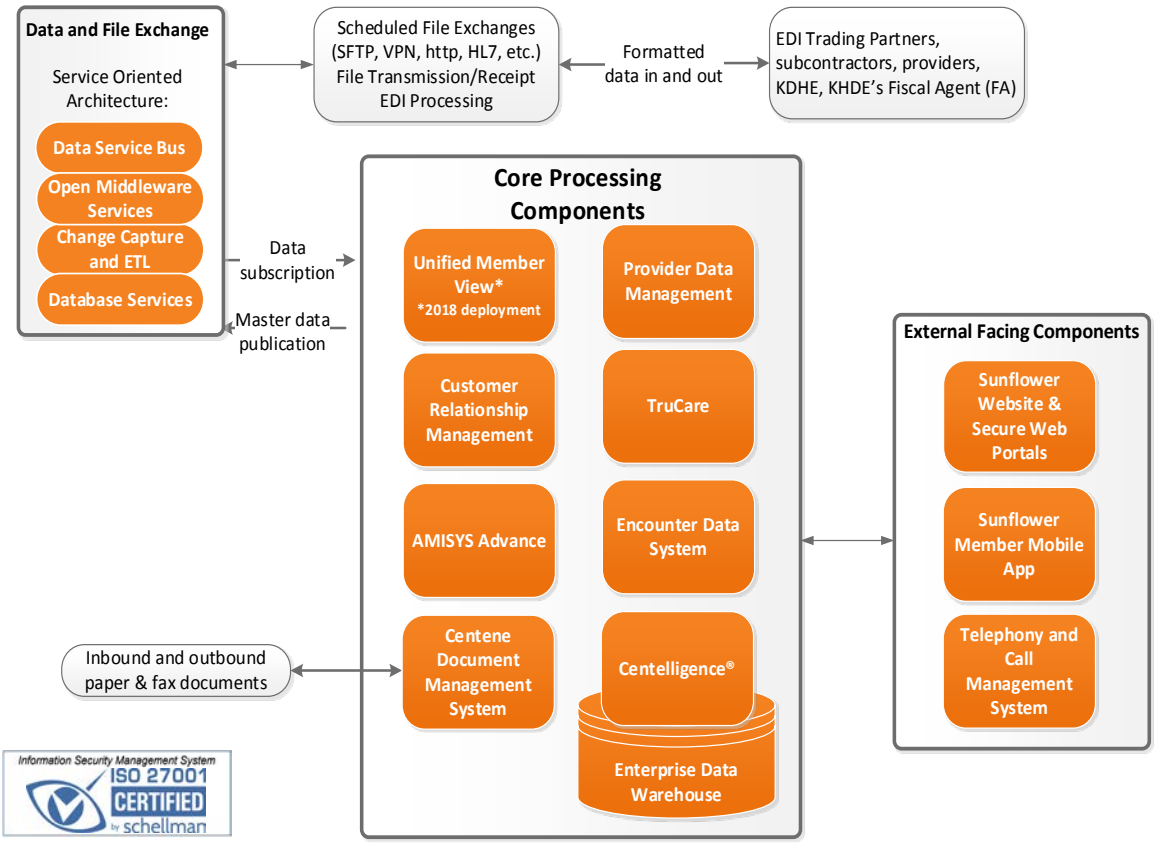
Sunflower understands that we are solely responsible for overseeing subcontractors, ensuring they deliver high-quality data, and that they are compliant with all Contract requirements related to State reporting. Therefore, we take an engaged, proactive approach with subcontractors, involving transparent, detailed communication of reporting requirements, and early communication when reporting issues arise. To this end, Sunflower follows the best practices outlined below.

- **Attend Quarterly Subcontractor Meetings**. Attending quarterly subcontractor meetings enables bidirectional communication, and the ability to proactively identify data issues.
- **Require Subcontractors to Submit Monthly and Quarterly Compliance Reports.** Monthly and quarterly reports from subcontractors enable us to track and confirm subcontractor performance metric compliance, and hold subcontractors accountable for performance.
- **Engage in Subcontractor Pre-Delegation and Re-Assessment.** Our pre-delegation and annual re-assessment processes enable review and enforcement of subcontractor policies.
- **Apply CAPs or Financial Sanctions.** Per contractual agreements with our subcontractors, CAPs will be applied if performance metrics related to encounter submission are not met. We will monitor subcontractors until all data compliance issues have been fully resolved.
- **Review New Requirements and Ad Hoc Requests.** When new, revised, or ad hoc reports are requested by the State, Sunflower's Subcontractor Oversight and Analytics teams will meet with subcontractors to ensure all new report requirements are understood.

Data Ingestion, Transmission, Generation, and Exchange Processes (5.16.E)

Sunflower's interoperable Management Information System (MIS) supports Secure File Transfer Protocol (SFTP) data exchanges with KDHE and other external trading partners (e.g., subcontractors), including daily and monthly HIPAA 834 enrollment and eligibility files, encounter reporting data, and provider files. In addition, our MIS also supports web service interfaces for use with the State's planned KMMS. We use Coviant Diplomat Transaction Manager (Coviant) to handle automated data exchanges with KDHE, which systematically checks for HIPAA code set compliance of HIPAA transactions, and for Health Level 7 transactions. Data flows to and from our Centelligence® Data Service Bus, the heart of our Service Oriented Architecture (SOA), and Coviant protects data exchanges with access controls, authentication, and secure configuration for data integrity during transmission. See ***Figure 5.16.A_Sunflower's MIS: Internal and External Data Flows.***

Figure 5.16.A_Sunflower's MIS: Internal and External Data Flows (5.16.E & 5.16.F.3)



Centelligence Data Service Bus Routes Data from Internal and External Partners (5.16.F.3)

Informed by MITA 3.0 design principles, the Centelligence Data Service Bus is an integrated set of open middleware services, including Java Messaging Services (JMS), implemented through standards-based SOA software; Request/Reply and Publish/Subscribe transaction messaging services, implemented through our Informatica Change Data Capture (CDC) middleware; Extract/Transform and Load (ETL) processes, also implemented with Informatica; and open

database connectivity interfaces, including Open Database Connectivity (ODBC) and Java Database Connectivity (JDBC). When Sunflower receives files from KDHE, our middleware routes that data to appropriate MIS components, and our Centelligence Data Service Bus routes data to and from our integrated core processing systems, including those outlined below.

- **Member Data Management/Unified Member View (UMV)**. Sunflower will implement an advanced member data management tool, our UMV system, which will further facilitate the management of all informational aspects of our members' relationship with Sunflower, across current and historic benefits, and product eligibility.
- **Customer Relationship Management (CRM).** CRM enables Sunflower to identify, engage, and serve our members and providers in a holistic and coordinated fashion.
- **Provider Data Management (PDM).** PDM enables core provider function management.
- **TruCare.** TruCare is our clinical care management and utilization management system.
- **AMISYS Advance (AMISYS).** AMISYS is our claims processing engine that enables us to process both medical and behavioral health (BH) claims.
- **Encounter Data System (EDS).** EDS is our encounter reporting system.
- **Centene Document Management System (CDMS).** CDMS enables us to complete document receipt, indexing, data conversion, and storage.
- **Centelligence**. Centelligence is our core health informatics platform, which supports our data warehousing, analytics, predictive modeling, and reporting capabilities.

Data Validation and Report Quality Control Checkpoints (5.16.F, 5.16.G, 5.16.J.3)

Sunflower's data validation and report quality control best practices, informed by our ***Sunflower Health Plan State Reporting Program*** Policy and Procedure, aim to improve reporting processes and eliminate erroneous or duplicate data. Sunflower will participate in all subcontractor data validation activities required by the State, prior to report submission. See ***Attachment 5.16_F Sunflower Health Plan State Reporting Program.***

- **Report Development.** When developing a State report, which is an iterative process, Sunflower's report Technical Owners (TO's) engage in the validation of data completeness and accuracy in accordance with State-outlined specifications.
- **Subject Matter Experts (SMEs).** Throughout a report's lifecycle (i.e., development, execution, maintenance, audit, report improvement) many SMEs will encounter that report. Whether it be Sunflower staff, staff from our parent company, or subcontractors, the SME's knowledge can enable them to validate report data.
- **Report Requirement Change or Issue.** When a report issue, or new report requirement arises, it is the responsibility of the Business Owner (BO), in collaboration with the Analytics team, to lead ad hoc meetings for review and discussion of key issues or changes.
- **System-Based Controls.** As an operating principle, our EDW presumes that inbound data is inappropriate for loading until validations are complete and data errors are within tolerance range. For example, our EDW can automatically reject data at the file-level when the number of errors in the file exceed tolerances. Our EDW performs quality checks horizontally, vertically, referentially, and temporally (trending) to ensure data quality.

- **Service Oriented Architecture of our MIS**. The SOA of our MIS, along with our master data management (MDM) approach to data storage, ensures that data is represented and stored accurately, completely, and uniquely (e.g., no discrepancies, errors, or duplicates).

Change Control Process (5.16.F.1). Sunflower has a formal change control process, and follows detailed, documented procedures when changing report data content and structure, or applications and processes. All report changes are initiated through our Change Management System, a process workflow, approval, and documentation tool, with a formal Change Request (CR). Through the CR process, the requestor provides information regarding the type of change, description of systems, and Sunflower operational areas affected. This information is used to evaluate the risk of the change, and will determine the required levels of approval necessary before the change is completed and migrated into production. Also, both configuration and program changes are tested by our technical staff and the end user before being submitted for production. To keep BOs informed, our Change Management System sends electronic updates at key points throughout the CR process, and as needed. Moreover, all report content, structure, application, and process changes are implemented with the goal of improving data collection and reporting timeliness, accuracy, and completeness.

Feedback Mechanisms to Improve Report Timeliness, Accuracy, and Completeness. Sunflower's key feedback mechanism for learning about opportunities to improve report content, structure, applications, or processes, is through our five-level internal report peer review process. By sending all reports through five levels of review, reports content and structure, along with the applications and processes used to produce reports, are able to be vetted thoroughly. If reviewers become aware of any report errors or inefficiencies, they would immediately notify the TO, who would submit a CR to resolve the issue, improving Sunflower's compliance and report timeliness, accuracy, and completeness. See ***Figure 5.16.B_Five-level Peer Review Process for Timely, Accurate, and Complete Reporting.***

Figure 5.16.B_Five-level Peer Review Process for Timely, Accurate, and Complete Reporting

Ensuring Compliance with Data Submissions (5.16.F.2).

Tools and Methodologies to Ensure HIPAA-Compliance and Data Integrity. To ensure that data submissions are HIPAA-compliant, Sunflower uses EDIFECS XEngine (EDIFECS), which validates claims data against required data structure rules and syntax. EDIFECS tests that conditional rules requiring secondary fields are accurate and complete, and ensures that data is in compliance with HIPAA Transaction Companion Guides. We use EDIFCES, in conjunction with Coviant, to support a wide range of data transmission acknowledgement protocols, and use these acknowledgements of data exchanges with KDHE as a control for assured delivery, data

integrity, and record balancing. We support the use of Public Key Infrastructure (PKI) security, not only for encryption, but for sender authentication purposes. Doing so ensures that data is transmitted un-tampered, and that receivers can validate the data's sender.

Tools and Methodologies Used to Determine Compliance with State Report Submissions.
Our Compliance Management System is a leading governance, risk management, and compliance software system that allows Sunflower to effectively administer and monitor our internal governance, as well as our contractual and regulatory oversight capabilities. Our Compliance Management System provides for workflow-enabled policy and procedure formulation (with total history of documentation and sign-offs), distribution of documents to appropriate internal departments and subcontractors, systematic tracking of compliance activities (also with auditable records of management approval and cited Contract and regulatory mandates), and ongoing, proactive assessment of compliance risks.

Sunflower frequently checks KDHE's Reporting System to stay informed of any rejected reports. Further, our Compliance staff uses our Compliance Management System to document key KDHE communications related to report status, in addition to continually monitoring all issues of noncompliance until they have been fully resolved. The Compliance team escalates issues of report noncompliance to the appropriate department and the Sunflower CEO/Senior Executive. Through our Compliance Management System, our parent company is also able to track and monitor report compliance-related communication from KDHE to Sunflower.

STATE REPORTING SYSTEMS, PROCESSES, AND QUALITY CONTROLS (5.16.H, 5.16.I, 5.16.J.2-7, 5.16.1.A)

Report Creation and Clinical Informatics (5.16.1.A)

Sunflower's comprehensive Centelligence health informatics platform collects, integrates, analyzes, and reports key data elements, and we will use this system to comply with all the reporting requirements outlined in Section 5.16 of the Contract, and listed in KanCare's Reporting System. Further, Centelligence's family of integrated decision support and health care informatics solutions produce actionable information and reports, including care gap and wellness alerts, key performance indicator dashboards, provider clinical profiling analyses, population level health risk stratifications, and Sunflower operational reports. Centelligence enables Sunflower to perform the following activities, among many others. ***See Table 5.16.A_Examples of Centelligence Capabilities.***

Table 5.16.A_Examples of Centelligence Capabilities

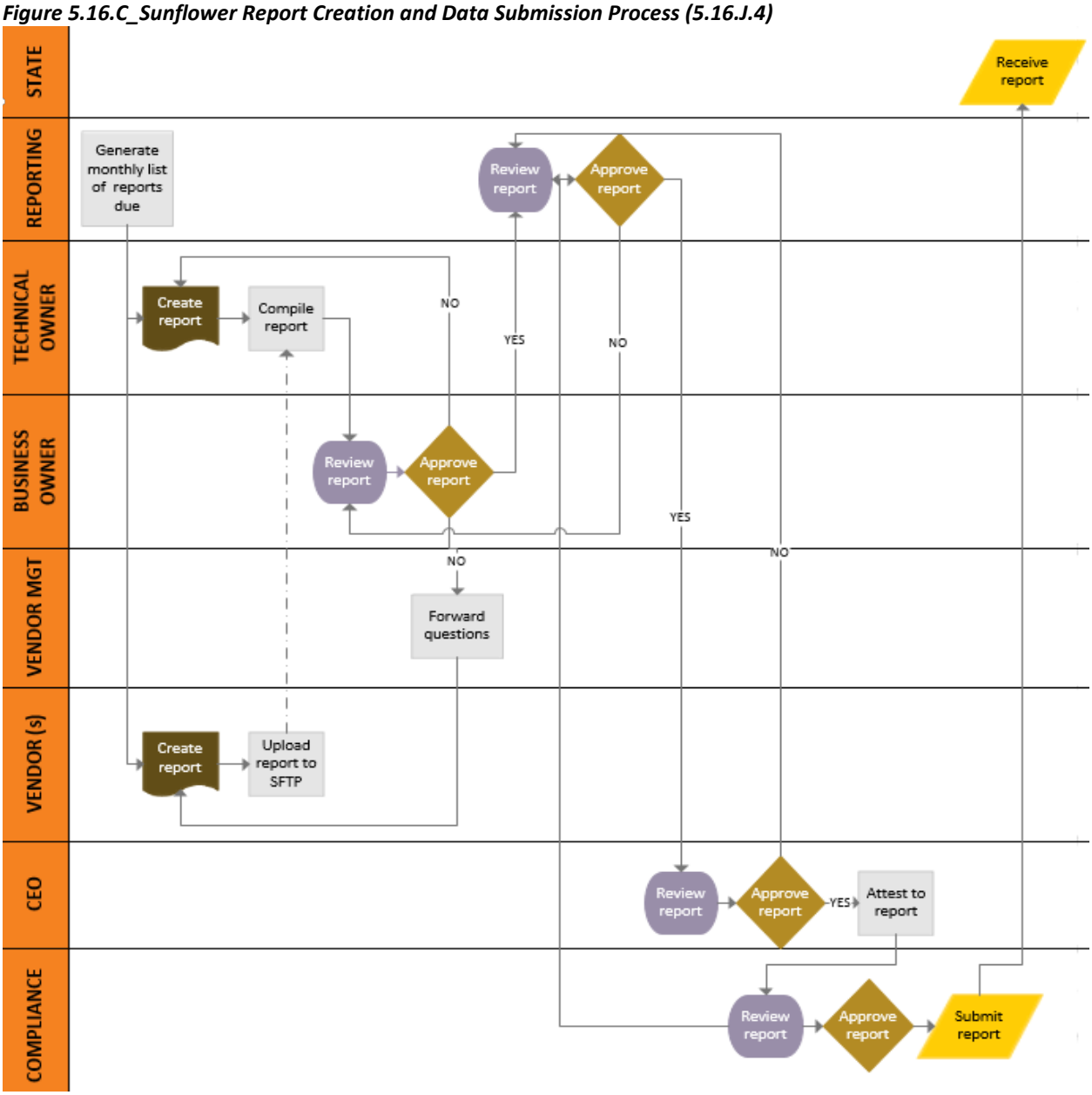
Centelligence Capability	Description
HEDIS Reporting	Centelligence includes our NCQA-Certified HEDIS Engine for quality reporting. Our reported HEDIS rates are audited annually by Attest Health Care Advisors, licensed by NCQA to conduct HEDIS Compliance Audits. EDW feeds member and claims data into its HEDIS Engine component, which then delivers NCQA-Accredited HEDIS reports.
Predictive Modeling	Centelligence provides our multidimensional, episode-based predictive modeling and care management analytics tool, which uses clinical, risk, and administrative profile information

Centelligence Capability	Description
	obtained from physical, behavioral, and pharmacy claims data, and lab test value data, to identify members who may need care management.
Flexible Reporting	Centelligence offers desktop reporting and online key performance indicator dashboards with "drill down" capability.

Centelligence: Powered by our Enterprise Data Warehouse. At the heart of Centelligence is our EDW, powered by Teradata's Extreme Data Appliance relational database management system technology. Our EDW continuously receives, integrates, and analyzes internal and external data, enabling Sunflower's analysts to efficiently extract and send any file, dataset, or report directly to KDHE via SFTP or secure e-mail. Claims data is continuously staged from AMISYS to the EDW, and nightly batches are loaded into the analytical and reporting layers.

Data Extraction, Report Types, and Data Submission (5.16.J.4). For ***standard reports***, Sunflower analysts extract data directly from the EDW, which enables us to control the parameters of the data we pull, and better ensure report timeliness and accuracy. Analysts automate standard reports using auto scheduling software, informed by the scheduling frequencies set forth by KDHE. For ***ad hoc reports***, analysts either use Centelligence report templates, our Centelligence ad hoc report builder, or extract and query the data directly from the EDW. Sunflower staff follow a comprehensive report creation and submission process involving five levels of peer review and approval, to ensure report accuracy and completeness. See ***Figure 5.16.C_ Sunflower Report Creation and Data Submission Process***. However, for new reports, we implement seven levels of peer review and approval to better ensure that reports are accurately developed from the start. Sunflower will continue to work with KDHE to receive approval on report formats, ensuring consistency across reporting for KDHE.

Figure 5.16.C_Sunflower Report Creation and Data Submission Process (5.16.J.4)



KDHE Portal to Foster Reporting Transparency. In an effort to increase transparency, Sunflower has the capability to offer KDHE a secure portal for access by authorized State personnel, with KDHE's approval. Through this secure portal, KDHE can retrieve reports, and enhance their ability for oversight, compliance monitoring, collaboration, and expanded communication abilities with Sunflower.

Clinical Informatics. In addition to data collection and reporting, our Analytics team engages in clinical informatics, driving evidence-based practice, improved care quality, care gap closure, and cost reduction for Sunflower, and our partners. Examples include the following activities.

- **Provider Profile Care Gaps Algorithm and Report.** Sunflower's Clinical Informatics staff developed a proprietary algorithm to identify members with care gaps, and appropriately match members to providers. With this information, our Clinical Informatics staff create a Provider Profile report that informs providers on where they stand compared to other providers on a variety of quality measures, such as member adherence for eye exams, and their A1c test. Provider Profiles are sent to providers throughout the year, specifically when opportunities for improvement or care gap closure arise.
- **Preferred Prenatal Care Quarterly Report and Incentives**. Sunflower has developed a provider incentive program where contracted providers are incentivized to provide timely prenatal care for members. In tandem, our Clinical Informatics staff have developed a proprietary algorithm to analyze notification of pregnancy (NOP) data to identify if pregnant members have completed a timely prenatal visit in their first trimester. Quarterly reports are sent to providers, giving them detailed and high-level views of members' prenatal visit timeliness, and the provider's incentive history.
- **Algorithm to Identify New Pregnant Members within our Providers' Geographic Area.** Sunflower uses a proprietary algorithm to identify newly enrolled pregnant members who live in areas geographically close to in-network provider offices. This daily list of new, pregnant members enables Community Health Service Workers to target outreach and inform/assist members in receiving prenatal care with in-network providers near them.

Combination of Key Fields Needed to Identify Services (5.16.J.2)

Accurate service identification in our data records supports KDHE's KanCare program administration, and allows KDHE to establish actuarially sound capitation rates. Our MIS monitors data field accuracy, which allows us to analyze service line item details linked back to the original data, and to ensure all key fields are populated when data are submitted. We also ensure that Third Party Liability (TPL) data is indicated as billed by the provider, whether at the service line or claim level. We regularly monitor and utilize all resources available, such as updates to the KanCare Guide and companion guides, in order to ensure we stay up to date on data submission specifications, and consistently provide all key fields, per KDHE requirements.

Data Quality Controls, Coding Consistency, and Consistency across Data Sources (5.16.J.3)

Sunflower engages in a variety of data controls to ensure coding consistency and consistency across data sources. First, our SOA, and the near real-time Informatica Change Data Capture capabilities of our middleware, integrate and consolidate data, creating meaningful and actionable data and reports. Additionally, our data quality controls include multiple levels of accountability, from data lineage tracking to active data cataloguing, helping to ensure that valid, reliable, and accurate data are obtained. Finally, our EDW design assures that data is logically collected, conveying an accurate representation of Sunflower's operations.

Sunflower's data integration and naming/formatting standards also enable consistency across data sources, and are based on the same goals and principals of CMS' Medicaid Information Technology Architecture (MITA) 3.0 standards. Our databases also enforce American National Standards Institute (ANSI) standard data types. Our EDW provides the master cross reference of

our data names and formats, and systematically maps each data element name, and contextual use information with equivalent metadata, for each production application. From an external user perspective, our data has the same functional name and use, and at the application database level, names are mapped via our EDW. Through the EDW's centralized repository of code lists, we enforce all industry-standard code sets and formats, including HIPAA-mandated sets. For data formats not governed by industry standards, we enforce formats used in the system of record of that data element.

Tracking, Trending, and Monitoring Data Submissions and Revisions (5.16. J.5)

Report Data Submissions. Sunflower's Analytics team maintains an internal documentation system to track all State report submissions, including detailed report submission information (e.g., report name, submission date, and submitter's name). As a part of this documentation system, Sunflower also tracks when reports are rejected, the reason for rejection, the changes made for resubmission, and the resubmission date.

Report Data Revisions. Sunflower is also careful to track that all State report change requests have been received, acknowledged, documented, and completed. When report change requests are received from the State, Sunflower uses the same internal documentation system to track the name of the report that is being changed, the assigned Sunflower BO, the report production frequency, the State-required report changes, and the description or details of the change, including when the report change notification was received, and what action has been taken to implement the requested change.

Noncompliance (5.16.H, 5.16.I)

Sunflower understands that we will be held responsible for errors or noncompliance resulting from our actions, and that we are responsible for ensuring that all data complies with State quality standards, including changes to data or reports. Sunflower will accept all State-administered sanctions, should we ever be out of compliance, or fail to correct noncompliance within KDHE's timeframe.

Implementing Timely Corrective Action Plans (5.16.J.6)

Sunflower understands that in order to be effective at swiftly mitigating reporting noncompliance, either internally at Sunflower, or with subcontractors, we must adhere to timely processes for developing and implementing CAPs. Sunflower will submit a CAP within 15 calendar days following notice. The CAP will include details regarding a timeline and specific actions proposed to correct deficiencies. Sunflower understands that in the event a deficiency is not cured, KDHE could impose a sanction, as defined in Attachment G of the Contract.

Tools and Methods to Determine Compliance (5.16.J.7)

With Sunflower's rigorous Compliance processes and methodologies, supported by our Compliance Management System, we will meet all current and new reporting compliance

requirements. Our Compliance Management System, a leading governance, risk management, and compliance software system, enables the following processes and methodologies.

- Administration and monitoring of internal governance
- Contractual and regulatory oversight
- Workflow-enabled policy and procedure formulation
- Distribution of documents to appropriate internal departments and subcontractors
- Systematic tracking of compliance activities
- Ongoing, proactive assessment of compliance risks
- Monitoring State-rejected reports, and resubmissions, by documenting all related communications from KDHE, and tracking subsequent report re-submission

5.16.1. REPORTS AND AUDITS

KANSAS-BASED TEAM ENSURES HIGH-QUALITY KANCARE 2.0 REPORTING (5.16.1.A)

Sunflower's expert Kansas-based staff, streamlined reporting processes, and Centelligence health information system for data collection and reporting, enable us to deliver high-quality KDHE reports, as outlined in Section 5.16 of the Contract, Attachment H, and the KanCare Reporting System. During Sunflower's KanCare tenure, we have used our robust foundation of reporting resources to effectively partner with KDHE, ensure that we deeply understand KDHE's reporting and data collection needs and challenges, and modify Sunflower's reporting formats and processes to reflect these needs. For example, throughout the current Contract period, we have had ongoing contact with KDHE, including monthly in-person meetings and regular electronic and telephonic communication. Sunflower's Kansas-based reporting team has also enabled us to respond expediently to KDHE's reporting requests, including modifications to report specifications, templates, formats, or timetables, without compromising report accuracy, completeness, or timeliness. Sunflower has also ensured that regardless of report modifications, all reports are auditable. Due to our demonstrated success with the State, and the efficiencies realized by our refined reporting processes and technology, Sunflower is confident that we will continue to honor our reporting commitments for KanCare 2.0.

Collaborating with KDHE

Sunflower has aimed to be a key partner to KDHE throughout the KanCare Contract period. Two examples of when we successfully

Sunflower in Action…

Customer Service Report. *When an increased need for data integrity in the Customer Service reports arose, Sunflower partnered with KDHE to overcome unique data challenges related to efficiently and accurately bringing in internal and external data sources from multiple subcontractors, and in multiple file formats. We aimed to ensure report data integrity by modifying data elements in our code and data sets, and educated our staff on the new categories, to ensure reports were created accurately the first time.*

Step Therapy Pharmacy Report. *In response to a legislative policy requiring members to start on generic pharmaceuticals, Sunflower collaborated with KDHE to develop an algorithm to determine the impact of this policy. This algorithm, which eventually became a shared algorithm to produce the Step Therapy Pharmacy report for all three KanCare managed care organizations (MCOs), was the product of several meetings with KDHE and Sunflower, and has helped the State to determine the policy's value.*

collaborated with the State on reporting processes are: the Customer Service report and the Step Therapy Pharmacy report.

TIMELINESS, ACCURACY, AND COMPLETENESS OF REPORTS (5.16.J.1, 5.16.1.B, 5.16.1.C)

Ensuring Data Received from Participating Providers is Accurate and Complete (5.16.1.B)

Sunflower understands that we are solely responsible for the quality of all data and reports delivered to KDHE, including subcontractor data, and our front-end data collection and claims editing processes reflect this. We will continue to use provider and subcontractor claims data to supply reports to KDHE and all other partners. Further, since claims data is a primary Sunflower data source, we place a high value on ensuring that these data are accurate and complete. The following processes and controls help us secure high-quality reporting data, and ensure that reports are accurate, timely, and complete.

- **Flexible Claims Submission Options.** We encourage providers to efficiently submit claims, and give them flexible submission options to do so. We support over 100 direct connections with regional clearinghouses and provider groups to ensure ease of EDI claims submission. We also support submission through KMAP's clearinghouse; direct data entry submission options on our secure Provider Portal, including our LTSS Claims Wizard feature; submission through our multi-payer portal; and receipt of paper claim forms.
- **Reporting.** Through EDI reports, Sunflower can identify patterns of inaccurate claims, galvanizing our Provider Relations staff to provide targeted provider technical assistance.
- **Provider Training.** Sunflower will use a blend of training and support to ensure providers realize the importance of submitting accurate, timely claims for all services rendered. To this end, we offer in-person claims training; webinars; access to Clear Claim Connect, where providers can check adjudication logic prior to claims submission; access to our online EDI Ramp Manager system, allowing providers to on-board through interactive EDI testing and certification for direct EDI HIPAA file submissions; and supplemental support from our EDI Help Desk and Provider Relations staff, as needed.
- **Claims Liaisons.** Our Claims Liaison staff provide additional support, investigation, research, and guidance on claims related issues identified by our Customer Service Representatives and LTSS Claims team. If a question or issue arises, our Claims Liaison staff are assigned to research the claim issue and provide guidance on the best course of action. Depending on the research, the claims may be resubmitted for reprocessing, system updates may be implemented, or provider education may be requested.
- **Inbound Claim Edits.** Upon claim receipt, our HIPAA compliance checking software validates data against ASC X12 HIPAA Version 5010 syntax for data structure, tests for conditional rules requiring secondary fields, and helps ensure data is in compliance with HIPAA Technical Review Guides, Kansas's Medicaid MCO Companion Guides, HIPAA operating rules, and the MCO System Manual as we process the claim. This helps assure that KDHE reports are made up of the highest quality data.
- **Edits and Audits Performed During Adjudication and Payment.** Once our MIS checks submitted claims for HIPAA compliance, completion, and valid information, those claims are electronically loaded into AMISYS for adjudication, where a unique transaction number

and time stamp are assigned to all claims, linking together all available information. AMISYS applies Sunflower rules for covered services; verification of member eligibility for dates of service on the claim; matching of claim to service authorizations, provider network status, and provider eligibility to render the services on the claim; and application of appropriate fee schedules. AMISYS also performs edit checks for copays, TPL, and Medicare, and performs automated clinical and fraud, waste, and abuse edits, until the claim is finalized to a paid or denied status. Adjudicated claims are also reviewed prior to payment for duplicates. After claim adjudication, all data elements from the claim are stored in the EDW, enabling us to create HIPAA-compliant encounters.

- **Ensuring Quality Subcontractor Data.** In order to facilitate clean and accurate data streams from subcontractors, we attend quarterly subcontractor meetings, require subcontractors to submit monthly and quarterly compliance reports, engage in subcontractor pre-delegation and annual re-assessment processes, apply CAPs or financial sanctions, and hold subcontractor meetings to go over requirements of new reports.

Since 2015, Sunflower report submission to KDHE has improved from five to six days prior to deadline, on average.

Delivering Timely Reports (5.16.J.1 & 5.16.1.B). Sunflower is committed to delivering timely reports to KDHE, and will submit all reports on or before the scheduled due dates, outlined in the table below. Our commitment to timely reports is also evidenced by the implementation of internally-driven quality controls, ensuring we adhere to, and exceed, the State's deadlines. For example, if a monthly report is due to KDHE on the 20th of every month, Sunflower requires the report to be submitted internally one week prior, in this case, the 13th. See ***Table 5.16.B_Sunflower Early Report Submission Due Dates.***

Table 5.16.B_Sunflower Early Report Submission Due Dates

Report Frequency	Sunflower Vendor Internal Due Date	Sunflower Internal Due Date	State Due Date
Weekly	Monday by 1pm	Monday by 3pm	Monday by 5pm
Monthly	10th of the Month	13th of the Month	20th of the Month
Quarterly	15th of the Month	23rd of the Month	30th of the Month
Annually	15th of the Month	23rd of the Month	30th of the Month

In addition to internal deadlines, the flowchart below outlines other quality controls put in place to ensure timely report submission. See ***Figure 5.16.D_Quality Controls to Ensure Timely Reporting.*** All of these controls have successfully reduced the number of late State reports since 2015 from 10% to 1%. Sunflower has also demonstrated our ability to submit reports early, an indicator of our commitment to report timeliness**.** Early report submission has improved from five to six days prior to deadline, on average.

Figure 5.16.D_Quality Controls to Ensure Timely Reporting

Delivering Accurate and Complete Reports (5.16.J.1 & 5.16.1.B). Sunflower ensures that all reports are accurate and complete, as defined in the Contract, by employing a multi-level peer review process. We require all new reports to go through seven levels of peer review starting with the BO through the CEO/Senior Executive and CO. Once reports have been created, approved, and automated for the first time, any time thereafter, there are only five levels of peer review. Due to this process, Sunflower has increased the percent of KDHE-accepted reports from 89% to 95%. Sunflower will continue to prioritize the implementation of strong quality controls to ensure that KDHE receives accurate and complete reports, the first time, for KanCare 2.0.

In 2017, the number of KDHE-accepted reports increased to 95% with only 5% returned or needing more information.

Ensuring Reporting Compliance through the QAPI Program (5.16.1.B). All Sunflower reporting is subject to frequent review, under our Quality Assessment and Performance Improvement (QAPI) program, to ensure reports are exceeding quality standards. In 2016, Sunflower was working to implement a new grievance and appeals report template, and identified that member grievances were not being addressed in accordance with the Contract. Sunflower was not meeting the requirement for 98% of grievances to be acknowledged within 10 calendar days, and 98% of member grievances to be resolved within 30 calendar days. Upon discovering this issue, Sunflower took swift action to address it, including prompt, transparent communication with KDHE, developing and sharing an action plan for remediation, and taking immediate corrective action. Corrective actions included the following activities:

- Identification of the noncompliance root cause
- Identification of corrective interventions and action implemented on the problem cases
- Education of Sunflower staff to resolve root causes and prevent further occurrences
- Revision of the work process related to member grievances to support compliance
- Monitoring data, processes, and outcomes until sustained compliance was met

Following the corrective action, Sunflower demonstrated immediate improvement the following quarter on both acknowledgement and resolution metrics, along with maintaining sustained performance in alignment with the Contract. Sunflower will continue to engage in the QAPI program to identify, analyze, and mitigate instances of report noncompliance.

Standard and Ad Hoc Reporting Requests (5.16.1.C)

Sunflower uses scheduling software to automate reports in the appropriate format and frequency, including any modifications or revisions that KDHE sets forth. For standard reports, analysts extract data from the EDW, and for ad hoc reports, analysts either use report templates, our Centelligence ad hoc report builder, or extract and query data from the EDW. All reports include standardized elements to ensure that data is comparable across all MCOs.

Long-Term Services and Supports and Behavioral Health Ad Hoc Report Requests (5.16.1.C). In the event that KDHE cannot secure operational data through existing reports, at KDHE's request, Sunflower will expediently deliver desired ad hoc reports. Our EDW houses key LTSS and BH metrics, which can be leveraged to complete ad hoc reporting requests within the timeframe outlined by KDHE.

REPORTING COMPLIANCE (5.16.1.D-K)

Corrective Action Plans (5.16.1.D)

If Sunflower, or any of its subcontractors, is found to be out of compliance with the Contract, through a report submission, filing, examination, audit, survey, inspection, investigation, or substantiated Grievance and Appeal, we will submit a CAP within 15 calendar days following State notice. Key details in CAPs, are not limited to, but will include the following.

- A problem statement
- Members found to have been affected by the deficient practice(s)
- Immediate action(s) taken to resolve issues of members who were impacted by the issue
- Specific actions proposed to correct the deficiency
- Sunflower staff member(s) responsible for the implementation of the CAP
- A date for when the CAP will be implemented, including a timeline of incremental steps
- Measurement(s) used to evaluate CAP implementation outcome(s)

Sunflower in Action…

Since 2013, Sunflower has been successful in only receiving one CAP, to which we acknowledged and responded to the request promptly, and with a detailed proposal to address the noncompliance. Sunflower attributes this to its organizational emphasis on removing any system compliance issues, and progressively and proactively addressing any person-centered compliance issues.

Sunflower understands that in the event that a deficiency is not cured, KDHE could impose a sanction, as defined in Attachment G of the KanCare 2.0 Contract.

Audit Procedures and Record Retention (5.16.1.E-I, 5.16.1.K)

Audit Procedures (5.16.1.E-I). Sunflower will work in cooperation with any Federal or State agency request to inspect, audit or reproduce needed records. These agencies will have access to Sunflower, our parent company, and any subcontractor offices, as necessary to conduct inspections or audits. Sunflower has undergone numerous audits over the last five years, all of which we have fully cooperated with. The Compliance team has a dedicated staff person who

coordinates these audits, interacts directly with the State contact, and ensures that audits are completed in line with the Contract. This includes everything from logistics of the onsite, to organizing and submitting requested documents. Sunflower staff are actively engaged in all audits, and Compliance fully reviews all reports from the State, establishing plans to meet the subsequent requested or required process changes, in response to audit findings. Further, Sunflower will also ensure that our parent company, and all subcontractors, will provide the results of an annual audit, performed by an Independent Certified Public Accountant, to the State.

Record Retention (5.16.1.K). Sunflower, in accordance with its Records Retention policy, will retain all records and materials, including financial records, relating to Sunflower's provision of and reimbursement for all activities related to the Contract with KDHE, for no less than a period of ten years.

Identification of Patients to Make Disproportionate Share Hospital Payments (5.16.1.J)
In order to calculate Disproportionate Share Payments, Sunflower will provide KDHE with all information necessary to determine the hospital services provided under the KanCare 2.0 Contract, in addition to the information needed to identity the hospitals providing these services. The aforementioned information will be leveraged from our encounter data and submitted to the State in the format and frequency determined by KDHE. We will also provide any additional data requested throughout the Contract period to meet this need.

5.16.2. IMPOSITION OF SANCTIONS

UNDERSTANDING OF REPORTING COMPLIANCE AND SANCTIONS (5.16.2.A 1-7)

Sunflower understands the gravity of compliant reporting, and will continue to make every attempt to ensure compliant reporting procedures. If Sunflower foresees that there is potential for noncompliance, we will be transparent, and remain in constant communication with KDHE. If Sunflower ever falls out of compliance regarding reporting, we will ensure timely resolution of the noncompliance, as outlined by KDHE in Section 5.16 of the Contract. Sunflower understands the potential consequences of report noncompliance, such as suspension of further enrollment, suspension of capitation payments, liquidated damages, and termination of the Contract, and will comply with all sanctions incurred as a result.

5.16.3. HIGH LEVEL SCOPE OF WORK OF KMMS

5.16.3.1. KMMS BACKGROUND

Sunflower enthusiastically supports the State of Kansas, KDHE, and fiscal agent (FA) DXC in the development and implementation of the KMMS as it prepares for an increasing number of health care reform initiatives. Sunflower's own modular MIS stems from a design based on Service Oriented Architecture (SOA) and is based on the same goals and principals used by the Centers for Medicare and Medicaid Services (CMS) MITA 3.0 standards. Because of this, we have a deep understanding of how to achieve these standards and we possess the expertise to work with the State, KDHE, and DXC in their journey toward meeting the objectives and goals

for a modular MMIS in alignment with MITA 3.0 realized through successful implementation of KMMS.

As a user of the existing MMIS that has been in operation since 2002, and due to our history of supporting providers with related training and response to provider inquiries, we acknowledge that Sunflower will be involved in the planning and support of the implementation of the KMMS. Our same locally-based Provider Relations team and Customer Service Representatives will also support providers through training and timely response to service inquiries for the KMMS. Together, these two teams will work collaboratively to proactively engage providers on use of the KMMS. Our Sunflower Information Systems Director/Manager, in addition to our corporate IT Department, will support the planning and implementation aspects of KMMS and we're deeply committed to assisting KDHE to help the State achieve its goals for the modular MMIS. Our State MMIS, system interface, and technology experience and expertise demonstrates Sunflower's ability to support KDHE in their journey toward a modernized MMIS that meets CMS' Seven Conditions and Standards (7C&S) that promotes industry standards for information exchange and interoperability.

State MMIS, System Interface, and Technology Experience

Sunflower has demonstrated successful connectivity with KDHE, DXC, First Data, KHIN, and others, including our current interface with the Authenticare EVV system and Web Services Definition Language (WSDL) messaging interface with the MMIS to process claims with potential Spenddown involvement.

Through Sunflower's parent company, we have over 33 years of experience interfacing with state MMIS and fiscal agent systems, now serving over 7 million Medicaid members in 24 states. Our interoperable MIS has connections with Health Information Exchanges (HIEs) across numerous states, including our affiliates in Texas, Florida, Arizona, Arkansas, and Indiana. Our HIE connections leverage use of real time Application Programming Interface (API) web services supporting clinical data exchanges. Although we recognize the industry is moving toward APIs/Representational State Transfer (REST) web service interfaces, we still also support Simple Object Access Protocol (SOAP), WSDL messaging, and Web Services (WS-Security) in alignment with our 'no wrong door' approach to connectivity. Through our parent company, we have also demonstrated our ability to flexibly interface with other state systems possessing various levels of technological sophistication, including interfaces with Statewide Area Child Welfare Information Systems (SACWIS) for foster care programs and state public health department information systems for exchange of immunization data. We will leverage the IT expertise and resources of our parent company to implement real time web services interfaces between our MIS and KMMS.

We also have previous experience in working with technology partners, such as Cerner Corporation (Cerner). For example, our parent company worked previously with Cerner and our Texas affiliate to successfully design, develop, and deploy a secure web-based Electronic Health Record system in the service of children in the Texas foster care health plan. We will bring this

past experience in working collaboratively with technology partners, such as Cerner, to support the State's KMMS implementation with DXC.

5.16.3.2. KMMS ARCHITECTURE

KMMS Framework (5.16.3.2.1)

Sunflower has reviewed the proposed KMMS framework and State framework of the modernized, modular MMIS, including the modules representing the eight major categories of shared services. Sunflower affirms our understanding of the KMMS framework, which utilizes the Oracle®1 Service Bus for the SOA platform, Business Rules Engine (BRE), and Oracle Identity Management (OIM) for security roles, in alignment with the CMS Leverage Condition.

Interoperable MIS Ready to Interface with KMMS

Sunflower's interoperable MIS has the capability to interface with the MMIS using the framework and protocols depicted in Figure 1 in Contract section 5.16.3.2.1, including the ability to use shared services via the Enterprise Service Bus (ESB). Underpinning our MIS components is an architecture based on reliability, scalability, data integration, and interoperability, which enables us to interface our systems to the MMIS' Oracle Enterprise Service Bus (ESB) and KMMS framework for a modernized MMIS. Many of our own core and critical systems utilize an ESB for integration, further aligning with the MMIS's Oracle ESB and KMMS framework. Our MIS provides for flexible, low-risk implementation of interfaces via an architecture comprised of integrated components with industry-standard application, data, and communication interfaces. For example, our MIS is designed with micro services accessible via open APIs to service user and application functions in a scalable manner, and we support other web services such as SOAP, Representational State Transfer (REST), Web Services Definition Language (WSDL) messaging, and WS-Security.

Our MIS design allows us to implement connectivity quickly and reliably with KMMS. Our Coviant Diplomat Transaction Manager handles automated exchanges (transmission and receipt), and protects our exchanges with access control, authentication, and secure configuration features for data integrity protection during transmission. Our network backbone is highly redundant, allowing maximum network availability, enabling us to reliably interface with KMMS. All our MIS components conform to federal and State laws and feature table-driven, parameter-based configuration utilities that eliminate the need for custom software development and associated implementation risk.

Responsibilities of the MCOs (5.16.3.2.2)

Understanding MITA 3.0 Goals and Implementation of the KMMS Framework (5.16.3.2.2.A).

Sunflower understands and affirms our capability to fulfill our responsibilities as it relates to the KMMS. We affirm our commitment to helping the State achieve the MITA 3.0 standards and successful implementation of the KMMS framework. Through our parent company, we've demonstrated our investment to MITA 3.0, including a comprehensive assessment by our corporate Enterprise Architecture team to ensure our own MIS is in alignment with these standards. Given our own experience with MITA 3.0 and history of working with states

implementing MMIS interfaces, we are positioned strongly to work with the State throughout their KMMS implementation.

Implementing Web Service Interfaces (5.16.3.2.2.B). Sunflower will work with the KME and DXC team to implement real time web services interfaces for exchanging data between Sunflower and KMMS using standard-based protocols. In alignment with our 'no wrong door' approach, our MIS has the capability to support real time secure web services with the KMMS using SOAP, REST web services/APIs, WSDL messaging, and WS-Security to service user and application functions in a scalable manner. We have the capability, through our Centelligence Gateway, to exchange data with KMMS using HHS Office of National Coordinator (ONC), standards-based clinical data interchanges, including the Health Level Seven (HL7) Fast Healthcare Interoperability Resource (FHIR) and NCPDP. And today we use Public Key Infrastructure (PKI) based approaches for many production internal and external file and transaction purposes.

Supporting the Vision of Accessing Applications through Single-Sign-On (5.16.3.2.2.C)
Sunflower supports KME's vision to access applications through Single-Sign On (SSO). We are able to effectively support KME's vision because we have existing knowledge and experience with leveraging SSO within our own security models. For example, we use a centralized directory and authentication service that all applications and systems can use for authentication purposes and play the central role in coordinating identity and access management policies. Through this methodology, we ensure access to information, systems, and applications are limited to the user's access management profile while providing administrative ease so that users do not have to actively enter their credentials more than once.

Experience Working with State SSO Efforts. In addition to our own internal expertise with SSO, we have experience in working collaboratively with states in their efforts to develop SSO. For example, our Texas affiliate has worked with their State agency and its MMIS contractor on a SSO interface. This SSO effort allows our Texas affiliate providers to seamlessly access the State agency's system through their own secure Provider Portal, using encrypted Security Assertion Markup Language (SAML) tokens. The SSO's role based access control capability allows our Texas affiliate authorized providers to immediately access information all available via one login to their secure Provider Portal. Sunflower will bring this knowledge and experience to help support KME in their vision of SSO for their applications.

Across our affiliates, our MIS processes approximately 99 million inbound and over 810 million outbound membership record transactions per year.

Use of Standard EDI HIPAA Transactions (5.16.3.2.2.D). Sunflower supports and promotes data interoperability and secure exchange of information through the Electronic Data Interchange (EDI) subsystem of our MIS and has the capability to securely interact with KMMS. We support HIPAA secure file exchanges with KDHE and the KMMS, other trading partners, other state

agencies, providers, subcontractors, and HIEs, including all industry standard EDI HIPAA transactions, such as ANSI ASC X12N file formats. Today, we have an extensive network of connectivity and we support over 100 direct connections with regional clearinghouses and provider groups to ensure ease of EDI transactions. The EDI subsystem protects file exchanges with access controls, authentication, and data integrity protection. We use EDI functional acknowledgements as a further control for assured delivery, data integrity, and record balancing. We support the use of PKI security for both encryption and sender authentication, which ensures that data files are transmitted un-tampered. Once received, our Centelligence Data Service Bus, an integrated set of open interoperability middleware services, routes data to and from our core processing subsystems. EDIFECS XEngine is our HIPAA compliance checking software that validates data against required data structure rules and syntax ensuring data is in compliance with standard HIPAA transaction formats.

Compliant with Required HIPAA Transaction and Operating Rules. Sunflower complies with rules related to HIPAA, and certifies the truthfulness, accuracy, completeness, and timeliness of data submitted to KDHE, or other agencies, per 42 CFR 438.242.18 and 455.19. Our scalable MIS is fully adherent to industry standards, including Strategic National Implementation Process (SNIP) compliance Levels 1 through 5, and HIPAA Security and Privacy Rules (45 CFR 160, 162, and 164). We verify all providers and subcontractors' HIPAA 5010 and NCPDP compliance through our delegation oversight process, and verify our member communications are compliant with federal Section 508 standards and Web Accessibility Initiative guidelines. We also comply with the following rules: HIPAA Security, HIPAA Privacy (45 CFR 160 and 164, and 42 CFR Part 2), HIPAA Transaction and Code Set (TCS) (45 CFR 162), CAQH CORE Operating Rule Sets (Phase III certification), all the rules and regulations of our state Medicaid partners, and the most recent Administrative Simplification provisions regarding EFT and ERA.

Alignment with KME's Goal to Meet CMS' Seven Conditions and Standards (5.16.3.2.2.E)
Because our MIS architecture is already aligned with the CMS' 7C&S, Sunflower is well-positioned to help KME meet their goals. Our own MIS currently meets the 7C&S by:

- ***Adopting data and industry standards***, such as the Scaled Agile Framework (SAFe) approach for system change, Information Technology Infrastructure Library (ITIL) for implementation of tested and approved changes, security policies informed by the International Standards Organization (ISO), a globally recognized information security framework, and National Institute of Standards and Technology (NIST), and the OAuth 2.0 framework, an industry-standard protocol for data authorization
- ***Promoting secure data exchange*** through use of PKI and protection of electronic PHI through access controls, intrusion detection, and data loss prevention technologies
- ***Promoting reusable components*** through standard interfaces and modularity
- ***Promoting efficient and effective data sharing*** through our Centelligence Gateway for HHS ONC, standards-based data interchanges, including HL7 FHIR, Continuity of Care Document (CCD)/Consolidated Clinical Document (C-CDA) exchanges, and other standardized health information transactions

- ***Providing a member-centric focus*** through design of public websites, secure web portals, and mobile apps, designed to make information easily accessible to members, such as our mobile-friendly Sunflower website, which detects what type of mobile device a member is using and adjusts presentation accordingly
- ***Supporting interoperability and integration*** using open architecture and data standards by securely transmitting and receiving data in all open industry, state proprietary, and government mandated format
- ***Supporting integration of clinical and administrative data*** to enable better decision making via our high performance Enterprise Data Warehouse (EDW) powered by Teradata technology, an integral component of our Centelligence health informatics platform

Coordination with KME and DXC for Implementation and Testing Activities (5.16.3.2.2.F-I)
Sunflower will mobilize corporate executive, business, and technical resources experienced in their respective areas with our existing Kansas operations to coordinate with KME and DXC on implementation and testing initiatives performed by KME and DXC. Our Sunflower Information Systems Director/Manager, will serve as the primary liaison between our corporate IT Department, DXC, and KME to help with facilitation and coordination activities related to interface implementation and testing, providing test data for non-production environment testing, and participation in end-to-end testing of modules. In addition, we will work with KME and DXC to implement changes due to future MITA versions. We will meet as frequently as KME and DXC desires to ensure the project remains on track.

5.16 Attachments

POLICY AND PROCEDURE

sunflower health plan

DEPARTMENT: Compliance	**DOCUMENT NAME:** Sunflower Health Plan State Reporting Program
PAGE: 1 of 12	**REPLACES DOCUMENT:**
APPROVED DATE: 10/2014	**RETIRED:**
EFFECTIVE DATE: 07/2014	**REVIEWED/REVISED: 10/2016**
PRODUCT TYPE: ALL	**REFERENCE NUMBER:** KS.COMP.40

SCOPE: Sunflower Health Plan and Centene Corporate.

PURPOSE: To document and communicate the Sunflower Health Plan State Reporting Program.

POLICY: It is the Policy of Sunflower Health Plan to provide timely and accurate reports and data in compliance with the state contract.

REFERENCES :

ATTACHMENTS:

REVISIONS:	**DATE**
• Added Reviewed/Revised Date of 09/2015 • Changed Reporting Program date to 2015 • Changed Approval from Manager Compliance to Director Compliance	9/9/2015
• Changed footer to 9/15 • Annual Review-Updated to reflect new structure	10/2016

APPROVAL

The electronic approval retained in Compliance 360, Centene's P&P management software, is considered equivalent to an actual signature on paper.

Director Compliance: _____Approval on file_____

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SUNFLOWER HEALTH PLAN

STATE REPORTING PROGRAM

2016

State Reporting Program Description

OVERVIEW:

Centene Corporation (Centene) recognizes the significance of State Reporting to our business as it is the primary data set a State Partner utilizes to value our service, measure health outcomes, and determine our performance to requirements outlined in contracts. State Reporting is a key business process at Centene that relies on the engagement of multiple areas in the organization to ensure our regulators receive an accurate and timely view of our business performance on contractual or regulatory requirements. The State Reporting Program is designed to describe the roles and responsibilities of the various stakeholders and the process that will be utilized to produce and deliver reports to our State/Federal Regulatory Partners ("Regulators").

GOAL:

To ensure all reports and data delivered to State agencies are submitted timely and that such reports accurately reflect business performance in accordance with the specifications and templates outlined by our Regulators.

DEFINITIONS:

Change(s) – A modification of a report that is in the Development process or In Production. A modification can include any of the following:

- An update, addition/deletion/substitution of data;
- Change in programming to extract a different set, type or source of data;
- Change in formulas;
- Reformatting/updating/replacing a current template;
- Updating timeframes of data collection; or
- Updating timeframes for submitting a report.

Development – An iterative process for defining, creating and refining a report, including the validation of the completeness and accuracy of data in accordance with outlined specifications.

In Production - The automated process that will extract the data and deliver the data/report into the designated location without manual intervention from a Developer.

Issue - A data element or report template for which a stakeholder raises a question or for which a stakeholder is disputing the accuracy or completeness.

Manual Report – A final report, previously approved for format and content that requires a Developer to manually execute the program and/or manipulate data into the final format or requires the HPCD or BO to copy/paste data into the template accepted by the Regulator.

Move in to Production – The final stage at which the Health Plan confirms that the content and/or structure of the report meets all specifications; therefore, the report can be moved to an automated process that will extract the data and deliver the data/report into the designated location without manual intervention from a Developer.

New Report – A request from a State partner to develop and produce a report that collects data not previously collected and submitted.

TOOLS & SYSTEMS:

Agile – Group of software development methods based on iterative and incremental development, where requirements and solutions evolve through collaboration between self-organizing, cross-functional teams.

Amisys – Claims adjudication system.

Business Objects – A business Intelligence tool that creates reports from data extracted from EDW.

Compliance 360 – The State Reporting Module in Compliance 360 will be utilized for the tracking of new/change/issue requests for state reporting. The tool will also be utilized to track progress, volume of requests, priority and ongoing challenges or issues across the organization.

Customer Relationship Manager (CRM) – The system used to manage interactions with members and providers, including the documentation of grievances.

Enterprise Data Warehouse (**EDW) –** The enterprise wide system used to store data from other systems (Amisys, TruCare, CRM) and from data files received from Regulators and Vendors.

Informatica – Enterprise Translation Language (ETL) used to create files and reports from data extracted from EDW.

MS Access – Microsoft Database used to store and report on data.

Microstrategy – A new business Intelligence tool that creates reports from data extracted from EDW.

TruCare – The Medical Management system used to document authorization data, Case Management notes and clinical appeal data.

ROLES:

Corporate Compliance. The corporate compliance department will develop and facilitate the structure of the State Reporting Program.

The duties of the Corporate Compliance Designee (CCD) include:

- Create and maintain the program description for State Reporting, facilitating input from key stakeholders to continually improve the process;
- Train Health Plan Compliance and Compliance IT Reporting (CITR) staff on the process and tools used to manage state reporting;
- Monitor new and change requests by entity and, in partnership with CITR, establish reporting priorities across the organization;
- Facilitate monthly meetings with Health Plan Compliance Officers to adjust priorities of requests based on overall needs across the organization;
- Participate in on-going health plan and CITR working meetings to mediate and/or provide clarification on requirements and ensure reports are appropriately prioritized;

- Act as liaison to new business implementation to assess/prioritize workload or participate in State Reporting meetings until new business is fully transitioned;
- Report to Corporate Compliance Committee on:
  1) Health Plans identified at risk due to on-going State Reporting issues,
  2) Volume of new/change requests by Health Plan, and
  3) Health Plans with reports in development cycle greater than 90 days.

Compliance IT Reporting (CITR). This team is responsible for the accurate development and programming of processes to ensure timely and accurate production of data extracts and reports. The team consists of a Department Manager, Business Analysts and Developers.

The duties of the CITR team include:

- Participate in working meetings with the Health Plan Compliance Designees (HPCD), Reporting Team, Health Plan Vendor Manager, Business Owner (BO) and Subject Matter Expert (SME) to understand reporting specifications, determine location to send reports and timeframes for deliverables;
- Documents and distributes minutes during meetings call by CITR to meet Reporting Team, HPCD, BOs, SMEs and CCD.
- Participate in the Development process.
  - Writes programs, in accordance with the report specifications provided by the Regulator and BO, to extract data in the designated format;
  - Develops templates to emulate state templates, as systems allow. In the event a system cannot emulate a State template, the data will be extracted and provided to the Health Plan BO in a usable format.
  - Raises questions in the event a business specification is unclear;
  - Delivers accurate test/final reports to the location, and within the agreed upon timeframes, as documented by the Reporting Team in partnership with HPCD;
  - Utilizes quality process checks to validate staff work during the development cycle;
  - Performs quality review of work prior to submission to health plan.
- Document programming process to ensure there is a backup who can execute programs or modify a program in the event of a staff absence;
- Utilize the Compliance C360 – State Reporting Module to document progress and obtain final approval on reports prior to promoting to an In Production status;
- Maintain a master schedule of all meetings with health plans and publish this schedule to all health plan Compliance Officers on an annual basis, or as the schedule changes.
- Notify Reporting Team in a timely manner of any roadblocks with normal delivery of reports/data extracts.
- Periodically conduct a cursory review of generated reports/data to ensure the report/data was extracted in accordance with specifications and that all fields are correctly populated (i.e. field with no data or zeros).

Health Plan Compliance Department (HPCD). This team is responsible for the oversight of their entity's State Reporting.

The duties of the HPCD include:

- Train (Reporting Team) on the process and tools used to manage state reporting;
- Provide last Q&A of reports prior to submission
- Deliver reports in a timely manner to the Regulators in accordance with the delivery method specified by the Regulators;
- Attend ad-hoc meetings with Reporting Team to adjust priorities of requests based on overall needs across the health plan;
- Participate in on-going health plan and CITR working meetings to mediate and/or provide clarification on requirements and ensure reports are appropriately prioritized;
- Escalate to CEO in the event a BO is untimely in completing reports and such untimeliness could result in the entity's failure to meet report submission timeframes;
- Monitor and audit high risk reports;
- Communicate with CEO, BO and Compliance Committee on health plan risks associated with State Reporting.
- Communicate with state reporting liason regarding report issues, coordination of status of reports including returned reports
- Track return reports

Reporting Team. The Reporting Team is the health plan team responsible for oversight of their entity's State Reporting and with ensuring timely and accurate reports.

The duties of the Reporting Team include:

- Utilize State Reporting System to generate report deliverables
- Review reports as a final quality check to ensure the accuracy of the report template, naming conventions and format.
- Document all on-going reporting deliverables in Compliance 360- Projects or Documents and notify the BO and SME and if applicable, the CITR staff of report specifications, templates, responsibilities and due dates, within 24 business hours (or as soon as reasonably possible) as early in the process as possible;
- Awareness and oversight of new/change report/issue requests, entered by BO, in the Compliance 360 – State Reporting Module within 24 business hours (or as soon as reasonably possible) of receipt of request/issue from Reporting Team;
- Facilitate meetings with HPCD, all BOs, SMEs and CITR to ensure new or changed reporting requirements are clear. In the event a requirement is not clear, coordinates with HPCD and seeks clarification from State/Federal partner;
- Facilitate meetings with HPCD and Manager, Vendor Management and Vendors to outline Vendor responsibilities for State Reporting, including timeframes for delivery and State templates to be utilized;
- In coordination with HPCD establish prioritization of State Reporting for the Health Plan;

- Escalate to CITR Manager, of any missing reports no later than 3 business days following the expected delivery date; Follow up with BO regarding questions/issues identified during the review of reports;
- Ensure BO accountability for their assigned State Reports;
- Engage with HPCD to understand State Reporting risks and issues identified by Regulators;
- Engage with CITR and BO to ensure accurate data is being provided on State Reports;
- Escalate to HPCD in the event a BO is untimely in completing reports and such untimeliness could result in the health plan's failure to meet report submission timeframes;
- Obtain CEO, or designee, report attestations as required by Regulators.

Business Owner (BO). The BO is the health plan Executive - Business Area Manager, or their designee, with accountability for the accuracy, completeness and timely submission of their assigned state reports. The BO shall have a clear understanding of their business and become the experts on their assigned State/Federal Reports.

The duties of the BO include:

- Ensure understanding of report specifications/requirements and articulates these expectations to the SME, HPCD, Reporting Team and CITR;
- Participate and lead when appropriate in all meetings where their reports are discussed including State meetings. In the event the BO is unavailable, they will ensure a designee with decision making authority is able to participate;
- Enter new/change report/issue requests in the Compliance 360 – State Reporting Module within 24 business hours (or as soon as reasonably possible) of receipt of request/issue from Reporting Team;
- Organize and/or facilitate ad hoc meetings or discussions with Reporting Team, HPCD, the State, CITR, SME, Vendor or any other individual, as necessary, to work through challenges, validate data accuracy or rework programming to ensure the report meets state specifications;
- Ensure timely reviews of their reports during the development cycle and raise any concerns with the accuracy or completeness of the data to the Reporting Team, HPCD and CITR team;
- Work with the Reporting Team in conjunction with HPCD to establish priorities for reports still in the development cycle;
- Provide final approval of reports prior to moving to an In Production status;
- Communicate within 24 business hours (or as soon as reasonably possible) with Reporting Team and HPCD in the event a Regulator communicates changes to reports or provides new templates directly to BO;
- Work directly with other business areas, Reporting Team and HPCD to complete any reports not generated by the CITR. Refer to ***Other Types of Data/Reports*** outlined below.
- Review all assigned reports In Production within one (1) business day of delivery to the health plan and clearly articulates any Issues to the Reporting Team and HPCD;

- Notify Reporting Team, HPCD and CITR, using the Compliance 360 – State Reporting Module of any missing reports no later than one (1) business day following the expected delivery of an In Production report to the health plan;
- Use the current 'Instructions for State Reporting Compliance' report preparation process outlined by HPCD;
- Ensure reports are reviewed by applicable SMEs, BO Executives and/or management prior to submission to Reporting Team and HPCD. When received by Reporting Team and HPCD it is assumed that this review has been completed;
- Ensure reports are delivered to Reporting Team and HPCD within the designated timeframes to guarantee timely delivery to the Regulator and;
- Maintain documentation that supports the data submitted in the reports to Reporting Team / HPCD submitted to the Regulator for future internal and external audit purposes.

CEO. The CEO is the health plan executive with ultimate responsibility for the submission of timely and accurate reports/data to the Regulators.

The duties of the CEO include:

- Review reports to ensure familiarity with the report/data and execute attestation in adequate time to ensure delivery of reports within the designated timeframes;
- Follow up with BO regarding questions/issues identified during the review of reports;
- Ensure BO accountability for their assigned State Reports;
- Engage with HPCD to understand State Reporting risks and issues identified by Regulators.

Subject Matter Expert (SME). Other individuals within the organization (corporate, health plan or Vendor) who have knowledge or can provide a validation of the data presented in the State reports. The SME is not the owner of a report.

Duties of the SME include:

- Provides timely feedback to the BO regarding questions or requests for validation;
- May provide other business reports to the BO to be utilized in the validation process;
- May serve in other capacity as designated or requested by the Reporting Team, CITR, BO, HPCD or CCD.

GUIDELINES:

The following guidelines should be considered to ensure an effective use of all resources dedicated to this process. The program description serves as a guide and tool for effective development and extraction of data for delivery to State partners. The CCD, HPCD, Reporting Team, BO, SME, CITR team and CEO are encouraged to have conversations regarding State reporting, as all these individuals are partners in the process. Due to the complex process for developing a State Report, resources must be dedicated, engaged and accountable to one another. The process can only be successful if all parties are accountable to meeting agreed

upon timeframes and engaging in the dialogue necessary to work through this iterative and dynamic process.

Report Requests/Issues – for CITR related reports:

1. All requests for new reports, changes or issues must be submitted through the Compliance 360 State Reporting Module.
    a. If an issue is identified on a report In Production, a request for change must be opened in the Compliance 360 State Reporting Module to ensure documentation of the issue and escalation to the CITR.
    b. If an issue is identified on a report in the Development cycle, the issue shall be documented in the Compliance 360 State Reporting Module.
        i. If a report change is not currently open in Compliance 360 for the report in question, and the report is still in development cycle, a change request shall be opened in C360 to track all issues/updates moving forward through this process.
    c. If a State Partner issues a new reporting requirement, all new requests will be opened in the Compliance 360 State Reporting Module.
2. Requests for new reports, changes or identified issues will no longer be accepted through email, instant message or telephone.
3. The BO, Reporting Team and HPCD are responsible for understanding the report specifications sent by their Regulators and to obtain clarification as appropriate from the Regulator and/or SME when the documents are unclear. Once the Compliance 360 request is opened, the BO and Reporting Team and as applicable HPCD, should have a meeting with the CITR team to review, in detail, expectations for the report. Review ***Meetings*** section outlined below.
4. The BO should review their reports within 1-2 business days of receipt from the CITR team, or as it is made available, in the designated share folder. Issues should be noted and reported in Compliance 360 within this timeframe.
5. CITR, BO, Reporting Team and HPCD will work together to resolve any technical issues with the shared folder where reports are placed.

Report Templates -

1. The CITR Developer will utilize best efforts to recreate and automate the State template.
2. If the Developer is unable to reproduce a State template to the exact specifications, it is the responsibility of the BO to make any manual adjustments to the templates, including formatting, adding footers, headers or other footnotes.
3. If a State template cannot be recreated by the CITR Developer because of limitations in available systems and tools, and the State template must be utilized due to

programmed cells, locked cells or a new template format each reporting period, the CITR Developer will create a usable data format and put it In Production. The BO will utilize health plan resources to copy/paste the usable data into the State template.

4. If a Manual Report is produced, the following Quality checks will be utilized:
    a. The Developer's work on the manual report will be verified by at least one other member of the CITR team prior to delivery to the health plan.
    b. Any manual manipulation by the BO will be verified by a SME, with a final review conducted by the BO executive or team member with knowledge of the report, as applicable, prior to delivery to the Reporting Team.

Meetings -

1. The CITR team will have an established schedule of standing meetings for each health plan to review reporting issues, discuss new templates or review progress on reports in development.
    a. The agenda for the meetings will be established by the Reporting Team, HPCD and BO (as applicable) based on their priorities.
    b. The CITR team will document minutes and distribute to all meeting participants.
    c. The meetings with the Reporting Team, HPCD and BO (as applicable) will be canceled in the event the health plan requests a reschedule/cancelation or if health plan representatives do not participate within 10 minutes of the scheduled start time.
    d. If meetings are consistently canceled by the Reporting Team, HCPD or BO (as applicable), the CITR will reach out to the Reporting Team and HPCD to determine if meetings are necessary.
    e. In the event on-going meetings are canceled, there will be at least one monthly meeting scheduled as a touch base with the Reporting Team, HCPD and CITR team.
2. The BO, in collaboration with the Reporting Team and HPCD, should lead ad hoc meetings with the CITR team and other SMEs to discuss any complex reporting issues, including validation of new report requirements. These meetings could be held in addition to standing meetings with the CITR team.

Vendor Data –

1. Health plan Vendor Manager is responsible for communicating State reporting requirements to Vendors and ensuring Vendors send data to the health plan in the necessary time to complete and submit accurate reports to State partners.
2. Not all Vendor data is available in Centene's EDW. The CITR team will notify the Vendor Manager and BO with a copy to Reporting Team and HPCD if Vendor data is not

available in EDW. The CITR team will provide notification via email and in adequate time for the health plan to coordinate with the Vendors.

3. If the Vendor Manager, BO, Reporting Team or HPCD has concerns with the Vendor data extracted from EDW, the Vendor Manager will open an issue in the Compliance 360 – State Reporting Module. The Vendor Manager, Reporting Team and BO will work with the CITR Developer to determine possible root causes.
    a. In the event the root cause is associated with the data received from the Vendor, the Vendor Manager and BO will notify their Vendor contact for immediate resolution.
    b. In the event the Vendor is not cooperative in resolving the root cause, the Vendor Manager will notify the Reporting Team and HPCD. HPCD will facilitate engagement with the Vendor at a corporate level, as necessary.
4. If a health plan(s) identify ongoing issues with Vendor data, the HPCD will notify the CCD and a Vendor CAP will be initiated. The CCD will monitor the Vendor CAP until the data issues have been fully resolved.

On-going communication –

1. As new requests/changes/issues are opened or status updates provided in the Compliance 360 – State Reporting Module, automatic email notices will be sent to the Reporting Team, HPCD, BO, SM, CITR and CCD providing updates on the development of reports. Stakeholders responsible for State reports must review emails in a timely manner to ensure the process moves forward.
    a. If the Vendor Manager, Reporting Team, BO, HPCD, SME, CITR staff or CCD are out of the office, a designee must be identified and the HPCD will update the item in Compliance 360 – State Reporting Module to include the designee in the notifications.
    b. If a Reporting Team, BO, HPCD or SME leave the organization or move to a new role, the BO manager, Reporting Team or HPCD will update any open request/issues to reflect these changes.
2. Individuals should be courteous and respectful of others time and arrive promptly to meetings, return phone calls or respond to emails.
3. In the event the CITR Developer, Vendor Manager, BO, Reporting Team or HPCD needs to escalate an issue, they should contact the CITR Manager or CCD via phone, email or IM for immediate intervention.

Other Types of Data/Reports –

1. **Call Statistics** – Call data, like abandonment rate, hold time, call volume, is not available in EDW and must be obtained from the Call Center Business Owner.

2. **GeoAccess Reports** – Business Owners need to coordinate with Provider Data Management to run GeoAccess reports.
3. **Credentialing Data** – EDW has limited data elements on provider data. Reports specific to credentialing will need to be coordinated by the health plan or Corporate credentialing units.
4. **Member event, other activities** – Health plan will need to develop methodology for tracking events if the Regulator requires reporting of such data.
5. **Narrative reports** – In the event Regulators require an executive/narrative summary of data, it is the responsibility of the BO to complete this portion of the report.
6. **Report Program Requirements** – CITR will document and provide report parameters to Reporting Team, BO and HPCD, as needed to ensure reports are accurate.

5.17 Staffing

5.17. STAFFING

SUNFLOWER DEMONSTRATED SUCCESS

Sunflower Health Plan (Sunflower) brings an established and experienced team of over 400 staff that currently support the KanCare program. Sunflower prides itself on being a place where our employees enjoy working and we continually strive to provide an enriching work experience. Our team is 100% present and invested in Kansas and in the communities in which our members and staff live and work. This Kansas-specific knowledge and experience of our staff sets Sunflower apart. Our success is demonstrated by:

- An average annual staff turnover of less than 11%, which is significantly lower than the national average of 19% for the healthcare industry
- An over 12% increase in our employee engagement scores over the past two years
- Our ability to attract, develop, and retain experienced staff as demonstrated by our member-facing service coordination staff who have an average of over 20 years of health care and community-based experience.
- Our alignment to KanCare 2.0 goals as demonstrated by an employee self-report which indicated that 5.8% of our Kansas-based staff are living with disabilities, exceeding the State's goal of 5% by the end of the first year of KanCare 2.0 operations.
- A comprehensive training and education program where staff continuously hone their skills and gain fulfillment from their work supporting KanCare enrollees.
- Our staff's contribute to the betterment of Kansas through participation in events and causes that support Sunflower's mission to transform the health of the community one person at a time. For example, 82% of Sunflower's workforce participated in the 2017 United Way campaign, with more than $50,000 of personal donations pledged to local charities across Kansas.
- Our local presence in Kansas including our three office locations in Lenexa, Topeka, and Wichita.

Compliance with Scope of Work

Sunflower will leverage existing staff and make appropriate adjustments to support compliance with all KanCare contracts and all KanCare 2.0 requirements described in Section 5.17 of the Scope of Work (SOW). Below we detail our overall staffing approach including key personnel, hiring of people with disabilities, training, and facilities management. For ease of review we have included SOW references in the headers and within the narrative when applicable.

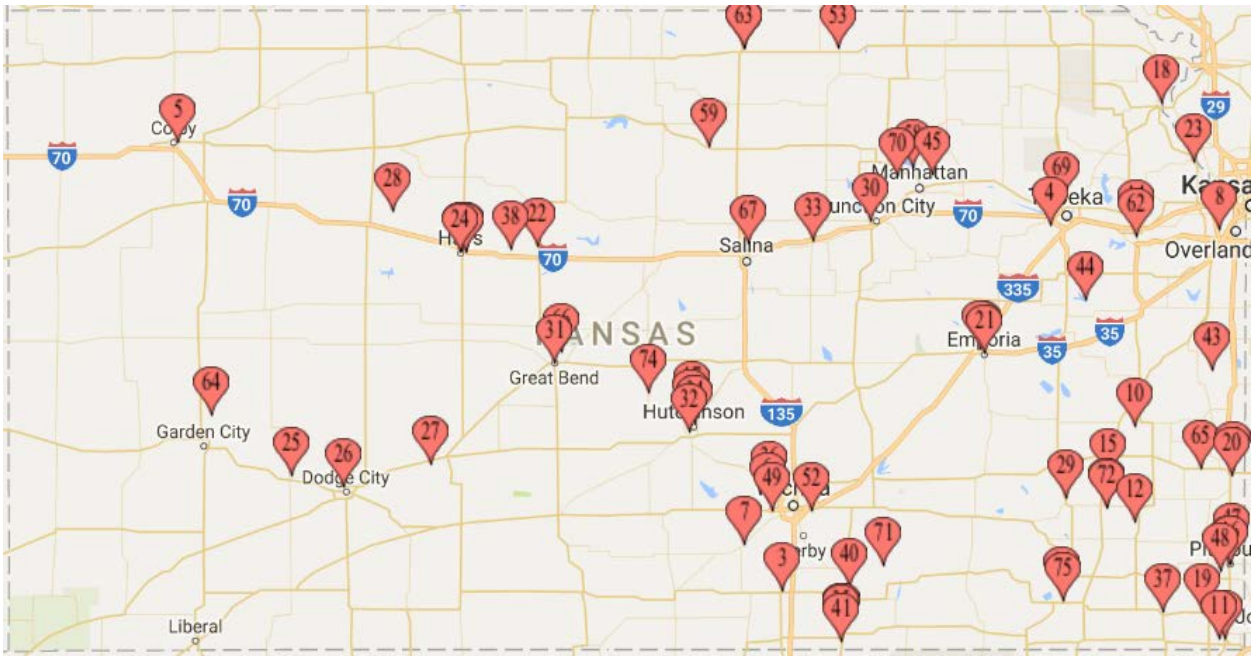
5.17.1. CONTRACTOR(S) STAFFING REQUIREMENTS

LOCAL APPROACH- KANSANS SERVING KANSANS

While our staff are primarily located in the Lenexa, Kansas area, Sunflower has staff located across the State of Kansas. Through remote workers and our regional offices in Topeka and Wichita, we draw staff from the communities where our members live. This enables Sunflower to more effectively serve Kansans from all parts of the state. ***Figure***

5.17.A_Remote Staff across Kansas below shows the location of Kansas-based Sunflower staff who work remotely.

Figure 5.17.A_Remote Staff across Kansas



DESCRIPTION OF STAFFING PLAN (5.17.1.A)

Sunflower's staffing plan has been established to maintain capability for performing and carrying out all functions, requirements, roles and duties required by the Contract. Our staffing plan leverages the best practices of our parent company Centene Corporation (Centene), as refined over 33 years of experience supporting similar Contracts in 29 other states. Centene's operating model revolves around a high-touch approach with members and providers through local health plan operations; developing and maintaining a highly-qualified, Kansas-based staff that shares Sunflower's passion for providing exceptional service to the members, providers and communities we serve.

Because staffing plans are tailored to enrollment levels and service areas, and for the sake of consistency and clarity, the staffing plan and narrative below are based on an estimated projection of Sunflower enrollment of approximately 130,000 members. If actual enrollment is materially higher or lower, adjustments to the plan may be appropriate.

Our staffing plan includes all required key personnel positions and adequate staffing levels in key departments. Additionally, our service coordination staff will be augmented by contracted Community Service Coordinators (CSCs) as described in Section 5.4 of this proposal. See ***Figure 5.17.B_Key Personnel Staffing Model*** below for our staffing model depicted as a functional organizational chart. For ease of review, in the table below we provide a cross-walk between

the key personnel position titles and the internal Sunflower titles. For consistency, below and throughout our proposal response, we use the Key Personnel position titles as stated in 5.17.1.

In the event a specific functional area requires additional support to maintain a high level of member or provider service, or should we observe a notable increase or decrease in membership, we will adjust our staffing levels accordingly. Sunflower will closely monitor performance and staffing levels, particularly during the go-live period and the first year of operations for KanCare 2.0. When enrollment increases, we will recruit additional staff in a timely manner; we have structured staffing plan scenarios in place to align with membership increases at multiple volume levels. If needed, we also may leverage temporary staff, Centene health plan and corporate staff, who can step in on an interim basis to supplement staffing. We will ensure that a complete knowledge transfer occurs from the employee leaving the position to the new employee.

Sunflower Health Plan’s response to this section is provided in our Proprietary Proposal.

Sunflower Health Plan's response to this section is provided in our Proprietary Proposal.

DESCRIPTION OF BACK-UP PERSONNEL PLAN (5.17.1.B)

In accordance with Contract requirements, Sunflower will provide KDHE with written notification of changes to key personnel. We will fill key positions on an interim basis within 15 calendar days and on a permanent basis within 90 calendar days. Sunflower will ensure that knowledge is transferred from an employee leaving a position to a new employee to the extent possible. Sunflower acknowledges and agrees that all Key Personnel positions must be filled within 60 calendar days of departure, unless a different time frame is approved by the State.

Our preparedness for staffing changes is supported through organized succession planning. Currently 100% of our key personnel positions have succession planning in place.

Staff Turnover Contingency Plans

Replacement of Key Personnel. To address the risk that a vacancy may occur with one of our Key Personnel, Sunflower will leverage the best practices of our affiliate health plans and prepare a contingency plan which includes a list of required back-up corporate or affiliated health plan personnel who can step in on an interim basis. If necessary, a member of Sunflower's Senior Leadership team will step in on a short-term basis to fulfill the position requirements until a new key staff member is hired. We will ensure that a complete knowledge transfer occurs from the employee leaving the position to the new employee through a comprehensive succession plan. In order to sustain Sunflower's supply of trained personnel and maintain bench strength to support staff vacancies, each year we will conduct succession planning at the Manager, Director, Vice President, and Executive level.

All Key Staff and Other Staff Positions. Sunflower's Senior Leadership team will meet weekly to discuss staffing issues and to identify staff from other functional areas that may be available to temporarily fill an open position or to offer assistance in an area with a recent vacancy. If needed, we also may leverage staff from other Centene health plans or Centene's corporate office, who can step in on an interim basis to supplement staffing levels.

With an average annual turnover of less than 11%, which is significantly lower than the national average of 19% for the healthcare industry, our employees take pride in working for Sunflower and helping transform the health of their communities.

Recruiting Qualified Staff. When a position vacancy occurs, or when a new position is created, Sunflower's Kansas-based Human Resources (HR) team will act immediately to recruit and hire a qualified candidate for that position. Sunflower and each of its affiliate health plans across the country share an active applicant tracking database and consistently maintain a dialogue with qualified candidates in order to keep a steady flow of strong potential applicants "in the pipeline." By continuously evaluating parties who have an interest in employment, the organization is able to quickly and efficiently fill open positions. Open positions are posted internally on our company-wide intranet so employees at all Centene subsidiaries have access to open employment opportunities. We will also post open positions externally on our corporate website. Other recruitment avenues include:

- Job board websites including, CareerBuilder.com, LinkedIn.com, Indeed.com, SimplyHired.com, and Diversity.com
- Kansas Nursing Newsletter
- Networking events with local diversity-focused business groups.
- National Black Nurses Association
- Executive Recruiting Firms/Agencies including Morgan Hunter Recruiting in Overland Park
- American Council for the Blind Job Connection
- Standard Job Fairs and Veterans Jobs Fairs (collaboration with Congressman Yoder)

- The National Association of Hispanic Nurses
- Kansas Chapter of the National Association of Social Workers
- Kansas Pharmacists Association Job Board and Newsletter

Educating and Training Replacement Staff. Once a vacancy has been filled, it is critical to on-board the new employee in an efficient and effective manner. The replacement employee will go through new employee orientation to acclimate to Sunflower and familiarize them with operational policies and internal procedures. The next step is to familiarize the replacement staff member with the KanCare program including all policies, procedures and contract requirements. We will ensure a knowledge transfer when possible from the exiting employee to the replacement employee. During this knowledge transfer process, the new employee will be trained on all software programs and all departmental policies and procedures. In cases where the position directly interacts with the members, for instance, care managers, all efforts will be made to ensure warm handoff between the exiting employee and the new team member.

5.17.2. CONTRACTOR(S) KEY PERSONNEL

KEY PERSONNEL REQUIREMENTS (5.17.2.A AND 5.17.2.B)

Sunflower has identified employees for each of the Key Personnel positions identified in Section 5.17.2.C. These highly qualified staff are already in place and in many cases are currently performing the duties of the positions they will hold under the new contract. Where required, full-time Key Personnel positions are held by a single, employee dedicated to that position. All Key Personnel listed in this proposal are dedicated to the KanCare contract and are based out of the Sunflower offices in the State of Kansas. Where applicable, staff hold current Kansas licensure.

KEY PERSONNEL (5.17.2.C)

Below are the names of the Key Personnel as well as short biographies and personal statements describing their role and accomplishments in serving the KanCare program.

Senior Executive/Project Director- Chris Coffey, Plan President and CEO

- 6 years with Centene
- 4 years at Sunflower
- 21 years in health care

Plan President, Chris Coffey, has worked in health care both as a clinician and as an executive for over twenty years. His experience includes nearly fifteen years on the provider-side serving as an administrator for medical group practices, ambulatory surgery centers, acute rehabilitation hospitals, and specialty hospitals while, prior to his administrative roles, he practiced as a board certified registered occupational therapist within skilled nursing facilities, acute hospitals, and home health agencies for five years. In the most recent years, Chris has served as the VP of Operations for Centene, the interim Plan President for Centene's Arizona

subsidiary known as Bridgeway Health Solutions, and within Sunflower where Chris served as the COO for a year before becoming the Plan President in June 2015.

As KanCare 2.0 places greater emphasis on Social Determinants of Health and Independence (SDOHI), Sunflower is positioned well under Chris's leadership as his experience as an occupational therapist placed him within patient's homes to address various social determinants. That experience will serve as the foundation for Sunflower's new program(s) around addressing such social determinants. Under Chris's leadership Sunflower's turnover has been reduced by nearly half resulting in a total turnover of less than 11% with the majority of Sunflower's leadership being in their role, if not since inception of KanCare, shortly afterwards. This retention of staff and leadership has served as the core to Sunflower's continued success in population health metrics, stakeholder satisfaction, and statewide awareness of Kansas' most vulnerable populations.

Chris serves as the Chairman of the Board for the Kansas City Chapter of the American Diabetes Association and on various Centene and Centene Subsidiary Boards to help leverage best practices across the country in improving health outcomes. Leading a team of qualified, engaged employees who share in a passion and mission to serve the needs of those who are underserved and most vulnerable provides me the greatest satisfaction.

"Nothing provides me greater satisfaction than helping some of the most vulnerable population secure high quality health care and helping them to understand the local resources available to them to live a healthier lifestyle. I believe in, and try to make it a daily goal, to strive toward accomplishing our Company tagline of "Transforming the health of a community one person at a time". Working with over 350 engaged Sunflower staff to assist our 130,000 KanCare members is an honor. There are many success stories to share but one of the greatest I have experienced here in Kansas was helping a young man who suffered from mental illness and had many physical comorbidities transition into becoming a fully employed, stable, productive young man. This member was considered a threat to himself and society. He was uneducated and had been removed from his family after repeated altercations with his mother and siblings. After months of intense case management by Sunflower, this member earned his GED, secured employment, entered into an apartment lease, and was reunited with his family once again. To me, and the rest of the Sunflower team, this is what it is all about."

-Chris Coffey

Senior Executive Finance Officer- Terry Weathers, Senior VP-Finance

- 5 years at Sunflower
- 33 years in health care
- Certified Public Accountant

Terry Weathers, CPA provides financial leadership for all Sunflower populations served under KanCare, and she has served in this role since inception in 2013. Terry is responsible for

monthly financial reporting to the State and on-going rate setting coordination with KDHE and actuarial teams. Timely analysis of emerging trends and unexpected outcomes has allowed her to bring to the KDHE's attention items that ultimately impacted future rate setting and program valuation. In previous roles Terry received a national health care instructor award, organized and executed a national Internal Audit conference attended by over 800 health care auditors, and she was responsible for completing a major tax-exempt bond restructuring which required five transactions over three years and involved innovative partnerships never previously utilized. Terry currently serves as the Board Chair of the Visiting Nurse Association of KC and on a Healthcare Financial Management Association Committee. Terry brings deep financial expertise, having spent over 30 years in health care finance ranging across external audit leadership with a big four public accounting firm, internal audit executive start-up roll with major Catholic health systems, and a financial executive position with the region's only pediatric health system.

"My role is focused on ensuring that Sunflower is a good steward of the State's financial resources, and therefore I take seriously overseeing that we are properly managing and monitoring Sunflower's financial results. As a finance partner, we have been able to assist the State in developing and refining monthly/quarterly financial reporting templates to ensure that KDHE has timely and accurate insight into program performance. We also work diligently to ensure that the Medicaid reporting templates submitted and used in rate setting activities are complete and accurate, and during the year we inform KDHE as we see financial trends developing outside of actuarial expectations."

-Terry Weathers

Compliance Officer- Carmen Mills, VP-Compliance

- 3 years at Sunflower
- 11 years in health care
- Certified in Healthcare Compliance (CHC) and Healthcare Privacy Compliance (CHPC)

Carmen Mills brings experience with state and federal government agencies and over 10 years in health care compliance management to her role as Sunflower's Compliance Officer. As Compliance Officer, Carmen tracks statutory, regulatory and contractual requirements as they are applicable to Sunflower's operations. She develops and maintains policies, procedures, and processes for compliance monitoring and oversees compliance programs including fraud and abuse and HIPAA compliance initiatives. Prior to working at Sunflower, Carmen led the compliance operations for health care providers including a diagnostic lab and an orthopedic products and services company. Carmen has a Masters in Sociology and holds certification from the Compliance Certification Board.

"As Sunflower's Compliance and Privacy Officer, I am responsible for ensuring that Sunflower adheres to the specific requirements of the KanCare contract as well as applicable State and Federal laws and regulations. I provide training, guidance and oversight to Sunflower employees

regarding these requirements, as well as conduct monitoring, auditing, and investigations to confirm that these requirements are being met. Through this work, I am in a unique position to serve both members and providers as well as support the State of Kansas's vision for the Medicaid program by ensuring we deliver the services we have committed to provide. One area of which I am particularly proud is the guidance and support my department provides to our colleagues when participating in State and EQRO audits. By organizing and facilitating these audits, the Compliance Department is able to minimize disruption to health plan staff which allows them to continue providing direct service to our members and providers while also ensuring that the State of Kansas has the information necessary to confirm we are in compliance with our contractual and legal requirements."

-Carmen Mills

Medical Director/CMO- Dr. Katherine Friedebach, Chief Medical Director

- 5 years at Sunflower
- 23 years in health care (17 years as a physician)
- Board Certified in Family Medicine
- Member, American Academy of Family Physicians

Dr. Katherine Friedebach is a Board-Certified Family Physician who has served as the Chief Medical Officer at Sunflower for nearly five years. As the CMO, Dr. Friedebach is responsible for clinical oversight of all health plan activities, including utilization management, quality improvement, clinical practice guidelines and clinical policies and procedures. Dr. Friedebach also serves as the health plan's liaison to the Kansas clinical community including our network providers and clinical leaders at KDHE. Through her work, Dr. Friedebach ensures that our Members receive all covered services in an appropriate manner supporting initiatives that focus on the delivery of the right services, at the right time, and in the right setting.
Prior to joining Sunflower, Dr. Friedebach served as the Chief Clinical Officer of the Community Health Center of Central Missouri, a multi-site patient-centered medical home focused on serving the community regardless of a patient's ability to pay. Throughout her career as a practicing physician, Dr. Friedebach has also provided comprehensive primary care to nursing home residents as a staff physician at two long term care facilities. Dr. Friedebach earned her M.D. from the University of Missouri Kansas City Medical School in 2000.

"I am excited every time I see a quality measure improve or the cost to care for a population with a chronic condition decrease because that means that our members are experiencing an improvement in their health. I also love working with that state and other stakeholders to review emerging therapies in medicine and policy development that ensures KanCare members get the most cost-effective, safe, and evidence-based health care. Our goal of better health outcomes at lower cost is a driving focus for everyone at Sunflower. This is evidenced by numerous Sunflower programs, such as Start Smart for Your Baby which is used to help our pregnant members get the care and support they need during pregnancy. Our innovative diabetes programs have resulted in significantly more Sunflower members benefiting from control of their diabetes in 2016 compared to 2014. The heart failure program is working to

make sure Sunflower members get the help they need to manage the symptoms of heart failure in their home without needing to go to the hospital or other residential facility. Simply put, the programs our teams design and implement to improve health all lead to the individual. This is the area that probably inspires me the most and gives me a tremendous sense of pride. I am honored to work with a talented team of professionals who regularly meet to collaborate and strategize on how to help individual Sunflower members navigate the health care system, their communities and all aspects of their lives. This multidisciplinary approach creates an environment that teaches me something every day and accomplishes the unimaginable on a regular basis. I have the best job in the world as part of the team that continually strives to improve the lives of the population we serve."

-Dr. Katherine Friedebach

LTSS Clinical Officer/Medical Director- Karl Haake, MD (Transitional Leader)

- 19 years as a practicing physician
- Board Certified in Anesthesiology and Pain Management

Dr. Karl Haake will serve as the interim LTSS Clinical Officer while Sunflower actively recruits a permanent clinician to fulfill this role. In this transitional leader role, Dr. Haake will assist in the transition of the new LTSS Clinical Officer who will be board certified in Geriatrics or a Gerontological Nurse Practitioner. Dr. Haake is currently the Pain Management Consultant for the Missouri Primary Care Association and lead facilitator for Missouri's Chronic Pain ECHO Project. He is an anesthesiologist who specializes in pain medicine and is certified by both the American Board of Anesthesiology and the American Board of Pain Medicine. He formed the first pain clinic at a Federally Qualified Health Center in the United States at the Community Health Center of Central Missouri and consults with hospitals, health systems, managed care organizations, private clinics, and FQHC's throughout the country regarding coordination of primary care, behavioral health, and pain management. He is currently the chair of the American Academy of Pain Medicine's Special Interest Group in Primary Care and previously served as interim Chief Medical Director for Home State Health, one of Missouri Medicaid's managed care organizations. As the LTSS Clinical Officer, Dr. Haake will oversee and be responsible for all primary and physical and Behavioral Health services provided to individuals receiving LTSS. Dr. Haake will work with the CMO, Behavioral Health Medical Director, Pharmacy Director and the Behavior Supports Director to ensure the integration of physical and Behavioral Health services and supports and LTSS.

LTSS Director/Manager- Stephanie Rasmussen, Senior Director of LTSS

- 5 years at Sunflower
- 28 years in LTSS (23 years working with I/DD populations)

Stephanie Rasmussen will serve as our Director of LTSS. Stephanie is currently the Senior Director of LTSS for Sunflower, and has worked for our plan for over 5 years. Stephanie brings more than 28 years of experience working with LTSS populations, and primarily with persons with I/DD. Stephanie previously worked for a Kansas I/DD provider directing services for adults

with I/DD, and also served as a consultant on their projects for placing persons out of closing state I/DD hospitals in California, Tennessee and Kansas. Stephanie also served as the Executive Director for one of the two Kansas I/DD provider associations, the Alliance for Kansans with Developmental Disabilities for three years; and worked for the State of Kansas for 1.5 years approving the transition plans for persons moving out of Winfield State Hospital and Training Center when it was closing. Stephanie currently serves on the Centene LTSS Policy Committee making sure that corporate policies meet the needs of persons in LTSS in Kansas, and leads the Sunflower LTSS Advisory Committee. She has been key in the participation of several initiatives including the Long Term Quality Alliance study of integrated care management for persons in MLTSS, a related video they produced, and providing presentations at the annual NASUAD conference on employment and Person Centered Planning for persons in MLTSS. Stephanie also recently participated in a targeted workgroup facilitated by the National Association of Dual Diagnosis to recommend best practice supports for persons with I/DD and MH. Stephanie serves on the Alumni Board of the Kansas Association for Youth, a leadership program for junior high and high school students sponsored by the Kansas State High School Activities Association.

"I enjoy my work with the development of corporate, state and Sunflower policies and processes related to LTSS care management and services. Through this work I am able to impact the quality, and effectiveness of these services for our members; and make decisions related to closing gaps in needed services for members. For example, prior to working for Sunflower I participated in the State's I/DD pilot advisory committee. Part of the role of this committee was to evaluate the current coverage of I/DD services and where there were opportunities for MCOs to fill the gap. As part of the Sunflower Leadership Team, I have been able to take that knowledge and recommend value added services that assist members who may be experiencing a gap in their current services. The value-added services include preventative dental care for adults, which as a significant need for the I/DD population, and respite for persons with I/DD who are on the state's waiting list for access. I was also able to use the knowledge gained from the pilot committee to recommend the supports offered by our LifeShare team, including Rapid Crisis Response for persons with I/DD who have a co-occurring behavioral health need."

-Stephanie Rasmussen

Behavioral Health Medical Officer/Medical Director- Dr. Sosunmolu Shoyinka, BH Medical Director

- 4 years at Sunflower
- 18 years in health care
- Board Certified by the American Board of Psychiatry and Neurology and the American Board of Addiction Medicine

Sunflower's Behavioral Health Medical Officer, Dr. Sosunmolu Shoyinka is board - certified in General Adult Psychiatry and Addiction Medicine and completed fellowships in Psychosomatic Medicine and Public Psychiatry at Yale and Columbia Universities respectively. As the Behavioral Health Medical Officer, Dr. Shoyinka oversees all Behavioral Health activities including coordination with KDADS. Dr. Shoyinka also provides clinical leadership to our BH-

focused service coordination activities and BH utilization management. In this role, Dr. Shoyinka works closely with the rest of the Sunflower clinical leadership team and services as a liaison to the BH provider community in Kansas.

Prior to joining Sunflower, Dr. Shoyinka served as the Director of Psychiatric Outreach Services for the Dept. of Psychiatry and Director of the Missouri State Behavioral Pharmacy Management Project, a joint project of the Missouri Dept. of Social Services and Dept. of Mental Health. Dr. Shoyinka's career has focused on health services administration, with a specific focus on integrating behavioral health and substance abuse treatment into primary care and publicly funded systems of psychiatric care.

"My work focuses on providing clinical leadership to the BH team on the care of our members, building collaborative partnerships, providing behavioral health perspective on policies and programs to the state, program development to improve quality and access to BH services, and training and staff development in BH knowledge and skills. I find my work fulfilling because, in contrast to providing direct clinical service to single individuals at a time, my current role allows me to leverage that same knowledge and expertise to impact an entire population."

-Dr. Sosunmolu Shoyinka

Behavioral Health Supports Director- Dr. Sandra Berg, Director, BH

- 4 years at Sunflower
- 19 years in health care
- Licensed Clinical Professional Counselor and PhD

Sandra Berg PhD, LCPC currently serves as our Behavioral Health Supports Director, with 20 years of experience in the behavioral health field. Sandra has a broad range of experience in leadership for behavioral health services, including, director of a children's psychiatric hospital, director of three psychiatric residential treatment facilities for children, and clinical director of a special purpose school. She has served on numerous advisory boards, including the Governor's Subcommittee for Children's Mental Health, state advisory board for PRTFs, and advisory board for 8th judicial district. She is currently an active member of the Adult Continuum of Care Committee, the Kansas Interagency Council for Homelessness, the Mental Health Coalition and the early childhood mental health workgroup.

Sandra began her career at Sunflower as a HEDIS specialist to broaden the awareness and implementation of HEDIS measures for behavioral health. Kansas currently leads the Centene companies in follow up after psychiatric hospitalization (FUH). The behavioral health team under Sandra's direction raised the HEDIS score for Initiation and Engagement for Substance Use Treatment (IET) from the 30th percentile to above the 50th percentile.

"I am passionate about transforming the delivery of behavioral health services in the state of Kansas. We can improve the quality of life for every member by insuring they receive the right services for their level of need. During 3 years of my tenure at the health plan, we were able to

significantly impact members' lives with substance use issues by connecting them with a care coordinator who walked with them through their treatment. I have been a member of several advisory groups to the state around policy and practices that have enhanced the service delivery to a vulnerable population. One such advisory group was the Adult Continuum of Care, who proposed the state hospital be supported as a needed level of care in Kansas."

-Sandra Berg

Pharmacy Director- Dr. Angie Zhou, Director- Pharmacy Services

- 4 years at Sunflower
- 9 years in health care
- Licensed Pharmacist and Doctor of Pharmacy

Angie Zhou, Director of Clinical Pharmacy Services, is a licensed Kansas pharmacist who provides oversight to the pharmacy benefit setup and pharmacy clinical activities at Sunflower. Angie works closely with the Pharmacy Benefit Manager, Case Management, and Quality teams to provide pharmacy expertise in health plan initiatives. In working with the Pharmacy Benefit Manager, Angie ensures compliance with State pharmacy policies and guidance and also appropriate care and member access to pharmacy benefit. In addition to pharmacy benefit services, Angie also directly oversee the Lock-In program as well as drug coverage/prior authorization on the medical benefit. Prior to Sunflower, Angie worked in Commercial/Health Exchange formulary management at another leading health insurance company, and has the experience in national market pharmacy formulary management strategies. Angie currently serves as adjunct clinical faculty for the University of Kansas School Of Pharmacy and oversees student pharmacists from KU as an experiential education site. Finally, the Sunflower pharmacy team has a combined 20 years of pharmacist experience in Commercial, Medicare, and Health Exchange pharmacy management.

"Appropriate use of medications is an important part of managing chronic conditions and improving health outcomes. As the Pharmacy Director, my team and I contribute to a multi-disciplinary approach for improving Members' lives."

-Angie Zhou

QM Director- Susan Hood, Director- Quality Management

- 4 years at Sunflower
- Over 20 years in health care
- Registered Nurse

Susan Hood, our Director of Quality Improvement is a Registered Nurse with over 20 years of experience in clinical settings, risk management and quality improvement. In her role, Susan assesses a variety of Quality metrics including but not limited to appeals, grievances, state fair hearings, HEDIS, Quality of Care, adverse incidents, member and provider satisfaction surveys

across all of the LTSS waivers and populations served to identify opportunities for improvement. Susan and her team implement practices tied to the state contract to ensure that members and providers rights for appeals, grievances and state fair hearings are protected and provided to members and providers as well as providing systems to support those rights. Additionally, compliance with the QMS is an integral part of Susan's role along with ensuring Quality metrics are monitored and trends are addressed to improve the services, care and satisfaction of both members and providers while also working to improve the care members receive which includes preventive and routine care.

"As the Director of Quality Improvement, I love that my role allows me to further impact and improve the lives of the members Sunflower serves. I became a nurse to help others and this role allows me to do just that in a much larger capacity of those I used to care for daily. Additionally, I am able to see the results in the year over year improvement of Quality metrics like HEDIS measures, CAHPS member satisfaction scores, and other data metrics where we have been able to provide education, improve processes or policies to impact the care members receive. My various clinical experiences as a registered nurse compelled me and provided me the ability to see the potential benefits of providing education, importance of routine care and preventive care to the members Sunflower serves to help them to achieve brighter futures, overall better health and quality of life. Overall, the goal is to help Sunflower members achieve "healthier today, better tomorrow."

-Susan Hood

Chief Data Analytics Coordinator- Beau Winfrey, Senior Manager- Data Analytics & Reporting

- 5 years at Sunflower
- 9 years in data and analytics

Beau Winfrey brings nearly a decade of data and analytics experience to his role as Sunflower's Chief Data and Analytics Coordinator. In this position, Beau is responsible for reviewing data across populations and programs, including data from subcontractors. Through the use of the Centelligence analytics platform, Beau and his team facilitate reporting that provides Sunflower departments with actionable information to improve outcomes through rapid-cycle process improvement. Beau is also responsible for data reporting to KDHE including responding to ad hoc reporting requests. Prior to joining Sunflower, Beau served as a Senior Business Analyst at Farmers Insurance Group. Beau is a graduate of the University of Kansas in Lawrence.

"Every decision has to be supported by data and facts. Leading the team that provides data not only to internal stakeholders, but external stakeholders gives me a great sense of pride and accomplishment. Accurately reporting roughly $1.1 billion dollars annually is nothing to take lightly. The data is the detail that shows the success of KanCare. KanCare not only impacts the lives of members' lives, but it also impacts the lives of every single residence in the state of Kansas. Being able to provide that data that allows both Sunflower and KanCare to monitor the success of the program is an amazing feeling and I am proud to be a part of this program."

-Beau Winfrey

Member Services Director/Manager- Sharon Traylor, Senior Director- Customer Service

- 11 years at Centene (5 years at Sunflower)
- 22 years in Kansas Medicaid managed care
- 41 years working in health care

Sharon Traylor is a highly adaptable, hands on leader with more than 40 years of experience in health care. Sharon joined Sunflower as the Director of Customer Service in 2012 bringing her experience of Medicaid Managed Care from the states of Kansas and Missouri. Almost 25 years of Sharon's work history is Medicaid Managed Care for the State of Kansas. Sharon completed the Certified Managed Care Executive program sponsored by America's Health Insurance Plans (AHIP) in 2003. Sharon's experience includes customer service, claims operations, quality assurance, system implementations, NCQA and quality improvement processes across health care sectors, including provider front and back office. Currently, Sharon is responsible for the operational, service performance, process improvement, system innovation and NCQA and state requirements for Sunflower's Customer Service department. She oversees a team of customer service representatives, quality analyst, workforce analyst, business analyst and management staff dedicated to serving Sunflower's KanCare members and providers.

"It is important to me that every member and provider calling Sunflower receive the best service possible. Our Customer Service team has the opportunity to impact a member's life multiple times a day. They will assist with anything from ordering an ID card to reaching out to a provider or vendor with the member on the phone to help them resolve their concern. I have the opportunity to listen to our Customer Service representatives phone calls for various reasons and one of my favorites was a member on the IDD Waiver who was calling us to change his PCP. He was a young man and learning to handle his own business needs. He was on the call with his aide and she stated what she was trying to accomplish by having him handle the PCP update on his own. He was a little shy, but my Customer Service representative walked him through every step on providing his information to verify HIPAA, confirming his PCP and letting him know a new ID card was coming to him without any worry of how long she was on the call with him. His aide and my Customer Service Rep. gave him accolades on what a great job he did on the call. He was so proud of himself and his aide was very thankful with service and time Sunflower took to assist her with our member. Every day we get the opportunity to make a difference for our members."

-Sharon Traylor

Health Services Director/Manager- Terie Beverlin, Director, Utilization Management

- 5 years at Sunflower
- 25 years working in health care
- Registered Nurse

As the Health Services Director, Terie has hands-on role in coordinating the development, design, implementation, and ongoing monitoring of the organizations utilization review functions ensuring integration with care coordination for all members. Responsibility of assuring financial and human resource management, leadership, quality and operational management objectives are a prime focus for Terie to achieve clinical, financial and utilization goals for the department. Throughout her several decades in health care, Terie has been able to touch a variety of populations giving her specific insight into how effectively implementation programs that align with quality goals, working as a strategic partner with the Chief Medical Officer to implement industry best practices. Focus on continuous process improvement and positive member and provider experiences are a priority for Terie and drive the day to day work that is done within her department.

I was born and raised in the Lenexa area and knew that I wanted to continue my career in health care impacting the individuals I was living amongst. When I came across Sunflower and saw that the aim was to have their interactions at a local level, I knew this was the place for me. I began my career with Sunflower on the Care Management side and transitioned into a leadership role for Utilization Management. Utilization management is an essential piece of the puzzle that implements proactive procedures and processes to ensure that the economy of the health care industry remains healthy and is many times the starting point of collaboration and integration of multiple different disciplines. Many times, issues that members are dealing with in their homes, community, and personal life are discovered through the review of the clinical documentation and then we at the health plan are then able to assist or intervene to positively impact their outcomes. It allows the health plan to also ensure that providers are providing appropriate care and utilizing the states resources effectively. We are able to positively impact members lives when they need it the most and possibly identify areas that we could assist with that the member might of possibly not have even realized was an issue.

-Terie Beverlin

Service Coordination Director/Manager- Lori Howard, VP of Medical Management (Transitional Leader)

- 5 years at Sunflower
- 10 years in health care in Kansas

Lori Howard, Centene Regional VP of Medical Management will serve as a transitional leader in the role of Service Coordination Director while Sunflower actively recruits for a permanent staff member to fulfill this position. Lori will contribute to implementation planning for KanCare 2.0. Lori is a Registered Nurse and an experienced managed care executive who led the design and implementation of Long Term Services and Supports (LTSS) and Long Term Care (LTC) programs including seven 1915c waiver programs: I/DD, Severe Emotional Disturbance (SED), Frail Elderly (FE), Physically Disabled (PD), Technology Assisted (TA), Autism, Traumatic Brain Injury (TBI) as well as the Work Opportunities Reward Kansans (WORK) employment program. As the Service Coordination Director, Lori will be responsible for all service coordination activities and will

actively collaborate with the BH supports Director and the Health Services Director to provide comprehensive, holistic care to our Members.

Provider Relations Director/Manager- Doug Klise, Director- Provider Relations

- 4 years at Sunflower
- 10 years in Medicaid managed care
- 30 years working in health care

Sunflower's Provider Relations Director, Doug Klise, has been working with the Kansas provider community for nearly 30 years, including 10 years working with Medicaid provider networks in the state. As the Provider Relations Director, Doug is responsible for Provider services and Provider relations including resolving Provider payment issues and developing and executing Provider training and education programs. Doug also serves as the Sunflower single point of contact for KDHE related to escalated provider concerns. Prior to joining Sunflower, Doug managed field operations for Medicaid managed care plans in South Carolina and Kansas. Doug also served in Provider services and Provider education roles at Blue Cross and Blue Shield of Kansas.

Working in the Provider Relations area allows me to utilize my skills of diplomacy and collaboration to handle delicate situations and issues between the provider community and the health plan. My role is to lead staff in providing broad education related to understanding Medicaid rules and how to effectively work with the health plan that benefits not only the provider but also the health plan in reducing administrative costs on both sides. An example relating to this involved a large health facility wanting to term their contract over perceived issues. After a large amount of research, it was determined that not all of the issues were the health plans fault and the provider had more than a fair share of internal issues to deal within their organization. Though working with various areas within our company and frequent contact with the provider, we were able to repair the relationship with the provider and have since included them in a pay for performance quality program.

-Doug Klise

LTSS Provider Representative- Alana Dotson, Provider Network Specialist

- 4 years at Sunflower
- 7 years in health care
- 15 years working with the I/DD population

As the LTSS Provider Representative, Alana Dotson assists IDD providers in navigating their relationship with Sunflower. She assists with claims issues, service authorization, and using the Sunflower Secure Web portal. Alana acts as a liaison between providers and various Sunflower departments (e.g. Pharmacy, Service Coordination) to ensure that our members receive the best care possible. Alana also helps trouble shoot when providers have concerns with KDADS,

CDDO's and internal staff. Alana also contributes to Sunflower's internal Extraordinary Funding Committee and helped to establish the committee for the Wichita region.

Alana spent 8 years at the Sedgwick County CDDO (largest CDDO in the state). She completed eligibility and BASIS assessments, served on the funding committee, reviewed extraordinary funding requests, and completed Quality reviews with service providers.

"I love that my work is helping our providers who serve some of our most vulnerable members. The IDD providers need to focus on serving our members and providing them with the best care. I love knowing they can call me and I can assist with answering questions or helping understand a claim concern or question about where and who to ask for anything else they might need. I'm able to coordinate between our providers and the health plan. My previous work for a CDDO has allowed me to have a good understanding of all aspects of the IDD world and help our IDD providers navigate the managed care world."

-Alana Dotson

BH Provider Representative- Chad Benhardt, Manager- Network Development

- 4 years in BH network management with Centene
- 6 years in Medicaid managed care
- 13 years in health care

Sunflower's BH Provider Representative, Chad Benhardt, is a recognized provider relations, operations and customer relations leader. In his role as BH Provider Representative, Chad leads provider services for our BH network providers and serves as an internal advocate for BH providers in the areas of contracting, service authorization, and claims payment. Prior to joining Sunflower, Chad led regional network management for a national home care benefits management company.

"My role within Sunflower is very gratifying and self-rewarding knowing that we are helping some of the most vulnerable populations with in the state of Kansas. In the behavior health sector we are helping those that often times misunderstood and stamped with a stigma that can be very hurtful and detrimental to a person's self-perception and trust of others. By working with our providers and developing a strong and trusting relationship my role helps to ensure that our members are getting the quality care they deserve and need. Knowing that I am a part of that help to our members gives me a sense of accomplishment and I am proud to say that I am Sunflower employee."

-Chad Benhardt

Network Management and Contracting Director/Manager- Debra Burnham, VP- Contracting and Network Development

- 10 years at Centene
- 5 years at Sunflower

- Over 30 years in health care

Debra (Deb) Whited Burnham is Vice President of Contracting/Network Development with Sunflower. Deb is known for her commitment, integrity, resourcefulness and willingness to share information that makes a positive difference to others. As Vice President, she promotes a culture of excellence through leadership and oversight of the health plan's contracting and provider relations activities relative to operations and business development. In this role, she enjoys educating and mentoring other Centene health plans on "best in class" processes and workflows for provider contracting, provider enrollment, provider data loading and auditing, and credentialing. She has been with Centene since 2007. She holds a Masters in Management from Baker University and a degree in Business Administration from Fort Hays State University.

"Through my role at Sunflower, I enjoy overseeing the education, training and support to providers in our network across the State of Kansas. In previous roles, prior to Sunflower, I worked for some of the very providers in our network and understand the importance of providing the necessary tools to providers so that their focus is on the member and not on administrative barriers to serving our members."

-Deb Burnham

Subcontractor Oversight Staff- Greg Herdlick, Manager- Vendor Management

- 4 years at Sunflower
- Over 20 years in health care

Greg Herdlick, Manager of Vendor Management, has over 20 plus years in the health care industry working in both Finance and Operations. He received his MBA in 1996 and has been working in health care since that time. Greg currently serves as the Manager of Vendor Management where he oversees several vendors who provide important services to Kansas residents. At a minimum, Sunflower Vendor Management team meets with specific vendors quarterly to review their metrics to ensure all deliverables are met within the State's guidelines and that our members are receiving their requested services in a professional and timely matter. Some of these benefits include dental, vision, non-emergent medical transportation, behavioral health just to name a few. Greg takes full accountability and works to resolve any issues that are escalated from a member related to any activity contracted with business partners outside of Sunflower's brick and mortar.

"While my role as Vendor Manager is more 'behind the scenes', I thoroughly enjoy working with our partners daily which enables our members to utilize their benefits and obtain the services needed to improve their health outcomes. Personally, knowing every day that a member(s) is using one of our vendors to improve their day-to-day life, motivates me to do the best job I can to make a positive impact on our community."

-Greg Herdlick

Transition of Care Coordinator- Kyle Jones, Manager- Case Management

- 3 years at Sunflower
- 5 years in Medicaid managed care
- 28 years in health care

Kyle Jones, Sunflower's Transition of Care Coordinator, has been overseeing case management services in a variety of positions since 2010. As the Transition of Care Coordinator, Kyle is responsible for working across Sunflower internal departments to support complex transitions of care cases such as discharges from a nursing facility to the community with complex home and community-based service needs. Prior to joining Sunflower, Kyle managed the case management team at another KanCare MCO. Kyle also spent 10 years as the Director of Children's Attendant Care at the Mental Health Association of South Central Kansas.

"I enjoy working at Sunflower because it has been my life's passion assisting others. I have had the opportunity to work with various members at different points of their lives to assist and improve their quality of life. Helping others has always been important for my own self-worth and job satisfaction in hope that someday if I need assistance someone will be there for me. My entire career in health care has been directly providing case management service to Medicaid members. The opportunity I have had since the implementation of the KanCare program has been the ability to use my leadership skills coupled with my education and experience to positively impact the social, behavioral, and health outcomes of our members."

-Kyle Jones

Housing Services and Supports Coordinator- Sherry Biddle (Transitional Leader)

- 30 years of experience supporting people with I/DD
- Certified Trainer for Quality of Life Assessments

Sherry Biddle, the Community Living Facilitator will serve as our transitional lead prior to the full-time hire of a Housing Services and Supports Coordinator. Sherry works directly with members, internal & external teams and other stake holders to increase the Quality of Life for members and ensure they live in the least restrictive setting possible. When teams identify barriers to least restrictive settings, Sherry works closely with them to find other residential alternatives including connecting them with resources in the community such as the Housing Authority. Sherry is a certified trainer for Quality of Life Assessments. She is also a certified trainer for Mental Health Approaches to I/DD through NADD. Sherry is the facilitator for Sunflower's Extraordinary Funding Committee and ensures funding is reviewed annually. Sherry participates on the Behavioral Health Advisory Workgroup with Sedgwick County. Sherry participates on numerous statewide workgroups including the HCBS group and the Waiver Integration Stakeholder Engagement group. Sherry helped develop the Shared Living manual. Sherry received certification from the Kansas Institute of Positive Behavior Supports. Sherry has been a member of Epsilon Sigma Alpha (philanthropic sorority) for the past 15 years. This

sorority supports Heartsprings and St. Jude Hospital. Sherry brings with her 30 years of experience supporting people with Intellectual and Developmental Disabilities (I/DD).

Sunflower has identified an experienced and qualified candidate to fill this role. This candidate has over 23 years' experience implementing, managing, and overseeing housing programs, initiatives, and policies and procedures in Kansas. A leader in their field, this candidate has experience working with LTSS and I/DD populations and direct experience working with KDADS. Having served as a board members on both the Board of Directors for Community Action and Board of Directors for the Kansas Statewide Homeless Coalition, this candidate brings unique expertise to this role.

Employment Services and Supports Coordinator- Cheryl Laaker, Lifeshare- Trainer

- 2 years at Centene
- 4 years in Medicaid managed care
- 28 years in Long Term Services and Supports

Cheryl Laaker, the Employment/Meaningful Day Pathway Facilitator works directly with members, internal teams and external teams to increase the quality of life of members through administering assessments, providing resources and providing training to change cultural norms. When teams identify barriers to employment for members, Cheryl works with the member and their providers and families to provide resources and brainstorm solutions which may include implementing Project SEARCH. As Statewide Project SEARCH coordinator, Cheryl facilitates and leads trainings quarterly as well as monthly collaboration meetings; participates in several steering committee meetings for individual sites and assists in implementation of new programs providing trainings and identifying partners to implement the program. Cheryl also works closely with National Project SEARCH to assure fidelity of programs across Kansas. Cheryl holds a position on the board of the Kansas Chapter of APSE (Association of People Supporting Employment First), participates in the Transformers group (a group of key state stakeholders dedicated to supporting employment first); participates in the FEAT trainings with Families Together, and participates in the Community of Practice for the LifeCourse Framework. She is also a certified trainer for Mental Health Approaches to I/DD through NADD (An association for persons with developmental disabilities and mental health needs). She provides coordination and participates in statewide calls for Disability Mentoring Days across the state. To stay current with employment practices across the state, she follows the Kansas Commission of Disability Concerns, Kansas Council for Developmental Disabilities and the Employment First Oversight Commission Meeting. She pulls from her 28 years of experience in the field of developmental disabilities to encourage individuals to increase independence through employment and quality programs.

"Working at Sunflower/LifeShare has allowed me to share my vision of a person focused quality of life for all members. Through collaboration with the LTSS care coordinators, I am able to enhance a member's quality of life by completing our quality of life assessment, providing resources for employment, providing leadership for the Project SEARCH sites statewide and

developing new Project SEARCH sites throughout the state. As an example of the impact of this philosophy on the members, I worked with a young man who recently transitioned from high school to adult services and was not successful in his current environment. He was often non-compliant and argumentative with staff. Through the quality of life process, I was able to identify that he really wanted employment vs doing community activities with day services. I was able to change the philosophy of the provider through trainings about employment and benefits and the provider now supports the member in a job. He has been so successful in his job the provider has reduced hours directly supporting him."

-Cheryl Laaker

EPSDT Coordinator- Mariza Greenwald, Manager- Quality Improvement

- 4 years at Sunflower
- 5 years in Medicaid managed care
- 18 years in health care, Registered Nurse

Mariza Greenwald is the Medical Review Unit where she is responsible for the development and management of the Medical Review Department, including its nursing staff. She brings more than 27 years of health care experience to her current position, which includes reviewing claims and medical records for potentially avoidable readmissions to identify quality and/or overpayment issues and managing the team that processes all the requests for release of Sunflower's medical records. Her accomplishments while in this position, include creating and implementing all Sunflower policies and procedures regarding 30-Day Readmission Review corporate initiative; assembling a multi-disciplinary work group from across Centene to assist with the implementation of 30-Day Readmission Review initiative; and serving as a resource to other Centene health plans for the implementation of this initiative. Previously, she was Sunflower's Manager of Utilization Management (UM) where she and her team developed and managed a medical utilization management department that provided managed care to Kansas Medicaid recipients. Department responsibilities included receiving and reviewing prior authorization requests for medical and waiver services and communicating determinations to providers; promoting and ensuring compliance with federal and state regulations and contractual agreements; developing, implementing, and maintaining UM programs to facilitate the use of appropriate medical resources and control costs; and actively participated in ongoing staff training and development.

"My position entails oversight of how well the quality of health care services are delivered to our members. The Quality team performs various interventions to reach out to members for education and assistance in accessing their health care benefits. We also monitor the quality outcomes of provider services given to our members. As our members are among the most vulnerable in the population, it is essential that Sunflower staff advocate strongly for them. This is part of our corporate beliefs and engrained in Sunflower culture from the top down. After reaching out to a member's mother to remind her of upcoming childhood vaccinations, one of my staff received a voicemail in response. The message was lengthy and heartfelt and the mother expressed gratitude to Sunflower staff for the care and concerned she had received. She

explained a bit about the circumstances that led to the need for Medicaid and said she was now able to transition off Medicaid to a commercial insurance product. The mother expressed that the care and respect she was shown as a Sunflower member was outstanding and helpful at a time when she needed support. Being able to provide a positive impact on the lives of many by what Sunflower does motivates me to give 110% every day and be grateful to work at Centene."

-Mariza Greenwald

Foster Care Coordinator- Brenda Soto, Manager- Case Management

- 2 years at Sunflower
- 21 years working in the Kansas Foster Care System

Brenda Soto, LSCS will serve as our Foster Care Coordinator. Brenda is currently the Foster Care Clinical Manager and brings more than 20 years of Child Welfare experience working within Kansas for two different Lead Agencies (KVC Behavioral Healthcare and Kansas Children's Service League, more than 10 years of experience in developmental disabilities with 1 CDDO, Cottonwood, INC. and is trauma informed trained in Trauma Systems Therapy as a Master KVC Trainer. As the foster care subject matter expert, she provides leadership for the Sunflower Foster Care Medicaid product and provides clinical supervision for the Care Coordination team. Brenda represents Sunflower and works closely with Kansas foster care partners and stakeholders at the following community meetings; KVC Behavioral HealthCare round Tables, KVC Behavioral HealthCare Kansas Community Advisory Board, KanCare Meetings, Psychiatric Residential Treatment Facility Stakeholders Meeting, the High Needs KanCare workgroup and the Psychotropic Medication workgroup, (the descriptions of these meeting are attached). Brenda has additional experience as the past Foster Care Clinical Manager/subject matter expert in Mississippi for the Magnolia Health Plan's Medicaid product.
She has assisted in the development of the Sunflower's Transitioning Youth Program, written about in the response. She additionally will assist in the development of the Adoption Program discussed in the response as well.

"As the Foster Care Clinical Manager and Kansas native, I have the honor of representing Sunflower at all State Foster Care meetings and the ability to shape the Foster Care Program through years of foster care experience in the state of Kansas. The Foster Care Department contains 6 dedicated staff with a combined total of more than 140 years of Child Welfare experience with expertise in trauma, attachment, case management, state resources and many therapeutic models. This dedicated group provides support to the foster care membership through excellent service coordination. We live by the saying, "Every interaction is an intervention." Whether that intervention is by phone or face-to-face, our interactions make a difference in the lives of our members. Additionally, that impact goes beyond the members and touches our community partners, the CMHC's, private providers, the dedicated workforce of both Lead Agencies: KVC Behavioral Health Care and St. Francis, and the outstanding Foster Families/Relatives/ and Non-Related Kin, who support our members every day. Together we can make a difference, 1 foster child at a time."

-Brenda Soto

Grievance and Appeals Director/Manager- Michelle Collins, Manager- Quality Improvement

- 2 years at Sunflower
- 15 years in health care
- Registered Nurse

As Manager of Quality Improvement, Michelle Collins is responsible for ensuring that our Members and Providers have a good experience with Sunflower and that they are able to access the Sunflower Member or Provider Grievance and Appeals Systems. Michelle also works to ensure that Sunflower operates the Grievance and Appeals Systems in accordance with applicable state and federal guidelines.

Throughout her 14 plus years as a Registered Nurse, Michelle has carried out Quality Improvement functions for over half of her career. In a previous role in the senior living field, Michelle worked with members on the HCBS-FE waiver to ensure they received high-quality care in the Assisted Living setting. More recently, Michelle served as Quality Improvement Coordinator and Director of Nursing in a Federally-Qualified Health Center in central Kansas where she implemented a Vaccines For Children program. The annual childhood vaccination rate for 2-year-olds at the clinic increased from 9% when the program was implemented to 83% by the time Michelle left the clinic.

"I specifically chose to come to work at Sunflower in order to be a part of an organization that provides services to those who need it most. I take pride in being able to play a role in improving the quality of care provided to Medicaid beneficiaries in Kansas. I really enjoy that I am able to see the impact that we have on members on both the individual level (i.e. discussing a grievance resolution with a member and hearing them say "thank you so much") as well as on an aggregate level (i.e. overall number of member grievances has trended downward year over year since 2015). I'm able to see that we are doing good things over all, but also experience the personal impact that we have on individual members."

-Michelle Collins

Provider Appeals Director/Manager- Elaine Parker, Manager- Claims and Contract Support Services

- 5 years at Sunflower
- 17 years in Medicaid managed care
- 37 years in health care

As the Provider Appeals Director, Elaine Parker provides leadership and oversight of provider and system configuration activities. Provider set up is critical to provider reimbursement. As contracts are signed Elaine's team creates the tool used by the Centene's Provider Data Management team for accurate provider data loads. Elaine has weekly interaction with the

State Policy team. The Policy team meeting is used to communicate new policies, policy changes and updates to the health plan. Elaine facilitates the weekly internal policy meeting. The Internal Policy meeting is used to communicate the State Policies to each functional area within Sunflower. The meeting time is also used as a time to discuss how the policy impacts the various teams within Sunflower. Elaine oversights the activities related to timely configuration of the claim system. Elaine has more than 30 years of claim related experience. 17 of the 30 years has been specific to Kansas Medicaid.

"I like that my work provides lots of variety. Today we might be reviewing provider contracts for provider setup, tomorrow we are working on system configuration to comply with State policies. Our work is behind the scenes but it's critical to accurate provider reimbursement. The goal of the business analyst is to get it right the first time. When mistakes are made they are addressed quickly. Our quick responses allows Sunflower to build better relationships in the provider community."

-Elaine Parker

LTSS Member Advocate- Ian Kuenzi, Member Advocate (LTSS)

- 5 Years at Sunflower

Ian Kuenzi has served in multiple positions at Sunflower and has been a Sunflower Member Advocate since August 2016. Ian has been an individual disability rights advocate for at least 20 years. Ian has Cerebral Palsy and uses personal care services to independently live on his own and work at Sunflower. Ian's knowledge of services gives him a unique prospective on how to assist Sunflower members with HCBS. Ian provides advice to HCBS members when issues arise and assists them in navigating the system. Ian also monitors and tracks members on the PD wait list. He provides community resource referrals for non-covered services. Ian attends state meetings, hearings, and workgroups providing the disability prospective about how Members might be affected by policy. Ian also provides education to newly hired staff at Sunflower about disability rights history and education to the community about expectations for people with disabilities. Ian has also helped to develop a children's book about disability acceptance.

"Sunflower has embraced Disability rights and Medicaid in a way that no other Medicaid company has. We teach a training course about disability rights history. Also we look at the whole person and quality of life not just the medical diagnosis. While I've worked for Sunflower I have had the opportunity to assist a families with IEPs to make sure that they get what they are entitled to in schools. I have assisted one family to successfully advocate for extended school to stop regression over the summer. I also have assisted in advocating community placement for a member to receive residential services over institutions."

-Ian Kuenzi

BH Member Advocate- Jeannette Bass, Member Advocate (BH)

- 5 years with Sunflower

- 13 years in health care

As a proven investigative researcher with an emphasis on employer and customer privacy protections, Jeanette Bass has served Sunflower as the Grievance and Appeals (G&A) Coordinator since 2012 and has more than 30 years' experience in fraud investigations and quality assurance. Currently, she manages the grievance process with our transportation vendor, analyzes and addresses member and provider grievances, and facilitates the G&A Committee meetings. She also uses her extensive experience in negotiations, medical claims, bankruptcy, and quality assurance to collaborate with subject matter experts in complex cases and liaison between members, provider, and regulatory agencies. Recent accomplishments include responsibility for the preparation of grievance cases and facilitation of presentations for corporate and state audits. Previous experience includes developing and implementing efficient quality assurance testing resources, providing analytical assistance to various staff and policy holders as a malpractice representative, and working as a Senior Finance Investigative Analyst, where she lead a team of fraud investigators, developed and facilitated training curriculums, and monitored electronic profiling systems.

"I consider it a blessing that in my position here at the health plan, I am able to be a contributor to the overall opinion our members have of their experiences as participants in the Sunflower. I am excited to arrive to the office daily, knowing the likelihood is great that I will be able to help multiple members meet their needs, and as a result, they gain better health outcomes. I begin each day with the goal to create the most satisfying health care experience possible for every member I come into contact with. Willingly, I take all the time necessary to provide direction for utilizing all the benefits and services we have available. Additionally, I encourage our members to give us feedback, because it gives us the opportunity to make changes and improve upon the matters that concern them. In summary, I am committed to being active in expanding upon the ways by which the health plan can exceed member expectations, as they are our priority!

I recall receiving a grievance from a parent who felt our member had been unfairly removed from a residential facility. By assisting parent in every way that he requested, a team of us were successful at re-establishing services appropriate for member's needs. At the conclusion, I can honestly say that I felt that member and his family were in a better position as a result of having a dedicated team of Sunflower representatives who cared about the needs of our member."

-Jeannette Bass

Information Systems Director/Manager- Dr. Jonalan Smith, VP- Operations

- 4 years at Sunflower
- Over 15 years working with Medicaid Members and Providers in health care industry
- Licensed Pharmacist and Doctor of Pharmacy

A Pharmacist by training, Dr. Jonalan Smith, Sunflower's VP of Operations will serve as our Information Systems Director. In his role overseeing operations, Jonalan will oversee all information systems functions supporting our contract with KDHE. Jonalan is experienced in

Sunflower's IT systems and their interfaces with KDHE and its other vendors. Jonalan has worked in health care both as a clinician and as an executive for over fifteen years. His experience includes over ten years on the provider-side serving in leadership roles within a behavioral health focused pharmacy services provider both in Kansas and across the country. Prior to his administrative roles, he practiced as a pharmacist located within Community Mental Health Centers and other practice settings.

Jonalan served as the 2017 President and Chairman of the Board for the Kansas Pharmacists Association, and he also has served on the Kansas Health Information Exchange Board of Directors, the Kan-HIT Advisory Committee, the KDHE Preferred Drug List Advisory Committee, the Kansas Pharmacy Foundation Board of Trustees, and other boards and committees. Jonalan received his Doctor of Pharmacy from the University of Kansas in Lawrence, and continues as Adjunct Faculty with the University of Kansas School of Pharmacy providing a training site for student pharmacists at Sunflower.

"Working at Sunflower has been extremely rewarding to me both personally and professionally. The ability to have a direct impact on individual members, our entire membership from a population health perspective, and our direct service providers that help our members lead healthier and better lives. Although the working directly with members and personally seeing their improved outcomes is typically the most rewarding aspect of what I get to do, the things I am most proudest of have been the ability to build strong relationships with our direct service providers who provide care for our members. These relationships have allowed Sunflower to support our direct service providers in an enhanced way that has led to improvements in our members' health and lives. Just one example would be Sunflower enhancing our Medication Therapy Management Services benefit setup to allow more of our local network pharmacists provide reimbursed MTM services that are most appropriate for our KanCare members, which has resulted in wonderful outcomes and reduced overall medical costs."

-Jonalan Smith

Claims/Operations Manager- Michelle Boller, Senior Manager- Operations

- 5 years at Sunflower
- 13 years at Centene
- 22 years in health care

Michelle Boller has the expertise and experience for providing oversight to our claims and encounter processing for Sunflower. Michelle brings more than 20 years of experience in health care operations. Michelle focuses on innovative and strategic initiatives to improve overall outcomes to claims timeliness, claims processing and encounter processing. Michelle has played a key role in provider education efforts, support of other functional areas and the impacts to claims and/or encounter processing. Throughout the previous years in the KanCare program, Michelle has been instrumental in developing and implementing numerous process improvements that have a positive effect to both our members and providers. Michelle also

brings eight years of experience in internal auditing with Centene through which she was exposed to numerous different Medicaid managed care state plans and their operations.

"The Senior Manager of Operations role allows me to work collaboratively with many different functional areas and entities. I strive to ensure that we are regularly reviewing and implementing process improvements within operations to provide the best level of service to both our members and our providers. Throughout the years of being a member of the Sunflower operations team, I have personally implemented many process improvements that have had a positive impact to our providers, members and other customers. I continue to challenge my team to implement process improvements to ensure that operations are functioning most effectively."

-Michelle Boller

STAFFING IN PLACE PRIOR TO CONTRACT START (5.17.2.D)

Sunflower is currently fully operational with existing staff that support compliance with all program requirements. As an existing KanCare MCO, our staff will be in place prior to the Contract Start date. Key Personnel positions that are being proposed with Interim staff will be filled with permanent staff within 90 days of the Contract start state. To the extent that staff assignments change as a result of new program requirements, or incremental staff is added, these changes will occur prior to the contract start date.

OTHER PERSONNEL (5.17.2.E)

Sunflower maintains robust staffing across several functional areas and departments. These other personnel work with our Key Personnel, identified above, to support efficient operations and superior service to our members and providers. For example, in addition to the Key Personnel, Sunflower is creating three locally-based positions to support our members, providers, and the KanCare 2.0 program. These positions are:

- Director of SDOHI, Nan Perrin

  As Director of SDOHI, Nan will oversee our SDOHI Center of Excellence (COE) team comprised of Transition of Care Coordinators, Housing Specialists and Employment Supports Specialists, and Member Advocates. These Specialists promote community integration and independence and provide technical assistance and supports to the member, the member's assigned SCs/CSCs and IC Team. This team will work closely with our Director of LTSS.
- Director of LTSS Operations, Dana Podrebarac

  As Director of LTSS Operations, Dana will oversee Sunflower's System of Care (SOC) Liaisons. Our SOC Liaisons cross-system trained and include our Foster Care Liaison, State Hospital Liaisons, HCBS Program Liaisons, Educational Liaison, Criminal Justice Liaison, and Children and Youth with Special Health Care Needs (CYSHCN) Liaison. These SOC Liaisons enhance member care by supporting providers and working to identify and close system of care gaps and barriers, share information, advocate, and facilitate linkages between the healthcare and community-based service systems. Liaisons also act as a single point of

contact to help resolve system issues, facilitating cross-systems protocol improvement and supporting ongoing coordination

- Manager of Community Service Coordination and Electronic Visit Verification (EVV), Sarah Kirgan

Our Manager of Community Service Coordination and EVV will report to our Director of LTSS Operations.

"Our inclusive workplace is owed to our continued support and enhancement of these statewide employment opportunities as well as our current workforce, which passionately promotes the abilities and successes of all people."
-Chris Coffey, Sunflower President and CEO

Functional Area Staffing Ratios

As membership levels change, we will adjust our staffing levels to achieve a consistent quality of service. ***Table 5.17_A Functional Area Staffing Ratios*** below shows our staffing levels by functional area in terms of Full Time Equivalent staff per 10,000 Members.

Table 5.17_A Functional Area Staffing Ratios

Functional Area Staffing Ratios (FTE per 10,000 Members)	
MEDICAL AFFAIRS AND LTSS– Includes Service Coordination, Utilization Management, Community Health Workers, and Quality Improvement	21.69 per 10,000*
NETWORK (OPERATIONS) – Includes Provider Relations, Provider Data Management, Contracting, Network Development	1.69 per 10,000
COMPLIANCE – Includes Government Relations, Compliance and Legal	0.46 per 10,000
MEMBERSHIP (OPERATIONS) – Includes Member Services, Member Experience, and Enrollment	3.07 per 10,000
FINANCE – Includes Corporate Finance, Health Plan Accounting, Actuary, Billing, and Financial Planning and Analysis	0.61 per 10,000
EXECUTIVE/OPERATIONS – Includes Executive Leadership, Claims/Encounters, Marketing and Communications, Training, Facilities, Pharmacy, Provider Services, Vendor Management, Data Analytics, and System Operations	3 per 10,000

**Does not include contracted CSCs*

HIRING INDIVIDUALS WITH DISABILITIES (5.17.2.F)

Sunflower believes that the strongest teams are diverse teams and we actively recruit team members who are representative of the communities we serve. This includes employment of individuals with disabilities in a variety of capacities across the organization. Sunflower is a leader in employing people with disabilities, and we will build on our established efforts in this area to develop our Hiring Individuals with Disabilities Plan which will be submitted to the state within 60 days of contract award. Specifically, our plan will leverage Sunflower's leadership role in Project SEARCH, a program designed to transition people with disabilities from school to employment. Sunflower has been selected as the statewide manager for Project SEARCH in the State of Kansas. Through this program, we have benefitted from important contributions from Project SEARCH interns while providing important job skills training that benefits Project SEARCH participants.

Sunflower has already achieved the State's goals for hiring individuals with disabilities. According to employee self-reported information 5.8% of our current, Kansas-based staff are living with disabilities exceeding the State's goal of 5% by the end of the first year of KanCare 2.0 operations. Through providing a workplace that is accommodating of individuals with disabilities we will continue to recruit and hire qualified individuals with disability with a goal of increasing the proportion of our Kansas-based staff who live with disabilities by 1% a year until people with disabilities comprise 10% of our total Kansas-based staff.

Our success in engaging and hiring people with disabilities has been recognized as a best practice. The Greater Kansas City Business Leadership Network (GKCBLN) named Sunflower as the **2016 Dis*Ability* Champion Award recipient** as a result of its work with Project SEARCH and overall efforts to engage individuals with disabilities in meaningful employment.

Additionally, Sunflower's parent organization, Centene, was named to the 2017 list of the **Best Places to Work for People with Disabilities**, presented by the American Association of People with Disabilities and the U.S. Business Leadership Network. The company earned the distinction after scoring a 90 out of 100 on the Disability Equality Index (DEI), a national benchmarking tool that measures businesses on their disability inclusion policies and practices.

Centene National Disability Advisory Council Members which includes two representatives from Kansas, Martha Hodgesmith and Mike Oxford

Working at Sunflower: The Story of an Employee with Disabilities – Ian Kuenzi

Over the past 5 years I've had the honor and privilege of working for Sunflower. Sunflower has embraced Disability rights and Medicaid in a way that no other Medicaid company has. We teach a training course about disability rights history. We look at the whole person and their

quality of life, not just the medical diagnosis. While I've worked for Sunflower, I have had the opportunity to assist families with Individualized Education Plans (IEPs) to make sure that they get what they are entitled to in school. For example, I assisted one family to successfully advocate for extended school to stop regression over the summer. I have also assisted in advocating community placement for a Sunflower member to receive residential services over an institutional setting by challenging the norm. I've helped Care Managers (Service Coordinators) realize why members are not currently using services they have because there are underlying social issues they don't like to discuss because of their trust issues. I've gone to a few member homes to help problem solve HCBS issues they encounter. I also connect with members and their families by phone too. I like talking with younger members about their goals, employment opportunities and the fact that disability is not about what you can't do anymore but instead what you should do in spite of it. I collaborated with Sunflower to write a children's book about disability acceptance and present this story at schools, when asked. Collaborating to write a children's book is quite possibly the most important project I've been able to do at Sunflower because I want to help end the stigma of disability in the younger generation.

> *"Nothing is impossible for people with disabilities. Unlike other managed care companies, Sunflower understands this and does its best to help members live our lives."*
> ***-Ian Kuenzi, Sunflower LTSS Member Advocate (and person living with disabilities)***

During one of these book events I met a young 5-6 year-old boy who had been teased for using a wheelchair and left alone at recess because he couldn't play the games the same as other kids. I explained that I played lots of games at recess but first I had to get my classmates to change the way games were played so I could play. When I asked the young boy what he wanted to do as an adult he said cook so I told him that at recess he could get equipment or an accessible kitchen to help him cook. Nothing is impossible for people with disabilities, unlike other managed care companies, Sunflower understands this and does its best to help members live our lives.

To that end, on a personal level, Sunflower has given myself and others with disabilities the opportunity for good integrated employment and the opportunity to impact the system we are a part of. Because of my employment with Sunflower, I bought a house and new van when I needed one. When it comes to my HCBS services my Care Manager (Service Coordinator) always lets me drive, so to speak, and listens to what I really need and why.

COMMUNITY PARTNERSHIPS (5.17.2.G)

Sunflower's relationships with community based organizations provide direct value to our Members and also to Sunflower Staff. We have already established partnerships with various organizations that include community experts providing Sunflower with guidance, training and education that support an improved understanding of the Members we serve consistent with our focus on person-centered, integrated care. Examples of our current partnerships and the subjects on which they provide us with assistance include:

- Jewish Family Services- Trauma Informed Care for Holocaust Survivors

- Chamberlin Edmonds Emdeon- SSI Training
- Families Together and Kansas Guardianship Program-IEP Transition
- MindsMatter on TBI services
- Topeka Independent Living and Resource Center on Self Direction
- Community Living Opportunities on I/DD Services
- Keys For Networking

We will build upon our existing relationships with trade associations and faith-based organizations with whom we currently collaborate on issues ranging from provider network management to care coordination, to identify additional supports that these groups can offer to Sunflower. Building a mutually beneficial relationship with these stakeholders will make our program better, and serve the needs of our members.

Process for Building Community Relationships

Sunflower uses a variety of approaches for identifying community partners who can contribute expertise to our staff in areas including person-centered care. The process for building relationships with these organizations includes:

- **Engagement through Sunflower's established advisory committees.** Our advisory committees include representation from multiple community stakeholders. In addition to providing Sunflower with feedback about our program operations, Community Organizations contribute technical assistance and subject matter expertise through their participation on advisory committees.
- **Community-based staff relationships.** Our community-based Service Coordination staff have established relationships with community based organizations who serve our Members. These staff will seek opportunities to collaborate with those organizations to provide specialized training to our Member-facing staff.
- **Attendance of conferences and meetings in the community.** Sunflower routinely attends conferences and meetings hosted by trade associations and advocacy organizations. Sunflower staff who attend these events participate in educational sessions, panel discussions, and keynote speeches that enhance our understanding of the Members we serve.

82% of Sunflower's workforce participated in the 2017 United Way campaign, with more than $50,000 of personal donations pledged to local charities across Kansas.

Commitment to Our Community. At Sunflower, our staff value the communities we serve. We contribute to the betterment of Kansas through participation in events and causes that support Sunflower's mission to transform the health of the community one person at a time. With employees at the heart of our mission, they share the company's desire for a local presence by supporting charities throughout the year with their personal time and resources. These charities supported by Sunflower staff include the American Heart Association fundraisers,

Christmas in October home improvement for the disabled, Harvesters food drives, Christmas Bureau, Ronald McDonald House home-cooked meals, Happy Bottoms diaper drive, Special Olympics event volunteering and team coaching, Giving the Basics toiletry drive, Suicide Prevention Coalition community event volunteering, United Way fundraisers, Parkinson's Foundation fundraisers, Arthritis Foundation fundraisers, among many others.

5.17.3. STAFF, TRAINING, AND EDUCATION

INITIAL ORIENTATION AND ONGOING TRAINING (5.17.3.A)

Initial Centene and Sunflower Staff Training

Sunflower's goal is to attract, develop, challenge, and retain the best and brightest talent available. Training is important in creating an ideal work environment, raising the confidence and expanding the abilities of employees, and improving our ability to serve IHQHI program members. Centene's Training and Development Department has four major objectives:

- Maintain a standardized new-hire training checklist for each position
- Maintain a training curriculum that addresses all Centene core values, including cultural competency and disability sensitivity
- Increase use of technology, including web and computer-based training to reach a broader audience
- Continuously evaluate training and development needs and expand education and cross-training opportunities

This section describes both initial general training for all new employees and job-specific training, including examples in two functional areas.

New Employee Orientation

The Centene Corporate Training Department develops, maintains, and updates the new employee orientation information and materials provided to all new employees. Sunflower's local Manager of Human Resources will conduct new employee orientation locally. The training incorporates a combination of facilitator-led and Computer Based Training (CBT), and begins with an overview of Sunflower operations and the IHQHI program. After the Kansas based Medicaid program training, each new employee participates in an extensive CBT program called "Centene 101," which covers a wide variety of topics including the role of key functional areas and operational policies and internal procedures, as described in the table below. In addition, the Employee Handbook and all Sunflower Policies and Procedures will be made available to all employees and subcontractors via Centene's Intranet for easy access and review. The length of new-hire orientation training, including some department or job-specific content, usually runs 1-2 days. Centene 101 includes the following CBT courses as depicted in ***Table 5.17_B CBT Courses*** below.

Table 5.17_B CBT Courses

Name of Course	Course Description
Demo Course	Familiarizes users with web based training
Centene Overview	General description of Centene, including company history and senior leadership
Diversity and Anti-Harassment	Mandatory training explaining diversity and anti-harassment guidelines
Compliance	Mandatory training describing Centene's corporate compliance philosophy and programs
HIPAA Training	Mandatory member privacy training
Business Continuity Program	Describes the Business Continuity Program at Centene and how the department prepares the company's business units for response and mitigation of contingency events.
Preventing Workplace Violence	Mandatory training to prevent violence in the workplace
Publicly Traded Company Guidelines	Overview on what is expected as an employee of a publicly traded company
Cultural Competency	Basic overview of cultural differences, similarities, styles, and an appreciation of different cultures
Member/Provider Services Overview	Overview of the services extended to our members and providers through this department – telephone inquiry, Community Health Worker program, education, etc.
Billing Errors, Abuse and Fraud (BEAF)	Overview of BEAF and Special Investigation Unit of Centene, including False Claims Act issues
Provider Relations/Contracting Overview	Overview of policies on Provider relations and Provider network contracting as well as an overview of contract models and in-services
Integrated Care Management Overview	Overview of the services available to our members and providers, for example, Service Coordination, Disease Management, Utilization Management, referrals, pharmacy, etc.
Policies and Procedures	Overview of Sunflower policies and procedures and Centene's Intranet
Employee Benefits Overview	Explanation of employee benefits, updated annually or as benefits are enhanced
Visions Training	Overview of the Developmental Disability movement, including national and State perspe

Functional Area and Job-Specific Training

Certain positions within Sunflower will require specialized skills and expertise, such as negotiation skills for network development, clinical coding for billing or auditing support, and clinical analysis for Care Management. Each Sunflower department will provide supplemental new-hire and ongoing training that is specific to the requirements of a particular position. This includes position-specific coursework, which is delivered using a combination of CBT and traditional classroom learning, with tests to measure understanding. Below are further details on two examples of Sunflower's functional area trainings; one for Utilization Management staff, and one for Customer Service Representatives.

Utilization Management (UM) Staff Training

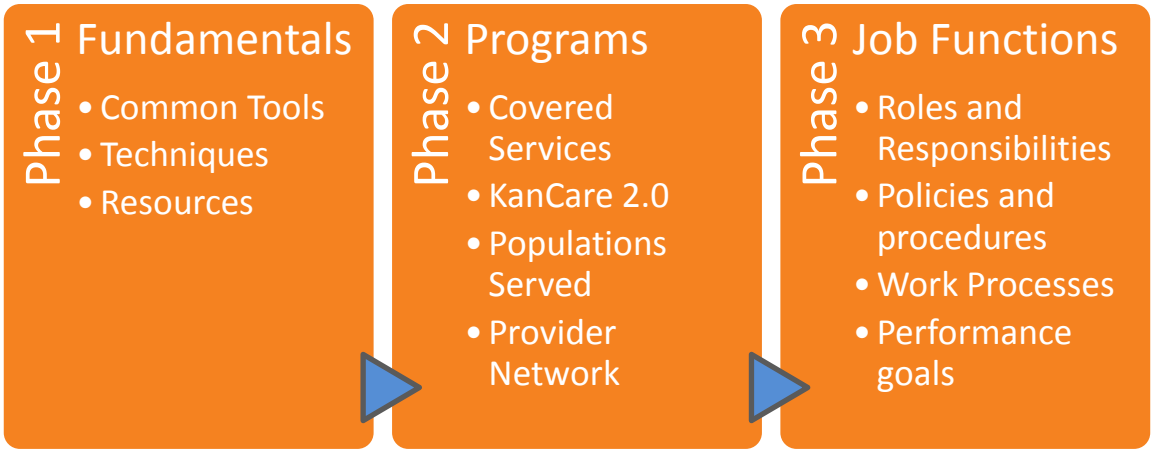
Upon hire, all UM staff will receive department-specific training from Sunflower's dedicated trainer on the following topics:

- Systems training, including for use of InterQual guidelines
- What managed care is and how it works
- History of managed care
- Managed care products
- Government health programs, how they differ from commercial health care plans, and how reimbursement works
- InterQual including severity of illness, intensity of service, and discharge criteria
- Clinical Practice Guidelines
- Care Management, including referral triggers and regional issues and resources
- Discharge planning
- Disease management
- Quality improvement, including current initiatives
- Inter-rater reliability

Customer Service Staff Training

The Customer Service Department's six-week training program will consist of three phases (see ***Figure 5.17._C_Customer Service Training*** below) including **Fundamentals**, which focuses on the common tools, techniques, and resources available to all staff members of the department; **Programs**, which provides a comprehensive review of covered services, KDHE program descriptions and requirements, populations served, and provider network; and **Job Functions**, which targets the specific roles and responsibilities of staff and introduces supervised, hands-on training. The Trainer conducts training in a classroom setting, supplemented by interactive, online modules described below in connection with ongoing training.

Figure 5.17._C_Customer Service Training



The first phase of training**, Fundamentals**, covers the following nine topics:

- **Customer Service Tools.** Customer service and telephone etiquette; active listening; the Avaya Call Management System; the CRM inquiry tracking, documentation and workflow system; call routing/warm transfers to other areas such as Care Management and Prior Authorization; coordinating three-way calls with our subcontractor for language translation.
- **Clinical.** Prior authorization process; Care and Disease Management Programs.
- **Claims.** Reimbursement models, claims review including filing requirements and guidelines, techniques to detect other insurance, resubmission and resolution processes, AMISYS Advance Claims Processing System.
- **Provider Processes.** Credentialing and recredentialing, the Medical Home concept, Sunflower's Provider Portal, provider complaints and appeals.
- **Secure Member Portal.** Self-service features for members such as how to order a replacement ID card replacement, update demographic information, complete online health risk screenings or assessments, view the online Provider Directory, change PCP.
- **Subcontractors.** Roles and scope of responsibility, and interface protocols.
- **Legal.** HIPAA and confidentiality of member information; detection and reporting of fraud, abuse and waste.
- **Resources.** Internal Intranet site containing Sunflower's policies and procedures, quick reference guides, information about Kansas-wide programs, local community resources (such as homeless shelters and food banks), Sunflower's Provider Manual, Member Handbook, and Emergency Management Plan.
- **Human Resources.** Sunflower's organization structure, Ethics and Compliance, conflict resolution, and quality improvement initiatives.

The second phase, **Programs**, includes an in depth review of covered services, IHQHI program requirements and features, populations served, demographics (urban vs. rural) and the importance of the Medical Home and coordination of services through each member's PCP. After successfully completing this module, participants progress to topics such as income levels and member eligibility categories, orienting new members to services, assisting new members through transition periods (such as from fee-for-service), screening and preventive services including EPSDT, access to emergency services, indicators of possible behavioral health crisis and the process for immediately accessing a behavioral health clinician to talk with the member, coverage for urgent or emergent needs, and complex conditions and when to transfer calls to Care Managers who can provide members with clinical information and support. Sunflower will require all staff to complete our **Cultural Competency Training Program** upon hire and annually thereafter. This program is based on the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards). Sunflower and each of our Centene affiliates follow all 15 CLAS Standards. The training reviews daily challenges facing many members such as poverty; Limited English Proficiency (LEP); low literacy; limited mobility; behavioral health conditions; and lack of shelter, food, childcare, and social supports.

We will require Customer Service Representatives (CSRs) to participate in **annual recertification training, which is based on CLAS Standards** and uses role-playing, presentations, and case discussions, with emphasis on developing skills to communicate appropriately and address members' linguistic and disability related needs and cultural differences. CSRs will receive training on listening for members' needs and anxieties, and identifying potential life stressors that may affect how they do or do not access care. We also will require biannual refresher training for staff with member contact, including CSRs.

Member Services staff will be trained on disability sensitivity, using People First Language. In addition, our training will include a review of our member education campaigns to ensure that staff are prepared to answer member questions and provide related educational materials upon request.

The third phase, **Job Functions**, will review department and individual performance goals for all staff members, specific roles and responsibilities, and related policies, procedures, and workflows. To enable staff to effectively participate in cross-functional dialogue and process improvement initiatives, and ultimately to improve service delivery, our training will include an in depth review of the role of other Sunflower departments and their staff responsibilities, and how the departments and staff relate to one another.

CSRs will learn about the role of the Community Health Workers, who are health outreach workers from the communities we serve and are familiar with the distinctive characteristics and needs of the local area. Community Health Workers receive comprehensive training and are an integral part of our Care Management teams. For example, Community Health Workers will make home visits to high-risk members and members we cannot reach by phone. CSRs learn how outreach in the member's home can improve prenatal and other health outcomes and appropriate use of Emergency Department (ED) services. CSRs also learn about the role of the Grievance and Appeal Coordinator in assisting members in State fair hearings.

In addition to topics described above, CSRs must be proficient at helping members select a PCP; educating members about appointment timeframes for preventive, routine, urgent and emergent services; processing member identification and demographic updates; making real-time PCP changes and fulfilling ID card requests; and educating members on the availability of self-service tools on the Member Portal. CSRs also will assist new members who have not proactively selected a PCP during the enrollment process or whose choice of PCP is not available. CSRs must facilitate three-way calls to assist members with making doctor appointments, intake and document member complaints for referral to a Grievance and Appeal Coordinator, and identify Members who may have special health care needs and who should be warm transferred to Care Managers for needs assessment.

Near the conclusion of the Job Functions phase, the Trainer will introduce hands-on training through involvement in real-life and real-time situations for our CSRs. Senior staff will conduct shadowing, during which they observe the new staff member's technique and competence and provide guidance and coaching. The duration of shadowing will depend on the skills and

confidence of each new staff member, who must demonstrate proficiency prior to graduating from the program and independently performing his or her job.
During this final phase of training, the Trainer and Quality Specialist will begin call monitoring of CSRs via our Call Witness application, which records calls and captures screen navigation to evaluate the effectiveness of the interaction, efficiency of the CSR's system navigation to obtain and document information, and cultural appropriateness.

Ongoing Training

Sunflower will use Cornerstone, a corporate wide learning management system complete with online courses available to all affiliates, to enhance our classroom training. The tutorials provide on-demand, anytime learning, at a pace set by each individual. Examples of applicable course content includes communication skills, conflict resolution, basic problem-solving skills, behavioral and interpersonal competencies, time management skills, computer skills, and health care reform.

The Cornerstone technology is flexible and intuitive and will allow Sunflower to develop our own course content, incorporate videos from external sources, create flexible scheduling including parameters around frequency, duration, and our own required completion dates. In addition, courses may include a real-time assessment with guided corrections as well as post-tests to evaluate CSR understanding of course content. The system provides a variety of management tools and individual employee files containing certificates of completion, all of which aid in maintaining current, individualized educational development plans for staff.
On an ongoing basis, through Cornerstone, our Trainers will develop and deploy continuing education modules addressing topics such as cultural competency, Sunflower's quality improvement programs and initiatives, new DHS requirements, and a variety of other topics. The management team within each department will require ongoing training sessions regarding department wide emerging issues, trends, and program requirement changes in advance of their implementation. Cornerstone will issue department notifications of upcoming training to all staff, and provide management with electronic notices to confirm which staff required to participate have in fact participated in the training within the timeframe indicated, along with the results of any related content mastery testing.

Additionally, our Service Coordination department hosts a weekly webinar series on Wednesday mornings where a variety of topics are covered, including the required training topics reference below as well as Sunflower-specific trainings on our systems, policies and priorities. These webinars are also leveraged to provide skills and knowledge training including condition-specific clinical information and tips for following work processes and minimizing errors.

ANNUAL STAFF TRAINING AND EDUCATION PLAN (5.17.3.B AND 5.17.3.C)

Sunflower will submit an annual staff training and education plan for KDHE approval that includes a description of our comprehensive training program detailing the frequency of training, training topics and targeted staff for each training. Our plan will include a specific approach for training Sunflower staff, delegates and contracted CSCs on the fundamentals of Service Coordination. More information about training for Service Coordination staff can be found in Section 5.4.10 of this proposal. The plan will build upon our current training offerings within our Integrated Care Management department. In 2017, Sunflower offered over 3,000 hours of training to Service Coordination staff.

In 2017 Sunflower offered over 3,000 hours of specialized training to our Service Coordination Staff.

Supervisory and Management Training

In addition to the training programs discussed throughout this response, Sunflower will provide specific training related to effective people leadership and building strong and diverse teams for both external and internal job applicants who are hired to fill supervisory and management positions. Described below are three such training programs:

Fundamentals of Management at Centene. This program emphasizes Centene's Core Beliefs, Mission, & Vision and how they provide the foundation for leadership at Centene. The training goes on to explain Centene's standards and expectations for business conduct. Trainees are taught to apply best practices, policies and procedures to become effective, empowered People Managers. The program teaches participants how to locate and utilize practical resources, offers guidelines and tips for effectively hiring and managing staff, pay procedures, time-off requests, compensation and performance management. Trainees are educated on how to effectively utilize Centene's Organizational Development and Training Programs. The program teaches People Managers how to create and develop high performing teams, and incorporate effective time management and delegation techniques into everyday operations.

Supervision 101. This training is a standardized program for all supervisors, managers, and senior management that provides comprehensive baseline orientation to key organizational policies and procedures impacting staff leadership. Key topics include performance management, compensation philosophy and practices, legal issues, team building, interviewing and recruiting, and other key issues that leaders are faced with in their everyday interactions. The program is offered semi-annually or on an as needed basis. It is facilitated by the Corporate Human Resources Manager. Generally, it lasts one full business day. PowerPoint presentations, as well as a variety of handouts, role-playing exercises, and group activities are part of the interactive learning.

Behavioral Interview Training. This program, intended for anyone in a leadership role, focuses on two key areas of human resources management: 1) the core competencies that are used as the basis for all job descriptions and performance management activities within the health

plan, and 2) the behavior based interviewing model, a standardized process that has been confirmed as reliable in recruiting for top talent. The program is offered to new leadership, generally on a semi-annual basis or as needed. It is a mandatory program for all management at the health plan. The Human Resources Manager conducts the training in a half-day format. Participants learn through a formal PowerPoint presentation as well as practice interviews with one another and video learning.

"In 2017, I was able to train over 100 Sunflower staff in the QPR method of suicide prevention gatekeeper training. This training provides them with the tools to be aware of those at risk and how to successfully intervene to keep that person safe. Since the trainings, I have had staff reach out to me to share their appreciation of the trainings and their increased confidence in having difficult conversations with those at risk."
-Len Harvey, Sunflower Staff Training Coordinator

Sunflower views training and organizational development as an ongoing process. In addition to the above programs, we will also ensure that supervisors conduct regular performance evaluations for their staff and that these evaluations include professional development planning. Development plans are intended to develop employees holistically and to increase their overall skill sets for the benefit of the organization. Additionally, Sunflower's Management staff will attend an annual strategic planning retreat and will participate in regular leadership meetings in addition to other development and training programs.

STAFF TRAINING COORDINATOR (5.17.3.D)

Sunflower has designated Dr. Leonard Harvey – Manager, Training and Development as our Staff Training Coordinator. Dr. Harvey is responsible for maintaining, overseeing, and evaluating our staff training and education plan. Dr. Harvey has:

- 3.5 years at Sunflower
- Over 25 years in Health care
- Doctorate in Nursing

Through the delivery of new hire training, precepting, and focused education; Dr. Harvey and his staff prepare care managers to best support our members and help improve their outcomes. The education team has developed extensive role based curriculums for trainings, a robust preceptor program to support staff, and a strong auditing –to- training feedback mechanism that drives new learning opportunities.

STAFF TRAINING TOPICS (5.17.3.E)

In addition to the training topics referenced earlier in this response, our staff training and education plan includes all of the training topics outlined in section 5.17.3.E. ***Figure 5.17.C_Training Topics*** below shows the minimum required training topics and how they are addressed in our staff training and education plan.

Figure 5.17.C_Training Topics

Training Topic	Impacted Staff	Frequency
Continuous Quality Improvement including rapid-cycle improvement approaches	All Employees	New Hire Orientation is done as needed per staff needs.
Advance Directives	(1) All Employees (2) Care Managers	(1) Initial Training provided at New Hire Orientation. (2) Training element for the discussion of Advance Directives during face to face visits with members Annual training provided and is done as needed per staff needs.
Member Rights	Care Managers	Initial Training provided at New Hire Orientation. Annual training provided and as needed per staff needs.
Cultural Competency	All Employees	Initial Training provided at New Hire Orientation and is done as needed per staff needs
Community integration and independent living including functional limitations and SDOHI	Care Managers	Initial Training provided during orientation. Annual training provided and as needed per staff needs.
Early identification of LTSS Members for NF Diversion	Care Managers	New Hire Orientation; ongoing support as needed
Compliance with HIPAA and other State and Federal rules and regulations	All Employees	Annual
Pharmacy Benefit	Case Managers and Customer Service Representatives.	Annual
Identifying and Reporting Adverse Incidents and Member Grievances	All Employees	New Hire Orientation and per staff needs.
Behavioral Health and Co-occurring disorders	(1) Behavioral Health Care Coordinators monthly behavioral training. (2) Case Manager monthly behavioral health training.	Monthly training provided and as needed per staff needs.
The WORK Program and other Employment initiatives	Case Managers	Annual training provided and as needed per staff needs.
Transition of Care Processes	Care Managers	Post hospital discharge team. Training presented on 11.30.2016 and training is done as needed per staff needs.
The Role of Member Advocates	All Employees	Initial training done in the LifeShare Visions training during New Hire Orientation.
Identification of Fraud, Waste, and Abuse	All Employees	Annual

DOCUMENTED COMPLIANCE WITH TRAINING REQUIREMENTS (5.17.3.F)

Sunflower is able to document compliance with all training requirements. We keep accurate and complete records of all training activities including the topics covered and the employees

who have successfully completed the training. This information is documented by the training team through sign-in sheets that are scanned and collected. Online trainings are monitored and tracked through Centene's Learning Management System, Cornerstone. Cornerstone has reporting capabilities which we use to track completion rates, audit compliance, and document training activities for the State. Cornerstone also maintains individual staff learning transcripts which are kept in an employee's personnel file.

EVALUATING EFFECTIVENESS AND OUTCOMES OF TRAINING PROGRAM (5.17.3.G)

Once training concludes, participants and staff complete an anonymous 12 question web-based survey to rate training for overall satisfaction, efficacy, relevancy, and trainer ability. Training surveys are evaluated by the training manager and are used to identify strengths and weaknesses of the training curriculum and implementation; survey outcomes and qualitative feedback received from staff and leadership provide an evaluation mechanism for programmatic changes in content and delivery of training. We also require staff and participants to complete quizzes and applied use tests during training to assess efficacy. Staff are also audited by role to assess any knowledge or practice gaps after completing training. These results are used to determine effectiveness and identify improvement opportunities. Managers review performance evaluations and member satisfaction and complaint information to identify issues that may indicate strengths and weaknesses in training protocol or curricula. Managers schedule additional training, as needed, and continue monitoring via the methods above to determine effectiveness of new training. Our training manager evaluates industry best practices, State program modifications, and State administrative changes to continuously refresh our training curriculum.

POSSIBILITY OF LIQUIDATED DAMAGES (5.17.3.H)

Sunflower recognizes that failure to comply with training requirements may result in the assessment of liquidated damages pursuant to the terms of the contract.

5.17.4. FACILITIES AND EQUIPMENT

KANSAS FACILITY (5.17.4.A AND 5.17.4.B)

Sunflower maintains its headquarters at **8325 Lenexa Drive, Lenexa, KS 66214**. Our headquarters are approximately 60 miles from KDHE offices in Topeka. Additionally, we maintain two regional offices that house our Integrated Care Management team:

- **Topeka:** 534 South Kansas Ave, Suite 1325, Topeka KS 66603
- **Wichita:** 2024 N. Woodlawn Ave, Wichita, KS 67208

OUT-OF-STATE FACILITIES (5.17.4.C)

While all of our member and provider-facing functions operate out of our Kansas offices, Sunflower does receive support from our parent company, Centene. We receive some operational support from locations outside of the state of Kansas. Centene maintains robust

policies and procedures related to physical security. These policies and procedures are applicable to all Centene locations and will be provided to the State.

STATE-PROVIDED SPACE (5.17.4.D)

We understand that the State will not provide facilities or equipment for Sunflower's use. We do recognize and appreciate the State's offer to provide one cubicle for visiting Sunflower staff in their downtown Topeka offices.

5.18 WORK Program

5.18. WORK PROGRAM

SUNFLOWER DEMONSTRATED SUCCESS

Sunflower Health Plan (Sunflower) has many initiatives to help members find their path out of poverty through employment and independence. Sunflower is committed to helping its members maintain the highest levels of independence and supports them in their community integration goals. Our success is demonstrated by:

- Our robust Work Opportunities Reward Kansans (WORK) program has been in operation since January 2013 and currently has 140 WORK participants.
- More than 98% positive member responses on the 2017 Sunflower WORK program KPI quality of life metrics.

Compliance with Scope of Work

Sunflower is currently in compliance with all KanCare contracts and all KanCare 2.0 requirements described in Section 5.18 of the Scope of Work (SOW). For ease of review we have included SOW references in headers and within the narrative.

OVERVIEW (5.18.A-D)

Sunflower and other Centene health plans have partnered with Centene's Corporate Long-Term Services and Support (LTSS) Team to create meaningful measures for the LTSS population, including members in WORK. These measures are tracked in our Key Performance Indicator (KPI) Dashboard. The dashboard includes both clinical, quality metrics as well as quality of life metrics.

WORK EXPERIENCE

Over 98% of Sunflower WORK program members from 2017 answered positively on the below Sunflower KPI quality of life metrics:

- Member is active outside the home
- Member decides their daily routine
- Member feels safe where they live
- Member is satisfied where they are living
- Member can see their family and friends when they want

Sunflower members who participated in the WORK program in 2014, 2015, and 2016, remained in the program an average of almost 4 years (45+ months).

From Q4 2016 to Q3 2017 Sunflower saw a 6% (94% to 100%) increase in:

- Members deciding on their daily routine
- Members who are satisfied where they are living
- Members who can see their friends and family when they want

KDHE makes it possible for members with disabilities to meet career goals and increase income/savings without decreasing medical coverage through the Working Healthy program, a Medicaid buy-in program. To be eligible for Working Healthy, a Sunflower member must be

between the ages of 16-64, a Kansas resident, meet the Social Security definition of disability, and already employed with a minimum monthly income. If a Working Healthy eligible member also needs Activities of Daily Living (ADL) or Instrumental Activities of Daily Living (IADL) support, he/she may qualify for the WORK program. WORK provides access to home and community based-like services through a needs assessment, personal assistance services, independent living counseling, and assistive services. Sunflower provides members with flexibility and maximizes self-direction through this "cash and counseling" model.

Sunflower was named a 2016 DisAbility Champions Award recipient by the Greater Kansas City Business Leadership Network.

To identify potential WORK participants, Sunflower Community Service Coordinators (CSCs) will provide member education to individuals on the Intellectual and Developmental Disability (I/DD) and Physical Disability (PD) waiting lists and on the I/DD, PD, and Traumatic Brain Injury waivers, in addition to receiving information from KDHE on members potentially eligible as WORK participants. Currently, Sunflower's Member Advocate and Community Health Workers provide outreach to individuals on waiver waiting lists and also share information and assist with connecting members who are identified as appropriate WORK candidates.

Sunflower embraces the WORK program and has a Member Advocate who participates in the WORK program and provides peer-to-peer support.

Sunflower has a Member Advocate who participates in the WORK program and engages in providing peer-to-peer support with and education of persons in LTSS and WORK, including support with finding caregivers and self-directing their services. WORK participants engage in a variety of careers from tutoring, to restaurant labor, to business. Studies conducted by Jean Hall of KU Medical Research state that employed disabled Medicaid recipients experience improvement of health status, greater overall wellbeing, increased independence, and decrease in medical expenditures.

WORK SERVICE COORDINATION STANDARDS

Administrative Standards (5.18.E)

The Sunflower WORK Program is conducted according KDHE, the WORK Program Manual, all State regulations and policies, and maintains written service coordination procedures to implement the requirements for WORK service coordination. Additionally, whenever WORK standards conflict with general service coordination standards, Sunflower's program adheres to the WORK program manual, which takes precedence. Members are assisted by Sunflower Service Coordinators (SCs) specifically trained to assist WORK participants. The WORK Program Supervisor, and designated WORK point of contact for KDHE, is in continuous contact with the department and available for referrals, questions and any other concerns the State may have. She provides regular training to the team, and ongoing training and contact with our Independent Living Counselor (ILC) providers.

Staff Standards (5.18.F)

Sunflower's WORK Program has been operational from the time that WORK was included in KanCare. It currently has approximately eight WORK-trained SCs throughout the State. As discussed in 5.4.8, for members with a LTSS need, the member will be assigned to an SC that shall have at least a bachelor's degree in social work, rehabilitation, nursing, psychology, special education, gerontology, or related health and human services area or be a Registered Nurse (RN). The assigned SC will also have at least one year of experience working with individuals with LTSS needs, and at least one year of experience working directly with waiver populations. Additionally, the SC responsible for providing services to I/DD members will meet required qualifications outlined in K.A.R. 30-63-32-Article 63 and comply with qualifications as described in the State's HCBS Waivers.

WORK Expertise and Training. By design, each region of the State has at least one local SC with WORK expertise. Sunflower WORK SCs are knowledgeable and practiced, averaging 3.5 years of experience assisting Sunflower WORK participants. These SCs undergo general service coordination, as well as WORK-specific training through Sunflower. In addition, they have completed KDHE's WORK training and meet all requirements as laid out in sections 5.4.8 and 5.4.10 of the KanCare 2.0 contract. WORK SCs participate in all Sunflower service coordinator trainings and meet quarterly with the WORK Program Supervisor. There is ongoing and annual training that includes, but is not limited to, topics specifically identified by the State. Sunflower will develop a comprehensive onboarding and training program, as described earlier, and in complete compliance with 5.4.10.

Sunflower WORK SCs will engage with all potential WORK participants as necessary, and at a minimum, quarterly. Our goal is to help our members leverage the WORK program for better health and independence outcomes. SCs will also be in communication with ILCs to help connect members to the core and specialty services these providers offer for supporting independence and inclusion.

The SCs that partner with WORK members have had the opportunity to see the results of both the member's improved emotional and physical health that a rewarding career and financial stability brings. The health of our members and their ability to obtain and maintain employment, go hand in hand. When we keep our members mentally and physical fit, they are able to work and lead healthier lives. Our satisfaction in working with our members mirrors their own fulfillment. At Sunflower, we take pride in supporting members throughout their employment journey as well as their engagement in their communities. We have been able to engage and directly support members by an excellent team of SCs who manage and coordinate care on a daily basis.

General Standards (5.18.G)

The Sunflower WORK SCs currently participate in member assessments and will work diligently in the future to make an accurate assessment of the member's needs, ensuring members have a comprehensive understanding of all the benefits and responsibilities of the WORK Program. They will conduct ongoing review and monitoring of services and individualized budgets,

making referrals when necessary. To optimize the coordination of services for WORK participants, SCs actively work with KDHE's WORK Program Manager, Working Healthy Benefits Specialists and ILCs. All Sunflower training for the needs assessor and budget approval roles, will be based on, and be in full compliance with, KDHE trainings.

WORK Needs Assessment (5.18.H)

All Sunflower WORK needs assessments will be conducted by Sunflower in the member's home within 14 days of referral. This yearly, face-to-face assessment, determines how many hours of help a person qualifies, resulting in a monetary allotment. The WORK SC will use the WORK Assessment/Allocation Tool to complete the assessment with the member and/or the member's representative. Sunflower will focus on the member's self-identified needs, using a person-centered and directed planning process to complete the assessment, as described in Section 5.4. Sunflower WORK SCs facilitate the member, or member representative, identifying his/her own needs.

Sunflower in Action…

Our coordination, advocacy, and brokering of services have positive impacts on member's lives. In 2017, one of our WORK members struggled continuously with her health, declining to the point of possibly needing to discontinue her employment. Our program specialist worked closely with her independent living counselor, medical providers, the Working Healthy benefit specialist, and the WORK Program Manager to ensure services met her needs. We worked with our financial management service partner to provide education about using agency and self-direct services. We continued back-up planning with her to increase use of informal supports thereby using resources more efficiently. Sunflower approved a home modification to maintain her independence. This combination of services kept her in the program and improving her health so that she could maintain her employment.

The assessment is sent to an ILC who assists the member in developing a proposed Individualized Budget, a strategy for how allocated funds are used to pay for personal and employment services. Before approving the budget, the SC will ensure the Individualized Budget has:

- All the required elements
- Meets the needs of the member
- Reflects the amount, duration and scope of assistance identified during the WORK assessment
- Ensures the emergency backup plan meets all of the criteria required by the State
- Confirms there is no conflict of interest contained in the Individualized Budget

If the requested budget does not have all of the required elements, the SC will work with the member and ILC to make sure it is complete. The Individualized Budget will then be reviewed in accordance with the requirements of the WORK Program Manual, and approved by the Sunflower WORK SC and in consultation with the Sunflower WORK Program Supervisor. The SC will review all documentation received from the ILC to ensure the member is receiving the appropriate services and that those services are being billed correctly. The Sunflower SC will, on an ongoing basis, monitor the member's monthly allocation and Individualized Budget,

including but not limited to: temporary adjustments to the member's monthly allocation, monitoring of carryover funds, providing prior authorization or facilitating the request for approval of assistive services, and completing a reassessment for the member if necessary. The Sunflower WORK Program Supervisor will manage and monitor, in conjunction with Sunflower's Financial Management Services (FMS) provider, the members' individualized budgeted funds, expenditures, and carryover funds.

While Sunflower will approve and monitor Individualized Budgets, WORK members have budget authority over these funds and are allowed to determine the rate of pay and schedule for self-directed care attendant services through the individualized budget. Some of the services available include, but are not limited to: home meals, personal care services, transportation to a job, and up to $7500 per year in assistive tech/home mods, including dentures, when needed.

WORK Service Coordination Reporting Requirements (5.18.I)

Sunflower complies with all WORK reporting requirements. As described in Attachment H of the RFP, Sunflower provides on a monthly basis a WORK Allocation Report, WORK Enrollment End Date Report, and WORK Good to Go (GTG) Report. On a quarterly basis, Sunflower provides a WORK ILC Billing Audit File and WORK Participant Funds Summary. These reports detail members' WORK participation dates, monthly allocation amounts, amounts spent on services, ILC's name and dates of services for which claims were paid, and carryover and overflow budget amounts.

Sunflower has collected employment data in our routine assessments since 2013 and has used it to supplement state data. More recently, we have refined that method to include a more detailed assessment to better capture actionable data on our member needs and included them in our refined reporting suite.

Electronic Case Record Standard (5.18.J)

Sunflower maintains an accurate and complete electronic case record for each WORK participant that adheres to all relevant State and Federal statutes, as well as being HIPAA-compliant. We use TruCare to support our clinical service coordination processes, including member WORK assessments. In addition to any criteria the State may require per 5.4.15, a Sunflower WORK member's electronic case record includes, at a minimum:

- The most recent WORK assessment
- The most recent WORK Individualized Budget
- An emergency back-up plan
- Disenrollment from WORK information, if applicable
- The member's Person Centered Service Plan

WORK Program Disenrollment (5.18.K)

Should Sunflower be notified by KDHE that a WORK participant has lost his/her Working Healthy eligibility and needs to be disenrolled from the WORK program, the Sunflower WORK SC will help the member evaluate his/her eligibility for any HCBS waivers or waiting lists. We will coordinate with the State's WORK Program Manager to ensure the least disruptive transition for the member. The Sunflower SC will also promptly update the member's electronic case record to reflect the reason for disenrollment and identify any waivers or waiting lists the member has been moved to.

WORK Provider Network (5.18.L)

Sunflower's current FMS vendor is a Kansas-based provider that maintains a registry of local Personal Care Services (PCS) workers. This resource is an added value to our members as it allows us to more efficiently connect our WORK participants with the resources they need to establish and maintain their independence. Our current FMS vendor is an active partner with Sunflower to promote the welfare of our members, and to support their ability to manage their individualized budgets. Sunflower will also utilize an FMS evaluation tool to continually evaluate our FMS partner to ensure it is the most qualified provider. This evaluation tool is currently being developed by Applied Self Direction in partnership with Centene. All monthly and quarterly reports the FMS provider provides to Sunflower, we will accordingly submit to the State, including grievances and appeals reports and accounting reports.

Grievances and Appeals (5.18.M)

Members enrolled in WORK have access to all the regular medical benefits of a KanCare enrollee, as well as the same rights and access to the Sunflower Grievance and Appeals system as other members.

5.19 Member Independence Initiatives

5.19. MEMBER INDEPENDENCE INITIATIVES

SUNFLOWER DEMONSTRATED SUCCESS

Sunflower Health Plan (Sunflower) is a leader in promoting employment and independence among individuals with all abilities in Kansas, and based on this success, we can uniquely support the State's new member independence initiatives. Across all of our work, we adhere to the belief that members with all abilities should have the opportunity to become fully integrated into their communities, including having access to employment opportunities in competitive, integrated workplaces (if desired by the member). Sunflower knows that Medicaid can play a key role in ensuring members have the necessary supports to achieve these goals related to employment and independent living, and with that in mind, we are integrating the Charting the LifeCourse Framework (LifeCourse) into our current Person Centered Support Planning model and Service Coordination workflows to support members no matter their circumstances to identify and work towards these goals. Our experience, fully described throughout this section, includes:

- Sunflower was presented the DisAbility Champion award in 2016 from the Greater Kansas City Business Leadership Network for our commitment to employing individuals with disabilities as well as noteworthy programs and initiatives that support their employment practices.
- Our role as Kansas Statewide Employment Coordinator for Project SEARCH
- The diverse range of services and supports provided by the Sunflower LifeShare program
- Our extensive leadership involvement in statewide councils and programs promoting employment and independence for KanCare members
- Employment of a Member Advocate who participates in the WORK program and engages in providing peer-to-peer support with and education of persons in LTSS and WORK, including support with finding caregivers and self-directing their services.

In addition, our parent company and affiliate health plans bring a range of relevant experience (including managing member accounts and coordinating 1915(i) state plan amendment services) that we can leverage and build on in support of the State's Member Independence Initiatives.

Compliance with Scope of Work (SOW)

Sunflower is currently in compliance with all KanCare contracts and all KanCare 2.0 requirements described in Section 5.19 of the Scope of Work (SOW). Throughout this section, for ease of review, we have included SOW references in headers within the narrative. We have also referred to Sunflower (Plan) and Community Service Coordinators collectively as "Service Coordinators" in many instances, understanding that depending on each individual's unique needs and situation, they may have one or the other as their single point of contact.

5.19.1. KANCARE 2.0 WORK REQUIREMENT INITIATIVE

KANCARE 2.0 WORK REQUIREMENT INITIATIVE (5.19.1.1.A)

Sunflower is prepared to work with the State of Kansas to facilitate the Work requirement for able-bodied adults proposed in KanCare 2.0 and to provide the appropriate linkages if the program is approved by CMS and implemented by the State. We understand that when implemented, KanCare members who do not meet the work requirements or the exceptions outlined in the State's Section 1115 Medicaid Demonstration Waiver Application will not be eligible for KanCare coverage. We acknowledge that the Work requirement may be implemented on or after January 1, 2019 and no later than July 1, 2020.

SUNFLOWER'S LEADERSHIP IN EMPLOYMENT SUPPORT AND LINKAGES TO STATE AND COMMUNITY PROGRAMS IN KANSAS (5.19.1.1.B & 5.19.1.1.C)

Since our inception in 2013, Sunflower has maintained a leadership role in both connecting our members to employment supports, and supporting statewide efforts to enhance employment and workforce programs for varied populations. Following are examples of Sunflower's existing and planned programs and linkages to job training and employment supports that will help able-bodied adults meet the Work requirement. We also describe Sunflower's many employment-related activities and experience targeting individuals with disabilities, from which we can also draw to help support the KanCare 2.0 Work Requirement.

Sunflower Transition to Employment Program (STEP)

There are nearly 173,000 adults between the ages of 18-64 in Kansas without a high school diploma or GED and over 700,000 adults between the ages of 25-64 without meaningful postsecondary credentials. Sunflower recognizes that part of our responsibility is to care for the "whole person health" of our members. This includes empowering and supporting our members in reaching their health goals and life goals.

STEP is a workforce development and employment support resource program to identify and remove employment barriers for all of our members within the communities we serve. STEP will provide employment resources and opportunities to achieve financial independence for our members and provide a connection for our members to existing community resources. The framework of STEP will be implemented throughout the state; partnering with community organizations to provide opportunities for our members to further their education and pursue meaningful employment. STEP will include community job fairs, GED vouchers, referrals and assistance with career counseling services. As a Referral Resource, we will connect members with a benefits specialist to learn how their income may impact their benefits, refer members to various organizations such as End Dependence Kansas and Accelerating Opportunities in Kansas as well as assisting with completion of paperwork and follow-up.

As part of this program, Sunflower will continue to be a **referral source** for identifying individuals who potentially meet the qualifications of the Kansas WORK and Working Healthy programs. We will refer Sunflower members, provide eligible members in WORK with the choice of Independent Living Counseling (ILC) providers, connect members to our WORK FMS

provider, provide peer support from our LTSS Member Advocate who participates in WORK, and provide the needs assessment and approved member budget.

Sunflower is the statewide coordinator of Project SEARCH, which prepares students and young adults with disabilities for competitive employment (described further below). Sunflower is a member of the Sedgwick County Business Leadership Network and the Greater Kansas City Business Leadership Network. Sunflower was presented the DisAbility Champion award in 2016 from the Greater Kansas City Business Leadership Network for our commitment to employing individuals with disabilities as well as noteworthy programs and initiatives that support their employment practices.

Sunflower was named a 2016 DisAbility Champions Award recipient by the Greater Kansas City Business Leadership Network.

Community Partnerships. Sunflower will leverage existing community partnerships where we administer our workforce development program for our members with disabilities as part of our STEP program. Sunflower will continue participating and partnering with organizations such as Project SEARCH and the Transformers Group, which provides a venue for various organizations such as Vocational Rehabilitation and the Department of Commerce to work together and provide education across the State for families and individuals interested in employment. As described further below, Sunflower also participates on the planning committee for Disability Mentoring Days and participates on the Association of People Supporting Employment First (APSE) Kansas Chapter Board to further policy advocacy for Employment First and provide trainings across the State. Additional current and future partnerships include:

- **Workforce Partnership.** Workforce Partnership is committed to building a workforce development system that meets the needs of job seekers and employers throughout the state of Kansas. They provide job search assistance, interviewing skills practice, resume assistance, trainings, and other supports. Sunflower Health will partner with this organization to provide services for our members.
- **Accelerating Opportunities in Kansas.** The Kansas Board of Regents, in partnership with the Kansas Department of Commerce, has implemented Accelerating Opportunity in Kansas (AO-K) to transform the delivery system for adult education in Kansas by delivering career and technical education at the same time as adult basic skills instruction within a career pathways framework. The KS Department of Children and Families supports AO-K with TANF funds to provide tuition scholarships for TANF-eligible students who enroll in approved AO-K pathways. Sunflower will identify and refer eligible Sunflower members to this pathways program and provide assistance with applying for scholarships, completing all paperwork and enrolling in the program. Once enrolled the Sunflower Employment Specialist would periodically follow up with the member to see if they need additional support to complete the program such as transportation or childcare services.
- **GOALS – Generating Opportunities to Attain Lifelong Success.** GOALS is a 3-year pilot project of the Kansas Department for Children and Families funded by the USDA. It provides eligible Kansans with employment assistance and career navigation. Sunflower

will contract with GOALS to assign a GOALS Career Navigator with eligible Sunflower members. The GOALS Career Navigator provides guidance and support through four service phases – Stabilize, Train, Place and Sustain. The Career Navigator will be part of the care team for members in case management. The Career Navigator will work closely with the Sunflower Employment Specialist to identify eligible recipients and promote care coordination and data sharing to continue support for program recipients. Sunflower will also contract with GOALS to help recruit and retain skilled employees to work at Sunflower.

- **Additional referrals**. Sunflower also makes referrals for members who may qualify for or benefit from training, information and employment opportunities from the following organizations:
  - Workforce Development Centers
  - State Benefits Specialists
  - Pre-Employment Transition Specialists through Vocational Rehabilitation
  - All End Dependence Kansas (EDK) contractors
  - School transition specialists including Johnson County Transition Council
  - Business Leadership Networks
  - Multiple contractors for supported employment, in coordination with Vocational Rehabilitation and through HCBS across the state
  - Targeted Case Managers and Independent Living Counselors
  - Circles USA
  - Families Together
  - Disability Rights Council

Additional Components of STEP. In addition to the activities, resources, and partnerships described above, STEP also includes:

- **GED Prep Test Vouchers.** For Sunflower members who are interested in pursuing their GED (cost for the test may be absorbed as part of the AO-K pathways program), Sunflower will provide vouchers to purchase the GED prep test for each testing section (4 sections).
- **Scholarship Program.** Sunflower members wanting to pursue a college degree would complete a STEP scholarship application. The scholarship will be funded by Sunflower employees through fundraising opportunities held throughout the year. Sunflower will seek partners to provide matching funds.
- **Job Fairs.** Sunflower will partner with Walmart stores, FQHCs, and other community organizations throughout Kansas to host job fairs and career counseling seminars. The job fairs will include local employers, career counseling and job placement as well as support services.
- **Supported Employment Incentive Program.** Sunflower will provide enhanced reimbursement for providers that implement supported employment programs as part of which members hold a successful job for six months at minimum wage or above for at least 25 hours a week.

Leadership Participation in Promoting Workforce Development Across Kansas

As part of Sunflower's overall commitment to promoting independence, our senior staff participate in numerous boards and committees dedicated to enhancing work opportunities across the State, including:

- **Transformers**: A group formed to increase collaboration among entities working towards employment in the state, including Vocational Rehabilitation Services, Workforce, Kansas Youth and Empowerment, Department of Commerce, a Community of Independent Living Center, and other individuals that are champions for employment. The group conducted town halls across the state of Kansas to get feedback from families and individuals about the barriers to employment. We are in the process of planning a conference to help disseminate information.
- **Association for People Supporting Employment First (APSE)**: We serve on the Kansas Chapter Board and chair the subcommittee for communications. The Board supports and promotes employment first policies and provides related trainings and education to stakeholders across the state.
- **Family Employment Awareness Training**: We participate and present at the trainings provided by Families Together, which offers information to families about employment services and supports, and inspires families to start encouraging their children at a young age, and teaching them skills that promote future employment success such as being accountable for responsibilities.
- **Subcommittee on Employment for the Medicaid Functional Eligibility Instrument (MFEI):** Sunflower helped develop work-related questions for the state assessment tool that determines if Kansans qualify for Medicaid LTSS, to understand the kinds of supports needed, including employment supports, and to drive self-directed, person centered plans.
- **Disability Mentoring Days**: One of our senior staff members is part of the planning committee for the Disability Mentoring Days held annually in Olathe, KS and Kansas City, MO. Disability Mentoring Days support individuals with disabilities to visit local businesses, gain information about job openings, learn how to create a resume, and gain actual hands-on experience with different employers. As part of this effort, Sunflower coordinates our local volunteer efforts to support the activities, as well as coordinates across our local Service Coordination teams, who, in turn, notify student members on their caseloads of the upcoming events. Sunflower also participate in the monthly state calls to offer guidance and assistance to support Disability Mentoring Day programs across the state.
- **Employment First Oversight Commission (managed by the Kansas Commission on Disability Concerns)**: Sunflower attends these Commission meetings and assists with report summaries as the Statewide Coordinator for Project SEARCH.

In addition to the above Boards/Committees, Sunflower supports the dissemination of best and evidence based practices related to supporting individuals to become employed. For example, Sunflower participates in the dissemination of the LifeCourse Framework across the state of Kansas, and will include integrating this framework into our own person centered assessment

and service planning processes (further described in Section 5.19.2 below). This curriculum promotes individuals and families taking control over the development and implementation of their person centered goals, setting a life trajectory with action steps and supports identification of informal community and employment resources as an alternative to paid supports.

Project SEARCH

As of Jan. 2, 2016, Sunflower Health Plan/LifeShare became the statewide manager for Project Search. Project Search is a nationwide program which supports students with disabilities with obtaining competitive employment when graduating from high school. The project is designed to develop partnerships between school districts and local businesses to offer internship opportunities for students with disabilities who have an employment goal and are transitioning out of high school. Nationwide, Project Search has a 73% success rate for job placement post-graduation. In Kansas, Project Search has experienced a 78% success rate.

Sunflower also became a business internship site in 2015, has hosted three interns and hired one full-time. Additionally we hired another Project SEARCH graduate. Sunflower's Director of Human Resources has been invited to be on the steering committee for Project Search.

Through Sunflower's leadership, 8 sites were awarded for employment outcomes:

- ***1 received a 100% reward***
- ***4 received 80%***
- ***3 received 70% or better***

Project SEARCH has facilitated a total of 78% positive employment rate.

As of mid-May, Kansas Project Search had 35 of 70 interns who secured competitive employment post-graduation. Many were still in the process of applying. 90 interns have been selected to participate during the 2017-2018 school year which is an increase from 72 in 2015 and 83 in 2016-2017. During 2017, one additional school district has signed up to participate in Project Search and will begin their technical assistance phase. Kansas also has a Project Search program for adults in Johnson County and Wichita.

Outreach:

- Kansas currently has 12 Project Search sites, including one adult site in Johnson County and one adult site in Wichita.
- Outreach to individuals with disabilities is based upon each local site plan, and includes involvement by the school district and local CDDO.
- Participation is not limited to Sunflower members, the project is available to all transitioning students (or adults) in each local site.
- The site plan may include interviewing students to determine post-graduation goals, and willingness to participate with the intent of becoming employed.

In the role of Statewide Coordinator, Sunflower has expanded Project SEARCH in both the number of internship locations in Kansas and the number of students participating – the program has grown from 72 interns in 2015/2016 to 90 interns in the 2017/2018 school year. Since the program's inception in the fall of 2011, over 350 Kansans have participated, with approximately 200 businesses in the state permanently hiring interns.

As part of our effort to be a model employer of the populations we serve, Sunflower has hosted four Project SEARCH interns and hired two former interns for full-time positions through a competitive interview process. Sunflower's successful participation has resulted in the Centene Corporate office becoming a host site as well, and several of our other affiliate health plans are also exploring becoming Project SEARCH host sites.

Sunflower in Action…

"Cody" is a 20-year old Project SEARCH graduate who lives with his dad and step-mom in Perry, Kansas. Cody's dream job was to work at the University of Kansas (KU) but his school IEP team placed him at a sheltered workshop in the nearby city of Lawrence. Our Employment Pathways Facilitator (described below) met Cody and, as a subject matter expert on employment, was aware of the Project SEARCH internship program at KU. She discussed the opportunity with Cody and his parents, and they were excited and supportive of competitive employment. She began the process resulting in Cody and two other students from his school district being chosen to be interns their final year of high school. As part of the program, they were treated like "real" employees working towards competitive employment by or within three months of graduation. A full year later, Cody graduated from Project SEARCH. Not only was Cody celebrating a successful internship experience, he was starting a full-time job the following Monday at the University of Kansas as part of their environmental services team. Cody's father said that being part of Project SEARCH has really broadened Cody's horizons and that he had really grown over the year long program. Cody learned valuable work skills, established new friendships and gained confidence through Project SEARCH. Being an intern at KU, also gave him the competitive edge needed to secure competitive employment on campus and his dream job.

Employment Pathways Facilitator

Sunflower's LifeShare program currently supports individuals with disabilities in Kansas to prepare for and obtain employment through our Pathways program. The Employment Pathways Facilitator works with local students with intellectual and developmental disabilities (I/DD) through Project SEARCH, described above. She also participates with and links members to Kansas Department of Children and Families' Vocational Rehabilitation Services as well as local employment services, assisting their Service Coordinators to connect members with needed employment-related resources. Sunflower's LifeShare program also provides subject matter expertise on supporting member employment and assists our Service Coordinators to address barriers with individual members who have a competitive employment goal. This program will become part of our new Social Determinants of Health and Independence Center of Excellence (SDOHI COE).

Enhanced Employment Status Identification and Engagement for Targeted Groups

Sunflower updated our Service Coordination work processes so that at each contact, our Service Coordinators use assessments to evaluate the health and quality of life, including questions related to the member's employment status and employment related goals. Employment goals are incorporated into the members' Plans of Service/Person Centered Support Plans, and Sunflower provides members with education about supports that will complement and not duplicate services for which they are eligible (e.g., Home and Community Based Services (HCBS)). When necessary, we advocate and coordinate with appropriate vocational services and resources on behalf of these members. We further modified our training for Sunflower's Integrated Physical and Behavioral Health Service Coordination team to include additional workflows/strategies for discussing during each member contact numerous employment relevant topics, including barriers to employment, employment strategies, and employment resources available for Kansans. The ultimate intent of these workflows is to ensure all members living with SPMI and/or SUD members have an opportunity to connect to employment resources as desired.

Early in Sunflower's history, we recognized the challenges inherent in identifying and engaging members that have serious and persistent mental illness (SPMI) and/or substance use disorder (SUD) in employment support services. Ultimately, as shown in Table 5.19.1.A_Unique Members with Discussion of Employment in Behavioral Health Case Notes, Sunflower's revised Service Coordination work processes resulted in a 24.21% increase in unique members with behavioral health conditions who had a discussion of employment in 2016 compared to 2015 – the first step toward exploring work opportunities.

Table 5.19.1.A_Unique Members with Discussion of Employment in Behavioral Health Case Notes

Year	Unique Members	Percentage Increase
2015	190	Baseline
2016	236	24.21%

In addition, in 2016, Sunflower began partnering with the State to obtain employment-related data for members with SPMI, based on information submitted by CMHCs through the State's Automated Information System (AIMS), through which we identified 909 unemployed Sunflower members living with SPMI. Sunflower used this data to identify members with SPMI who are unemployed with whom we conduct employment related outreach and engagement activities that correspond to the workflows above. Sunflower successfully reached 236 members as identified in the table above.

Governor's Behavioral Health Services Planning Council Vocational Subcommittee, Individual Placement and Support (IPS) Model

Sunflower actively participates in the Governor's Behavioral Health Services Planning Council Vocational Subcommittee, which is committed to coordinating supported employment activities and reviewing statewide infrastructure in promoting and sustaining supported

employment for Kansans with disabilities. Through our participation, Sunflower has made numerous recommendations for sustaining supported employment within Kansas, including expanding the use of the Individual Placement and Support (IPS) model by CMHCs. IPS is an evidence-based approach to supported employment for individuals with mental health disabilities. Recognizing IPS' effectiveness in supporting individuals with behavioral health conditions to obtain competitive employment, Sunflower disseminated the best-practice recommendations from the Governor's Subcommittee to key stakeholders and promoted the IPS model's adoption among CMHCs through face-to-face meetings, provider education, and an enhanced payment rate for implementation of the model. Today, 12 CMHCs are implementing this model, and as illustrated in Table 5.19.1.B_Billed Summary of Enhanced Rates for Supported Employment Services, 268 unique members received 17,298 units of supported employment services in 2016.

Table 5.19.1.B_Billed Summary of Enhanced Rates for Supported Employment Services

Year	Unique Members	Billed Units *(1 Unit = 15 minutes)*
2015	261	16,620
2016	268	17,298

Provider Site Visits and Employment Data Integrity

Sunflower actively engages providers in Kansas that provide supported employment services through in-person meetings that include reviewing each provider's service delivery methods, the rates of employment for members within their catchment area, and data integrity with submission of employment data through the State of Kansas' AIMS. In 2016 alone, Sunflower made on-site visits to Pawnee Mental Health Services, Johnson County Mental Health Center, Four County Mental Health Center, Prairie View Mental Health, and the Mental Health Association of South Central Kansas. During these visits, the partners reviewed employment data, specifically comparing the data collected and reported by the State to what is submitted by the CMHCs. During these discussions, the facilitator and providers were able to understand the intent of employment data submission and better define employment classification. For instance, we discovered that members who volunteered or worked in a shelter were not classified correctly. Ultimately, remediation for appropriate employment tracking allowed providers to submit more accurate member employment data and preserve data integrity. This, in turn, allows better identification of opportunities for outreach, and more accurate tracking of progress toward member employment and independence.

Education of Members (including those on the HCBS I/DD and PD Waiting Lists)

Sunflower regularly provides information about employment supports to members, including persons on the I/DD and Physical Disability Waiver waiting lists, along with eligibility information about the Kansas WORK program. As part of their work, Sunflower's Member Advocate and Service Coordination team identify whether each member is employed

Approximately 15% of Sunflower's LTSS members report having either paid or volunteer jobs, as reported monthly in our LTSS Dashboard.

or wants to be employed, and then they make a referral to the state Benefits Specialist or other employment support entities as relevant to each member's goals, eligibility, and needs. Within the new Community Service Coordination model, this work will be transitioned to Community Service Coordinators (for members for whom Community Services Coordination is appropriate), with training for these community providers provided by Sunflower. As needed, the Community Service Coordinators will have access to our Member Advocate for additional education and peer support services.

EMPLOYMENT SUPPORT AND WORKFORCE DEVELOPMENT PROGRAMS IN OTHER STATES (5.19.1.1.B.1)

In addition to building on Sunflower's extensive current workforce support activities in Kansas described above and in Sections 5.18 and 5.19.2, we will leverage our affiliates' best practices across the country to promote competitive, integrated employment and independence for able-bodied adults and other populations, including the following.

LifeShare Pathways Programs

Centene's LifeShare programs and services, currently being implemented across 13 states, develop and deliver Person Centered Solutions including education supports for people with I/DD and others with disabilities, through both direct services and managed care functions. The Lifeshare Pathways program supports people with developmental disabilities in their path toward independence. LifeShare's LifeCoaches and Employment Specialists work on a one-to-one basis with individuals who have paid employment as their primary goal to train for, obtain, and maintain their job. From creating resumes, to filling out applications, submitting applications, setting up interviews, preparing for interviews, and having private meetings to ensure support is provided with obtaining a job, LifeShare helps individuals meet their employment goals. LifeShare offers on the job oversight and assists with providing supported employment when needed. For those individuals with the goal to work independently and/or with natural supports, LifeShare works with them to build their capacity until they are able to work on their own. The individuals that LifeShare supports are competitively employed, working alongside people of all abilities in a variety of industries. In New Hampshire, for example, the LifeShare Pathway Employment Facilitator is working to increase interest in supportive employment and to address individuals' and families' questions about how paid employment affects their eligibility for services and social security.

Indiana HIP 2.0 Medicaid Work Requirement

Our Indiana affiliate is currently working with the state as it designs the Medicaid work requirement under Indiana HIP 2.0. The Plan's approach is to leverage existing community capacity to support this initiative, heavily supporting and referring to the many existing community-based organizations whose mission and expertise are in job training, workforce development, and other employment supports, rather than try and replicate those services internally. Indiana's current voluntary program, Gateway to Work, is a feature of the Healthy Indiana Plan (HIP) that helps connect HIP members to Indiana's workforce training programs, work search resources, and potential employers. HIP members who are unemployed or working

less than 20 hours a week are referred to available employment, work search and job training programs that will assist them in securing new or potentially better employment. Our affiliate plan educates members about these opportunities through social media and member emails on a quarterly basis. Further, the health plan is collaborating with Uber to explore providing HIP members with access to transportation to support employment-related activities.

MLTSS Employment Support Pilot

During the fall of 2016, an affiliate launched a pilot program to increase the number of MLTSS members seeking jobs and obtaining employment. Interventions included:

- A designated internal Employment Liaison conducted employment trainings for all case managers (CMs), covering existing employment resources and tools, and the pilot workflows and processes to document and follow up on a member's interest in employment. Leadership received training on disability employment-related rights, regulations, and resources.
- CMs discussed the employment-related questions on the plan's comprehensive assessment with every member at every member visit, and documented responses in TruCare as part of ongoing assessment conversations. The care management workflow was revised to include referrals to the Employment Liaison if a member expressed an interest in obtaining paid employment.
- The Employment Liaison conducted outreach and sent employment information packets. Interested members received a phone assessment, coaching, individualized employment support including connections to job training and benefits counseling, assistance addressing employment-related barriers, and ongoing follow-up.

The pilot found that although a majority of the MLTSS members are not employed nor interested in paid employment, there are some members who are interested, strongly identify themselves as capable contributors, and desire to work in their surrounding communities. From this pilot, we learned that increasing staff and member awareness about employment, strengthening community partnerships that support member employment, and amending care management workflows to include referral to an internally designated Employment Liaison has the potential to increase member job-seeking activities and employment outcomes.

5.19.2. MEDIKAN EMPLOYMENT OPPORTUNITY INITIATIVE

SUNFLOWER'S RESPONSIBILITIES UNDER THE MEDIKAN EMPLOYMENT OPPORTUNITY INITIATIVE (MEDIKAN INITIATIVE) (5.19.2.1)

As described, Sunflower has served as a KanCare MCO since 2013, and today we provide services and supports to approximately 130,000 members. Across our membership, as described throughout this section, we support numerous individuals living with disabilities, physical and behavioral conditions, and barriers related to Social Determinants of Health and Independence (SDOHI) to stabilize their immediate needs, diverting them from needing a disability determination and supporting them to obtain and maintain employment, thereby

promoting self-sufficiency and independence. Specifically, we have implemented a number of successful initiatives on behalf of members with characteristics similar to those who will be eligible for the MediKan Initiative, including those described above in Section 5.19.1.

Our experience implementing all of these initiatives, as well as that of our parent company and affiliate health plans, collectively inform our approach to supporting members who will be eligible for the State's new MediKan Initiative. Our approach includes:

- Assessing member needs and preferences using the LifeCourse Framework and Person Centered Thinking tools as cornerstones of our approach
- Providing a comprehensive and integrated set of benefits to address each member's holistic needs
- Contracting with community providers who are trained to provide employment supports
- Performing choice counseling activities
- Training our Service Coordinators and Community Service Coordinators on Employment First philosophy, offering competitive employment as a first option

PLAN TO EVALUATE INDIVIDUAL'S NEEDS (5.19.2.1.C.1 & 5.19.2.2.E)

Sunflower and our affiliate health plans have a long history of conducting comprehensive, holistic needs assessments that engage members in a discussion about their needs and lifestyle preferences related to medical, behavioral health, and SDOHI. Our holistic approach to person centered assessment and planning and care delivery is currently supported through the Person Centered Thinking training and tools we have provided to our Service Coordination team, and it will be complemented by use of the LifeCourse Framework. LifeCourse is an evidence informed framework developed by the Missouri University Center for Excellence in Developmental Disabilities and currently being disseminated for implementation in Kansas by the University of Missouri—Kansas City (UMKC) with support from KDADS and the Kansas Developmental Disabilities Council. Although originally developed for members living with intellectual and developmental disabilities (I/DD), the framework has been adapted to support individuals of all ages and abilities. Today, Sunflower team members are participating in the LifeCourse Framework's Community of Practice and are supporting the development of training for this program. One of our team members has been appointed to the National LifeCourse support coordination workgroup, and is the lead for this workgroup in Kansas. Moving forward, we will utilize the LifeCourse tools to assist our KanCare members to develop a set of goals related to their vision for a good life, identify how to find or develop services and supports, and create a life plan (their Person Centered Service Plan) that includes the components that it takes to live the lives that they want to live. The framework facilitates Sunflower's ability to ensure that our assessments are member and family driven, focusing on self-determination, community living, social capital, and economic sufficiency. The emphasis of our assessments is on supporting each member to plan for desired life outcomes (e.g., employment, self-sufficiency), rather than just identify services and supports that they need.

The Core Belief behind LifeCourse—that all people have the right to live, love, work, play, and pursue their life aspirations in their community—seamlessly aligns with the goals of the State's MediKan initiative. Therefore, Sunflower will build upon these time-tested processes, through which our Service Coordination team first meets each member where they are and then engages them to identify their own goals, as well as the services and supports necessary to meet those goals, using evidence based strategies like Motivational Interviewing and Person Centered Thinking. Each MediKan member will be assigned a Service Coordinator (at either the Health Plan or community-level, as fully described in Section 5.4) who will serve as the member's single point of contact and engage him/her in a comprehensive assessment using this process.

As part of the assessment, the Service Coordinator will engage the member (and others as desired by the member) to complete the Health Screening and Health Risk Assessment (HRA), following up with additional screenings/assessments during the process based on the member's HRA results. Since our inception, Sunflower's HRA tool has included additional SDOHI-related questions to assess each members' social, economic and cultural barriers, employment and living arrangement status, available natural supports, as well as the need for reasonable accommodations. Specifically for our LTSS members, Sunflower asks about their participation in paid or volunteer employment opportunities as part of our LTSS Key Performance Indicators metrics, which is based on the quality of life outcomes in National Core Indicators for Aging and Disabilities. We currently have questions in our HRA related to SDOHI and are comparing those to questions from the Protocol for Responding to and Assessing Patient's Assets, Risks, and Experiences (PRAPARE) to gather additional information for each member related to transportation, housing status and stability, education and employment (including work history, work goals, and the member's strengths and challenges related to obtaining and maintaining a job), and criminal/incarceration history.

In addition to the HRA, which includes SDOHI assessment questions, and based on each MediKan member's identified needs, Sunflower utilizes a number of additional evidence based screening and assessment tools, including but not limited to:

- PHQ-2 and PHQ-9, to screen for depression
- CAGE, to screen for alcohol abuse/dependence
- Columbia Suicide Risk Assessment, to screen for suicidal/homicidal ideation
- Child Report Of Post-traumatic Symptoms (CROPS), to assess for a broad range of post-traumatic symptoms among children
- OHIO Scales Form, to assess problem severity and functioning related to behavioral health issues among youth
- The Edinburg Postnatal Depression Scale, to assess new mothers for post-partum depression

As required, and based on each member's unique needs, Sunflower will also ensure that State-required assessment tools (e.g., the Medicaid Functional Eligibility Instrument (MFEI)) are integrated into the assessment process.

INDIVIDUALIZED PLAN OF SERVICE/PERSON CENTERED SERVICE PLAN DEVELOPMENT (5.19.2.1.C.2 & 5.19.2.2.F)

Based on the assessment process completed with each member, Sunflower currently uses Person Centered Thinking strategies and plans, including the LifeCourse Framework, to engage in a process of service and support planning based on the member's goals and assessed needs. The LifeCourse model includes a number of tools and templates that support member self-determination including tools that help each member create a vision of their desired full and meaningful life and identify services and supports that will help him/her achieve that vision based on where they are today. Our member-centric, individualized approach to Plan of Service/Person Centered Support Plan (PoS/PCSP) development emphasizes active engagement in care in order to support member independence and achieve better compliance, health outcomes, and quality of life. Throughout the development and implementation of the PoS/PCSP, the member remains at the center of all service planning and implementation activities.

With the inclusion of the member's family/caregiver(s) and identified supports (if desired by the member), the member drives the services and supports they receive. Sunflower is well versed in providing members an integrated combination of Medicaid benefits, while also coordinating with additional benefits that address the individual's needs and promote employment and self-sufficiency. For example, as part of our support for individuals receiving Long Term Services and Supports (LTSS) within our existing KanCare contract, our Service Coordinators support members to become fully integrated in their chosen community by encouraging and supporting them to seek (paid and voluntary) employment opportunities, including working in competitive, integrated settings. We first link members to available community resources to help support their goals. For example, many of Kansas' Centers for Independent Living (CILs) offer community based employment services to assist individuals with disabilities to obtain and keep meaningful employment, and we connect our members to these services on an ongoing basis. We also maintain an online Community Resource Database on our website that enables members, caregivers, and Service Coordinators alike to identify community resources relevant to each member's goals and needs, ranging from resources related to food, housing, and transportation services to employment, child care, and disability and access-related services. We then look at other funded options like Vocational Rehabilitation Services. When available under a member's HCBS benefits, we offer employment supports first, before offering day habilitation or other segregated services, while also understanding the member has a choice.

For KanCare 2.0, all Plan and Community Service Coordinators will receive training in the LifeCourse Framework and have access to these tools to use with our members, including those enrolling in the MediKan initiative. Each member's PoS/PCSP will be based on the member's self-identified goals that relate to supporting greater independence and self-sufficiency,

including those related to health, behavioral health, functional status, and quality of life such as daily engagement in meaningful activity (e.g., employment) and/or remaining in their home. For each goal, we will support the member to develop an action plan, with concrete milestones and assigned responsibility for each element. Based on these goals and action plans, the Service Coordinator will support the member to identify and access a culturally appropriate set of integrated services and supports that relate to his/her medical, behavioral health, social, functional, reasonable accommodations, and other assessed needs and conditions. For further detail on PoS/PCSP development, please reference Section 5.4.

CONTRACTS WITH COMMUNITY BASED PROVIDERS (5.19.2.1.C.3, 5.19.2.1.C.4, & 5.19.2.2.B)

As described throughout this application, Sunflower currently contracts with an extensive network of providers that are able to meet the diverse needs of the MediKan population. This includes community health centers, CMHCs, HCBS providers, and other community partners (e.g., CILs) that offer services to meet the needs of MediKan members. In addition, Sunflower brings experience contracting with and supporting many of these providers to implement initiatives similar to the MediKan initiative, and we look forward to leveraging and building upon this experience in partnership with the State.

As described above, Sunflower currently works with 12 CMHCs that provide Individual Placement and Support (IPS)/Supported Employment to individuals living with behavioral health conditions. To support the implementation of this initiative, Sunflower promoted the IPS model's adoption through face-to-face meetings and provider education with these CMHCs. Today we offer them an enhanced payment rate to implement the model with fidelity with our members living with behavioral health conditions. These efforts resulted in 268 unique members receiving 17,298 units of supported employment services from these providers in 2016. Although the CMHCs do not connect with the State's Vocational Rehabilitation and Workforce System as part of their implementation of IPS, outside of this initiative, when appropriate and based on each member's unique needs and eligibility, Sunflower supports the CMHCs to refer members to the State's Vocational and Rehabilitation Workforce system.

Of Sunflower members on the IDD waiver (ages 21-64), 24% reported they have paid employment and 7% reported that they have volunteer jobs.

In addition, since our inception in 2013, Sunflower has contracted with community providers across the state to provide supported employment services to our members living with disabilities under the HCBS Waiver benefits. We contract with a number of HCBS providers offering Supported Employment services through the I/DD Waiver, as well as Independent Living/Skills Building Services through the SED Waiver, both of which are services that are similar to those that will be available under the expanded MediKan Initiative's benefit package. Based on this network capacity, in October of 2017, 41 members with I/DD had authorizations for Supported Employment, while 98 members with SED received Independent Living/Skills Building services. Many of these HCBS providers also provide services within the State's Vocational Rehabilitation and Workforce System as well, and when this is not the case, Sunflower supports these providers to connect with the State's

Vocational Rehabilitation and Workforce System in order to ensure coordination and non-duplication of services to help each member to achieve his/her employment goals.

As part of our current contracting and credentialing processes, we ensure that our network providers have appropriately trained/certified staff members. For the MediKan initiative, we will build upon this process, described in Section 5.5, to ensure that all providers with whom we contract have staff trained and certified to provide employment supports. As per our existing process, we will support MediKan providers to connect to the State's Vocational Rehabilitation and Workforce Systems.

Monitoring Community Partners (5.19.2.2.B)

Sunflower monitors the performance of our community providers, including those delivering HCBS and other employment-related supports and services, using our time-tested processes to monitor performance and compliance with KanCare contract requirements (fully described in Section 5.5.8 on Network Management). Our comprehensive approach to provider monitoring combines credentialing, quality, and compliance activities, with accountability and oversight for performance residing with the Quality Assurance Performance Improvement (QAPI) Committee. All of this information is brought together at the individual provider level to evaluate provider performance and educate or initiate corrective action as indicated. It is also evaluated at the system level to inform network wide training and outreach efforts. In order to ensure comprehensive quality monitoring processes for our LTSS members and those in our WORK Initiative Program, for KanCare 2.0 Sunflower's monitoring processes will be supported by our LTSS Quality Committee, which will perform similar activities to the QAPI but monitors LTSS providers and member outcomes specifically.

In addition to the provider monitoring process, Sunflower also has experience monitoring fidelity to evidence based model(s) for employment supports. For example, as part of our CMHC/IPS initiative, two trained staff members from Sunflower audit member records to ensure fidelity to the IPS model in collaboration with KDADS. To date, all 12 of the CMHC sites have been audited by these trained auditors, and Sunflower continues to support the agencies that implement the model through the provision of training and support. Additionally, as described in Section 5.19.1, Sunflower regularly meets with the CMHCs to monitor integrity of the employment data the CMHCs are submitting to AIMS. These meetings are designed to support providers to understand the intent of employment data submissions and better define employment classification. For instance, during the early stages of the pilot, we discovered that members who volunteered or worked in a shelter were being classified as unemployed by some of the CMHCs. Through our monitoring process, we were able to quickly identify this error and provide additional education to the specific CMHCs about the appropriate classification of members' employment/unemployment status, resulting in higher quality data within the statewide database.

CHOICE COUNSELING (5.19.2.1.C.5 & 5.19.2.2.G)

Sunflower is prepared to support eligible members to determine whether or not they want to participate in the MediKan initiative through choice counseling services, leveraging our existing experience providing these types of services. Today, Sunflower embeds the principles of choice counseling into our training on person centered approaches to care that all staff receive, and our Service Coordinators participate in formal training about how to offer choice counseling to members. We plan to offer this training to our Community Service Coordinator partners in KanCare 2.0. Further, as part of our WORK program (further described in Section 5.18 above), we staff a full time Employment Specialist and WORK Program Supervisor, along with a specific team of Service Coordinators who are assigned to members in the WORK program. The WORK Program Supervisor has deep knowledge of the WORK program's eligibility requirements, which allows her to serve as the WORK Subject Matter Expert (SME) for the Service Coordination team, as well as the primary liaison to the State's WORK Program Manager. Sunflower also has a full time Employment Specialist who provides additional subject matter expertise to our Service Coordinators on all types of employment supports. Our Member Advocate, who also participates in the WORK program, provides peer-to-peer assistance to members in WORK and other long-term services.

Sunflower employs a Member Advocate who participates in the WORK program and provides peer-to-peer support.

In addition, as part of our support for members receiving LTSS, our existing Service Coordinators provide eligible members with counseling services to support them to choose from a variety of LTSS benefit options (e.g., HCBS and/or WORK services as an alternative to institutional care, employment as an alternative to sheltered day services, self-direction versus agency-direction). To support members across the country to make informed decisions related to their benefit options, Centene partnered with Applied Self Direction, formerly the National Resource Center for Participant-Directed Services, to develop a Self-Direction Toolkit and Video, designed as member-facing educational resources to support decision making about self-determination, which Sunflower leverages to support these choice counseling activities on behalf of Kansans that we serve.

For these member independence initiatives for which choice counseling is a possibility, including this MediKan initiative, Sunflower will build upon our experience providing these types of supports. Under KanCare 2.0, Sunflower will train all of our Plan and Community Service Coordinators on the eligibility criteria and benefits related to each of the State's Member Independence Initiatives so that they can conduct choice counseling services for eligible members as these members are identified. These trainings will be provided during new hire orientations, as well as during annual refresher courses. Further, Sunflower will designate an experienced full time person for each member independence initiative that requires choice counseling, similar to the currently designated WORK Employment Specialist. In line with this process, for MediKan, the Employment Specialist will serve as a resource to all of the Service Coordinators to support their ability to implement choice counseling services for this initiative.

The Employment Specialist's manager will be responsible for serving as the back-up in the event this person is absent or the position is vacant.

In addition to our personnel and training, in order to ensure members receive sufficient information to make an educated choice, we will work with the State to develop educational resources (similar to our self-direction toolkit described above) for our staff and providers to share with members to support them to make an informed decision about whether they want to participate in the member independence initiative (after they are deemed eligible). With State approval, this Toolkit will be available through an "Employment Resources" section on Sunflower's website, which includes all available resources and tools related to supporting members to become employed. For example, the MediKan toolkit will include a description of the program, including a comparison of the benefits the member is eligible for if they continue their SSA disability determination application versus if they decide to discontinue the determination process and pursue the expanded MediKan initiative benefit package.

ADDITIONAL RELEVANT EXPERIENCE

Experience Working with Similar Populations (5.19.2.2.A & 5.19.2.2.C)

Sunflower has extensive experience serving members similar to the MediKan population, including individuals with a combination of physical and behavioral disabilities, as well as socio-economic issues that may be a barrier to a stable lifestyle and their ability to obtain/maintain gainful employment. Based on our experience, we are acutely aware that in order to achieve optimal member outcomes, we must address the needs of members from a comprehensive perspective, taking into account all factors including but not limited to physical, behavioral, and socioeconomic considerations. We work closely with all providers and Service Coordinators to ensure that all services, covered and non-covered, are available to the member as needed. As a health plan partner with the State of Kansas, our coordinated, comprehensive approach is designed to promote personal responsibility and appropriate use of services for all of our members, the vast majority of whom have experienced or are experiencing unstable socioeconomic situations that impact their health. As described throughout this application, our approach to meeting member needs revolves around a high-touch, individualized approach that supports each member's personal goals to achieve health and wellness, as well as increased independence.

Today, Sunflower serves approximately 12,500 KanCare members who qualify for LTSS, including a high percentage of members with I/DD who fall into the state's tier 1 and 2 categories based upon level of need. Overall, Sunflower provides support to nearly half (46%) of the State's I/DD population, and 67% of persons with I/DD who are residing in an ICF/ID facility. More than 17,500 of our members have a diagnosis of Serious Mental Illness. This number includes approximately 5,000 members with SED and 2,000 members with SPMI. Many of these members have co-occurring health, physical health, and behavioral health conditions. We support them through a combination of medical, behavioral, and in-home services and supports, as well as coordination with non-covered services and supports. On an ongoing basis, we engage these members and their support teams to take part in their health and wellbeing

and to set goals and action steps which will increase their independence and integration. We further train our staff and providers in evidence based approaches for member engagement, including Motivational Interviewing, Person Centered Thinking, and Strengths-Based and Positive Psychology, to support their ability to provide personalized, engaging services to each member that support the identification and achievement of each member's goals and preferences.

In addition to Sunflower's experience within Kansas, our parent company, Centene, has more than 33 years of experience implementing managed care solutions for Medicaid populations, including those similar to Kansas' MediKan population. The longevity of our affiliate plans' programs reflects the confidence of our state and community partners in serving these individuals. For example, our Wisconsin affiliate originally contracted with the State in 1991 and is still there today; our Indiana affiliate is one of the longest standing Medicaid managed care plan in Indiana, contracted since 1995; and in Texas, our affiliate has held a contract with the State since 1998.

Centene plans currently serve over 12.3 million members in publicly funded healthcare programs across 29 states. Today, Centene currently operates the largest Managed LTSS program in the country, serving over 233,000 members receiving LTSS in 2017, with a Pennsylvania LTSS plan launching on January 1, 2018 with an additional 7,000 members. The table below demonstrates, by State, the breadth of populations served by Sunflower and our affiliated Centene health plans who are similar to those who will be eligible to participate in the MediKan initiative, as well as those whose socio-economic situation is unstable and impacts their health.

Figure 5.19.2.1_Sunflower and Affiliate MediKan-relevant Populations Served by State

Population	Sunflower Serves Population? (Y/N)	Number of Sunflower Affiliates that Serve Population
TANF	Y	20
Medicaid Expansion	N	14
CHIP	Y	18
ABD (non-duals)	Y	17
ABD (Medicaid only dual-eligibles)	Y	10
Long-Term Services and Supports (including, but not limited to Medicaid-Medicare Plans)	Y	7
Foster Care	Y	11
Medicare Special Needs Plan	N	8
Correctional Healthcare	N	8
Health Insurance Marketplace (Ambetter)	Y	13
Intellectual/Developmental Disabilities	Y	3

Experience Providing Employment Supports (5.19.2.2.D)

As described above in Section 5.19.1, Sunflower has experience implementing and supporting a vast array of employment support services. For example, we retain statewide management responsibilities for Project SEARCH, an internship program for young adults with developmental disabilities who want to work. As the Statewide Coordinator of Project SEARCH, Sunflower provides ongoing support for the 12 Project SEARCH host sites in Kansas, including partnering with host business sites to provide supported internships and work experiences to individuals with disabilities, expanding the program in number of interns and sites around the state. In addition, Sunflower serves as a host business site for interns, as does Centene at their St. Louis headquarters. Since the program began in the fall of 2011, 78% of Kansas participants, secured competitive employment. Moving forward, as part of our Project SEARCH efforts, we plan to collect one year post participation employment outcomes for individuals who participate in Project SEARCH who have given their permission for us to obtain this information.

Other initiatives through which we provide employment supports, all of which are described above in 5.19.1, include:

- Sunflower Transition to Employment Program (STEP), a workforce development and employment support resource program to identify and remove employment barriers for all members within the communities we serve
- Sunflower's LifeShare Program, through which we match members with an Employment Pathways Facilitator who supports individuals with disabilities to prepare for and obtain employment
- Our workflows, services, and supports that specifically identify and engage members with SPMI and SUD with goals related to employment in relevant supports, including our partnership with the CMHCs to implement the IPS model

SCENARIOS (5.19.2.2.H)

Daniel is morbidly obese and has a SUD and a criminal record. He has prior work experience but has been unable to maintain steady employment post incarceration. (3.19.2.2.H.1)

Needs Assessment

Given Daniel's history of incarceration and behavioral health related needs, Sunflower matches him with a local Community Service Coordinator at Hunter Health Clinic to be his single point of contact for the person centered planning process. Sunflower will support the Community Service Coordinator by pairing them with our System of Care Criminal Justice Liaison who is specially trained to support members who are transitioning from incarceration back to the community, as well as providing training and support as described below.

To support engagement in services, the Community Service Coordinator will contact Daniel to arrange a home visit to get to know him, start to build a relationship, and complete his Health Screening and HRA. Using Motivational Interviewing and the LifeCourse Framework, the Service Coordinator engages Daniel in a discussion about his goals, during which it is learned that

Daniel is highly motivated to attain employment, but feeling frustrated by his perception that his previous employers fired him "for no reason." Daniel's Service Coordinator engages him in a strengths assessment, which illuminates that Daniel enjoys carpentry and building furniture out of reclaimed wood. He indicates that he would like to pursue this hobby as a career, but that he does not know where to begin. Daniel also shares with his Service Coordinator that he has a three year old son, and while he is no longer with the mother of his child, he remains motivated to provide for and be a positive role model for his son. Daniel has a high school diploma and some college education, though he dropped out of college after two years.

In addition to information on Daniel's education and employment, his HRA identifies that he has not seen a Primary Care Provider in more than 3 years, and that his SUD use is primarily opiates with some alcohol abuse on occasion. Daniel's housing is stable, as he currently lives with his brother, and he and his brother are both content with this arrangement. Daniel's Service Coordinator also identifies that due to his morbid obesity, Daniel finds it difficult to leave his home, which resulted in him missing a number of work days at his last job, ultimately contributing to his most recent firing. He does not own a car, so to get around he either asks his brother for a ride or takes the bus, which is often unreliable and inconsistent.

In addition to the tools described above, Daniel's Service Coordinator uses the following evidence based tools:

- PHQ-2, on which Daniel screens positively for depression
- CAGE, on which Daniel screens positively for mild alcohol dependence

As part of the person centered planning process, Daniel's Service Coordinator provides him with choice counseling support, discussing his coverage options, including participation in the MediKan initiative that can support him to achieve his goal of becoming a carpenter. To support this discussion, Sunflower provides the Community Service Coordinator with tools and resources, including our MediKan Initiative Choice Counseling toolkit that lays out Daniel's expanded benefit options under the MediKan initiative. Following these discussions, Daniel determines that he wants to participate in the MediKan initiative to access the enhanced KanCare 2.0 benefits, including vocational support services.

Plan of Service/Person Centered Support Plan. Based on Daniel's preferences, as well as his co-occurring behavioral health and health conditions, Daniel's interdisciplinary team includes him, his brother, his Community Service Coordinator (who serves as his single point of contact), Sunflower's Plan Service Coordinator who brings expertise supporting members with histories of criminal justice involvement, a Sunflower Health Coach (who is a registered dietician nutritionist), behavioral health and medical specialists, his providers listed below (as desired by Daniel), and anyone else Daniel chooses to participate. With support from his Community Service Coordinator, Daniel develops his PoS/PCSP that centers around his self-identified goals and integrates his holistic needs related to health, behavioral health, and SDOHI-related needs.

Table 5.19.2.3_Daniel's PoS/PCSP

Daniel's Goals	Services and Supports to Support Daniel to Meet Goals
"I want to get and maintain a job as a carpenter."	• Daniel's Plan Service Coordinator at Sunflower specializes in working with members with histories of incarceration, so she supports his Community Service Coordinator to help him connect with employers who are able and willing to hire individuals with histories of incarceration • Connect Daniel to the Kansas Works for Success Program out of the Mental Health Association of South Central Kansas that assists low-income fathers in finding sustained employment, pay child support, and improve their family relationships. As part of their program, Works for Success will offer Daniel a Mentor to provide support and guidance that is focused on the goals and activities of his development plan. The Mental Health Association of South Central Kansas also provides IPS and can support provide Daniel with additional support to find a job/opportunity through that model to help him move towards becoming a carpenter • Connect Daniel to Sedgwick County Providers, the local Kansas Rehabilitation Services (KRS) agency that can provide Daniel with non-medical transportation to get to his job, as well as support him to obtain carpentry related books, tools, and supplies necessary for him to begin work.
"I want to be a good role model for my son."	• Support Daniel to access care through the provision of Non-Emergency Medical Transportation (NEMT). • Support Daniel to link to additional resources to support his engagement with his son through the Strong Dads program, an early fatherhood engagement program for fathers of children ages 0-5 years out of the Kansas Department for Children and Families. • Connect Daniel to the Hunter Health Clinic for Service Coordination, Primary Care Services, and substance abuse treatment services, including monitored detoxification (if necessary), individual and group therapy, case management, support groups and family support services. The Hunter Health Clinic also offers mental health services to treat Daniel's depression. • Connect Daniel to Preferred Family Healthcare for MAT, who will closely coordinate with the Hunter Health Clinic's Service Coordinator and treatment team • Support Daniel's SUD treatment using Sunflower's Centelligence predictive modeling solutions and SUD Segmentation Model, which uses clinical history, claims, diagnoses, and social indicators to stratify members into one of three risk groups: high (likely to be actively abusing drugs); medium (trending towards active opioid abuse); and low (unlikely to be abusing opioids). On an ongoing basis, with appropriate consent from Daniel, Sunflower will monitor and share Daniel's risk level with his Community Service Coordinator, who will support his interdisciplinary care team to provide him with services and supports to lower his risk level for opioid abuse/addiction. • Connect Daniel to peer support services through the Breakthrough Club, a Wichita based consumer-run organization • Connect Daniel to myStrength, a self-directed online peer support tool that Daniel can access at home from his computer. In addition, in 2018, Sunflower is planning to pilot an expansion of myStrength that offers behavioral health coaching to members. Therefore, through this pilot, Daniel will have access to a myStrength health coaches, who are available to respond to questions and offer encouragement he interacts with the application.

	• Enroll Daniel in Sunflower's Adult Weight Management program, through which Daniel will be assigned a Health Coach who will offer telephonic outreach, education and support services to help Daniel to improve his nutrition and exercise patterns in order to manage his weight and minimize health risk factors. • Connect Daniel to the Greater Wichita YMCA, which offers a 16-week Diabetes Prevention Program for individuals at high risk for developing type 2 diabetes that focuses on nutrition and physical activity. After the 16-week course, Daniel can participate in monthly maintenance sessions to support him to continue his progress. • Because Daniel is on SNAP, educate and enroll Daniel in our "Double Up Food Bucks" program, which will double every dollar he spends on fruits and vegetables at participating famers markets and grocery stores in the Wichita area • Coordinate with Daniel's parole officer (if applicable) to ensure that all of Daniel's re-entry requirements are addressed

Required Trainings. As described throughout this Member Independence Initiatives section, Sunflower supports the CMHCs who are implementing IPS, including the Mental Health Association of South Central Kansas, through training and education to help them implement the IPS model with fidelity. Given Daniel's comorbid behavioral health and medical issues, the entire team will receive trainings on the Collaborative Care Model, which includes education about how chronic medical conditions like obesity affect members' behavioral health conditions and vice versa. In addition, Sunflower will seek to partner with an agency that specializes in working with individuals with histories of criminal justice involvement, such as the Central Kansas Foundation, to supplement and enhance our training on the special needs of this population.

In addition, all providers with whom Daniel engages, including his Service Coordinator, will receive training on a number of topics relevant to supporting Daniel's care through our Provider Services team:

- The LifeCourse Framework, including the use of LifeCourse tools to supplement assessment and PoS/PCSP development/implementation
- Member engagement strategies, including Motivational Interviewing and Person Centered Services
- Coordination of care and care management
- Cultural competency, disability literacy, and person centered planning
- Independent living counseling (ILC) training
- Use of Sunflower web-based tools, including the Provider Portal and Community Resource Database

In addition, Sunflower will engage some of Daniel's providers, including his PCP and Service Coordinator to participate in Project ECHO (Extension for Community Healthcare Outcomes), a collaborative model of provider education that will offer Daniel's Interdisciplinary Team members training and support related to opioid addiction.

For additional skills development, Daniel's Interdisciplinary Team will also have access to Sunflower's online Practice Improvement Resource Center (PIRC), a searchable compendium of educational information and trainings on evidence-based practices, practice guidelines, multi-media content, and interactive tools to help Sunflower's team and our network providers support member care. Specifically, to support Daniel, his interdisciplinary team will have access to trainings related to the following topic areas:

- ASAM criteria for SUD, including levels of treatment, dimensions used to evaluate treatment needs, high risk use
- Behavioral Health 101, which provides an overview of mental health and substance abuse disorders, suicidality, treatment & recovery
- Co-occurring disorders, which identifies relationship between mental health issues and substance use, and provides an overview of assessment and treatment approaches
- Medical Consequences of Drug Abuse, which explores the relationship between addiction, mental health, and physical health
- Mental Health and the Criminal Justice System
- Motivational Interviewing
- Positive Psychology
- Strengths-Based Treatment
- Poverty Competency, designed to increase awareness of how poverty effects members, how it impacts wellness, and the correlation between poverty and mental illness
- SMART (Specific-Measurable-Attainable-Realistic-Timely) Goals, which trains providers in how to develop and incorporate SMART goals as part of treatment planning
- Substance Use Overview, including training on the DSM-5, levels of SUD care, stages of change, and recovery
- Mental Health First Aid

All of these online trainings are free of cost and available to the interdisciplinary team 24/7. Additionally, many of these courses offer CEU credits (as applicable to each professional), and there is no limit to the number of online courses interdisciplinary team members are able to view.

Anna has severe depression, SUD and an eighth grade education. She has a stated desire to be a veterinarian when asked what type of employment interests her. She has been directed to seek a Social Security disability determination, but is unsure if this is what she wants to pursue. (3.19.2.2.H.2)

Needs Assessment

Given Anna's severe, co-occurring mental health and substance use conditions, Sunflower matches Anna with a Community Service Coordinator that is a licensed clinical social worker out of Prairie View, Inc., who can support her behavioral health needs. Supported by Sunflower's training and support, Anna's Community Service Coordination visits Anna in her home in order

to engage her in care using a person centered engagement model that is informed by the LifeCourse Framework. At the outset of the meeting, Anna expresses that she is not interested in going to treatment and is considering applying for a disability determination. Using Motivational Interviewing, Anna's Community Service Coordinator engages her (and her mother who is a primary part of Anna's support network) in a discussion about her goals, during which she expresses her strong desire to be a veterinarian. Based on this stated goal, the Community Service Coordinator provides choice counseling to Anna and her mother about the option to access expanded employment and educational benefits through the MediKan initiative, providing her with educational materials from our MediKan Initiative Choice Counseling toolkit that clearly outline her benefit options. During the initial conversation about the initiative, Anna states that she does not think anything will help and that she just wants to access disability benefits and live her life. The Community Service Coordinator continues the choice counseling conversation during her next few meetings with Anna, engaging Sunflower's Employment Specialist in these conversations to answer Anna and her mother's specific questions about the MediKan initiative's benefit package and how this could help her achieve her goal to become a veterinarian. Anna has been working part time at Walmart in McPherson but doesn't get enough hours to support herself. Her mother is an administrative assistant at McPherson College and would like to retire in two years. However, she will not be able to retire if she continues to need to support Anna. Ultimately, based on Anna's veterinary aspirations and Anna's mother's desire to retire, Anna and her mother decide not to pursue a disability determination and to instead access the MediKan initiative's enhanced benefit package to help support Anna to achieve her goal and increase her independence and ability to support herself through competitive employment.

During the HRA, Anna's Community Service Coordinator conducts the HRA with Anna, through which we identify that Anna dropped out of school due to severe learning disabilities that her previous school was unable to accommodate, but that she desires to pursue more education than she has today. Anna also states that she feels guilty about her alcohol use, but that she has not ever felt motivated to seek treatment because she doesn't "see the point."

In addition to the HRA, Anna's Service Coordinator uses the following evidence based tools as part of her comprehensive needs assessment:

- PHQ-9, on which Anna screens positively for depression
- CAGE, on which Anna screens positively for alcohol abuse
- Sunflower's Functional Needs Assessment, which identifies that Anna's mother supports several of her IADLS today, including preparing food, transportation to appointments, and housekeeping

On an ongoing basis, Anna's Service Coordinator will also engage Anna's mom in a Caregiver Assessment and refer her to follow up supports in order to identify and meet her needs as Anna's primary caregiver.

Plan of Service/Person Centered Support Plan. Anna's interdisciplinary team will include Anna, her mother, her Community Service Coordinator (who is a behavioral health clinician and will serve as Anna's primary point of contact), the Sunflower Service Coordinator assigned to Prairie View, Inc., a medical specialist, her providers listed below, including a teacher from McPherson Community College (as desired by Anna), and anyone else Anna wishes to participate. Her Service Coordinator will support her to develop the following PoS/PCSP that centers around her expressed goals, but also focuses on engaging her in services to stabilize her behavioral health conditions so that she can move towards achieving those goals.

Table 5.19.2.4_Anna's PoS/PCSP

Anna's Goals	Services and Supports to Support Anna to Meet Goals
"I want to become a veterinarian"	• Support Anna to connect to the adult education program at Hutchinson Community College, which will support her to increase her basic skills in math, reading, and writing, and prepare for and take the GED Test. • Ensuring informed choice, the Community Service Coordinator will educate Anna and her mother about the services and supports available from the McPherson County Community Developmental Disabilities Organization (CDDO), which can provide a CDDO eligibility assessment and additional community based living and employment services and supports for Anna based upon her eligibility • Refer Anna for a Learning Disability assessment and connect her to Vocational Rehabilitation access to services that will support her education and employment • Connect Anna to the Mcpherson County Humane Society, which has volunteer opportunities to support the animals at the shelter and can support her to learn more about animals and gain valuable volunteer experience • Link Anna to a Community Service Coordinator from Prairie View, Inc., a Mental Health and Addictions Treatment Center that offers a continuum of services and support to meet Anna's addiction and mental health needs. Because Anna has expressed resistance to behavioral health treatment, once trust has been built between Anna and her Service Coordinator, the Service Coordinator will provide Anna with education and information about the resources that she can access at Prairie View, including resources that link to her expressed goal, like Vocational Services that can support Anna to become employed once she is ready. The Service Coordinator will have a discussion with Anna about her goal of becoming a veterinarian, supporting her to realize that in order to accomplish this goal, she must address her mental health and addiction. In addition, Anna's Service Coordinator will ensure that Anna is connected with a primary care provider, such as the GraceMed McPherson Family Clinic, which can offer her Screening, Brief Intervention, and Referral to Treatment (SBIRT), which will provide her with a brief SUD intervention (e.g., education) designed to engage her in treatment based on her positive SUD screening. Finally, the Service Coordinator will also connect Anna to peer support services, linking Anna to a peer specialist that is in recovery and can support her to move towards recovery when she is ready.
"I want to feel motivated to get out of bed in the morning."	• In addition to engaging Anna in services from Prairie View, Sunflower will enroll Anna in our Depression Management program, which is based on the IMPACT model of evidence based depression care. Based on her PHQ-9 results, Anna is stratified into the Moderate Risk category, through which she receives ongoing mail and telephonic outreach from the Disease Management team (based on her uncontrolled, severe depression), in

	coordination with her Prairie View treatment team, as well as monthly re-assessment of her depression symptoms to monitor treatment response • Connect Anna to myStrength, which she can access from home to support her behavioral health wellness, including on demand activities and educational resources, as well as behavioral health coaching. • Ensure Anna is connected to the GraceMed McPherson Family Clinic for medical, dental, and vision care
Anna's Mom: "I want to support my daughter to live independently"	• Based on the results of Anna's mom's Caregiver Assessment, connect her to Centene's Caregiver Support program, which includes access to a comprehensive Caregiver Resource Center that offers information about early symptom and exacerbation identification, managing illnesses, and balancing needs, as well as tools, tips and resources, including links to community-based services and resources for caregivers. • Connect Anna's mom to myStrength, which offers tailored supports and resources for caregivers to reduce compassion fatigue • Support Anna's mom to identify a local Retirement Planning Advisor in the community who can help her plan for retirement, while Anna is working to increase her ability to live independently through the above supports

Trainings. Anna's entire interdisciplinary team will be trained in Behavioral Health 101 and Substance Use Overview, to support their understanding of how her depression and SUD impacts her daily functioning. Sunflower will also train Anna's Community Service Coordinator in Sunflower's Caregiver Assessment process, using LifeCourse as an overall framework for the process. In addition, all providers on Anna's interdisciplinary team will receive training in the following relevant topics from our Provider Services team:

- Member engagement strategies, including Motivational Interviewing
- Behavioral Health and Utilization Management
- Coordination of care and care management
- Cultural competency, disability literacy, and person centered planning
- Independent living counseling (ILC) training
- Use of Sunflower web-based tools, including the Provider Portal and Find a Provider tool
- Clinical Practice Guidelines related to the IMPACT model for depression treatment

Anna's interdisciplinary team will also have access to online trainings from our PIRC, including the following:

- ASAM criteria for SUD
- Co-occurring disorders
- Medical Consequences of Drug Abuse
- Motivational Interviewing
- Positive Psychology
- Strengths-Based Treatment
- Poverty Competency
- SMART Goals

- Mental illness signs and symptoms, which provides an overview of how mental illness is defined and basic symptomology of common mental disorders, including depression
- Providing Independence for Clients: A Provider's Guide to Successful Client Outcomes and Titrating Services, specifically to support mental health providers to titrate services for effective client outcomes
- Recovery principles, that offers education on providing recovery oriented care and promoting client resiliency
- Stages of Change, which reviews the five stages of readiness for change and their relationship to the recovery process
- Mental Health First Aid

Robert has diabetes and has been unable to maintain stable housing. He often goes long periods of time without the medication he needs. While he has worked with service coordinators in the past, his homelessness has made it difficult to maintain consistent care. (3.19.2.2.H.3)

Needs Assessment

In order to conduct an HRA with Robert as part of his Service Coordination, Sunflower must first locate and engage him in care. Given that he is homeless, Sunflower's Plan Service Coordinator partners with a local homeless services agency, such as Cross Lines Community Outreach, Inc., in Kansas City, to help locate Robert. The staff at Cross Lines informs Sunflower's team that Robert comes into their Don Bakely Community Annex for food and a shower on Tuesday and Thursday mornings, so Sunflower's Service Coordinator goes out to the Don Bakely Community Annex the following Tuesday to meet with Robert, talk to him, and begin to build a relationship with him, assessing his goals and needs when he is ready.

Importantly, Sunflower recognizes that Robert may be distrustful of "the system" and unlikely to engage in the HRA immediately upon meeting with us. Therefore, we will utilize a multi-pronged engagement strategy, initially meeting with Robert with a Cross Lines staff member who he trusts, as well as identifying and meeting Robert's immediate needs (e.g., linking him with a shelter at which to sleep, providing him with a warm blanket and a cup of coffee, etc.) before trying to engage him to complete the HRA. As described above, Sunflower's team is also trained in person centered engagement strategies, including the LifeCourse Framework and Motivational Interviewing, which we use to meet Robert where he is and engage with him around his self-identified goals. Through the engagement process, we learn that Robert wants to get a job to earn enough money to own his own home.

During the HRA, Robert's Service Coordinator identifies that Robert's diabetes is out of control given his infrequent use of diabetes medications. He indicates that he does often need to choose between meeting his basic needs (e.g., buying food) and obtaining his medications, which means that he often doesn't fill his prescriptions regularly. He isn't regularly connected

with any providers, though he has previously been linked to a local primary care provider for his diabetes, and he doesn't have any family or natural supports.

In addition to the HRA, Robert's Service Coordinator will use the following evidence based tools to assess his needs during the comprehensive assessment:

- PHQ-2, which indicates that Robert does not have any depression symptoms
- CAGE, which indicates that Robert does not have any symptoms related to alcohol abuse/dependence

Although initial information that Sunflower received about Robert's situation seemed to indicate that he may be eligible for traditional KanCare 2.0 benefits rather than MediKan, using the LifeCourse Framework, the Service Coordinator engages with Robert and learns that he is a veteran and has a history of Post-Traumatic Stress Disorder (PTSD) that impacts his day-to-day functioning. He experiences frequent insomnia, distorted vision and hearing that results in sensory overload, and occasional migraines, all of which make it difficult for him to maintain a consistent schedule. After learning this information, Sunflower coordinates with the State, which, after some consideration and coordination with Sunflower, deems him eligible for the MediKan expanded benefit if he decides this is the right course of action for him. The Service Coordinator provides Robert with choice counseling to support him to assess his benefit options. Based on his strong desire to work in order to own his own home, Robert determines, with support from his Plan Service Coordinator, that the MediKan initiative's expanded benefits is an option that will best support him to achieve his goals.

Plan of Service/Person Centered Support Plan. Robert's interdisciplinary team will consist of Robert, his Plan Service Coordinator (who is a Registered Nurse given his diabetes diagnosis), the Sunflower Housing Specialist, and his service providers described below (as desired by Robert). His PoS/PCSP will focus on getting him stably housed, while also stabilizing his diabetes so that he can enhance his ability to live independently and decrease his likelihood of having to pursue a disability determination moving forward.

Table 5.19.2.5_Robert's PoS/PCSP

Robert's Goals	Services and Supports to Support Robert to Meet Goals
"I want a home of my own"	• Connect Robert to homeless services resources at the Kansas City Public Library's "Coffee and Conversation" initiative, which include job counseling, transportation assistance, and other social services that can help people get back on their feet. • Based on his goal of earning enough to own his own home, the Plan Service Coordinator will connect Robert to the GoodWORKS Career Resource Center out of Goodwill of Western Missouri and Eastern Kansas, which will match Robert with a Goodwill career professional who provides individualized job search and employment related assistance, including assistance with job exploration, resume preparation, online job listing navigation, online applications, as well as the use of job search tools. • Sunflower's Housing Specialist will work with other community based housing services agencies in the Kansas City areas to together support Robert to identify viable housing options based on his goals and needs in his chosen community. By working with the Kansas

	City Kansas Housing Authority (KCKHA), we support Robert to complete an application for public housing in collaboration with the KCKHA Resident Selection staff to attain a 1 bedroom apartment in Kansas City. Robert uses Cross Lines Community Outreach's address to receive communications related to his application. • Connect Robert to Sunflower's Call Center, who can link Robert with a non-medical transportation support provider in the community, listed in the Community Resource Database, to support him to access the resources included in his PoS/PCSP.
"I want to feel like I have control over my own health and wellbeing"	• Robert's Service Coordinator identifies that Robert did not remain connected to his previous Primary Care Provider due to the distance he had to travel to reach the provider's office. Therefore, Robert's Service Coordinator will link Robert to Swope Health Services, a 10 location FQHC that also operates a mobile medical clinic within the Kansas City metro area specifically designed to serve individuals who are homeless. In addition to both medical and behavioral health care (to support his co-occurring conditions and treat his PTSD symptoms), Swope Health Services also offers resources to homeless individuals related to housing and employment. • Connect Robert to the Kansas City Veterans Administration (VA), which can provide him with resources and supports related to his PTSD, including coordination with the team at Swope Health Services, as well as peer support groups and services. • Enroll Robert in Sunflower's Diabetes Management Program, which will link him to a Health Coach (a Certified Diabetes Educator) that will offer him medication compliance education and support, tools for self-blood glucose monitoring, screening and addressing diabetic complications, and unlimited support calls with his Health Coach • Ensure Robert has access to NEMT services and supports to reach these appointments • Provide Robert with a SafeLink Phone to help him have telephonic access to Sunflower, his providers and United Way Kansas City's 211 service

Training. Everyone on Robert's interdisciplinary team will receive training on engagement techniques, including Motivational Interviewing and the LifeCourse Framework, to help support their ability to meet Robert where he is and engage with him around his own self-identified goals. We will also provide training in Poverty Competency, which is designed to teach providers and practitioners to more effectively reach and engage members who are impoverished, including individuals who are homeless. In addition, Sunflower will work to partner with a community provider who specializes in providing services to individuals who are homeless, like the Greater Kansas City Coalition to End Homelessness, who can support additional training about the unique needs of individuals who are/were formerly homeless. Finally, Sunflower will engage the Kansas City VA to provide training to Robert's interdisciplinary team on the unique needs of veterans and individuals living with PTSD.

All providers with whom Robert engages will receive training on a number of topics from our Provider Services team, including:

- Coordination of care and care management
- Cultural competency, disability literacy, and person centered planning
- Independent living counseling (ILC) training

- Use of Sunflower web-based tools, including the Provider Portal, the Find a Provider tool, and the Community Resource Database

Robert's interdisciplinary team will also have access to Sunflower's PIRC to access on demand, online trainings on any of the following topics:

- Positive Psychology
- Strengths-Based Treatment
- SMART (Specific-Measurable-Attainable-Realistic-Timely) Goals, which trains providers in how to develop and incorporate SMART goals into treatment planning
- Recovery principles, that offers education on providing recovery oriented care and promoting client resiliency
- Stages of Change, which reviews the five stages of readiness for change and their relationship to the recovery process
- Mental Health First Aid

Ryan is being discharged from the State Department of Corrections. He has a high-school education and prior work experience. He has been determined eligible for KanCare and has selected the CONTRACTOR(S)' plan. (3.19.2.2.H.4)

Needs Assessment

Sunflower will match Ryan to our Plan Service Coordinator that specializes in Transitions from Correctional settings back to the community. She will serve as Ryan's single point of contact for his transition activities, meeting with him and the Department of Corrections staff in order to support his discharge prior to his release date and develop a transition plan to help support his transition back to the community. Ryan's transition plan will be informed by our person centered planning process and his HRA, which indicates that he has previously held a diverse range of jobs, but has had difficulty maintaining steady employment his entire working career. Ryan was first arrested for a minor drug charge, but since that time, he has been in and out of prison a few more times for parole violations. However, Ryan's Plan Service Coordinator determines, through his HRA, that Ryan does not have any addiction issues, something that she will continuously monitor following his discharge as part of his PoS/PCSP. Once he is discharged, Ryan will return to live with his sister in Salina, KS. While Ryan and his sister are both content with this arrangement in the interim, both express their desire to get Ryan his own place to live as soon as possible. During their conversation, Ryan also tells the Service Coordinator that he found religion while in prison, so he wants to connect with a Presbyterian congregation when he returns to his home community.

Ryan expresses a desire to be self-sufficient (including obtaining a job and an independent stable housing situation so he can move out of his sister's apartment), but that he has always struggled due to the fact that he is extremely hard of hearing. He indicates that even though he wants to be a mechanic, based on his hearing impairment, he does not believe that this goal is achievable, so he is considering applying for a disability determination. Based on this, his Plan

Service Coordinator engages him in a conversation about the options available to him under the MediKan initiative, including available accommodations that could support his employment goal, and ultimately Ryan determines that this benefit package makes sense based on his eligibility and goals. In addition to the HRA, Ryan's Service Coordinator will also implement the following evidence based assessment tools to assess his holistic needs:

- PHQ-2, which indicates that Ryan does not have depressive symptoms
- CAGE, which indicates that Ryan does not have symptoms related to alcohol abuse/dependence

Plan of Service/Person Centered Support Plan. Building on his transition plan, Ryan develops a PoS/PCSP, with support from his Service Coordinator, that centers around supporting him to successfully re-enter the community and obtain substantial, gainful employment and stable, independent housing. His interdisciplinary team will include Ryan, his sister, his Plan Service Coordinator (who specializes in individuals transitioning out of the criminal justice system and will serve as his single point of contact), the Sunflower Member Advocate, Sunflower's Housing Specialist, his Parole Officer, Ryan's providers (as desired by Ryan), and anyone else Ryan wishes to participate.

Table 5.19.2.6_Ryan's PoS/PCSP

Ryan's Goals	Services and Supports to Support Ryan to Meet Goals
"I want to get a job as a mechanic."	• Ryan's Service Coordinator is specially trained to support individuals with histories of criminal justice system involvement to successfully re-enter the community, including helping them find employment. She will work with Ryan to help him access educational and employment opportunities. The Service Coordinator will also coordinate with Ryan's parole officer to ensure that all re-entry requirements are incorporated into his PoS/PCSP. • Link Ryan to Catholic Charities of Salina, Inc., which offers a community re-entry program that may be able to support him in identifying and accessing employment and necessary accommodations to ensure this goal is accessible to him • In addition, Ryan has expressed a desire to work towards becoming a mechanic, so we will connect him to Salina Area Technical College, which has an Automotive Technology program that is accredited by the National Automotive Technicians Education Foundation (NATEF). The Sunflower Member Advocate can support Ryan to help him connect to/obtain the necessary accommodations, support, and resources to assure that all applications/forms are completed (application for the program, financial aid, need for accommodations, etc.) based on his care plan goals and needs, and that he has all accommodations necessary to participate in the curricula based on his hearing difficulties • Connect Ryan to the Disability Rights Center of Kansas, who can support Ryan (complementing the work of Sunflower's Member Advocate) through their Self Advocacy for Deaf or Hard of Hearing initiative, which offers free resources and tools to obtain employment related and other accommodations for daily living.
"I want to move out of my sister's house	• Link Ryan with Sunflower's Housing Specialist, who will work with the Salina County Housing Authority to support Ryan to apply for a Section 8 Housing Choice Voucher and identify a housing option that is right for him when he is ready

into my own home"	• Ryan's ability to live independently necessitates him remaining in good health. Sunflower's Plan Service Coordinator will ensure that he is connected to community providers who can support his health and wellbeing. This includes connection to the Salina Family Healthcare Center, an FQHC that offers medical, dental, and pharmacy services • Based on Ryan's expressed faith and interest in getting involved in the community, Sunflower will connect him with religious resources, such as the First Presbyterian Church in Salina, which offers worship services, community events like concerts and yoga, as well as volunteer opportunities

Ultimately, when Ryan obtains and maintains a job as a mechanic, there may come a time where he is no longer eligible for KanCare due to income limitations. Sunflower brings extensive capacity and experience supporting member transitions, including those between Medicaid and Marketplace Plans. Our Service Coordination team constantly monitors each member's eligibility, ensuring that we are able to proactively identify when a member is about to transition off of Medicaid and supporting members like Ryan to determine the plan that is right for them. In Ryan's case, he determines through these conversations that he would like to enroll in Sunflower's Ambetter Plan, so we connect him to a local agency, such as the Salina Family Healthcare Center, that has a Marketplace Broker who can support him to enroll in this plan with no loss in coverage, ensuring continuity of care during the transition.

Training. All members of Ryan's interdisciplinary team will receive training on the LifeCourse Framework, and we will partner with a local community provider (as described above) to enhance Sunflower's training related to individuals with histories of criminal justice involvement. In addition, all network providers that serve Ryan will receive training from our Provider Services Team on:

- Member engagement strategies, including Motivational Interviewing
- Coordination of care and care management
- Cultural competency, disability literacy, and person centered planning
- Independent living counseling (ILC) training
- Use of Sunflower web-based tools, including the Provider Portal and Find a Provider tool

Finally, Ryan's Interdisciplinary Team will also have access to online trainings and educational materials from PIRC, including:

- Mental Health and the Criminal Justice System
- Motivational Interviewing
- Positive Psychology
- Strengths-Based Treatment
- Poverty Competency
- SMART Goals
- Stages of Change

Linda has schizophrenia and Hepatitis C. She is being discharged from a state hospital. (3.19.2.2.H.5)

Needs Assessment

Given Linda's discharge from the Osawatomie State Hospital, Sunflower will first engage her prior to her discharge via one of our State Hospital Liaisons, who will support Linda at the state hospital, in coordination with her interdisciplinary team. Based on her impending discharge and mental health needs, Sunflower will match Linda with a Community Service Coordinator from the Wyandot Center for Community Mental Health (who will serve as her single point of contact), who will lead the development of her transition plan that will support her to successfully transition back to the community. Linda is transitioning back to live with her mother, who will be her primary caretaker moving forward; therefore, Linda's Community Service Coordinator will involve her mother right from the start of our person centered assessment and planning process (with Linda's expressed desire and approval), ensuring that Linda and her mother's needs are met in preparation for and following her transition. Given her acute mental health and medical needs, Linda's Community Service Coordinator will be a licensed clinical social worker, but her interdisciplinary team will also include a Registered Nurse who can support the integration of services and supports related to her Hepatitis C into her PoS/PCSP.

Linda's HRA identifies that both her schizophrenia and Hepatitis C are under control with her current medication regimen, but it also illuminates the fact that Linda has a history of medication non-compliance in the community due to her low to moderate functional level. She expresses a desire to get a job once she returns home, at which point her Service Coordinator engages her and her mom in choice counseling so that they can consider the different benefit options for her, including enrolling in the MediKan initiative that would offer her enhanced benefits to support this goal. Linda and her mom agree that the MediKan initiative is the best option for Linda.

Linda's Service Coordinator will work with Linda's mother to conduct a Caregiver Assessment related to her needs. During this assessment, Linda's mom expresses excitement that her daughter is coming home, but also has some anxiety about making sure her daughter remains on her medication. She requests additional support from Sunflower to ensure Linda keeps taking her medications, so this identified need/request is integrated into Linda's PoS/PCSP, and closely monitored by her Community Service Coordinator (with support from Sunflower on an ongoing basis) following her transition.

In addition to the HRA and Caregiver Assessment, Linda's Service Coordinator will include the following as part of her comprehensive needs assessment:

- A Functional Needs Assessment, which identifies that Linda needs help with several IADLs, including showering/bathing, getting dressed, and organizing her day. Based on this, Linda's Service Coordinator will refer her to the CDDO following her transition for an eligibility determination.

Plan of Service/Person Centered Support Plan. Linda's interdisciplinary team will include Linda, her mother as her primary caretaker, Linda's Community Service Coordinator, Sunflower's Plan Service Coordinator (an RN who can support Linda's diagnosis of Hepatitis C), and her service providers (as desired by Linda). Her PoS/PCSP will be based on the transition plan that she and her mother develop with the Community Service Coordinator to support her to successfully transition back to the community.

Table 5.19.2.7_Linda's PoS/PCSP

Linda's Goals	Services and Supports to Support Linda to Meet Goals
"I want to live in the community"	• Connect Linda to the Swope Health Services, which provides integrated medical and behavioral health services to allow Linda to get treatment for her Hepatitis C from an integrated team of community practitioners, as well as the Wyandot Center for Community Mental Health, which works closely with Swope Health Services to provide integrated behavioral health care both on site at the health center, as well as at their own CMHC site. Wyandot will provide Linda with Service Coordination, as well as a more robust set of support services for individuals living with mental health conditions (to complement those offered by Swope Health Services), including art therapy, peer support services, recovery oriented group therapy, and 24/7 crisis stabilization services. The Wyandot Center also offers IPS and can support Linda to achieve her employment and education related goals. • Swope Health Services' team will work closely with Linda's Community Service Coordinator to provide ongoing monitoring of Linda's follow up visits and lab testing results, to ensure Linda's transition back to the community is smooth and that she is receiving all services and supports that she needs in order to be successful. • In addition, connect Linda to a local Vocational Rehabilitation provider for additional employment related support services. • Based on Linda's education/vocational goals, connect Linda to vocational or volunteer opportunities that meet her needs, such as IPS at the Wyandot Center • Connect Linda to the University of Kansas Health System's psychiatry department for community based psychiatric treatment and support with medication adherence.
Linda's Mom: "I want to be able to support my daughter in the community"	• Based on the Caregiver Assessment results, link Linda's mom with Caregiver Support resources, including Sunflower's Caregiver Journal and Centene's Caregiver Program, which offer support resources for balancing needs as a caregiver, as well as links to community-based services and resources. Linda's mom will also be linked with Sunflower's Caregiving Collaborations™ program, a HIPAA-secure care collaboration application that can be accessed via the internet using devices such as smart phones, tablets, and desktop computers. This caregiver application uses innovative technology that will bring clinically relevant health information and resources directly into the hands of Linda and her mom, and allows them to connect directly to Linda's Service Coordination team about issues that they experience (e.g., issues related to Linda's medication adherence), through group chats, at a time that is convenient for them. • Based on Linda's mother's expressed interest in advocacy to reduce the stigma of mental illness on behalf of her daughter, connect her to the Greater Kansas City Mental Health Coalition, that can provide volunteer opportunities to participate in these efforts (such as the Speak Up Walk), a network of similarly oriented individuals in her community, and connection to support resources across the greater Kansas City metropolitan area

Training. Sunflower provides training and support to the Wyandot Center to support them to implement the IPS model with fidelity. In addition, all members of Linda's interdisciplinary team will receive training on the Collaborative Care model, to support their ability to support Linda using principles of integrated care that take into account and address both her behavioral health and medical needs, as well as on the LifeCourse Framework, which will contribute to their ability to meet Linda and her mom where they are, as well as engage and support them to achieve their expressed goals.

All providers with whom Linda engages will receive training on the following topics from our Provider Services team:

- Member engagement strategies, including Motivational Interviewing
- Coordination of care and care management
- Cultural competency, disability literacy, and person centered planning
- Independent living counseling (ILC) training
- Use of Sunflower web-based tools, including the Provider Portal and Find a Provider tool

Finally, Linda's interdisciplinary team will have access to trainings and resources from Sunflower's PIRC, which will include:

- Behavioral Health 101
- Motivational Interviewing
- Positive Psychology
- Strengths-Based Treatment
- Poverty Competency
- SMART Goals
- Mental illness signs and symptoms
- Providing Independence for Clients: A Provider's Guide to Successful Client Outcomes and Titrating Services
- Recovery principles
- Stress Management for Caregivers, which provides tools and resources to support caregivers to recognize their own signs of frustration and implement stress management techniques including coping calming strategies, thought modification and identifying systems of support.
- Mental Health First Aid

Bill is 56 year old applicant with diabetes, back pain, and moderate depression. The Presumptive Medical Disability Team has determined that he has limitations and likely cannot do more than sedentary work in a setting of low social contact. While this might normally lead to a Medicaid allowance for an applicant of this age, he has a past sedentary work history so would be denied for Medicaid and allowed for MediKan. (3.19.2.2.H.6)

Needs Assessment

To begin, Sunflower assigns Bill to a Community Service Coordinator out of Valeo Behavioral Health Care based on his moderate depression and assessed risk of opioid addiction. During the first meeting with his Service Coordinator, Bill expresses confusion over the Presumptive Medical Disability Team's determination decision, so Bill's Community Service Coordinator walks through the determination decision with him and answers his questions. This leads to a choice counseling discussion, during which the Service Coordinators discusses Bill's option to enroll in MediKan, including the benefits that he would receive under this initiative. Bill expresses uncertainty about MediKan's fit for his needs, given the challenges he has experienced with finding and retaining employment up until this point (e.g., back pain, need for low social contact). The Service Coordinator, who has been trained by Sunflower in Person Centered Thinking, reframes the conversation with Bill to ask about his interests and goals for himself. Bill expresses an interest in both painting/drawing and video games, which he plays on a daily basis. This leads to a conversation about coding and computer programming, which Bill has always been curious about but has never received any training on. As part of the choice counseling conversation, Bill's Service Coordinator shares that participation in the MediKan initiative can help him access services and supports that could allow him to be trained in and ultimately obtain a job related to computer programming. Bill and his Service Coordinator together do a quick search for available programming jobs, and Bill learns that many of these jobs allow employees to work remotely from home, which would support Bill's need for low social contact. After some consideration, Bill agrees that the MediKan Initiative is a good option for him to pursue.

Bill's Service Coordinator engages Bill in a comprehensive needs assessment, starting with the HRA, that identifies that Bill has been taking opiates for his back pain for the past several years and also that he has some signs of issues related to alcohol abuse. Based on this, his Service Coordinator engages Bill in a comprehensive assessment of his opiate use, and Sunflower's team supports this assessment by using our predictive modeling tools and SUD Segmentation Model, which indicates that Bill is "Moderate Risk" for opiate use ("trending" towards addiction) due to his long history of use and co-occurrence of depression and alcohol use. Bill's wife passed away several years ago, about the same time that his back pain began, and since her passing, he has struggled to get out of bed. The Community Service Coordinator also learns from Bill that he does not currently have any natural supports, but that his need for low social contact does not carry over to settings outside of employment settings.

In addition to the HRA, Bill's Service Coordinator uses the following evidence based assessment tools to gather more information from him related to his needs:

- PHQ-9, on which Bill screens positively for depression
- CAGE, on which Bill screens positively for alcohol abuse (but not dependence)

Plan of Service/Person Centered Support Plan. Bill develops his PoS/PCSP, with support from the Service Coordinator, to prioritize stabilizing his back pain and addiction issues (including his opiate use) using an integrated approach that incorporates treatment for depression (given the strong correlation of depression, back pain, and opiate addiction). Bill's Interdisciplinary Team will consist of Bill, his Community Service Coordinator from Valeo Behavioral Health Care (who will serve as his single point of contact with the team), his Sunflower Service Coordinator (an RN), a Sunflower Health Coach to assist with Bill's diabetes and depression, and Bill's providers (as desired by Bill). As part of Bill's PoS/PCSP, we will encourage and support Bill to develop natural support resources and integrate them into his interdisciplinary team as appropriate and desired by Bill.

Table 5.19.2.8_Bill's PoS/PCSP

Bill's Goals	Services and Supports to Support Bill to Meet Goals
"I want to get a job in computer programming"	• Connect Bill to Valeo Behavioral Health Care that can provide Bill with treatment for his depression and substance use. Valeo also offers IPS, which can support Bill to achieve his programming-related employment goals. Based on Bill's expressed interest in art, he can also access expressive art and music therapy at Valeo, as well as contribute to Valeo's Creations of Hope Gallery, a collective of artists dedicated to the mission of raising mental health awareness and reducing stigma through the exhibition of art. • Support Bill to apply to an online program to learn computer programming, as well as work with Valeo to help him access a job that allows him to work remotely and practice his computer programming skills.
"I want to live without pain"	• Enroll Bill in Sunflower's Disease Management program for depression, which is based on the IMPACT model of care and will support him through ongoing outreach and education and connection to community resources.. • Connect Bill to a coach from Sunflower's Diabetes Disease Management program, which would work in close coordination with the behavioral health coach from the Depression Disease Management program through his single PoS/PCSP. Bill's Community Service Coordinator will lead and support this coordination across programs, working with Bill to prioritize his goals, develop interventions, and ultimately, improve both his physical and behavioral health outcomes • Connect Bill to new Beginnings Health Care Integrative Medical Center, which offers traditional primary care services, as well as non-traditional services to support Bill to manage his diabetes and chronic pain, such as massage therapy, reiki, and naturopathic medicine • Support Bill to access myStrength, which can provide him with on demand tools and resources, as well as behavioral health coaching, that support management of his depression • Connect Bill to a small peer support group at the Topeka Independent Living Center to reduce his social isolation.

Training. Bill's interdisciplinary team will all receive training in the Collaborative Care model, as well as have the opportunity to participate in an online Project ECHO for chronic pain management, led by Sunflower's Medical Director, which will support Bill's providers to better understand the root cause of his medication seeking behavior, symptoms, and treatment options. All providers will receive training on the following topics through our Provider Services team:

- Member engagement strategies, including Motivational Interviewing
- Coordination of care and care management
- Cultural competency, disability literacy, and person centered planning
- Independent living counseling (ILC) training
- Use of Sunflower web-based tools, including the Provider Portal and Find a Provider tool

In addition, the interdisciplinary team will have access to the following training topics from our online training resources:

- ASAM criteria for SUD
- Behavioral Health 101
- Co-occurring disorders
- Medical Consequences of Drug Abuse
- Motivational Interviewing
- Positive Psychology
- Strengths-Based Treatment
- Poverty Competency
- SMART Goals
- Substance Use Overview
- Mental illness signs and symptoms
- Providing Independence for Clients: A Provider's Guide to Successful Client Outcomes and Titrating Services
- Recovery principles
- Stages of Change
- Mental Health First Aid

5.19.3. TRANSMED EMPLOYMENT OPPORTUNITY INITIATIVE

TRANSMED INITIATIVE (5.19.3.1)

If the TransMed Initiative is approved and implemented in Kansas, Sunflower will be fully prepared to participate using our and our affiliates' tools and experience with similar programs. An average of 5,897 adults receive Medicaid services per month under the current TransMed program for families who had been Medicaid eligible as Low-Income Families with Children and have lost financial eligibility due to increased earnings. Under the proposed Initiative,

individuals eligible for TransMed would have the option to either receive TransMed for a twelve (12) month period, or participate in the TransMed Initiative and receive Independence Accounts that encourage them to (i) maintain employment, and (ii) transition out of Medicaid and onto the health insurance exchange (Marketplace) or other commercial insurance plans. Below we describe our experience in Kansas and other states that uniquely prepares us to: manage and monitor Independence Accounts; train our staff and educate members about choosing to participate in the TransMed Initiative and appropriately using the Independence Accounts; and inform participants about accessing health insurance through the Marketplace or other available vehicles.

LOCAL AND NATIONAL EXPERIENCE WITH INDEPENDENCE ACCOUNTS/HSAS (5.19.3.2.A)

Sunflower's Working Healthy/WORK program

As described in Section 5.18, Sunflower has had a robust Work Opportunities Reward Kansans (WORK) program since it was incorporated into KanCare, currently with 140 participants. Sunflower members with disabilities who are employed and need ADL or IADL support may quality for the WORK program and have an Individualized Budget, from which they can purchase self-directed or agency-directed personal and employment services and assistive devices. The members can save a certain amount of money from month to month for approved purchases. Sunflower has a financial management services (FMS) provider that manages the funds of these members and Independent Living Counselor providers who help members with budget management and service coordination. In conjunction with the FMS provider, Sunflower monitors the accounts of members in WORK, submitting monthly and quarterly expenditure reports to the State. Sunflower's program is highly effective, with 98% of our WORK program members answering positively on the below quality of life metrics in 2017:

- Member is active outside the home
- Member decides their daily routine
- Member feels safe where they live
- Member is satisfied where they are living
- Member can see their family and friends when they want

Between January 1 and September 30, 2017, more than 45,000 Sunflower members earned CentAccount® Rewards worth nearly $650,000. Of earned rewards, members purchased pain relief, cold and allergy medication, baby care, household products, and skin care.

SUNFLOWER'S MEMBER LOYALTY/CENTACCOUNT PROGRAM

Since 2013, Sunflower has coordinated a CentAccount® reward program that rewards members for completing easy, simple healthy behaviors. When members make certain healthy choices, reward dollars are automatically put on their CentAccount® rewards card and mailed to them. Today, the CentAccount® rewards card can be used to purchase hundreds of items at designated stores that help address SDOHI such as nutrition, baby care, groceries, over-the-counter medicine, and personal care items. Members can also log into their Sunflower member account to find a complete list of items they can buy and their rewards balance. Sunflower

manages and tracks the accounts, preparing monthly reports that document: number of cards mailed and activated, activated/pending/closed cards, rewards and spending (total and unique members), rewards types by month, spending by vendor per month, and other key information. See **Figure 5.19.3.2.A_Sample Page from CentAccount Monthly Report for November 2017**.

Figure 5.19.3.2.A_Sample Page from CentAccount Monthly Report for November 2017

envolve PeopleCare

Kansas Sunflower (KS)

CentAccount monthly report for end of November 2017

	YTD	Last month
Cards mailed:	23,214	1,875
Cards activated:	9,976	995
Activation rate:	43%	53%

Notes on gender percentages:
A) Percentages represent the proportion of total rewards per gender. For example, if $50,000 was rewarded and $20,000 was rewarded to male members, then the percentage would be 40%
B) Percentages represent the proportion of total spending per gender. For example, if $18,000 was spent and $6,000 was spent by female members, then the percentage would be 33%
C) represents the percentage of rewards spent for each gender. For example, If female members earned $100 and spent $20, the rewards spent would be 20%
D) Percentages represent the proportion of total unique members who earned rewards per gender. For example, if 100 unique members recieved rewards, and of those, 90 were male, then the percentage would be 90%
E) Percentages represent the proportion of total unique members who spent per gender. For example, if 80 unique members spent, and of those, 35 were female, then the percentage would be 44%
F) represents the percentage of members who spent rewards for each gender. For example, If 200

Card statuses as of end of November:

	card count	balance on cards	
Active cards:	36,405	$520,700.76	(currently active cards)
Pending cards:	39,979	$957,387.24	(cards that have been issued and are pending activation)
Closed cards:	53,873		(cards that were closed for member ineligibility or card replacement)

Rewards and spending 2017 YTD:

		By gender				
		F		M		
Rewards:	$776,670.00	$422,570.00	54%	$354,100.00	46%	(see note A, above)
Spending:	$215,676.98	$125,661.52	58%	$90,015.46	42%	(note B)
Rate of rewards spent:	28%	30%		25%		(note C)

Count of unique members who:		F		M		
Earned rewards:	53261	28291	53%	24970	47%	(note D)
Spent:	11837	6771	57%	5066	43%	(note E)
Rate of members who spent:	22%	24%		20%		(note F)

Average age of members who:	
Earned rewards:	14 1/4
Spent:	15 1/2

Digitally Enhanced CenAccount® Program. In an effort to better align our member incentives around how members interact with their environment and the health care system on a day-to-day basis, Sunflower is expanding our CentAccount® rewards program to offer additional member rewards for completion of health and wellness activities. In 2019, the CentAccount® card and member ID card will be combined into one card – making it more convenient for members to access and use their CentAccount® rewards. Members (or their parents/caregivers) can use the card at merchants they already use every day, such as nationally recognized retail stores to buy a wide variety of health-related items including some over-the-counter medications as well as goods and services not covered by Medicaid such as transportation (e.g. bus passes), utilities, pest control, childcare, and items promoting member wellness and safety (e.g. smoke detectors, fans, light bulbs).

Personalizing Member Incentives. Our new CentAccount® rewards program is personalized and tailored based on member preference and can be accessed through a member's smartphone or

through our Sunflower member mobile application. As part of our Centelligence® data and analytics platform, we will have the ability to customize a member's experience by sending targeted messages to eligible members notifying them of the potential to earn rewards for completing healthy behaviors specific to them. Using machine learning and complex algorithms, we will be able to detect patterns and predictive responses to create a smart system that better anticipate members' needs and delivers customized rewards to improve member experience.

Indiana's POWER Account

Our Indiana affiliate has maintained POWER (Personal Wellness and Responsibility) accounts for Healthy Indiana Plan (HIP) member since 2011. The POWER Account is a savings account meant to encourage members to stay healthy and use healthcare services in a cost-efficient way. Our affiliate maintains the account, allows members to view statements showing the balance online through the secure member portal, and educates members about the POWER account through the Member Handbook, website, Member Services, and other mechanisms. Recently our affiliate also began linking the account with the CentAccount Rewards program to pay member contributions.

Marketplace and Commercial Plan Health Savings Account (HSA) Experience

Sunflower will also leverage the expertise and systems used by Centene's health plans in managing HSAs in the Marketplace and commercial markets. Centene affiliates are participating in Health Insurance Marketplaces in 13 states. Centene health plans are active in large and small group commercial markets in four states.

OPERATIONALIZING THE INDEPENDENCE ACCOUNTS (5.19.3.2.B)

Sunflower will leverage our current capacity in managing the Working Healthy/WORK and CentAccount programs, as well as our affiliated plans' best practices with HSAs and Indiana's POWER account to operationalize the Independence Accounts for TransMed Initiative members, if implemented by the State. As noted above, our Indiana affiliate has been conducting POWER account management since 2011. To operationalize the program, the plan modified the account management, invoice, and payment collection tools used by Centene's Ambetter health plan in the Indiana Marketplace. Our affiliate has detailed policies and procedures that could be modified for managing Independence Accounts in Kansas, including processes for:

- Establishing the account for each member deemed eligible by the State
- Sending tailored welcome letters to members after receiving conditional eligibility files from the State
- Accepting deposits to the account from the State, members, and employers
- Pre-funding the account as necessary, and recovering those funds as appropriate
- Conducting member education about the account
- Monitoring use of account funds for covered services applicable to the member's benefit plan

- Managing rollover of funds from prior benefit periods, determining whether members earned preventive service discounts, and identifying overpayments for annual reconciliations.

Members may inquire about their balance at any time, and our affiliate is currently gearing up to provide individual balances to members on a regular basis. In operationalizing Independence Accounts and using an external provider to assist with fiscal management, we will consider all provider options and choose the most qualified FMS provider.

PROMOTING SOCIAL DETERMINANTS OF HEALTH AND INDEPENDENCE (5.19.3.2.E)

The TransMed Initiative's Independence Accounts have potential to help address social determinants of health and promote independence in multiple ways. For example, the funds could be used for job/skills training, transportation to work or to job interviews, child care during work hours, GED classes and exams – building on our STEP program. We will also learn best practices from our 2018 Life Ally pilot in Kansas, Illinois, and Wisconsin described below.

Life Ally Program

As part of our approach to addressing social determinants of health and independence (SDOHI), Sunflower supports members in overcoming their life barriers and promoting healthy communities by offering our Life Ally program. The cornerstone of Life Ally is Sunflower's Community Resource Database is a comprehensive online social utility for access to local social services and community resources, such as, food, housing, transportation, and education services that best fit members needs and can impact their health and wellbeing. Accessible to all members of the Integrated Care Team, such as Service Coordinators, Community Service Coordinators, Community Health Workers, members, and providers, our Community Resource Database allows users to complete a life barriers assessment and quickly locate recommended resources near them. The Community Resource Database includes features such as:

- Search capability by both keyword and filters
- Graphical resource mapping display and directions from as a little as a mile up to 50+miles
- Favorites and save functionality

Closing the Loop. Sunflower will provide members, as well as the Service Coordinators/Community Service Coordinators that serve them, closed loop referral tracking and coordination with contracted Community Business Organizations. Through this program, Sunflower will have the capability to track, trend, and report on membership needs (e.g., assistance with utilities) and utilization by geographic area and resolution of life barriers. Through our population health based SDOHI approach, we leverage technology to effectively and efficiently engage and support members. Our Life Ally program, coupled with our integrated model of care, community-based approach, and innovative member programs such as our Double Up Food Bucks (DUFB) program, Life Course training, PRAPARE, and Sunflower Transitions to Employment Program (STEP) provide needed services and supports to positively impact SDOHI.

Sunflower's staff focusing on Social Determinants of Health and Independence, including our coordinators of housing and employment services and supports, would welcome the opportunity to work with the State to consider and develop a list of "approved" Independence Account services and supports that help promote the goals of the TransMed Initiative.

CHOICE COUNSELING AND COMMUNICATION (5.19.3.2.F)

If asked to perform Choice Counseling activities, Sunflower would use existing knowledge and also leverage our effective communication strategies and Service Coordination program with Centene's member counseling experience in other states to help eligible individuals understand and decide whether to participate in the TransMed Initiative. We have learned from our Indiana affiliate the critical importance and challenges of effective member education related to new programs. As described in Section 5.19.2 (MediKan Choice Counseling), Sunflower would build on our successful approach using a designated Service Coordination team, as well as an Employment Specialist and Program Supervisor that supports WORK-eligible members to embed TransMed Initiative Choice Counseling in our Service Coordination and Community Health Worker Program. Our Service Coordinators will be trained to discuss the TransMed Initiative benefits and rules with eligible members, supported by an Employment Specialist who will be available to answer questions and assist in complex circumstances. We would use similar staffing, training, and member education processes to those described for MediKan Choice Counseling in Section 5.19.2.

In addition, if the TransMed Initiative is implemented, we will incorporate into new member meetings for individuals eligible for TransMed information about the TransMed Initiative option and how to manage their Independence Account. In support of this initiative, we will create an online resource center housed on our website that will include educational materials, links to other resources as well as a webinar training that can be viewed at the convenience of the member. Additionally, Sunflower will promote information about the option through a regular social media series that will break down the information in small, easy to understand doses to help educate and remind members of their option, and how to use their Independence Account to make optimal purchases.

MEMBER EDUCATION ABOUT PLAN CHOICES AND TRANSITIONING MEMBERS TO COMMERCIAL INSURANCE (5.19.3.2.C AND 5.19.3.2.D)

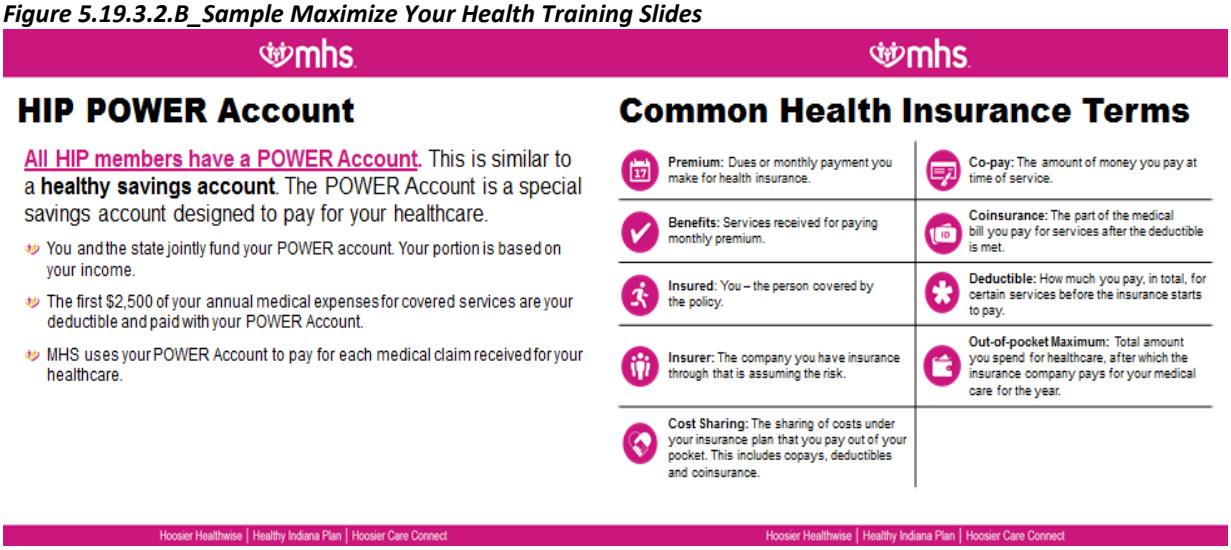
Sunflower understands the challenges our members often face related to understanding their health insurance options, and the effects their choices can have on their health and finances. We will build on our Indiana affiliate's Maximize Your Health financial literacy training, which educates members about:

- How health insurance works, filling out forms, finding providers and services
- How to care for yourself and manage disabilities
- How to manage their individualized accounts and earn financial rewards for getting care
- When and where to access care and making the most of benefits

- Additional supports via social media, email, and an online resource center

Our affiliate and the Indiana Minority Health Coalition are working together to reach more people with Maximize Your Health through an online resource center, events out in the community, and social media including Facebook, Twitter, Instagram, and a Blog, "Understanding how Health Insurance Works." See **Figure 5.19.3.2.B_Sample Maximize Your Health Training Slides.**

Figure 5.19.3.2.B_Sample Maximize Your Health Training Slides



Sunflower will also build on our experience with Independent Living Counseling supporting members in the WORK program, including helping the member develop a proposed Individualized Budget and manage the approved member budget.

Similarly, Sunflower Service Coordinators and Community Health Workers will be trained to educate TransMed Initiative members about their health insurance plan choices (commercial, employer-sponsored, Marketplace), and to help them transition to the private plans. In addition, we will provide information about and links to the Marketplace from our online resource center on our website.

The 2018 implementation of Ambetter from Sunflower Health in the Exchange in Johnson and Wyandotte counties will facilitate a smooth transition for our TransMed Initiative members into the Exchange. We will continue to expand Ambetter by Sunflower Health Plan across the state of Kansas in 2019.

5.19.4. 1915(I) OR OTHER EMPLOYMENT OPPORTUNITY PROGRAM INITIATIVES

SUNFLOWER'S RESPONSIBILITIES RELATED TO 1915(I) OR OTHER WORK PROGRAM INITIATIVES (5.19.4.1)

As described throughout this Section 5.19, Sunflower brings extensive experience supporting individuals with disabilities or behavioral health conditions to access services that support independence and employment. Within Kansas, Sunflower's relevant experience includes managing and providing care (including HCBS) for just over 9,000 KanCare members currently enrolled in the State's Waiver programs, fully described in Section 5.19.2 above. In addition, Sunflower's affiliate health plans currently operate in a number of states that have implemented 1915(i) initiatives, including Indiana, California, Texas, Mississippi, and Wisconsin. We look forward to leveraging our experience and working in partnership with the State to support their pursuit of a 1915(i) state plan amendment or 1915(i)-like Waiver on behalf of Kansans living with disabilities.

PLAN TO EVALUATE MEMBER NEEDS UNDER 1915(I) OR OTHER WORK PROGRAM INITIATIVES (5.19.4.1.B.1 & 5.19.4.2.C)

Under this initiative, Sunflower will use our time-tested process for holistically assessing members, fully described above in Section 5.19.2, that is informed by the Person Centered Thinking philosophy and will be complemented by the new LifeCourse Framework. LifeCourse includes a number of domains relevant for work program initiatives, all with associated tools that both Service Coordinators and members can use to support the evaluation of each eligible member's needs, including:

- **Daily Life and Employment**: Activities that are part of everyday life—school, employment, volunteering, communication, routines, and life skills
- **Community Living**: Where and how each member lives—housing and living options, community access, transportation, home modifications
- **Healthy Living**: Managing and accessing health care and staying well—medical, mental health, behavior, developmental, wellness, and nutrition
- **Social and Spirituality**: Building friendships and relationships, leisure activities, personal networks, faith communities

In addition to our person centered processes, Sunflower's Service Coordinators use the HRA, which has questions related to SDOHI in order to collect additional information including needs related to supporting member independence and employment.

INDIVIDUALIZED PLAN OF SERVICE/PERSON CENTERED SUPPORT PLAN DEVELOPMENT FOR 1915(I) OR OTHER WORK PROGRAM INITIATIVES (5.19.4.1.B.2, 5.19.4.1.B.3, & 5.19.4.2.D)

We will use our person centered planning process, described above in Section 5.19.2, to develop individualized plans of service for each member eligible for the 1915(i) program, which will include employment services and independent living supports for which the member is eligible, as well as Service Coordination to support members who are eligible for and/or participating in this initiative.

Contracting with Community Providers (5.19.4.1.B.4)

Our existing network of providers will serve as a base from which to draw in order to address the specific needs of this population. Today, our network includes more than 23,000 providers, including over 3,400 primary care providers, more than 7,300 specialists, and more than 1,500 LTSS providers able to meet the needs of individuals eligible for the 1915(i) benefits.

CHOICE COUNSELING (5.19.4.1.B.5 & 5.19.4.2.E)

Similar to that described above in 5.19.2, all of our Service Coordinators, including Community Services Coordinators, will be trained to provide choice counseling for the 1915(i) and/or other work program initiatives as needed. For the Kansas 1915(i) program, Sunflower will designate one Employment Specialist who will receive in depth training about the 1915(i)/ work program initiative requirements, in order to serve as a resource on this initiative the rest of the team and Sunflower's members, as needed.

RELEVANT EXPERIENCE WITH 1915(I) OR SIMILAR EMPLOYMENT PROGRAMS (5.19.4.2.A)

For information on Sunflower's experience supporting similar employment programs, including the types of services provided, number and percent of individuals who became employed and who maintained employment after one year, see section 5.19.2 above.

In addition to that experience, our affiliate health plans bring experience supporting and coordinating with 1915(i) programs across a number of states, including Indiana, California, Texas, Mississippi, and Wisconsin. Specifically, the Indiana Family and Social Services Administration (FSSA) has received federal approval for three 1915(i) State Plan Home and Community-Based Services programs: Adult Mental Health and Habilitation, Behavioral and Primary Healthcare Coordination, and Children's Mental Health Wraparound. While MCOs in Indiana do not have financial responsibility to pay for these 1915(i) services, they do have an obligation to ensure Medicaid-covered benefits are coordinated with and not duplicative of care available through the 1915(i) programs. Therefore, our Indiana affiliate identifies members who may benefit from 1915(i) services and reaches out to the member's service providers to coordinate care and avoid duplication and fragmentation of care. The 1915(i) services are incorporated into the member's self-management plan and housed in TruCare so that the member's Care Team can seamlessly coordinate these services as part of the member's care. Depending on the structure of each state's 1915(i) program, and the role of MCOs within each program, our affiliates in other states have experience playing similar roles. As our affiliate health plans' roles in these states is coordination rather than management, data on the numbers of individuals who attained employment and/or retained employment after one year are unavailable at this time.

RELEVANT EXPERIENCE PROVIDING EMPLOYMENT AND/OR INDEPENDENT LIVING SUPPORT SERVICES TO INDIVIDUALS WITH DISABILITIES AND/OR BEHAVIORAL HEALTH CONDITIONS. (5.19.4.2.B)

For a complete description of Sunflower's experience providing employment supports to individuals living with disabilities and behavioral health conditions, including types of services provided, number and percent of individuals who became employed, and number and percent of individuals who maintained employment after one year, see sections 5.19.1 and 5.19.2 above.

In addition, Sunflower does have experience providing and/or managing independent living support services to members receiving LTSS across our network. These services include:

- Home and Community Based Services (HCBS), including services like Transitional Living Services, Personal Care Services, Fiscal Management Services, Enhanced Care Services, Supported Employment, Residential Services, Day Services, Assistive Technology and Home Modifications, Nursing Evaluation Visit, Personal Emergency Response, Medication Reminder, Oral Health Services, Comprehensive Support and Wellness Monitoring.
- Transition Coordination, through a contract with Centers for Independent Living and other providers, to assist members leaving institutional settings to find housing, help purchase household supplies, and actively coordinate the member's discharge back into the community

Finally, Sunflower also refers eligible members to other community based independent living support services and resources outside of our traditional network, such as peer support, personal care services, and employment supports, from community resources like the CILs.

5.19.5. MEMBER-DRIVEN HEALTH CARE

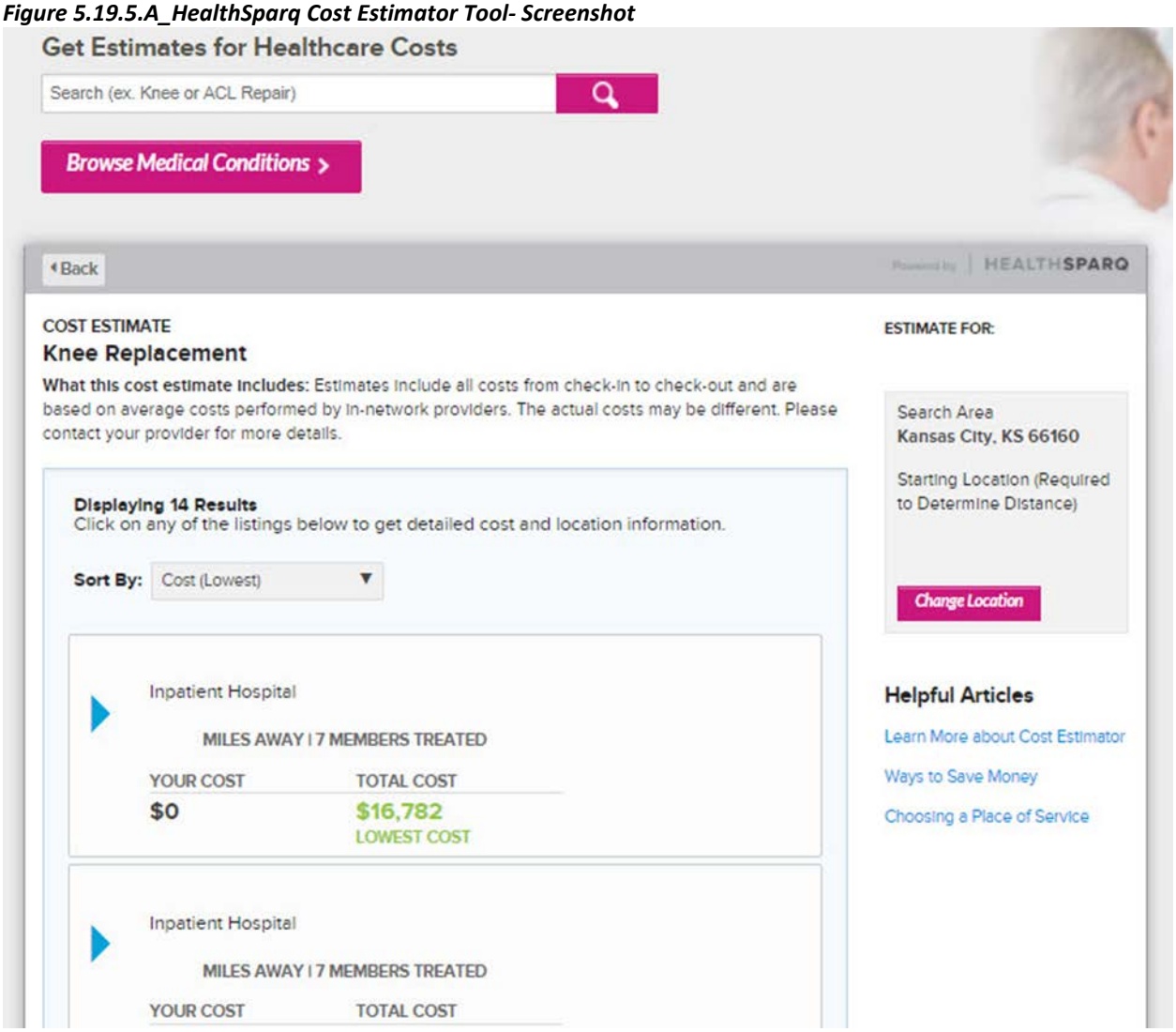
5.19.5.1. MEMBER-DRIVEN HEALTH CARE INITIATIVE DESCRIPTION

Experience with Member-Driven Health Care Initiatives (5.19.5.2)

Sunflower is committed to providing innovative solutions enabling member cost and quality transparency, with the goal of facilitating member-driven health choices, and ensuring that member decision-making is well-informed. To this end, Sunflower will leverage the experience of its affiliates across the nation, who have experience providing such tools.

For example, our Ambetter affiliates offer members the ability to estimate cost and research quality through the HealthSparq cost estimator tool. **See Figure 5.19.5.A_HealthSparq Cost Estimator Tool- Screenshot.**

Figure 5.19.5.A_HealthSparq Cost Estimator Tool- Screenshot



Additionally, our Indiana affiliate provides members with a cost information sheet, and connects members with Indiana's hospital quality comparison tool, available through the Internet. See **Figure 5.19.5.B_Sample Affiliate (MHS) Cost Report Screenshot.**

Figure 5.19.5.B_Sample Affiliate (MHS) Cost Report Screenshot

mhs
Your Choice for Better Healthcare

Cost Information
Average Cost Per Visit*

Service Type	HHW / CHIP / HCC / PE	HIP
Dr. Visit: PMP Sick Visit	$14.17 - $147.68	$8.98 - $197.86
Dr. Visit: PMP Annual / Routine	$87.00 - $100.00	$118.00 - $142.35
Dr. Visit: Hospital Inpatient	$28.43 - $158.09	$38.12 - $211.00
Hospital Emergency Room	$25.00 - $125.00 (including X-rays and Labs)	$20.57 - $170.46
Urgent Care	$15.25 - $112.39	$20.57 - $170.46
Specialist Visit	$14.17 - $147.68	$8.98 - $197.86
Laboratory	$1.52 - $2178.04	$1.52 - $3419.42
X-Rays	$2.00 - $1450.00	$2.67 - $1834.02
Vision Appointment	$4.62 - $339.68	$3.00 - $240.00
Mental / Behavioral Health Visit	$4.81 - $128.37	$24.88 - $170.64
Ambulance Transportation	$0.40 - $3172.27	Emergency only, $7.13 - $5037.94
Birth: Normal Delivery, Inpatient Hospital and Physician	$3,000-$5,000 (Not covered by PE)	$782.06 - $2238.74

HHW = Hoosier Healthwise
CHIP = Children's Health Insurance Program
HCC = Hoosier Care Connect
HIP = Healthy Indiana Plan
PE = Presumptive Eligibility for Pregnant Women

*These fees are subject to change as the fee schedule is updated regularly.

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Members with speech or hearing disabilities call (800) 743-3333 for TTY/TDD.

Similarly, Sunflower will develop a cost information report, made available in English and Spanish, and through the secure Member Portal. This resource will outline the cost of key member health care services, such as doctor, specialist, urgent care, and emergency room visits. To keep members abreast of provider quality information, Sunflower will include links to Medicare's national hospital and physician compare tools on the cost information report. We will also prominently display on our website and handbook a listing of publicly available resources for consumers to promote consumer choice related to quality such as The Joint Commission, NCQA Report Cards, Medicare Compare, and others.

Members will be made aware of these resources at many points of contact, such as from Customer Service Representatives, their Service Coordinators, Nurse Advice Line staff, and via the New Member Welcome Resources. By providing cost and quality information to members upfront, and in an easily accessible location and format, members will be better able to weigh the cost and quality of care against other key factors in health care decision making, such as provider gender, geographic location, and personality, among others.

As Sunflower rolls out its cost information report, we have the ability to track it to help assess its impact going forward. Bringing years of expertise and experience, we look forward to working with the State to further understand what drives member choices.

5.19.6. MEMBER INDEPENDENCE INITIATIVES REPORTING REQUIREMENTS

Under this KanCare 2.0 contract, Sunflower will comply with all reporting requirements that the State determines are necessary for the Member Independence Initiatives. As an existing KanCare contractor, we are well versed in complying with State reporting requirements, and we will leverage this experience to ensure our compliance with all requirements.

WORK REPORTING EXPERIENCE

For example, Sunflower provides on a monthly basis a WORK Allocation Report, WORK Enrollment End Date Report, and WORK Good to Go (GTG) Report. On a quarterly basis, Sunflower provides a WORK ILC Billing Audit File and WORK Participant Funds Summary. These reports detail members' WORK participation dates, monthly allocation amounts, amounts spent on services, ILC's name and dates of services for which claims were paid, and carryover and overflow budget amounts.

Sunflower has collected employment data in our routine assessments since 2013 and has used it to supplement state data. More recently, we have refined that method to include a more detailed assessment to better capture actionable data on our member needs and included them in our refined reporting suite.

MEANINGFUL MEMBER MEASUREMENT

In addition, our parent company, Centene, is at the forefront of meaningful member measurement and continues to engage in a variety of activities to inform this effort. We believe that this expertise can further support our ability to report on these State initiatives moving forward. For example, Sunflower and its affiliates have partnered with Centene's Corporate LTSS Team to create meaningful measures for the LTSS population, tracked in our Key Performance Indicator (KPI) Dashboard. Today, Sunflower's LTSS KPI Dashboard includes both clinical quality metrics (e.g., wounds, falls, incidences of Urinary Tract Infection, and flu vaccinations), as well as quality of life metrics, including employment status, member satisfaction with living arrangement, member participation in the community, and control over daily routine.

Sunflower looks forward to working with the State to effectively implement, participate in, and evaluate the member independence initiatives described throughout Section 5.19, as determined appropriate by the State and upon CMS approval. In partnership with the State and other Medicaid Managed Care Organizations (MCOs) participating in KanCare 2.0, we welcome the opportunity to leverage our existing programs and experience to implement each initiative, expanding and enhancing our existing network of community providers with workforce development expertise to promote member independence and meet desired outcomes.

5.20 KDHE-DHCF Additional Terms and Conditions

5.20. KDHE-DHCF ADDITIONAL TERMS AND CONDITIONS

Sunflower Health Plan acknowledges and confirms our understanding that upon Contract award, we will be required to complete and sign a Business Associate agreement as noted in Section 5.21.

5.21 Business Associate Agreement

5.21. BUSINESS ASSOCIATE AGREEMENT

Sunflower Health Plan has reviewed the preliminary language, including all terms and conditions for the Business Associate Agreement contained in the Contract, and will comply.

5.22 Compliance with the "Pilot Program for Enhancement of Contractor Employee Whistleblower Protections"

5.22. COMPLIANCE WITH THE "PILOT PROGRAM FOR ENHANCEMENT OF CONTRACTOR EMPLOYEE WHISTLEBLOWER PROTECTIONS"

Sunflower Health Plan (Sunflower) acknowledges and confirms that we will comply with the Pilot Program for Enhancement of Contractor Employee Whistleblower Protections as well certification and warranty with respect to disbarment. Sunflower follows the Centene Corporate policy, Prohibiting Retaliation Against Employees Individuals or Others. This policy compels us to take all necessary steps to refrain from intimidating, threatening, coercing, discriminating against, or taking any other retaliatory action against any employee, individual, or other for the exercise of any right under, or for participation in, any process established under applicable laws and/or regulations. Further, we support all employees in reporting any such concerns. This policy is specifically written to protect against any retaliation toward any employee, individual, or other for exercising their rights or participating in any process pursuant to internal policies, applicable law, and/or regulation. Additionally, any employee who commits or condones any form of retaliation will be subject to discipline up to, and including, termination. As part of this Contract, we will:

- A. Inform employees that they are subject to the whistleblower rights and remedies of this pilot program when working on any federal program or award
- B. Inform employees in writing about their whistleblower protections under 41 U.S.C. 4712 in the predominant native language of the workforce
- C. Ensure that we, our contractors, subcontractors, and grantees will include whistleblower requirements in any agreement made with a subcontractor or sub-grantee

5.23 Information Requirements

5.23. INFORMATION REQUIREMENTS

Sunflower Health Plan (Sunflower) understands that it may object, on moral and religious grounds, to providing, reimbursing for, or providing coverage of a counseling or referral service for a service for which it is otherwise required to provide or reimburse, and that if we have such an objection it must be communicated to KDHE part of this RFP response. Sunflower will also notify potential members before and during enrollment. At this time, Sunflower does not have any objections to providing or reimbursing for services. However, if during the term of the contract, Sunflower changes its policy concerning providing or reimbursing for a service on moral or religious grounds, we will comply with all state requirements and notify KDHE in accordance with 42 CFR § 438.10. We will also notify members of such a change within 90 calendar days after adopting the policy with respect to any particular service.

5.24 Retention of Records

5.24. RETENTION OF RECORDS

Sunflower Health Plan (Sunflower) follows Centene Corporation's Retention of Records Policies and Procedures and acknowledges compliance with all requirements for both Sunflower and all of its subcontractors. Sunflower will retain records for review and agrees to secure and make available to the State, its agencies, or those acting on their behalf, all of its books, documents, papers, records, or other evidence involving to the Contract for a period of no less than 10 years from the expiration date of this Contract. Our policies require that clinical and medical records, claim forms and supporting management systems include all pertinent information related to the member. This includes contractually requiring subcontractors to maintain adequate documentation for services provided to members for all delegated activities including Quality Improvement, Utilization Management, Member Rights and Responsibilities, and Credentialing/Recredentialing.

Our policies also strictly prohibit deliberately creating false or misleading records. Sunflower's Records Retention Schedule ensures the proper documentation and archival of plan activities, decisions, and compliance with all federal, state and contract requirements, including but not limited to, accounting, audit KDHE Contract requirements and tax requirements.

Additionally, information concerning litigation will be kept for one year following the termination of litigation, including all appeals, if the litigation exceeds five years. Delivery or access to records will occur within five business days of the request at no cost to the State.

5.25 Off-Shore Sourcing

5.25. OFF-SHORE SOURCING

Sunflower Health Plan (Sunflower) has a policy not to contract or subcontract for any services or resources with any company located off shore or providing services located off shore. If Sunflower discovers, through our Compliance Management System or other tracking, that a subcontractor with whom we work or have an agreement with moves their services/ resources off-shore or to a location outside of the United States, we will immediately notify the Procurement and Contracts and the respective agency in writing, indicating the desired new location, the nature of the work to be moved and the percentage of work that would be relocated and acknowledge that any action must first be approved by the Director of Purchases, and that failure to do so could result in termination of this Contract. We comply with all requirements concerning off-shore sourcing, including claims paid and financial institutions.

5.26 Termination at Expiration and/or Termination of Contract

5.26. TERMINATION AT EXPIRATION AND/OR TERMINATION OF CONTRACT

In the event of the termination of this Contract, prior to the end of the term or upon non-renewal, Sunflower Health Plan (Sunflower), in coordination with Centene, will assist the State in providing an orderly and efficient transition process at the end of the managed care contract term. Sunflower will strive to ensure that members' needs continue to be met seamlessly throughout the transition process and that disruption of services to members and providers is minimized. We agree to expressly follow the work plan specified by the State to transition to a new MCO and will absorb all costs associated with that termination, which will last at least three months but no longer than six months and will fully comply with all the new MCOs requests for historical utilization data including the Member Plans of Service and Person-Centered Service Plans for Service Coordination. Sunflower acknowledges that we will be responsible for providing in a timely fashion all necessary information to the State and the new MCO to ensure a smooth transition of responsibility, including Prior Authorized Covered Services. Sunflower agrees to continue to perform all required duties incurred prior to the actual termination date of the Contract. We will cooperate in good faith with state employees, agents, and independent contractors during the transition period between notification of termination and any replacement MCO. Additionally, Sunflower acknowledges to abide by all transitions in care requirements listed in Section 5.4.12, Care Transitions and Diversion Activities, of this Contract.

5.27 Post-Contract Obligations and Procedures

5.27. POST-CONTRACT OBLIGATIONS AND PROCEDURES

Sunflower Health Plan (Sunflower) agrees to and will comply with all post-Contract obligations and procedures requirements concerning Contract Termination, including the State's right to seek damages for breach of Contract; Continuing Obligations, including fulfilling all post-Contract items within the required timeframe; providing required timely Notices to Members; and providing the State all necessary encounter data in a timely fashion. Addressed below are points A through D:

- We confirm that a termination will not impede the state from enforcing its rights or remedies under this Contract or state or federal laws or regulations to recover damages, up to and including the right to recover damages for breach of contract.
- We confirm that we will comply with all six continuing transition obligations listed above as required, as well as other mandatory requirements to successfully fulfill transition responsibilities should there be a termination or Contract expiration.
- We confirm that we will comply with the 30-day advance notice to members in an accessible and easily understandable format that is sensitive to their visual impairments, language preferences, or other state requirements.
- In addition to providing encounter data, Sunflower acknowledges that we understand and will comply with the terminations or expiration requirements concerning our responsibilities to capitation withholds and other requirements related to this subsection.

6. RFP PURPOSE, CONTRACTORS' DUTIES, IMPLEMENTATION AND GENERAL ADMINISTRATIVE INFORMATION

6. RFP PURPOSE, CONTRACTOR(S)' DUTIES, IMPLEMENTATION AND GENERAL ADMINISTRATIVE INFORMATION

Sunflower Health Plan (Sunflower) acknowledges and will comply with all requirements outlined in Section 6. Per the State's response to the bidder's Questions and Answers Round 1 #56, 175, 243 and Questions and Answers Round 2 #2, Sunflower understands that Section 6 is for informational purposes only. We have used the information provided to develop our proposal response, as appropriate. For ease of review, please see ***Table 6_Section 6 Requirements Crosswalk*** which specifies the main location(s) in our response where each Section 6 requirement is addressed.

Table 6_Section 6 Requirements Crosswalk

SECTION 6.0 REQUIREMENTS CROSSWALK	
SECTION #	**SECTION # WHERE ADDRESSED IN PROPOSAL RESPONSE**
6.1 RFP PURPOSE	Technical and Cost Proposal
6.2 CONTRACTOR(S) RESPONSIBILITIES	**6.2.A** Technical Proposal Response Sections 5.2 through 5.27 **6.2.B** Technical Proposal Response Sections 2.5, 5.4, 5.5, 5.7, 5.9, 5.18, & 5.19 **6.2.C.1** Technical Proposal Response Sections 2.6, 5.3, 5.4, 5.5, 5.7, 5.9, 5.10, & 5.19 **6.2.C.2** Technical Proposal Response Sections 5.4, 5.5, 5.8, & 5.18 **6.2.C.3** Technical Proposal Response Sections 2.7, 2.8, 5.3, 5.4, & 5.5 **6.2.C.4** Technical Proposal Response Sections 5.4 & 5.5 **6.2.C.5** Technical Proposal Response Sections 2.8, 5.4, 5.5, & 5.7 **6.2.C.6** Technical Proposal Response Sections 5.2 through 5.27 **6.2.C.7** Technical Proposal Response Sections 2.7, 2.8, 5.2, 5.3, 5.4, 5.5, 5.6, 5.10, & 5.18 **6.2.C.8** Technical Proposal Response Sections 2.5, 5.2, 5.3, 5.4, 5.5, 5.7, 5.9, 5.10, & 5.17 **6.2.C.9** Technical Proposal Response Sections 2.5, 2.7, 2.8, 5.3, 5.4, 5.5, 5.7, 5.9, 5.10, & 5.19 **6.2.C.10** Technical Proposal Response Sections 5.3, 5.3, 5.5, 5.7, 5.8, 5.9, & 5.17 **6.2.C.11** Technical Proposal Response Sections 2.5, 5.3, 5.4, 5.5, 5.6, 5.7, 5.9, 5.10, 5.12 & 5.15 **6.2.C.12** Technical Proposal Response Sections 5.2 through 5.27 **6.2.C.13** Technical Proposal Response Sections 5.4, 5.9, 5.15 & 5.16 **6.2.C.14** Technical Proposal Response Sections 5.3, 5.4, 5.5, 5.7, 5.8, 5.9, & 5.17 **6.2.D**

SECTION 6.0 REQUIREMENTS CROSSWALK	
SECTION #	**SECTION # WHERE ADDRESSED IN PROPOSAL RESPONSE**
	Technical Proposal Response Sections 5.4, 5.5, 5.6, 5.7, 5.8, 5.14, & 5.15 **6.2.E** Technical Proposal Response Sections 5.3 & 5.8
6.3 STATE AGENCIES AND PROGRAMS	Technical Proposal Response Sections 5.2 through 5.19
6.4 CONTRACTOR(S)' PROPOSALS	**6.4.A.1** Technical Proposal Response Sections 5.3, 5.4, 5.5, 5.7, 5.8, & 5.9 **6.4.A.2** Technical Proposal Response Sections 5.4, 5.5, & 5.7 **6.4.A.3** Technical Proposal Response Sections 5.4, 5.7, 5.9, 5.12, 5.14, 5.15, 5.17, 5.18, & 5.19 **6.4.A.4** Technical Proposal Response Sections 2.5, 2.6, 5.3, 5.4, 5.7, 5.10, 5.17, 5.18, & 5.19 **6.4.A.5** Technical Proposal Response Sections 2.6, 5.3, 5.4, 5.7, 5.10, & 5.19 **6.4.A.6** Technical Proposal Response Sections 5.3, 5.4, 5.5, 5.9, & 5.10 **6.4.A.7** Technical Proposal Response Sections 5.4 & 5.9 **6.4.A.8** Technical Proposal Response Sections 2.5, 5.4, 5.5, 5.9, & 5.15 **6.4.A.9** Technical Proposal Response Sections 2.5, 2.6, 5.3, 5.4, 5.5, 5.7, 5.8, 5.9, 5.10, 5.15, 5.17, 5.18, & 5.19 **6.4.A.10** Technical Proposal Response Sections 2.4, 5.4, 5.5, 5.12, 5.14, 5.17, 5.20, & 5.21 **6.4.A.11** Technical Proposal Response Sections 5.3, 5.4, 5.7, 5.18, & 5.19 **6.4.A.12** Technical Proposal Response Sections 2.5 & 5.4
6.5 CATEGORIES OF ELIGIBILITY	Technical Proposal Response Section 5.3
6.6 GENERAL AND ADMINISTRATIVE INFORMATION	**6.6.A** Technical Proposal Response Sections 2.4, 2.5, 2.6, & 5.3 **6.6.B** Technical Proposal Response Sections 2.7 & 2.8 **6.6.C & 6.6.D** Sunflower acknowledges and complies. **6.6.E** Technical Proposal Response Section 5.6, 5.10, & 5.15 **6.6.F & 6.6.G** Sunflower acknowledges and complies.
6.7 ATTACHMENTS, EXHIBITS AND URL LINKS	Sunflower acknowledges and complies.

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