sunflower health plan™

KanCare 2.0 Medicaid & CHIP Capitated Managed Care RFP

Opening Comments

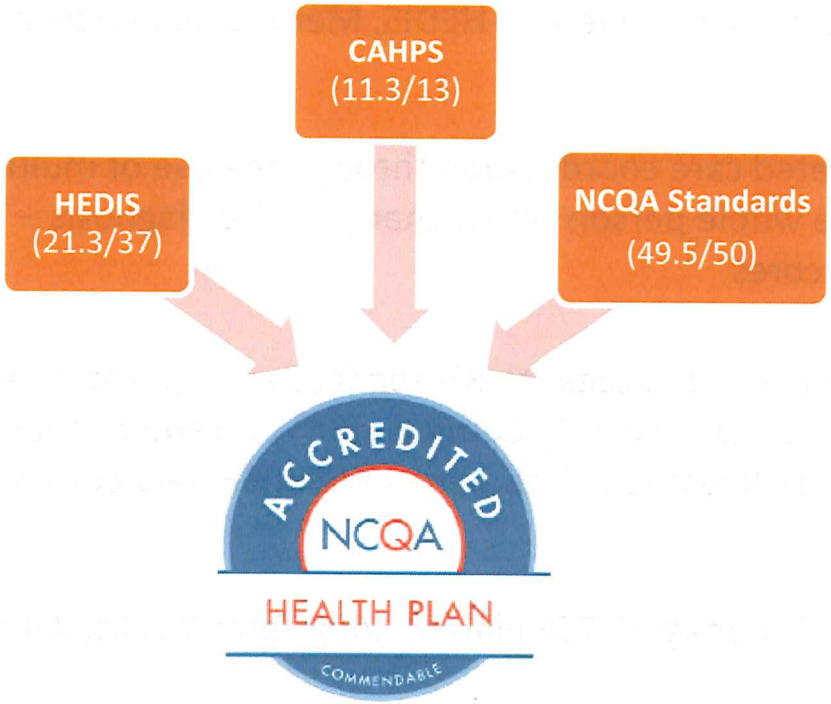
May 10, 2018

Sunflower Leadership

- Chris Coffey, CEO/Sr. Exec, Project Director
- Terry Weathers, SVP Finance/Sr. Director & Finance Officer
- Jonalan Smith, SVP Operations/Systems Director
- Dr. Katherine Friedebach, Chief Medical Director
- Dr. Sosunmolu Shoyinka, Behavioral Health Medical Director & Nat'l SUD Director
- Brian Holman, VP IT Strategy & Business Development
- Stephanie Rasmussen, VP LTSS/LTSS Director
- Carmen Mills, VP Compliance/Compliance Officer
- James Gardner, VP Government Relations
- Dana Podrebarac, Sr. Director of Case Management/Dir. of LTSS/MM Ops
- Susan Hood, Sr. Director of Quality Improvement
- Nanette Perrin, Dir. of Pathways & Rapid Crisis Response/Dir. of SDoHI
- Greg Herdlick, Sr. Manager of Operations/ Vendor Management
- Stephen Smith, Quality Improvement Coordination

Transforming the health of the community, one person at a time

sunflower health plan™



Sunflower is the first KanCare MCO to reach Commendable accreditation status with NCQA, with a goal to achieve and maintain Excellent status

Transforming the health of the community, one person at a time

sunflower health plan™

- Consistent year-over-year improvement in HEDIS, Member Experience and Provider Satisfaction
- Proven leader in integrated care coordination through the use of multi-disciplinary clinical teams that focus on the whole person rather than just the diagnosis – This is demonstrated by our HEDIS and CAHPS scores
- Setting 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.
- Named as an "exemplar" managed LTSS plan by Long Term Quality Alliance (LTQA)
- Impressive results in coordinating care for special populations, demonstrated by improved HEDIS quality outcomes in our HCBS population and exceptional member satisfaction with LTSS service coordination

Long Term Services & Supports

Member Survey 2017 Conducted by third-party analytics firm (SPHA)

sunflower

LTSS SATISFACTION SURVEY RESULTS	WAIVER TYPE					
	IDD	FE	PD	TA	TBI	Total
Number of Surveys Sent	4142	1790	2025	145	114	8216
Number of Surveys Returned	977	612	611	24	16	2240
Percent Returned	23.6%	34.2%	30.2%	16.6%	14.0%	27.26%
QUESTIONS	**IDD**	**FE**	**PD**	**TA**	**TBI**	
How satisfied are you with the help you receive from your Sunflower care manager? (Satisfied/Very Satisfied)	94.3%	97.2%	96.4%	95.8%	93.8%	95.50%
When you call your Sunflower care manager, do they respond within 1 business day? (Sometimes/Always)	92.9%	95.1%	95.7%	100%	100%	96.74%
Does your Sunflower care manager respect your personal beliefs and preferences during your discussions? (Sometimes/Always)	97.9%	98.5%	98.3%	100%	100%	98.94%
Has your Sunflower care manager talked with you about services that might meet your needs and goals? (Somewhat/Very Much)	79.4%	90.3%	93.9%	95.7%	100%	91.86%
Overall, how satisfied are you with the Home & Community Based Services you receive? (Satisfied/Very Satisfied)	96.1%	96.9%	95.3%	91.3%	100%	95.92%
Do the people who are paid to help you do things in the way you want them done? (Somewhat/Very Much)	96.3%	95.9%	96.1%	95.7%	100%	96.80%
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%	98.94%
Overall, how safe do you feel with the people that help you? (Safe/Very Safe)	98.5%	98.0%	98.5%	100%	100%	99.00%
How often do you do things with your friends, your family or in your community? (Sometimes/Always)	93.7%	74.2%	69.2%	87.0%	80.0%	80.82%
If you scheduled transportation through Sunflower, how satisfied are you with the transportation service you received? (Satisfied/Very Satisfied)	93.1%	90.4%	87.2%	50%	90%	82.14%
Overall, how satisfied are you with the care you receive from Sunflower Health Plan?	97.3%	97.1%	97.9%	95.8%	86.7%	94.96%

Innovative Strategies to Meet KanCare Goals

sunflower health plan™

Value-Based Purchasing Agreements

~60% of SHP members are attributed to providers under VBP arrangements
Currently expanding VBP model to include delegated risk and incorporate BH
Conceptualizing health home VBP model with CMHC's

Social Determinants of Health and Independence (SDOHI) Pathways

PRAPARE and KAMU Partnership
Member assessment tools identify areas for SDOHI intervention
STEP (Sunflower Transition to Employment Program)
Pathways

Integrated Service Coordination

Regionalization of clinical and non-clinical leads
Service Coordinator Portal for Targeted Case Managers and Centers for Independent Living and Project ECHO
Whole person, Person Centered Approach

Telehealth

Mobile IT tools for crisis screening, 24/7 psych consult line, CHF tele-monitoring, HomeLink, Project ECHO, telepsychiatry, etc.

Support from our partners

sunflower health plan™

"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." - ***Association of Community Mental Health Centers of Kansas, Inc.***

"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." – ***KVC Kansas***

"We are particularly impressed with the Sunflower Health Plan's commitment to social determinants of health… We are eager to work with the Sunflower Health Plan on efforts to merge practice transformation with value-based payment." – ***Kansas Association for the Medically Underserved***

RFP Letters of Support from: Senators David Haley, District 4; Jim Denning, District 8; 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)

sunflower health plan™

KanCare 2.0 Medicaid & CHIP Capitated Managed Care RFP

Additional Questions

May 10, 2018

Question 1

sunflower health plan™

The State requests that Centene affirm that they will comply with requirements in Section 5.1.

Sunflower affirms that they will comply with the requirements in Section 5.1

Question 2

sunflower health plan

The State requests Centene confirm that they will provide Statewide coverage.

Sunflower confirms that they will provide Statewide coverage

Question 3

sunflower health plan

Can Centene please provide additional detail on nursing home population tele-psychiatry pilot, particularly how the member is involved in the process?

The goal of the nursing home population tele-psychiatry pilot is to expand the availability of psychiatric medication management to members in nursing facilities in rural, frontier and underserved regions of the state.

- Consistent with our Integrated Service Coordination (ISC) model, the member is at the center of the tele-psychiatry program and process
- We will engage the member and provide necessary supports to enable them to actively participate.
  - ***For example:*** *to help empower the member and the member's circle of support and family members to ask questions about medication treatment, and promote informed decision making, we will provide participants with a list of sample questions they may want to ask their provider about the use of psychotropic medications.*
- Implement the pilot in select facilities

Question 4

sunflower health plan

How does Centene propose to receive reimbursement for tele-monitoring?

Recommendations

- Expansion of the use of specific HCPCS and CPT codes (with modifiers as applicable) for standardized billing and claims submission related to tele-monitoring.
- Cover both the initial set up and a per diem reimbursement for ongoing tele-monitoring.
- As proposed, services would be paid by Sunflower and included in paid claims for capitation rate setting purposes.

Background and Lessons Learned

- The availability of additional funding through reimbursement for tele-monitoring would allow Sunflower to expand our programs to other populations and conditions.
- Today, 21 States offer remote patient monitoring (RPM) and have some form of Medicaid reimbursement for RPM.
- Based on lessons learned from the 2013 I/DD LTSS services pilot, having encounterable codes and a standard process will alleviate administrative burden for providers, Sunflower, and the State.

Question 5

sunflower health plan

Please describe the process for referrals for needed support beyond service coordination.

- ***No Wrong Door*** – regardless of how or where member needs are identified (e.g. provider referral, customer service call, Health Screen), Sunflower will connect the member with timely and appropriate services and supports
- Key to Sunflower's Integrated Service Coordination (ISC) model is our member screening and assessment process
- For members in ISC Level 1, a Member Services Representative (MSR) or Community Health Worker (CHW) will make appropriate referrals for internal and external programs and resources
- For members in ISC Levels 2-4, referrals are captured and monitored through the Plan of Service or Person-Centered Service Plan (Service Plan)
- The HRA and needs assessment form the basis for the development of the individualized Service Plan, which documents member needs and referrals
- The SC is accountable for facilitating all referrals and ensuring members receive services as documented in the Service Plan

Referral Process

Support Beyond Service Coordination

sunflower health plan™

Jacob's Story

Jacob was a 15-year-old boy living with his grandparents in a split-level home. Jacob uses a wheelchair due to Progressive Muscular Dystrophy. Jacob's expensive lift broke, and as a result, he lost access to his accessible bathroom and the privacy of his own bedroom. Sunflower Health made it possible for Jacob to get a replacement lift, and with the help of Sunflower staff and neighbors, the extra work to demolish a porch and pour concrete was complete. Jacob's privacy and access to an accessible bathroom have been restored. After working with Jacob and his family, Sherry (the Pathways Community Living Facilitator) said, "It really shows how teamwork can make anything possible. Jacob is very fortunate to have such wonderful grandparents, good neighbors, and an awesome care coordinator."

Question 5 cont.

sunflower health plan

Please describe the process for referrals for needed support beyond service coordination.

Referrals for services and supports include KanCare covered services, value-added services, non-covered services, and other Sunflower programs and services. Examples of the various processes involved in referring members include:

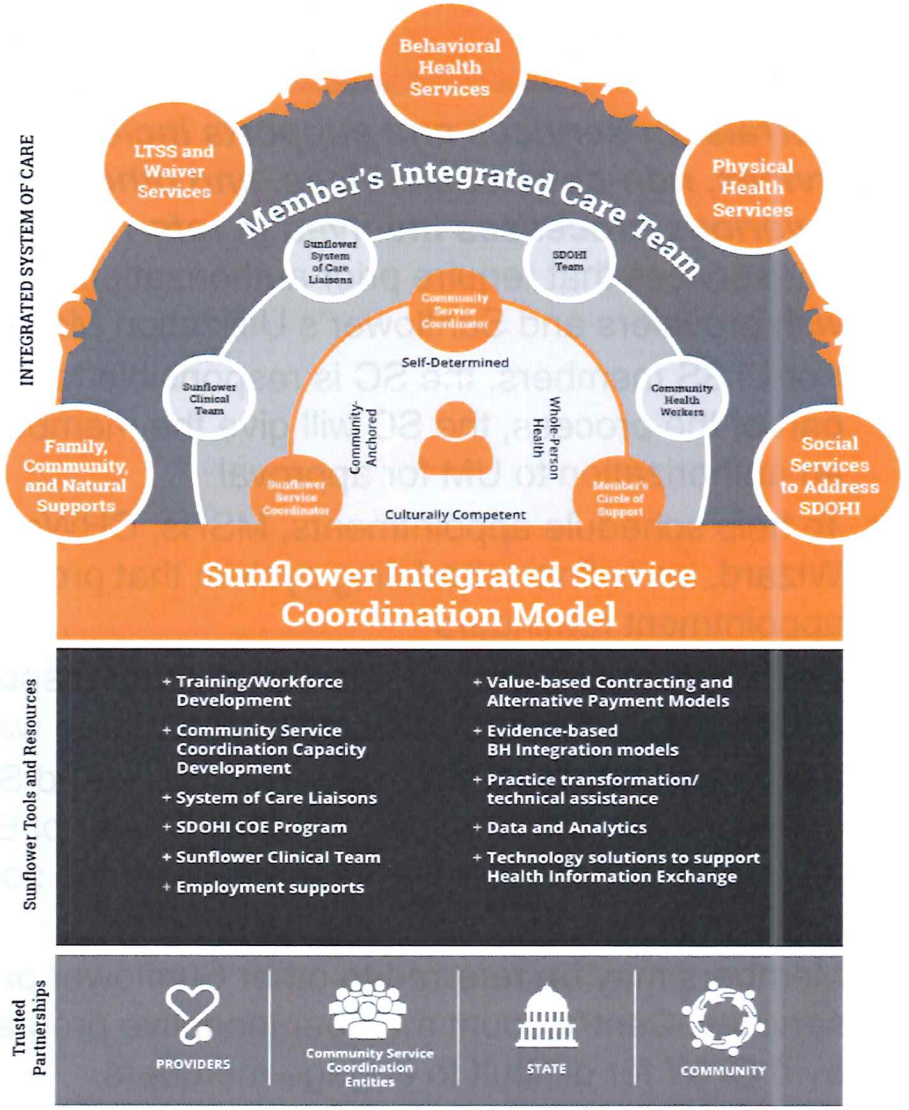
- For services that require prior authorization, the SC helps facilitate referrals and communicates with providers and Sunflower's Utilization Management (UM) team
- For LTSS members, the SC is responsible for authorizing all services in their Service Plan. As part of the process, the SC will give the members a choice of providers and will directly submit an authorization to UM for approval
- To help schedule appointments, MSRs, CHWs, and SCs will have access to Appointment Wizard, an online scheduling system that provides for real time appointment scheduling and text appointment reminders
- For NEMT, members are referred to our transportation provider by supplying LogistiCare contact information or participating in a three way call to help schedule transportation
- For community resources, MSRs, CHWs, and SCs leverage our community resource database and work with the Sunflower SDOHI Center of Excellence and integrated care team to identify resources and facilitate outreach to meet the social and other communities needs of our members
- Members may be referred to other Sunflower programs and services such as Interpreter services, CentAccount member incentive programs, Disease Management, Lock-In, or outreach by a CHW for difficult to engage members

Question 6

sunflower health plan™

Please describe your comprehensive approach to care management.

Our Integrated Service Coordination (ISC) model includes a ***comprehensive care management system*** and approach that put the member at the center of all ISC activities with the support of a Service Coordinator (SC).



Care Management System

Person and Family Centeredness

sunflower health plan

- SCs will serve as the single point of contact for the member and their family
- SCs will work in collaboration with the member and the member's identified circle of support to assure the member is able to participate in the care planning process to identify measurable physical health (PH), behavioral health (BH) and functional and social support goals and develop interventions
- We identify the level of support the member needs to be an active participant in the planning and designing of his or her Plan of Service or Person-Centered Service Plan (Service Plan)
- 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 Service Plan
- SCs will receive training and education on independent living and person and family-centered service planning principles

Care Management System

Timely, Proactive, and Planned Communication and Action

sunflower health plan

- Our case management platform, technology solutions and policies and procedures support communication and coordination among members of the Integrated Care (IC) Team, provider network, and contracted Community Service Coordination entities.

- Each Service Plan will be accessible to:
  - SCs and members' IC Team via TruCare and our SC Portal
  - Providers via our Provider Portal
  - Members (and family, caregivers and other supports) via our Member Portal and/or paper documents based on preference
  - Members can review with SC in person via tablet using TruCare mobile capabilities

- Providers, specialists, hospitals, State agencies and HIEs can interface with our Centelligence data exchange capabilities

- Sunflower will work with our hospital partners to receive Admission, Discharge, Transfer (ADT) transactions

Care Management System

Promotion of Self-Care and Independence

sunflower health plan

- Our ISC model promotes member self-care, the member's ability to self-direct their services, and independence
- SCs assess if the member has all services in place necessary to maintain independence in a safe and healthy environment, and that the member's current residence is adequate to meet their needs
- Requests for additional assessments related to change in need or condition may also come from the member or their legal guardian, KanCare, or other stakeholders
- Based on member preferences and assessed needs, the SC will make recommendations and present choices to the member for alternative living arrangements and services available that promote the least restrictive setting
- To proactively identify candidates interested in transition, we will utilize available transition data, inclusive of Minimum Data Set (MDS) data (transition coordination contracts)
- For members with chronic conditions we provide tools and resources to support member self care management
- Our Member Advocate 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

Care Management System

Emphasis on Cross Continuum and System Collaboration and Relationships

sunflower health plan

- Sunflower is committed to the integration of PH, BH, LTSS and the social services delivery systems through the engagement of members, providers and stakeholders from across systems and disciplines

- Our ISC model and local SCs focus on ensuring coordinated, integrated care across settings

- Sunflower's primary roles in supporting system collaboration include:
  - Supporting providers in delivering the best possible care to members
  - Promoting accountability
  - Delivering actionable information
  - Making linkages across the system
  - Being a local, accessible resource

- Supporting our SCs are our organized System of Care (SOC) Liaisons and dedicated staff, working collaboratively to identify and link to available resources in each community, including liaisons to each of the HCBS waiver programs, the WORK program, the judicial system and foster care

- Sunflower is currently building a Center of Excellence for SDOHI, including team members who are subject matter experts in housing, employment, access to food, utility assistance, transportation, and other SDOHI needs

Care Management System

Comprehensive Consideration of Physical, Behavioral, and Social Determinants of Health and Independence

sunflower health plan™

- Key feature 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
- SCs will work with the member and the member's integrated care team to examine the member's whole person needs and develop a Service Plan reflective of all needs and preferences
- SCs will engage the member in referrals and interventions based on all identified Service Plan goals and action steps
- Key elements of the Service Plan include identified PH, BH, functional, environmental and social support needs and approach to access covered benefits, value added benefits, and referrals to community-based services
- Our SCs have access to an integrated care team reflective of the holistic needs of the member

Care Management System

Promotion of Community Access and Participation for Members At-Risk for Isolation or Who Encounter Barriers to Participating in Community Activities

sunflower health plan™

- A core foundation of our model is to identify and address barriers to accessing services and meeting goals, including connecting members to housing, food, employment, education, social activities, and other peer and social supports
- Sunflower trains our SC team on Person Centered Thinking and Motivational Interviewing to support members in facilitating the development of their personal goals and driving the action steps
- Sunflower administers an additional Quality of Life survey tool to measure and track the quality of life of our members and intervene as appropriate
- In the Service Plan, member prioritized goals are established and barriers to meeting goals for community access and participation are routinely identified
- The SC assists the member with identifying strategies for accomplishing his/her community participation and integration goals and overcoming the identified barriers

Question 7

sunflower health plan

How will Centene handle assigning service coordinators for Members that cross multiple populations?

- Sunflower's goal is to match every member with a Service Coordinator (SC) most appropriate for the member's individual needs based on SC qualifications and experience working with similar populations
- Given the complexity of our membership, it is possible members will cross multiple populations, including, for example, members with physical health and behavioral health co-morbidities or youth in foster care who are also enrolled on a HCBS Waiver
- Our team-based Integrated Service Coordination (ISC) model is specifically designed to address such circumstances
- Our current system is to assign each member to a primary SC that is qualified to address the member's primary and longest-term need
- Through our team-based model, the primary SC can then access RNs, licensed behavioral health professionals and community health workers (CHWs) with diverse backgrounds who can serve as secondary SCs, supporting the primary SC and the member with services and needs related to their area of expertise
- The primary SC is the single point of contact who will coordinate and collaborate with the team to ensure all member needs are met and specialized expertise leveraged

EXAMPLE

- Member in foster care receiving IDD Waiver support
  - Primary SC = IDD Waiver SC
  - Team Support = Foster Care Team and BH clinicians

Question 8

sunflower health plan

Please provide proposed ratios for all populations.

Case load ratios by Level of Service Coordination.

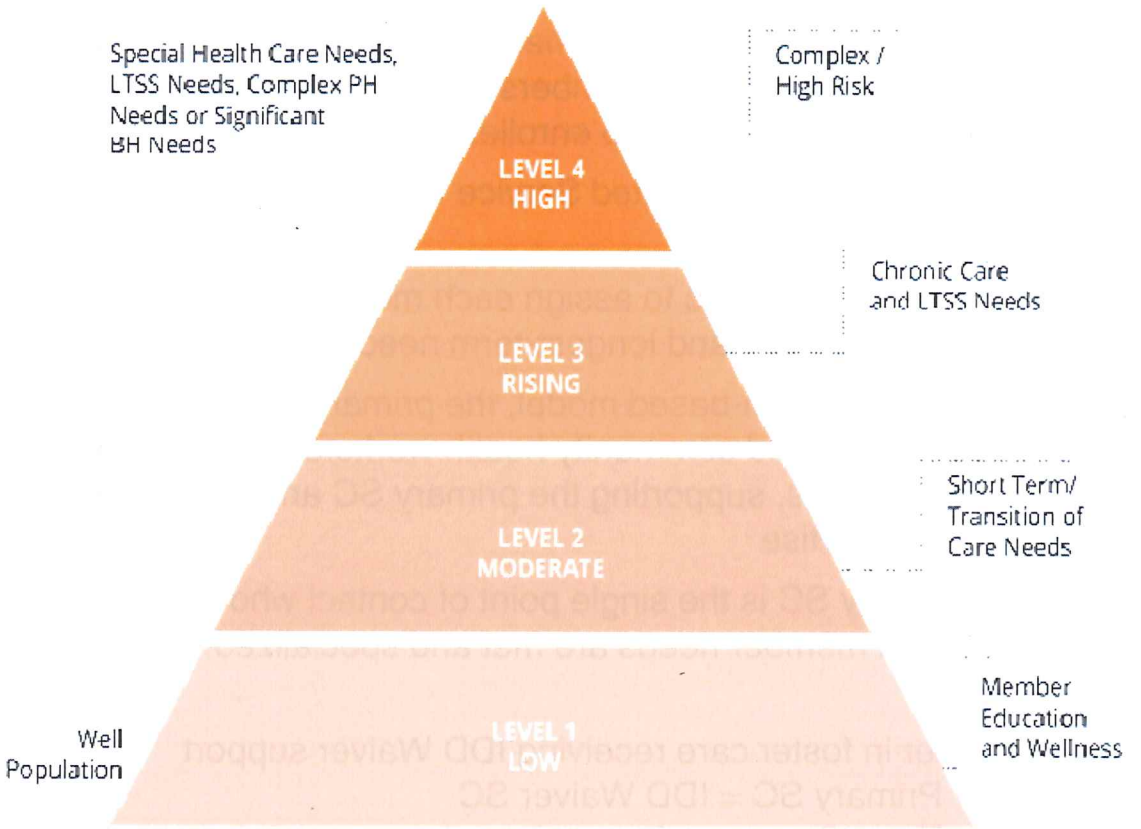
Level 4: 1:40 to 1:60

Level 3: 1: 60 to 1:80

Level 2: 1: 80 to 1:150

Level 1: 1:500

MOVEMENT BETWEEN LEVELS



Question 8

sunflower health plan

Please provide proposed ratios for all populations.

Sunflower deploys a transparent and data-driven methodology for determining Service Coordination ratios

Our staffing ratios for each Level of Service Coordination are driven by multiple factors, including:

- 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 or living alone since this impacts member density as well as potential risk)
- The member's level of risk (which influences the frequency of in-person visits and the post visit documentation required)

Question 9

sunflower health plan

B. Can Centene provide their overarching strategy for ensuring compliance?

In Compliance with, 42 CFR 441.301(c)(1)(vi) and 441.730(b), Sunflower will require its external Service Coordination or Targeted Case Management providers to demonstrate that they don't also provide or have interest in a provider of HCBS services.

If the only providers in a certain area are those that provide both Service Coordination and HCBS services, Sunflower will require the provider(s) to submit a Conflict of Interest Mitigation Plan demonstrating a compliant business and staffing structure.

The ***Mitigation Plan*** may include strategies such as:

- Not providing both Service Coordination and HCBS services to the same member
- Having a different reporting structure for SCs and HCBS services staff and managers
- Establishing separate provider organizations with different board of directors for HCBS and service coordination

Question 9

sunflower health plan

B. Can Centene provide their overarching strategy for ensuring compliance?

Technical Assistance for Providers that offer Service Coordination and HCBS Services:

- Making changes to the providers organizational structure
- Changing policy to only support persons in Service Coordination who don't receive HCBS from the provider
- Completely stopping one service or the other or separating services into different companies

Oversight and Monitoring:

- Sunflower SC reviews and approves member's Service Plan completed by external Community SC
- Pre-contracting and pre-delegation audit that assesses for potential conflicts of interest

Training:

- Educate members during SC visits about the potential conflict of interest when they have chosen a SC provider that also provides their HCBS services
- Offer and require training for external SCs to help them identify and address potential "red flag" situations
- Continue to offer training for our SCs to identify when an external SC has a potential conflict of interest and strategies to protect members from these conflicts

Ensuring Quality:

- Sunflower SC will route any identified quality of care concerns or member complaints to Sunflower's quality department and may provide information to member about rights and advocacy groups
- Submit AIRS report to the state as appropriate

Conflict of Interest Policy:

- Sunflower complies with the State's existing Conflict of Interest policy regarding members who have legal representatives who are paid caregivers for the member.

Question 9

sunflower health plan

A. Can Centene provide details regarding what they will do to address issues related to Conflicts of Interest once they are identified?

In Compliance with 42 CFR 441.301(c)(1)(vi) and 441.730(b) regarding Conflict Free Case Management, when a conflict of interest is identified with a member's service coordinator who is employed by, or has an interest in, the member's HCBS provider, Sunflower will engage in one or more of the following activities to mitigate the negative impact to the member:

- Educate members during SC visits about the potential conflict of interest when they have chosen a SC provider that also provides their HCBS services
- Offer the member a choice of a new Community Service Coordination provider
- The Sunflower SC for the member will participate in meetings during which the Person Centered Support Plan is developed or modified, or will contact the member after to ensure the member/legal representative's preferences and choices are honored within the plan
- If the member/legal representative expresses concern with the SC who has the conflict of interest, the Sunflower SC will complete the following steps:
    - Report this as a grievance to our quality department
    - Offer the choice of a different SC provider or if the member does not want a different SC provider, will offer to have a discussion with the current SC provider and member
    - Educate the member about assistance offered by the Disability Rights Center, Self-Advocacy Coalition of Kansas, or other rights and advocacy groups; and assist the member, if desired, to contact one or more of those organizations

If Sunflower identifies a trend of conflict of interest issues with a particular provider of service coordination and HCBS, Sunflower may require the provider to submit a revised conflict of interest plan.

Sunflower reviews all grievances related to conflicts of interest and works diligently with the SC to resolve those. The Sunflower Peer Review Committee will review and determine if further action is needed.

Question 10

sunflower health plan

Confirm and explain how Centene will meet the State's requirements regarding NEMT.

Sunflower confirms we will meet the State's requirements regarding NEMT. Our 2017 performance results demonstrate outstanding access to transportation services.

NEMT Performance Monitoring Program

- Frequent engagement with LogistCare
  - Interfaces multiple times per week
  - Monthly and quarterly scheduled meetings
  - Local and onsite visits and corporate-led vendor audits

- Performance Data Collection and Analysis
  - Measure Key Performance Indictors (KPIs) to monitor performance trends and identify any improvement needs
  - Validate LogistiCare's performance through feedback from member grievances and member feedback

- Continuous NEMT Process Evaluation and Best Practice Development
  - Ongoing process evaluation and improvement of subcontractors
  - As a result of member feedback and grievances received, we developed special processes and procedures to assist members who experience in-transit issues, such as delayed service, including a designated team to handle real-time member transportation needs

Question 11

sunflower health plan

Confirm that "State" means KDHE and KDADS.

Sunflower confirms that “State” is referring to KDHE and KDADS.

Question 12

sunflower health plan

Please confirm process for tracking and overseeing activity of Subcontractors.

Specific to customer service, subcontractors that provide this function on behalf of Sunflower include LogistiCare, Envolve Dental, Envolve Vision, Envolve Pharmacy, NIA and Nursewise (Member Only)

Multi-Layer Risk Management Approach

- Oversight Program to monitor adherence to performance standards and reporting accuracy (e.g. 90% of calls resolved in initial contact)
- Subcontractor Oversight Team (cross-functional staff)
  - Reports status of each subcontractor to Quality Improvement Committee
  - Joint Oversight Committee meetings at least quarterly with subcontractor and Sunflower representatives
- Subcontractor Monitoring Plan: annual plan that reflects the year's subcontractor monitoring
- Annual audit of subcontractor performance
- Monitoring compliance through our compliance management system
- Require monthly and quarterly dashboard reports from our subcontractors

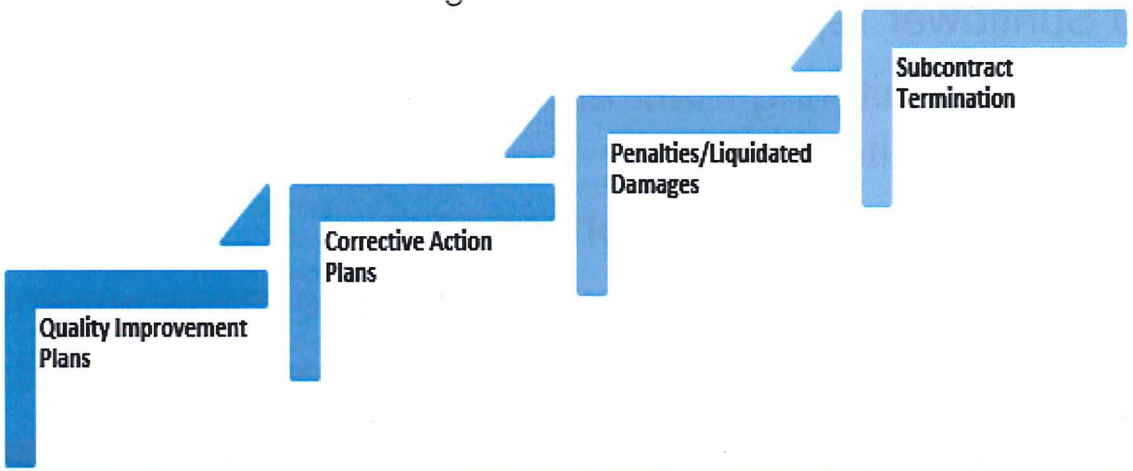
Question 12

sunflower health plan

Please confirm process for tracking and overseeing activity of Subcontractors.

Remedies for Subcontractor Performance Issues

- If a subcontractor is non-compliant, Sunflower will notify KDHE in writing within 5 days of discovery
- If we do not see a correction of the deficiency within that 30-day timeframe, we will then implement a Quality Improvement Plan (QIP)
- If the QIP requirements are not met, we will issue a formal request for Corrective Action Plan (CAP) to the subcontractor and immediately notify KDHE
- 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
- In the event of a termination, Sunflower will provide details of the transition plan for the services and new subcontractor arrangement



Question 13

sunflower health plan

How does Centene incorporate identified SDOH needs into the member's plan of care?

Capturing the various SDOH needs

Sunflower utilizes several methods for identifying Social Determinants of Health and Independence (SDOHI) needs:

- Our current Health Risk Assessment includes questions about SDOHI
- Our person-centered support planning process includes questions about each member's existing and preferred lifestyle and self-identified barriers, including SDOHI needs
- Sunflower is working collaboratively with KAMU, the Primary Care Association of Kansas, on implementation of the PRAPARE model (Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences) at community-based health centers (CHCs)
    - Administered by providers, the PRAPARE assessment tool is designed to assess for and address SDOHI, emphasizing measures that are actionable
- All assessment results are used as the basis of each member's Plan of Service or Person-Centered Service Plan (Service Plan)

Question 13

sunflower health plan

How does Centene incorporate identified SDOH needs into the member's plan of care?

Supporting the Service Plan and progress on SDOHI related goals

Member progress on Service Plan goals and activities, including covered and non-covered services, is monitored by the SC through regular contacts with the member including:

- Steps to achieving goals, including activities related to SDOHI
- SCs will assist the member with contacting a community organizations, or providers
- The SC may include another person in the member's circle of support assisting the member with exploring local resources
- Member referrals to Sunflower's SDOHI Center of Excellence team for consultation supports
- Members have the choice to change or modify their Service Plan at any time

Once a member has met a goal, the SC will assist the member to determine other goals the member may want to work on to further address a need, eliminate a barrier, or to address a different need or barrier

Question 14

sunflower health plan

Please verify whether you establish policies and procedures for all activities described in the procurement for member and provider grievances and appeals systems and processes.

Sunflower has established written policies and processes that complies with the current State contractual requirements and Sunflower would make any necessary updates to those policies and processes to ensure compliance with KanCare 2.0.

All revisions and updates would be submitted to KDHE for review and approval as per procedure prior to implementation.

Question 15

sunflower health plan

Does Centene meet the contractual requirement for the State's definition of clean claims?

Sunflower has adopted the State of Kansas's definition of clean claim: A clean claim means the definition set forth in 42 C.F.R 447.45, as amended. As of the effective date of a contract, such definition is a claim that can be processed without obtaining additional information from the provider of services or from a third party. It includes a claim with errors originating from the state's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

(This is also referenced in our provider manual for provider reference and consistent with the information in the RFP. This is aligned with standard federal definition of a clean claim in which Centene follows for the enterprise).

Question 16

sunflower health plan

Please explain your SUD process.

Our Health Information Technology and Health Information Exchange activities comply with 42 CFR part 2: Confidentiality of Alcohol and Drug Abuse Patient Records, and the Substance Abuse & Mental Health Services Administration's (SAMHSA) regulations governing the Confidentiality of Substance Use Disorder Patient Records updated in the Final Rule effective February of 2018.

SUD Process

- Member screening, assessment and referral
- The State's Kansas Client Placement Criteria (KCPC) system is the bidirectional platform used by our UM team to receive SUD service requests and communicate authorization
- Sunflower's SUD Service Coordination program has demonstrated statistically significant improvement in SUD treatment, initiation and engagement rates when compared to those not in Service Coordination

HEDIS Measure	Enrolled in Service Coordination	Not enrolled in Service Coordination
Initiation of SUD Treatment	49.6%	35.8%
Engagement in SUD Treatment	19.03%	11.81%

Question 16

sunflower health plan

Please explain your SUD process.

Use of Health Information Technology

- ***MyStrength:*** Sunflower augments the SUD process with MyStrength to ensure all members have access to an evidence-based behavioral health self-management tool.

HEDIS Measure*	MyStrength Users	Non-users
Initiation of SUD Treatment	54.72%	38.24%
Engagement in SUD Treatment	28.93%	12.7%

*statistically significant (initiation: p = .0013; engagement p = <.0001)

- ***SUD Segmentation Model and LIFT (Learn. Identify. Follow. Treat):*** offer a framework to identify high opportunity interventions as well as mechanisms to measure intervention efficacy and population health improvement over time.

Question 17

sunflower health plan

Centene's response was not provided directly to Attachment H. Does Centene have existing reporting that meets the detailed requirements in Attachment H, or does Centene have plans to provide the required reporting with demonstrated timelines for compliance?

Sunflower can fully support the required reporting with demonstrated timelines for compliance.

For all new reporting requirements we will have the reports and infrastructure in place to meet the requirements by the contract start date.

5.1.2

RFP BACKGROUND - REQUIREMENTS FOR CONTRACTOR(S) TO DEMONSTRATE

1. The State requests that Centene affirm that they will comply with requirements in Section 5.1.

Centene's affirms that they will comply with the requirements in Section 5.1

This page intentionally left blank

5.1.3

RFP BACKGROUND - GEOGRAPHIC SERVICE AREA

2. The State requests Centene confirm that they will provide Statewide coverage.

Centene's confirms that they will provide Statewide coverage.

This page intentionally left blank

sunflower health plan

5.4.1.E

SERVICE COORDINATION

3. Can Centene please provide additional detail on nursing home population tele-psychiatry pilot, particularly how the member is involved in the process?

TELE-PSYCHIATRY PILOT OVERVIEW

The goal of the nursing home population tele-psychiatry pilot is to expand the availability of psychiatric medication management and education to members in nursing facilities. Sunflower utilizes claims, assessments, and medication information gathered by the Service Coordinator from the nursing facility to identify members who are taking psychotropic medications.

Consistent with our Integrated Service Coordination (ISC) model, the member is at the center of the tele-psychiatry program and process. While in the nursing home, the member's assigned Service Coordinator engages the member and the member's legal representative in virtual conversations with the Psychiatrist. These consultations are designed to educate the member/legal representative about psychotropic medications the member is taking or that have been recommended, the potential side effects, detail about any plans to titrate medication and potential effects of the titration, and other information the member/legal representative may want to make a well-informed decision about the medication plan. As part of the program, we will engage the member and provide necessary supports to enable them to actively participate. For example, to help empower the member and the member's circle of support and family members to ask questions about medication treatment, and promote informed decision making, we will provide participants with a list of sample questions they may want to ask their provider about the use of psychotropic medications.

We are currently working with Genoa, the largest telepsych provider in the US and already working in Kansas, to implement the pilot in multiple counties. As part of the model, Psychiatrists will consult with the Nursing Facility physician staff, the member's Primary Care Provider and the member and their family/legal representative to evaluate the member's medications with an aim to confirm or amend treatment. This will include the decrease or tapering off of antipsychotics when appropriate. Recognizing the high percentage of our members that are dual eligible, as part of our ISC model, we will identify who the member's Primary Care Provider and/or prescriber is and engage them through the use of our Integrated Care Team, involving the Psychiatrist as appropriate. As part of our telemonitoring component and ICT process, the Psychiatrist may case conference with the members PCP to discuss the medication plan and make recommendations.

This page intentionally left blank

4. How does Centene propose to receive reimbursement for telemonitoring?

OVERVIEW

The availability of additional funding through reimbursement for telemonitoring would allow Sunflower to expand our programs to other populations and conditions. Today, 21 States offer remote patient monitoring (RPM) and have some form of Medicaid reimbursement for RPM, many with restrictions (i.e., only reimbursing to home health agencies, restricting the clinical conditions, limiting the type of monitoring device and type of information that can be collected). Other factors involved in telehealth coverage include practitioner licensure requirements, reimbursement variances between transmission v. facility fee (or both), and the location of telehealth services.

Recognizing the value and return on investment demonstrated through remote patient monitoring, Sunflower has invested in this technology in our medical management programs, including CHF and LTSS as described briefly below.

Sunflower Experience: CHF Telemonitoring Program

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. CHF Telemonitoring Program targeted members with a utilization pattern that suggested severe or sub-optimally managed:

- High total cost, primarily due to emergency room and inpatient utilization
- Billing:
  - Disease Management Program; initial assessment & initiation of the program
  - Disease Management Program; follow-up/reassessment per diem
- Preliminary Program Outcomes:
  - 31% reduction in Emergency Room PMPM Spend
  - 56.4% reduction in Inpatient PMPM Spend
  - 19.2% reduction in Total PMPM Spend
    - *increase spend in Other Medical and Specialist

Sunflower Experience: HomeLink Technologies

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.

RECOMMENDATIONS

Sunflower recommends the identification of specific CPT codes (with modifiers as applicable) for standardized billing and claims submission related to telemonitoring. Based on lessons learned described further below, having encounterable codes and a standard process will alleviate

administrative burden for providers, Sunflower, and the State. Multiple codes or modifiers would be needed to cover both the front-end expense for member set up, and following the initial set up, a per diem reimbursement for ongoing telemonitoring. A per diem structure will allow for any necessary changes to the level of monitoring based upon member change in condition. Possible codes, based on existing codes and current experience, include: assistive technology, disease management, etc. As proposed, services would be paid by Sunflower and submitted to KDHE and KDADS for inclusion in MCO capitation adjustments. As proposed, services would be paid by Sunflower and included in paid claims for capitation rate setting purposes.

LEVERAGING PREVIOUS EXPERIENCE

In order to facilitate past demonstration projects the State established specific codes for programs such as the I/DD LTSS services pilot in 2013. In addition, Sunflower has worked with the State to establish non-encounterable codes to better track and accumulate value added benefits including assistive services. Having learned what works and what does not from these previous experiences, Sunflower will work with the State to identify and establish codes to be used for tracking pilot telemonitoring programs. As the programs are proven and considered for expansion, codes can be expanded and authorized for encounter submission in order to properly track and fund these types of initiatives that lead to better health outcomes for our members and Medicaid program cost savings.

5.4.2

SERVICE COORDINATION - HEALTH SCREENING, HEALTH RISK ASSESSMENT AND NEEDS ASSESSMENT

5. Please describe the process for referrals for needed support beyond service coordination.

NO WRONG DOOR

Sunflower promotes a no wrong door approach. Regardless of how or where member needs are identified (e.g. provider referral, customer service call, Health Screen, etc.), Sunflower will connect the member with the appropriate services and supports. Through warm transfer, service referral, service coordination, or direct outreach, if we can't provide the needed service or support, we connect the member with the appropriate resources.

SCREENING AND ASSESSMENT TO IDENTIFY NEEDS

A key component of Sunflower's Integrated Service Coordination (ISC) model is our member screening and assessment process designed to assess and address each individual member's physical health (PH), behavioral health (BH), functional and social needs, including social determinants of health and independence (SDOHI). 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 to address each individual member's identified needs beyond service coordination.

For members whose Health Screen results indicate the need for a health risk assessment (HRA), the member's assigned Service Coordinator (SC) 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. All screenings and assessments are tracked in our TruCare care management system to ensure timely completion and appropriate follow up.

The HRA and needs assessment form the basis for the development of the individualized Plan of Service or Person-Centered Service Plan (PoS/PCSP), aligning a member's needs and preferences to services and interventions. The PoS/PCSP includes services and supports that the member needs to stabilize or improve his or her health, safety and well-being and address SDOHI. As part of Sunflower's ISC process, service needs are documented in each member's PoS/PCSP and the member's Service Coordinator (SC) authorizes or facilitates authorization of the member's PoS/PCSP and refers to needed services and supports. For example, for LTSS members, the SC is responsible for authorizing the services. As part of the process, the SC will give the members a choice of providers and will directly submit the authorization to UM for approval.

The member's SC is responsible for making or facilitating referrals for all needed supports and services, including KanCare covered services and non-covered services. Members may also be referred to other Sunflower programs and services. The various processes involved in referring members to needed services and supports are highlighted in the examples below.

Covered and Value-Added Services

Covered and Value-Added Services

In coordination and collaboration with the member and the member's PCP, the PoS/PCSP will reflect the need for covered services, including PH and BH services, primary and specialty care, inpatient and outpatient treatments, and transportation and other covered supports. For services that require prior authorization, the SC will help facilitate referrals and communicate with appropriate providers and our Utilization Management (UM) department to secure appropriate approval. For example, the SC will collaborate with UM about incoming requests and expediting authorization as appropriate to allow services to begin timely. If the member does not currently have a PCP, the SC will assist the member identify a new PCP and schedule an appointment. If the member needs a specialist or treatment referral, the SC will assist in finding a specialist or appropriate treatment program/facility. For services that do not require prior authorization, the SC will help the member identify an appropriate provider, help schedule the appointment, help schedule transportation as needed, and then follow up with the member to ensure the provision of services. Unique to our model, our SC will be able to directly schedule appointments through Appointment Wizard, an on-line appointment scheduling system that provides for real time appointment scheduling and text appointment reminders. Appointment Wizard allows SCs to schedule appointments with participating providers and issue text or email reminders for members. Staff 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.

For members who need non-emergency transportation support, the SC can refer members to Sunflower's transportation provider, or for other transportation needs the SC can work in collaboration with other members of the care team to locate and connect the member with community resources for other types of transportation support or assistance. The level of support provided is reflective of member needs, promoting independence but also ensuring members get the services needed. For example, SCs will provide members with appropriate phone numbers and questions to ask in scheduling services. If members are not comfortable scheduling the appointment on their own, the SC may do a three-way phone call with the transportation provider.

If a member would benefit from a value-added service available through Sunflower, the SC will educate the member on the availability of the added benefits and arrange for the provision of such services through identified vendors or other resources.

Non-Covered Services and Community Resources

Our comprehensive provider and community network is designed to facilitate whole-person care, continuity, quality, and member choice. This involves extending our referral base beyond the traditional set of providers to include a robust network of community-based services and supports. A member's HRA may identify services and supports not available through KanCare, including those needed to address SDOHI. The SC will leverage our community resource database and work with the Sunflower team to help identify community resources to meet these non-covered needs. For example, our team is comprised of the Director of SDOHI, Transitions Specialists, Housing Specialists and Employment Supports Specialists and Member Advocates. These available staff promote community integration and independence and provide technical assistance and supports to the member and the member's SC, both Sunflower and Community SCs.

Services and supports can span a large range of resources, for example non-covered transportation, meals, employment and housing supports, financial assistance to cover utilities, local support groups, local social clubs or activities, peer supports, volunteer opportunities, non-covered home modifications, and non-covered equipment or supplies. Based on individual member need, the SC will help facilitate outreach to identified community resources and refer and follow up as appropriate.

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.

Other Sunflower Programs and Resources

In addition to service coordination, members may be referred to or educated on other Sunflower programs or services such as interpreter services; our CentAccount member incentive program; Lock-In; Disease Management, including health coaching and self-management skills; and/or outreach by a Community Health Worker for difficult to engage members. For members in ISC Levels 2-4, referrals are captured and monitored through the PoS/PCSP. For members in ISC Level 1, a Member Services Representative (MSR) or CHW will make appropriate referrals for internal and external programs and resources, helping members to identify available resources and doing a warm transfer as appropriate. MSRs and CHWs also have access to Appointment Wizard to make real time appointments with participating providers. For high risk members without a cell phone, we can also 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.

MONITORING AND FOLLOW UP

The SC will routinely review the PoS/PCSP with the member during each member contact, to ensure receipt of recommended services and supports as outlined in the member's individualized PoS/PCSP. Contact method and frequency are driven by the member's individual needs and level of risk. SCs also monitor utilization reports to ensure members are receiving appropriate services and follow up accordingly.

This page intentionally left blank

sunflower health plan

5.4.6

SERVICE COORDINATION - MANAGED CARE ORGANIZATION SERVICE COORDINATION ROLES AND RESPONSIBILITIES

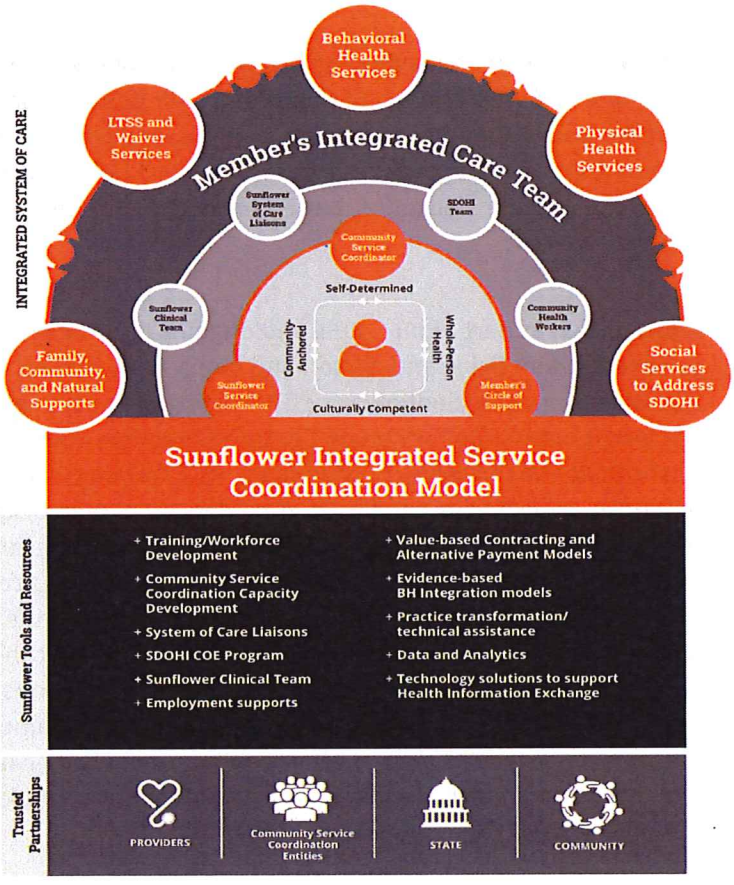
6. Please describe your comprehensive approach to care management.

OVERVIEW

Our Integrated Service Coordination (ISC) model, inclusive of care management, incorporates the evidence-based Integrated Care Management approach promoted by the Case Management Society of America, treating the whole-person and integrating all physical health (PH), behavioral health (BH), long term services and supports (LTSS), social and other services to create a system of care around each individual.

Our ISC model, depicted in Figure 6.1, includes a comprehensive care management system and approach that put the member at the center of all ISC activities with the support of a Service Coordinator (SC), either in the community or within Sunflower's ISC team, in accordance with Section 5.4.7 of the RFP. Regardless of who provides ISC services, Sunflower's role is to ensure a consistent, comprehensive, integrated and holistic care management system, through clearly delineated ISC policies, procedures, and programs; technology solutions; staff and community training; a high touch model and approach; and appropriate oversight.

Figure 6.1 Integrated Service Coordination (ISC) Model



Features of our care management system, as described below, include:

- Person and family centeredness.
- Timely, proactive, and planned communication and action.
- The promotion of self-care and independence.
- Emphasis on cross continuum and system collaboration and relationships. Comprehensive consideration of physical, behavioral, and Social Determinants of Health and Independence.
- Promotion of community access and participation for members at-risk for isolation or who encounter barriers to participating in community activity.

PERSON AND FAMILY-CENTEREDNESS

Person and family-centeredness is a key attribute of our care management approach. SCs 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 will work in collaboration with the member and the member's identified circle of support to assure the member is able to participate in the care planning process to identify measurable PH, BH and functional and social support goals and develop interventions to address the identified member goals. In addition to explaining our person and family-centered planning process, our SCs 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 family, 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 Plan of Service or Person-Centered Service Plan (PoS/PCSP). The SC will assist the member to identify friends, family, and community supports (e.g., friends from church or social groups, CILs, AAAs, CDDOs and/or Self Advocacy Coalition of Kansas) to support the member to assume an active role. 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 PoS/PCSP.

As part of our care management approach, 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 is to fully understand the member and his/her needs, strengths, goals, and lifestyle preferences through standardized assessments, motivational interviewing, Person Centered Thinking (PCT) strategies and active listening, so we can provide assistance that is consistent with the member's expressed preferences, values and culture.

Additionally, as part of our initial and ongoing training program, SCs will receive training and education on independent living and person and family-centered service planning principles. As an example of our training curriculum, Sunflower's 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 and the member's family, as appropriate. 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 PoS/PCSP.

COMMUNICATION AND ACTION

Timely, proactive and planned communications are critical features of our care management system. Our case management platform, technology solutions and policies and procedures support communication and coordination among members of the Integrated Care (IC) Team, provider network, and contracted Community Service Coordination entities. For example, each PoS/PCSP will be accessible to the Sunflower SC or Community SC and the member's IC Team via TruCare, and our SC 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. We also provide for Members and families a paper copy of the PoS/PCSP, if it is there preference. Members are also able to review their PoS/PCSP with their SC through our secure, web-based, TruCare mobile capabilities, which SCs can access through a tablet during in-person member meetings.

Providers, specialists, hospitals, State agencies and HIEs will be able to interface with our 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. From a care management perspective, ADT transmissions allow real time notifications to SCs of critical health care events, such as ED visits or inpatient admissions to an inpatient facility. This notification enables the SC to contact the member's PCP in a timely manner and promotes coordination between the SC, PCP and hospital to determine and facilitate the appropriate level of care of the member.

PROMOTION OF SELF-CARE AND INDEPENDENCE

Our ISC model promotes member self-care, the member's ability to self-direct their services, and independence. As part of our approach, 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 ensuring reasonable access to necessary care is not compromised. Therefore, during each contact with the member, the SC will assess if the member has all services in place necessary to manage his/her condition and maintain independence, and that the member's current residence is safe and adequate to meet his/her needs. For example, for members with chronic conditions, as part of our ISC model, we offer Disease Management programs for asthma, congestive heart failure (CHF), diabetes, hypertension, and obesity, that include health coaching and self-management skills training. If it is assessed that an alternative setting may be needed, or a less restrictive setting is an option, an evaluation will be made to ascertain if the member is able and/or willing to transition from one environment to another, or what additional services might be needed to maintain the member in a lower level of care. For members in a facility, SCs 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?"). Transition is most successful when members can see themselves elsewhere.

Throughout the care management process, SCs will educate members and their loved ones about the member's right to receive care in the least restrictive setting, evaluating the level and adequacy of the current setting at least annually. Requests for additional assessment may also come from the member or their legal guardian, KanCare, or other stakeholders for the member. To proactively identify candidates interested in transition, we will utilize available transition data, inclusive of Minimum Data Set (MDS) data. This data also documents member's risk factors to inform transition plans and backup

planning. Facility-designated SCs will build rapport with facility administrators, and partner with various programs to provide community integration opportunities for members considering transition, including the providers Sunflower has a VBP with for transition coordination services. Sunflower also offers peer-to-peer support from our Member Advocate to individuals who want to learn more about self-directed services, or who need assistance with successfully self-directing services.

CROSS-CONTINUUM AND SYSTEM COLLABORATION

Sunflower is committed to the integration of PH, BH, LTSS and the social services delivery systems to support whole-person care. This is carried out through our ISC model and local SCs focused on ensuring coordinated, integrated care across settings and disciplines. Sunflower has built upon our strong foundation serving members in KanCare to develop a member-centric ISC model and system of care framework (as illustrated in Figure 6.1 above). This framework is relationally based, with values that focus on the member and addressing their holistic needs. We recognize that whole-person care must be community-anchored, culturally competent, and self-determined, drawing from resources across the community and across the continuum. Sunflower's primary roles in supporting system collaboration across the continuum of care are to support providers in delivering the best possible care to members, promote accountability, deliver actionable information, make linkages across the system, and be a local, accessible resource. Supporting our SCs are our organized System of Care (SOC) Liaisons and dedicated staff, working collaboratively to identify and link to available resources in each community, including access to systems SCs may not be familiar with. This includes liaisons to each of the HCBS waiver programs, the WORK program, the judicial system and foster care. We also are currently building a Center of Excellence for SDOHI, including team members who are subject matter experts in housing, employment, access to food, utility assistance, transportation, and other SDOHI needs.

WHOLE PERSON CARE THAT ADDRESSES PHYSICAL, BEHAVIORAL, FUNCTIONAL AND SDOHI

A key feature 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 based on screening and assessment results. SCs will work with the member and the member's IC Team and chosen circle of support to examine the member's whole person needs and develop a PoS/PCSP that address these identified needs. Specifically, key elements of the PoS/PCSP include identified PH, BH, functional, environmental and social support needs and an integrated approach to meeting these needs, including the provision of KanCare covered benefits and services, value added benefits and services, and referrals to community-based services and resources, if indicated.

PROMOTION OF COMMUNITY ACCESS AND PARTICIPATION

The core foundation of our model is to support and maintain members in the community and in the least restrictive option that safely meets the member's needs. This requires us to connect members to housing, food, employment, education, social activities, and other peer and social supports as needed. Sunflower's ISC model and care management approach 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.

Sunflower's model promotes community participation and our process includes the identification of members who may be at-risk for isolation or members who are experiencing barriers to living in the community and fully participating in community activities. Sunflower has provided training to our SC team on PCT and Motivational Interviewing with the goal of utilizing these strategies to support members in facilitating the development of their personal goals and driving the action steps. We train 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.

The PoS/PCSP 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 for community access and participation are routinely identified, as well as possible solutions to the barriers. As part of our process, the SC assists the member with identifying strategies for accomplishing his/her community participation and integration goals and overcoming the identified barriers. Additionally, as part of the service planning process, SCs take into consideration and assess for the availability of family or other natural supports and the member's risk for social isolation.

As an additional tool, we currently administer a Quality of Life survey to measure and track the quality of life of our members and intervene as appropriate. We will also train our SCs 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.

CORE COMPONENTS OF CARE MANAGEMENT

To support the implementation of our comprehensive system, core components of our care management approach include:

- Initial identification of potential members for care management, identifying members through eligibility, risk stratification and predictive modeling, and provider or self-referral
- Obtaining member agreement for participation in care management and service coordination
- Identifying level of service coordination or care management needed, stratifying members into four 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)
- The assignment of a primary SC who may access other team members for specialized support
- A member screening and assessment process, utilizing a comprehensive set of health screening, health risk assessments and needs assessment tools, to assess and address each individual member's PH, BH, functional and SDOH needs, completed at least annually or upon a change in member status or condition
- A person-centered planning approach to help the member set goals related to areas of need and lifestyle preferences, documented in the PoS/PCSP
- Establishing steps for completing goals in collaboration with the member and the member's identified circle of support, documented in the PoS/PCSP

- Monitoring, reviewing and revising the PoS/PCSP to achieve progress as needed and upon member request, meeting with members at a frequency driven by their individual need and level of risk

5.4.8

SERVICE COORDINATION - QUALIFICATIONS FOR SERVICE COORDINATORS

7. How will Centene handle assigning service coordinators for members that cross multiple populations?

Sunflower's goal is to match every member with a Service Coordinator (SC) most appropriate for the member's individual needs. This is determined based on SC qualifications and experience working with similar populations. Given the complexity of our membership, it is possible members will cross multiple populations, including, for example, members with physical health and behavioral health co-morbidities or youth in foster care who are also enrolled on a HCBS Waiver. Our team-based Integrated Service Coordination (ISC) model is specifically designed to address such circumstances.

ASSIGNING SERVICE COORDINATORS

Our current system is to assign each member to a primary SC that is qualified to address the member's primary and longest-term need. For example, for members in long-term supports and services and/or foster care, this would be a SC with direct experience serving these populations. Through our team-based model, the primary SC can then access RNs, licensed behavioral health professionals and community health workers (CHWs) with diverse backgrounds who can serve as secondary SCs, supporting the primary SC and the member with services and needs related to their area of expertise. The member's primary SC assignment and secondary SC team members are logged into and tracked within our TruCare care management system.

As previously indicated, Sunflower will contract with external SC providers for the populations identified within the RFP. When a member's primary SC is external to Sunflower, the Community SC will have the same access to make referrals to Sunflower SCs and other Sunflower team members to be on the member's team. The Community SC will have access to bi-directional information sharing in TruCare through the SC portal to make referrals and assign secondary SCs.

Sunflower is currently working to provide access to the SC portal for IDD and CMHC Targeted Case Managers who work collaboratively with our SCs for members on the IDD and SED waivers. We will then expand this access to other external Community SC providers in 2019.

This page intentionally left blank

5.4.9

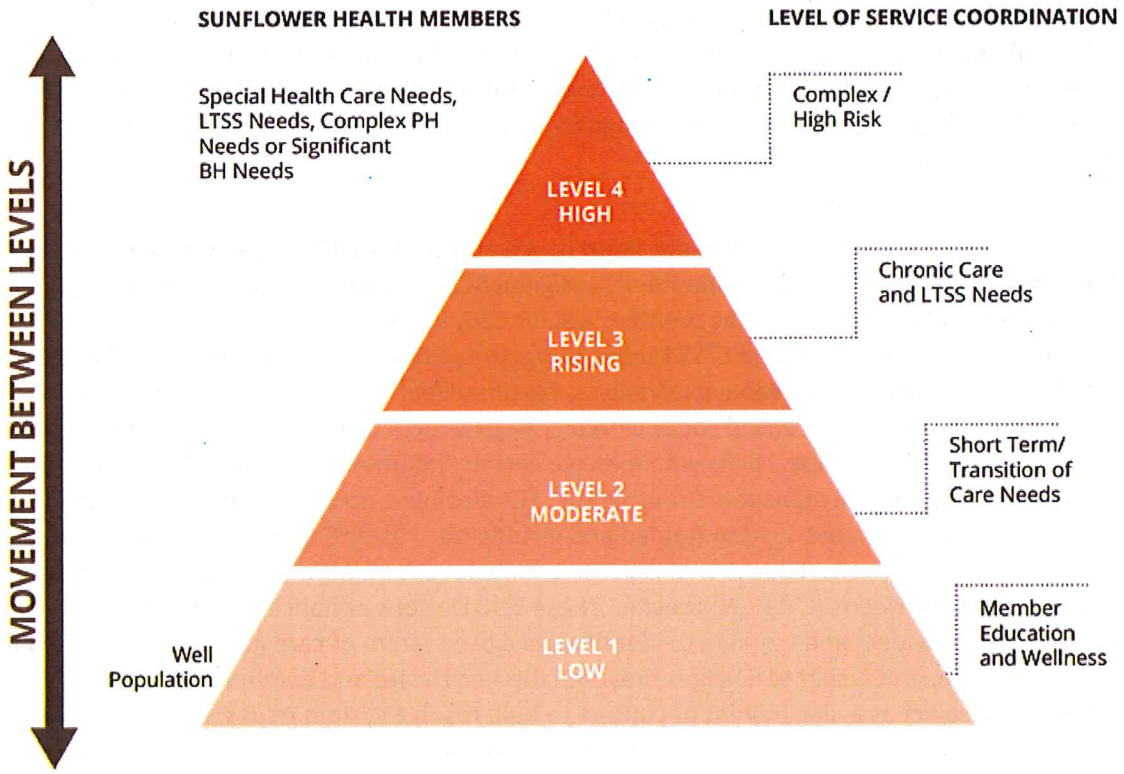
SERVICE COORDINATION – RATIOS

8. Please provide proposed ratios for all populations.

Our Integrated Service Coordination (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 8 Levels of Service Coordination***.

We stratify members into **four levels of Service Coordination - 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)**. 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. 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 Social Determinants of Health and Independence (SDOHI). Service coordination activities and tailored interventions may be delivered by Sunflower, providers, or the Community Service Coordination entities.

Figure 8 Levels of Service Coordination



Our member-centered, ISC recognizes that every member has different needs, commanding a varying level of service and interventions. For example, while not every member will require Level 4-Complex/High Risk level of services and interventions, any member, at some time, may need a higher level of service and support, such as short term or intermittent coordination of services, disease management or transition of care. Our model is designed to address the individual needs of the 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.

Our care coordination activities are deliberate for each level of care coordination. For example, care coordination activities under Level 1 include primarily health and wellness education and resource coordination activities, such as a PCP provision of education to a Level 1 member about age-appropriate preventive exams, 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. For members stratified into Level 2, 3, and 4 Service Coordinators have established activities, including assessment, interventions and care planning strategies that provide services coordination services that fit a member's individual situation. For this reason, our case load ratios are by Level of Service Coordination and not population.

CASELOAD RATIOS BY LEVEL OF SERVICE COORDINATION

Sunflower deploys a transparent and data-driven methodology for determining Service Coordination ratios. Our staffing ratios for each Level of Service Coordination are driven by multiple factors, including the geographic disbursement of members (since this impacts the time required for Service Coordinator 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 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 case load ratios also take into account our team based approach that includes the involvement of Integrated Care Teams that support the member's assigned SC. Sunflower provides 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), Community Health Workers (CHWs); and Program Specialists who manage certain initiatives/programs, such as our Start Smart for Your Baby® perinatal management program. SCs also have access to Sunflower's 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 SCs and 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.

The following are our case load ratios by Level of Service Coordination. Our case load ratio requirements for each Level of Service Coordination include ranges to account for the variables and factors described above.

- Level 1: 1:500
- Level 2: 1: 80 to 1: 150
- Level 3: 1: 60 to 1:80
- Level 4: 1:40 to 1:60

Sunflower systematically monitors our caseloads weekly, monthly and quarterly by the Service Coordination Managers and Supervisors and adjusts 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.

This page intentionally left blank

5.4.13

SERVICE COORDINATION – CONFLICT OF INTEREST

9.A. Can Centene provide details regarding what they will do to address issues related to Conflicts of Interest once they are identified?

In Compliance with 42 CFR 441.301(c)(1)(vi) and 441.730(b) regarding Conflict Free Case Management, when a conflict of interest is identified with a member's service coordinator who is employed by, or has an interest in, the member's HCBS provider, Sunflower will engage in one or more of the following activities to mitigate the negative impact to the member:

- Educate members during SC visits about the potential conflict of interest when they have chosen a SC provider that also provides their HCBS services
- Offer the member a choice of a Community Service Coordination provider that does not have a conflict of interest.
- The Sunflower Service Coordinator for the member will either directly participate in meetings during which the Person Centered Support Plan is developed or modified, or will contact the member after to ensure the member/legal representative's preferences and choices are honored within the plan.
- If the member/legal representative expresses concern with the Service Coordinator who has the conflict of interest, the Sunflower Service Coordinator will complete the following steps:
  - Report this as a grievance to our quality department
  - Offer the choice of a different SC provider or if the member does not want a different SC provider, will offer to have a discussion with the current SC provider and member
  - Educate the member about assistance offered by the Disability Rights Center, Self-Advocacy Coalition of Kansas, or other rights and advocacy groups; and assist the member, if desired, to contact one or more of those organizations

If Sunflower identifies a trend of conflict of interest issues with a particular provider of service coordination and HCBS, Sunflower may require the provider to submit a revised conflict of interest plan with increased separation of service coordination and HCBS, participate in further training on conflict of interest, and/or not provide service coordination and HCBS to the same members.

Sunflower reviews all grievances related to conflicts of interest and works diligently with the Service Coordinator to resolve those. Additionally, these may also be worked in parallel as a potential quality of care concern. Potential quality of care concerns related are reviewed in accordance with Sunflower's established policy/procedure which allows for review by the Sunflower Peer Review Committee to determine if further action is needed which may include up to the provider's termination from the Sunflower network. Additionally, any issues that arises to the level of an adverse incident will be reported through the states Adverse Incident Reporting System.

This page intentionally left blank

9.B. Can Centene provide their overarching strategy for ensuring compliance?

OVERARCHING STRATEGY FOR ENSURING COMPLIANCE WITH CONFLICT OF INTEREST

In Compliance with, 42 CFR 441.301(c)(1)(vi) and 441.730(b), Sunflower will require its external Service Coordination or Targeted Case Management providers to demonstrate that they don't also provide or have interest in a provider of HCBS services. However, we recognize that in many cases, the most qualified providers, and sometimes only willing providers, are those that also provide HCBS services. We also recognize that KDADS is currently working on a revision to the current state Conflict of Interest policy that may include criteria for qualified providers, and may include a transition timeline. Sunflower intends to comply with the new policy when implemented, and to assist with provider transition to compliance.

If the only willing and qualified providers in a certain area are those that provide both Service Coordination and HCBS services, Sunflower will require the provider(s) to submit a Conflict of Interest Mitigation Plan demonstrating a business and staffing structure that is compliant. The mitigation plan may include strategies such as not providing both Service Coordination and HCBS services to the same member, having a different reporting structure for Service Coordinators and HCBS services staff and managers, and/or establishing separate provider organizations with different boards of directors for HCBS and service coordination.

For providers that offer both Service Coordination and HCBS services to the same members, Sunflower will offer technical assistance for how the providers can move towards compliance with the CMS requirement. This may include transition steps, such as:

1. first making changes to the providers organizational structure to separate lines of supervision,
2. then changing policy to only support persons in Service Coordination who don't also receive HCBS from the provider,
3. then completely stopping one service or the other, or separating services into different companies.

Oversight and Monitoring

As part of our integrated service coordination model, Sunflower SC's review and approve member's PoS/PCSP completed by community service coordinators. When the CSC is employed by the members provider of HCBS services, the Sunflower SC will have an independent conversation with the member prior to authorizing the plan. We also as part of the contracting process conduct predelegation audits that include assessment of potential conflict of interests.

Training

Sunflower will also offer and require training for external Service Coordinators to help them identify potential "red flag" situations for which the conflict may negatively impact members, and strategies for how to address. These situations may include when a provider may be guiding members to live in certain types of living arrangements because of the provider's staffing or financial need, or when the Service Coordinator needs to offer a choice of other providers.

Sunflower will continue to offer training for our Service Coordinators to identify when an external Service Coordinator has a potential conflict of interest. We will train our Service Coordinators to educate the member about potential conflict of interest with the member's chosen providers, and to offer the member a choice of providers of Service Coordination that are not employed by, or have in interest in, the provider of HCBS services for the member. Further, Sunflower will train our Service Coordinators on strategies to utilize to protect members from the negative impact of conflict of interest, when the member's external Service Coordinator is employed by or has in interest in an HCBS provider the member utilizes. These strategies include:

- participating in and monitoring meetings when the Person Centered Support Plan is being developed
- calling the member after support plan meetings to gauge level of satisfaction with the plan that was developed,
- offering the member a choice of a service coordination provider that does not provide HCBS services to the member

Ensuring Quality

The Sunflower Service Coordinator will route any identified quality of care concerns or member complaints to Sunflower's quality department. The Sunflower Service Coordinator may provide information to the member about assistance offered through the Disability Rights Center, the Self-Advocacy Coalition of Kansas or other rights and advocacy groups as would be helpful to the member.

Conflict of Interest Policy

Sunflower complies with the State's existing Conflict of Interest policy regarding members who have legal representatives who are paid caregivers for the member. This includes making sure that the legal representative has either court permission to make decisions for the member and to be paid, or has an Appointed Designated Representative who participates in service plan meetings to help make sure the member's preference are honored regarding HCBS services.

sunflower health plan

5.5.5.5

PROVIDER NETWORK – NEMT STANDARDS

10. Confirm and explain how Centene will meet the State's requirements regarding NEMT.

Sunflower confirms that it will meet the State's requirements regarding NEMT. Our approach to complying with KanCare 2.0 NEMT service standards is built on a robust, ongoing, high-touch NEMT performance monitoring program to ensure quality and compliance with KanCare 2.0 requirements by our NEMT vendor, LogistiCare. LogistiCare has demonstrated reliability and responsiveness to member needs with an ability to meet and, in many cases, exceed the goals set forth in the KanCare 2.0 contract. More than 470 contracted providers serve every county in the state to drive members to and from medical appointments. In 2017, member trip volume averaged 5,311 per month. According to LogistiCare's latest report of on-time performance, 92% of trips to medical appointments were on-time. Our 2017 performance results demonstrate outstanding access to transportation services. Sunflower's NEMT performance monitoring program includes the following components.

FREQUENT ENGAGEMENT WITH LOGISTICARE

Sunflower interfaces multiple times per week with LogistiCare to address a variety of operational topics. Additionally, we conduct regularly scheduled meetings with LogistiCare on a monthly and quarterly basis. Our cross-departmental, monthly meetings with LogistiCare are designed to resolve any barriers to transportation access and monitor service delivery. We conduct both local on-site visits and corporate-lead vendor audits so we can review and improve service from the perspective of national benchmarks, KanCare 2.0 requirements, and local needs. For example, these regular meetings contributed to a decline in the volume of reported member grievances related to transportation. Our annual site visits with LogistiCare allow us to review year-over-year performance and establish benchmarks and performance improvement strategies for the following year.

PERFORMANCE DATA COLLECTION AND ANALYSIS

Sunflower analyzes and conducts ongoing reviews of a wide array of NEMT service data, including the following key performance indicators (KPIs), to monitor LogistiCare's performance trends, identify improvement needs and develop solutions:

- Ridership by product
- Timeliness access standards for all trips, including urgent care and facility discharge trips, missed appointments, and no shows
- Levels of service provided
- Call answering performance standards
- Call quality audit reports
- TP Claims payments timeliness
- Transportation complaints and grievances and resolution

In addition to the above data analysis, we validate LogistiCare's performance using a variety of mechanisms such as reviewing feedback collected from member grievances, member feedback provided to our call center and case managers, and LogistiCare's member calls audited by Sunflower's call center.

CONTINUOUS NEMT PROCESS EVALUATION AND BEST PRACTICE DEVELOPMENT

To complete the performance monitoring process cycle, Sunflower includes ongoing process evaluation and improvement as a cornerstone of our NEMT performance monitoring program. Sunflower has an enterprise-wide commitment to quality operations, efficient and effective delivery of services, and continuous improvement. We require that commitment from all subcontractors and maintain policies, procedures, and workflows to ensure cross-organizational involvement in and support to solution improvement strategies. For example, as a result of member feedback and grievances received, we developed special processes and procedures to assist members who experience in-transit issues, such as delayed service, including a designated team to handle real-time member transportation needs. These process adjustments have contributed to a year-over-year decline in transportation-related member grievances filed.

5.5.12

PROVIDER NETWORK - AVOIDING AND DISCLOSING POTENTIAL CONFLICTS OF INTEREST

11. Confirm that "State" means KDHE and KDADS.

Sunflower confirms that "State" is referring to KDHE and KDADS.

This page intentionally left blank

5.6.5

PROVIDER SERVICES - CUSTOMER SERVICE CENTER – PROVIDER ASSISTANCE

12. Please confirm process for tracking and overseeing activity of Subcontractors.

SUBCONTRACTOR OVERSIGHT AND TRACKING PROCESS

Sunflower provided a description of general subcontractor oversight processes in our response to Section 5.5.13.F of the KanCare 2.0 RFP. Below we describe Sunflower's subcontractor oversight and tracking processes for subcontractors to which customer service center responsibilities are delegated.

Multi-Layer Risk Management Approach

Sunflower will implement a multi-layer risk management approach to monitoring and evaluating our subcontractors' performance, including those subcontractors to which we delegate customer service center responsibilities such as LogistiCare, our Non-Emergency Medical Transportation (NEMT) subcontractor. We confirm that Sunflower and all subcontractors responsible for customer service center functions comply with all state requirements.

Following KDHE approval, Sunflower will leverage the Subcontractor Oversight Program of our parent company, Centene, with monitoring and oversight processes are built upon lessons learned and proven practices of our affiliate health plans. Sunflower, with support from Centene, 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 a local, dedicated Subcontractor Oversight team, which works in collaboration with the Quality and Compliance teams, located at the Sunflower office.

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 Centene Compliance staff; National Contracting; Information Technology staff; Sunflower and Centene 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. Sunflower's oversight and tracking processes for subcontractors to which we delegate customer service center functions will include monitoring compliance with service level requirements for operating a customer service center as outlined in the KanCare 2.0 contract. Sunflower ensures subcontractors successfully complete a pre-delegation audit,

reviews and analyzes data reporting submitted by subcontractors, and holds subcontractors accountable to established performance standards. Sunflower's subcontractor agreements require subcontractors to be held to the same standards required of us by KDHE. For subcontractors such as LogistiCare, who assume responsibility for customer service center functions, a Sr. Call Center Manager listens in on calls with LogistiCare customer service representatives when performing annual site visits to monitor performance against service level agreement expectations. Sunflower also has the ability to review subcontractor customer service call recordings at any time if a concern regarding call quality is identified. In addition, Sunflower business owners conduct Joint Oversight Committee (JOC) meetings with the subcontractor and other Sunflower representatives as needed at least quarterly, or more frequently if necessary, to review overall subcontractor performance 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 (QIC). 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, Subcontractor Oversight staff, in collaboration with Sunflower Quality and Compliance staff, will review required reports to ensure compliance with performance standards, and, on a quarterly basis, provide performance reports to the 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.

Annual Subcontractor Audits. Leveraging the experience of Centene's 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.

Monitoring Compliance through 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:

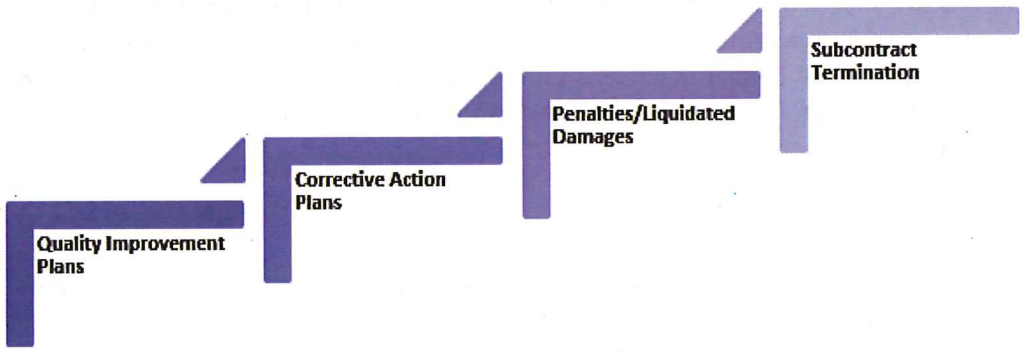
- Subcontractor Oversight Program Descriptions and corresponding Policy & Procedures
- Assessment reports
- Evidence of subcontractor adherence to performance standards (i.e. Dashboards)
- Minutes from key meetings (i.e. Joint Oversight Committee)

REPORTING SUBCONTRACTOR NONCOMPLIANCE

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 five business days of discovering any such non-compliance.

REMEDIES FOR SUBCONTRACTOR PERFORMANCE ISSUES

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. Sunflower expects 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
- 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. In one year alone, between 2015 and 2016, based on changes implemented by LogistiCare, we achieved a 31% reduction in grievances.

This page intentionally left blank

5.8.3.1

UTILIZATION MANAGEMENT - SOCIAL DETERMINANTS OF HEALTH AND INDEPENDENCE

13. How does Centene incorporate identified SDOH needs into the member's plan of care?

Sunflower utilizes several methods for identifying Social Determinants of Health and Independence (SDOHI) needs. Our current assessment tools, including our Health Risk Assessment Tools and Quality of Life Assessement tool, includes questions about SDOH, and our person-centered support planning process includes questions about each member's existing and preferred lifestyle and self-identified barriers, including SDOHI needs. Further supporting these efforts, we are working collaboratively with KAMU, the Primary Care Association of Kansas, on implementation of the innovative Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE) model at community-based health centers (CHCs). The PRAPARE assessment tool is designed to assess for and address SDOHI, emphasizing measures that are actionable. As part of implementation, we will work with CHCs to allow individual member results to be shared with Sunflower and made available to the assigned Service Coordinator (SC).

All assessment results are used as the basis of each member's Plan of Service or Person-Centered Service Plan (PoS/PCSP). The PoS/PCSP addresses physical health, behavioral health, functional needs, emergency back-up planning, and SDOHI. Once a SDOHI need is identified, that need is captured in the PoS/PCSP and the primary SC (either internal or external) discusses with the member, and member's team, options for addressing the need. Member goals and steps to achieving goals, including activities related to SDOHI, are captured in the PoS/PCSP as agreed to by the member.

Supporting the PoS/PCSP and progress on SDOHI related goals, the SC discusses with the member, and the member's team, who will take responsibility for completing each step for each goal. For example, this may include the SC assisting the member with contacting a community organization, or provider. Or, it may include another person in the member's circle of support assisting the member with exploring local resources. It may also include a referral to Sunflower's SDOHI Center of Excellence team for consultation supports.

Member progress on PoS/PCSP goals and activities, including covered and non-covered services, is monitored by the SC through regular contacts with the member to review each goal and determine if progress is being made or if the goal or steps need to be revised. Through this process, the member may identify a barrier to receiving covered services that is a direct result of a SDOHI. For example, the inability to keep medication refrigerated due to utilities being shut off. Members have the choice to change or modify their PoS/PCSP at any time. Once a member has met a goal, the SC will assist the member to determine other goals the member may want to work on to further address a need, eliminate a barrier, or to address a different need or barrier. In addition, Sunflower has a quality of life dashboard comprised of member report data on different quality of life metrics including employment, living arrangement and community access.

This page intentionally left blank

sunflower health plan

KAMU unity advocacy
THE PRIMARY CARE ASSOCIATION OF KANSAS

Joint Committee on KanCare Oversight
April 23, 2018

Chairman Hawkins and members of the committee – My name is Denise Cyzman, and I am the Executive Director of the Kansas Association for the Medically Underserved, also known as KAMU. I am here today to share an example of our collaborative work with Sunflower Health Plan.

First of all, I would like to express our appreciation to Chris Coffey for meeting with KAMU over the past two years to support Kansans' access to quality, appropriate health care and preventive services, in culturally-appropriate and community-based clinics. It was during conversations last fall that KAMU proposed three initiatives that Sunflower might collaborate with us. Sunflower was interested in our approach to utilize the community health worker model to facilitate practice transformation.

For the purpose of this project, practice transformation will include the integration of evidence-based best practices into clinic workflow, conducting educational and training events for the clinic staff as well as for targeted population and individualized technical assistance. This approach includes integrating and utilization of a social determinant of health collection tool (PRAPARE[1]), which has been nationally tested among community health centers.

Sunflower Health Plan will work with KAMU and the clinic to select targeted improvement measures, goals and establish quality improvement payments for reaching outcome goals.

This collaborative approach will leverage the efforts of the health plan, the clinic and KAMU to develop sustainable process improvements; support clinic efforts to improve health literacy through a culturally sensitive approach, while promoting a transition toward a value-based payment structure.

We thank Sunflower for their support of innovative approaches to care and working together to examine how together we can provide support to the clinics as they strive to enhance the healthcare system and improve the health of their communities. We look forward to working with them on this and other projects in the future.

[1] Additional information on the PRAPRE tool is found at: http://www.nachc.org/research-and-data/prapare/

This page intentionally left blank

ATTACHMENT D: 4.1, 4.2, 4.4.1, 4.4.2, 4.5.1, 4.5.2, 5.1, 5.2, 5.5.2

GRIEVANCE AND APPEALS

14. Please verify whether you establish policies and procedures for all activities described in the procurement for member and provider grievances and appeals systems and processes.

ESTABLISHED POLICIES AND PROCEDURES

Sunflower has established written policies and processes that complies with the current State contractual requirements and Sunflower would make any necessary updates to those policies and processes to ensure compliance with KanCare 2.0. Those revisions/updates would be submitted to KDHE for review and approval as per procedure prior to implementation.

This page intentionally left blank

5.14.1

CLAIMS MANAGEMENT - TIMELY CLAIMS PROCESSING

15. Does Centene meet the contractual requirement for the State's definition of clean claims?

Sunflower has adopted the State of Kansas's definition of clean claim: A clean claim means the definition set forth in 42 C.F.R 447.45, as amended. As of the effective date of a contract, such definition is a claim that can be processed without obtaining additional information from the provider of services or from a third party. It includes a claim with errors originating from the state's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

(This is also referenced in our provider manual for provider reference and consistent with the information in the RFP. This is aligned with standard federal definition of a clean claim in which Centene follows for the enterprise).

This page intentionally left blank

5.15.1

INFORMATION SYSTEMS - HEALTH INFORMATION TECHNOLOGY AND HEALTH INFORMATION EXCHANGE

16. Please explain your SUD process.

Sunflower Health Plan recognizes the importance of protecting members' right to privacy and confidentiality. Our Health Information Technology and Health Information Exchange activities comply with 42 CFR part 2: Confidentiality of Alcohol and Drug Abuse Patient Records, and the Substance Abuse & Mental Health Services Administration's (SAMHSA) regulations governing the Confidentiality of Substance Use Disorder Patient Records updated in the Final Rule effective February of 2018.

SUD PROCESS AND IMPACTING CARE

Utilization Management (UM) team, to receive SUD service requests and communicate authorization with providers. It is a longitudinal record that provides information about this activity over time to those who access the system. The KCPC biopsychosocial assessment provides critical and updated member information that Sunflower uses to improve health outcomes. With member consent, information is shared with providers and supports a comprehensive view of the member's experience and treatment they have received.

Our UM Team apply the KCPC when reviewing authorization requests for SUD services from our providers. Our UM Team document their application of KCPC in TruCare for purposes of ensuring that we consistently apply KCPC, and for any State auditing or reporting purposes. Additionally, UM team members place referrals to care coordinators who are responsible for member and provider outreach. Our care management program prioritizes members who are at higher risk, such as, pregnant with substance use, intraervenious drug use, residential services, etc. Sunflower's SUD Care coordination program has demonstrated statistically significant improvement in SUD treatment, initiation and engagement rates when compared to those not in care coordination as shown in the table below.

Measurement Year 2016

HEDIS Measure	Enrolled in Care Coordination	Not enrolled in Care Coordination
Initiation of SUD Treatment	49.6%	35.8%
Engagement in SUD Treatment	19.03%	11.81%

**statistically significant*

USE OF HIT AND HIE TO DRIVE CARE MANAGEMENT STRATEGY

MyStrength

Sunflower augments the SUD process described above with 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 MyStrength site also encourages members to take advantage of self-assessments that are available to gain better understanding into managing their own care. Sunflower currently recommends MyStrength

to all members to ensure everyone has access to an evidence based behavioral health self-management tool. Sunflower members who participate in MyStrength have statistically significant higher rates of initiation and engagement in substance use disorder treatment than members who do not participate in MyStrength as shown in the table below:

Measurement Year 2016

HEDIS Measure	MyStrength Users	Non-users
Initiation of SUD Treatment	54.72%	38.24%
Engagement in SUD Treatment	28.93%	12.7%

**statistically significant*

Expanding on MyStrength

The MyStrength member interface improves has proven successful outcomes to interface with the member and facilitates recovery. Although providers can refer members to MyStrength, they are unable to see their patients' MyStrength activity. Sunflower will expand on MyStrength this effective Health Information Technology to close the loop with the member's provider through the MyStrength provider portal. This Health Information Exchange will allow the member's provider to see the member's activity, support their progress and identify opportunities to strengthen the impact of their treatment.

LIFT and SUD Segmentation

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 and allows Sunflower to anticipate needs to formulate a true population health approach.

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 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. For example, interventions for individuals in the highest cost segment involve intensive treatments such as a

combination of medication management and case management. In contrast, interventions for segment 6 are focused on prevention. 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.

LIFT - Learn. Identify. Follow. Treat

LIFT predictive models specialize in early identification and prevention, before a high-risk individual's substance abuse worsens. Proactive identification of members that are likely to migrate from one segment to another allows targeted interventions.

This page intentionally left blank

ATTACHMENT H

DATA COLLECTION AND REPORTING

17. Centene's response was not provided directly to Attachment H. Does Centene have existing reporting that meets the detailed requirements in Attachment H, or does Centene have plans to provide the required reporting with demonstrated timelines for compliance?

Sunflower can fuly support the required reporting with demonstrated timelines for compliance. For all new reporting requirements, Sunflower will have the reports and infrastructure in place to meet the requirements by the contract start date.

This page intentionally left blank

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
1. Grievance and Appeal Reports(GAR)/ Appeals Resolution Timeframe	Report summarizing formal grievance and appeals including those related to physical and behavioral health, long term services and supports (LTSS), and pharmacy services, administrative law hearing requests and informal inquiries and resolutions. The report must also incorporate any grievance and appeals data related to determinations performed by a contracted entity on behalf of the CONTRACTOR(S). The GAR report must contain Member grievance, appeal and State Fair Hearing data, as well as Provider Reconsideration, Appeal and State Fair Hearing data. The report lists complaints from escalation to grievance. Types of appeals include: • Standard appeals: Numerator: Number of appeals resolved within 14 to 30 days. Denominator: Total	Quarterly	Y	Y	Y	**Key Elements** • Member Appeals, Grievances, State Fair Hearing and Provider Appeals, Grievances, Reconsiderations, and State Fair Hearings data are collected both within Sunflower and our Vendors. o Internal data ▪ Sunflower Health Plan (SFHP) data is collected by using MS SQL Server to query the OFLSQLDP902 database which stores CRM data. This includes both Member and Provider Appeals, Grievances and State Fair Hearings data. ▪ SFHP Provider Reconsiderations are collected from paid claims data using reconsideration based adjudication status reason codes within Teradata in the EDW database. ▪ Additional Provider Appeals data is sent to SFHP in an Excel template from the claims processing unit. ▪ Provider Grievances case data is pulled using CRM reporting functionality and is placed into Excel for reporting purposes. o Vendor data ▪ Evolve People Care submits Member Appeals, Grievances and Provider Appeals, Grievances and Reconsiderations data in an excel template. ▪ Evolve Dental submits Provider Appeals, Grievances and Reconsiderations data in an Excel template.

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
	number of standard appeals. • Expedited appeals: Numerator: Number of expedited appeals resolved within 3 business days. Denominator: Total number of expedited appeals received.					▪ Evolve Vision submits Provider Appeals, Grievances and Reconsiderations data in an Excel template. ▪ National Imaging Associates (NIA) submits Member Appeals data in an Excel template. • The above data is collected together and imported into HP_KS_OWN_TABLES, the SFHP analytics data base, using TOAD Data Point importation tools through a Teradata connection. o During the importation process additional internal data, (Vendors already supply this data) is pulled in from the EDW database using Teradata queries to populate Type of Waiver, LOC and Nursing Facility membership data. ▪ Type of Waiver is figured using HCBS related Health Status codes tied to the member's eligibility. ▪ Nursing Facility status is figured using NF related Health Status codes tied to the member's eligibility. ▪ LOC is used from the PL Premium Level Description tied to the member's eligibility. • Teradata is then used to query the GAR data stored in the HP_KS_OWN_TABLES database. o Member Summary data: Both received and resolved Member based Appeals, Grievances and State Fair Hearings stored in the HP_KS_OWN_TABLES database are queried with Teradata to provide the result set. o Provider Summary data: Both received and resolved Provider based Appeals, Reconsiderations and State Fair hearings stored in HP_KS_OWN_TABLES database are queried with Teradata to provide the result set.

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
						▪ Provider Grievances case data from step (1aiv) stored in excel is also utilized. o Member Grievances: Resolved Member Grievance data stored in HP_KS_OWN_TABLES database are queried with Teradata to provide the result set. o M&P Appeal Reason Summary/M&P Appeal HCBS Summary/M&P Appeal NF Summary: Resolved Member and Provider Appeals stored in HP_KS_OWN_TABLES database are queried with Teradata to provide the result set. ▪ HCBS members are identified by the member's Type of Waiver determined either in steps (1b) for vendor data or in (2ai) for internal data. ▪ Nursing Facility member status is identified by the NF status determined either in steps (1b) for vendor data or in (2aii) for internal data. o Member Appeals: Resolved Member Appeals data stored in HP_KS_OWN_TABLES database are queried with Teradata to provide the result set. o M & P SFH Reason Summary/ M & P SFH HCBS Summary/ M & P SFH NF Summary: Resolved Member and Provider State Fair Hearings stored in HP_KS_OWN_TABLES database are queried with Teradata to provide the result set. ▪ HCBS members are identified by the member's Type of Waiver determined in step (2ai). ▪ Nursing Facility Status is determined in step (2aii). o Member State Fair Hearings: Resolved Member State Fair Hearing data stored in the HP_KS_OWN_TABLES database are queried with Teradata to provide the result set.

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
						○ Provider State Fair Hearings: Resolved Provider State Fair Hearing data stored in the HP_KS_OWN_TABLES database are queried with Teradata to provide the result set.
2. Grievances - Transportation	Monthly report of grievances pertaining to transportation issues including no shows, late, and safety issues.	Monthly	**Y**	**Y**	**Y**	**Key Elements** • Transportation grievances are queried for the EDW system using Teradata to return the following information for any resolved grievances within the time frame reporting: ○ Date requested ○ Date received ○ Medicaid ID ○ Relationship to person filing grievance ○ Reason for grievance ○ Grievance narrative ○ Date completed ○ Days to resolve ○ Resolution details ○ Date of resolution ○ Provider type ○ Provider Name

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
						○ Member Level of Care information ○ Internal Identifier ○ Date of Acknowledgement Letter ○ Date of Resolution Letter **System Description** • Use MS SQL Server to query transportation related member grievances from the OFLSQLDP902 database. • Upload member grievance data from above into analytics database using Teradata. • Using Teradata, query uploaded grievance data from above with member eligibility data stored in EDW. **Submission Format** • The final result set is then placed in the report template in excel.
3. Preferred Drug List Report	List of prescription drugs, both generic and brand name that are preferred by the CONTRACTOR(S).	Monthly	**Y**	**Y**	**Y**	**Key Elements** • Weekly Preferred Drug file provided to Sunflower through SFTP and report is uploaded to Envolve Pharmacy Solution reporting database. • Database additionally houses data related to PDL categories based on state's provided PDL list. • After month's end, report is derived from matching paid claims at time of data pull with matching drugs from the weekly preferred drug file from previous month and matched to appropriate from PDL categories. • Report's raw data is being received from Envolve Pharmacy every month which indicates the data for the previous month.

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.

						• The data is broken down into the following categories based on the PDLs
						  ○ Total Preferred
						  ○ Total Non-Preferred PA Required
						  ○ Total Non-Preferred
						
						System Description
						• Sunflower SFTP site is used to receive data from Envolve Pharmacy directly
						• Data is uploaded into Sunflower's internal database to perform all the calculations required for the report.
						
						Submission Format
						• Final report is submitted in excel format matching state reporting requirements.

4. Prior Authorization Pharmacy Summary	Summary report of pre-authorizations. Metrics include:
	• Total standard pre-authorizations:
	  ○ 0–5 days
	  ○ 6–14 days
	• Total expedited pre-authorizations:
	  ○ 1 day
	  ○ 2–3 days
		Monthly	**Y**	**Y**	**Y**	**Key Elements**
						• Monthly report is ran based on drugs that would fall in PDL and clinical pharmacy and state provided J-codes for physician administered datasets for authorizations.
						• Prior authorization turnaround time is based off received date compared to completion date.
						• PDL and Clinical Pharmacy data is submitted to Sunflower monthly from Envolve and data is transformed into state reporting template along with Sunflower's data output for physician administered data to include the following.
						  ○ PDL Pharmacy

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
						○ Approved by UR ○ Approved by auto PA ○ Approved Amount ○ Denied by UR ○ Denied by auto PA ○ Estimated denied amount ○ Total # ○ Cost ○ Allowed PA months **System Description** • Data is housed within Envolve Pharmacy Solution database for PDL and Clinical Pharmacy PAs. And Physician Administered data is held within Sunflower's internal database. **Submission Format** • Final report is submitted in excel format matching state reporting requirements.
5. Step Therapy Savings Report	Utilization savings per month for Step Therapy.	Monthly	Y	Y	Y	**Key Elements** • Step therapy logic is created specific for each step therapy policy based on state report requirements. • At month's end, Envolve runs an automated report for each policy for rejected claims with a rejection for prior authorization needed for step therapy and data output from report is provided to Sunflower including the following each month. ○ Step Therapy Criteria ○ Total quantity of step therapy drug submitted units rejected

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
						○ Step therapy drug paid amount estimated units paid ○ Required step through drug paid amount ○ Estimated step therapy savings **System Description** • Data received from Envolve through SFTP site and inputted into state reporting template. **Submission Format** • Final report is submitted in excel format matching state reporting requirements.
6. Title 21 Vaccine report	Summary of number of vaccines paid for Title XXI children; stratified by age range and vaccine type.	Quarterly	Y	Y	Y	**Key Elements** • Members must be eligible for Title 21 at the date of services for one of the 31 specific vaccines. • Member's age is calculated based on the date of service to break into specified age ranges and all vaccines received are totaled for each of the following age ranges. ○ Birth ○ 1 – 2 Years ○ 3 – 6 Years ○ 7 – 18 Years ○ 19 Years ○ Grand total **System Description** • Data is pulled from the Enterprise Data Warehouse using Teradata for vaccines with dates of service in the reporting period.

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
						Submission Format • Final report is submitted in excel format matching state reporting requirements.
7. Medication Therapy Management Monthly Report	Summary of medication therapy management cases completed, including the number of comprehensive medication reviews, generated and completed number of targeted medication reviews, generated and completed number of patient and pharmacist declined cases, and number of participating pharmacies.	Bi-Annually	Y	Y	Y	**Key Elements** • Outcomes monthly provides data matching reporting requirements to Sunflower for previous month MTM activities. • Sunflower inputs received data into state report template broken down into the following categories. o CMR ▪ Cases created ▪ Cases completed • Served successfully • Patient denied • Pharmacist declined ▪ Total # of pharmacies with CMR cases ▪ # of pharmacies with successful CMR claims o TMR ▪ Cases created ▪ Cases completed ▪ Total # of pharmacies with TMR cases ▪ # of pharmacies with successful TMR claims **System Description** • Outcomes MTM handles all medication therapy management processes and also houses their MTM data. **Submission Format**

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
						• Final report is submitted in excel format matching state reporting requirements.
8. Prescription Prior Authorization Override Report	Report of prior authorization overrides with the following parameters: • 3-day • 5-day • 60-day • Override codes	Monthly	Y	Y	Y	**Key Elements** • Data will be derived for claims where override was completed at POS for 11112222333, claims was paid, and day supply was given for 3, 5 or 60 days. **System Description** • Prior Authorization override data housed within claim adjudication system and data is flowed into Envolve' s claims database • Data is contingent on PBM supplying data to Envolve. **Submission Format** • Summary will be provided based in excel matching the state report template.
9. Provider Participation - Adverse Actions Taken Against Providers	Report of any adverse action taken against a provider's participation in the program, including credentialing denials for fraud-related concerns.	Monthly	Y	Y	Y	**Key Elements** • Microsoft Excel is used to include the following provider specific information regarding adverse actions taken: o Date of adverse action o Provider name o NPI o Reason for adverse action o Date notified HHS-OIG o Prepay review o Withhold/suspension of payment o Repayment or Overpayment

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
						○ Corrective action plan ○ Termination for cause ○ Denial or credentialing/re-credentialing due to fraud/abuse **System Description** • Adverse Actions: ○ Prepayment - Healthcare Fraud Shield (HCFS) QueryShield System ○ Termination for Cause - SharePoint Site ○ Repayment of Overpayment - Compliance C360 System and AMYSIS • Sunflower Vendor Adverse Actions: RPD (Radiology Provider Database) System and Portico **Submission Format** • Final report is submitted in excel format matching state reporting requirements.
10. Overview of Corporate Compliance Department Activity	Activity report of Corporate Compliance Department to include: Name of compliance officer, meeting topics, staff training and education overview, communications to staff, disciplinary measures, and corrective actions.	Quarterly	Y	Y	Y	**Key Elements** • Data is pulled for any compliance related activity that occurred during the reporting period including: ○ Quarterly compliance committee meetings ○ New employee orientation ○ Business orientation ○ Any compliance trainings ○ Newsletter or email communications • A brief overview of any disciplinary measures that occurred including: ○ Enforcement of disciplinary measures ○ Identifying the internal monitoring/auditing activities

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
						○ Detected offenses ○ Response/corrective action imposed to correct offense **System Description** • Data is housed within multiple internal secure drives **Submission Format** • Final report is compiled and submitted in excel format matching the state requirements
11. Payment Integrity Report	Report of cost avoidance efforts through front-end edits and dollar amounts identified and recovered through Fraud, Waste and Abuse detection efforts.	Quarterly	Y	Y	Y	**Key Elements** • Costs avoided a determined by reviewing claims for specific rationale. • All avoided claims are totaled and bucketed into the following: ○ Bundling ○ Prior Authorization ○ MRI Edits ○ Psych DRG on Review ○ Medical Review ○ Medical Necessity ○ Suspect Duplicate ○ Manual Pricing • Possible payment issues are identified and reviewed by operations to determine if an overpayment was made. • All recouped claims are grouped into one of the following categories for reporting: ○ SUR ○ Medicare A & B ○ Private Health Insurance

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
						○ Special TPL ○ Medical Subrogation **System Description** • Claims data is pulled from our EDW using Teradata. • The following systems identify possible overpayments ○ CDR ○ Cotiviti ○ HMS ○ Optum ○ Equian ○ Rawlings ○ First Recovery Group ○ Aarete **Submission Format** • Final report is submitted in excel format matching state reporting requirements.
12. Disclosure of Ownership	Quarterly review of random sample of revalidated and newly contracted Participating Providers.	Quarterly	Y	Y	Y	**Key Elements** • The provider/practitioner list for the quarterly DOO report is pulled at the health plan and data is pulled from portico to include the following: ○ Provider Name ○ Individual or Entity/Group ○ Primary Address (street, state, zip) ○ Credentialed or Re-Credentialed ○ Tax ID ○ NPI

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
						• The report is sent to Sunflower's Corporate Credentialing team to pull all of the supporting documentation that is required including: o Date DOO received o Date Provider Contract Executed o Completed Prior to Contract (Y/N) o Verify Licensure (Y/N) o Checks completed prior to contract (Y/N) o Pass/Fail o Corrective Action Plan if Fail **System Description** • Provider data is stored within Portico **Submission Format** • Final report is submitted in excel format matching state reporting requirements. • All supporting documentation is compiled and reviewed prior to submission in pdf, excel and word formats.
13. Program Integrity Risk Assessment	CONTRACTOR(S) and SUBCONTRACTOR(S) assessments of Fraud, Waste, Abuse and Payment Integrity procedures. List top five vulnerable areas and corresponding mitigation plans.	Annually	**Y**	**Y**	**Y**	**Key Elements** • FY16 report and FY15 reports were PDF documents submitted containing the top FWA risks and mitigation plans as determined by the plan. **System Description** – N/A **Submission Format** • Final report is submitted in PDF format matching state reporting requirements.

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
14. Fraud and Abuse Report-MEMBER and PROVIDER	Status report of fraud and abuse investigations. Report to include both Member and provider summary statistics and lock in statistics.	Quarterly	Y	Y	Y	**Key Elements** Microsoft Excel is used to provide the following member or provider specific information: **MEMBER** • Date reported to or discovered by the health plan • Referral source • Suspected Fraud, Abuse, Waste and Neglect • Member Name • Medicaid ID • Date of Birth • Nature of complaint • Investigative actions **PROVIDER** • Referral source • Date investigation/audit opened • Date investigation/audit closed • Suspected Fraud, Abuse, Waste and Neglect • Provider Name • Provider NPI • Type of Provider • Nature of complaint • Investigation/audit status • Investigation/audit outcome • Overpayment • Reason investigation/audit continues beyond 90 days **System Description** • Member Fraud/MCO Provider FWA and all Vendor FWA (except transportation): Healthcare Fraud Shield (HCFS) QueryShield System • LogistiCare FWA: LogistiCad (LCAD) System

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
						• MCO PI Projects: AMISYS and Compliance C360 **Submission Format** • Final report is submitted in excel format matching state reporting requirements.
15. Provider Participation - Adverse Actions Taken Against Providers	Summary of adverse actions of provider participation. Report to include corrective action plans and timelines as well as an indication of reports to the Department of Health and Human Services' Office of the Inspector General (HHS-OIG).	Monthly	Y	Y	Y	**Key Elements** Microsoft Excel is used to include the following provider specific information regarding provider exclusions: • Date exclusion identified • Name or Provider/Person • NPI • Exclusion list(s) and/or site(s) in which the match was found • Termination for cause (exclusion) • Denial of credentialing/re-credentialing due to exclusion • Other • Date Provider/Person notified of action • Date state notified **System Description** • Exclusions: OIG/HHS LEIE Database, CAQH Universal Provider Source Track Module **Submission Format** • Final report is submitted in excel format matching state reporting requirements.

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.

16. Verification of Services Provided	Reimbursed services performed by Participating Providers verification report.	Monthly	Y	Y	Y	**Key Elements**
						Microsoft Excel is used for tracking of the health plan response to member follow-up on service received verification letters including:
						• Number of letters sent to members
						• Number of responses received (the following is tracked for any response)
						  • Member Name
						  • Medicaid ID
						  • Concern
						  • Action/response/outcome
						System Description
						• Compiled and tracked using SQL Server tables and Change Health.
						
						Submission Format
						• Final report is submitted in excel format matching state reporting requirements.

17. Customer Service Report, Member Services and Provider Services Phone Line Report, Telephone and Internet Activity Report Call Center Access and Responsiveness Report	Reports from CONTRACTOR(S)/Subcontractor(s)) is to monitor Member and provider services, nurse/triage nurse advice and utilization management lines to include but not limited to:
	• Total calls received
	• Calls abandoned within 30 seconds
	• Percent abandoned
	• Average talk time
		Monthly
		
		Quarterly and Annually
			Y	Y	Y	**Key Elements**
						• Call center data is held in CMS Support System which has a large content table breaking down each required metric for both provider and member calls including:
						  ○ Total calls offered
						  ○ Total calls handled
						  ○ Average seconds to answer
						  ○ Average length of call
						  ○ Total number of calls placed on hold
						  ○ Number of calls transferred
						  ○ Abandon volume
						  ○ Abandon rate

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
	• Average speed of answer • Percent answered within thirty (30) seconds Reports to monitor: • Call volume • E-mail volume • Average call length • Average hold time • Blocked call rate • Original contact resulting in grievance					**System Description** • CMS Supervisor Report is used to pull all call related data. • Customer service supervisors track each voicemail by time, date/time received, name, phone number, details of message, Member/Tx ID, Call back date/time, and comments within excel in regards to email volume. • The Verizon website is utilized to track the blocked call rate. • The types of inquiries are pulled to determine top reasons for any inquiry. **Submission Format** • All data is combined and the final report is submitted in excel format matching state reporting requirements.
18. IDD Residential Policy	Update of MCO's implementation of State IDD Residential Pay Policy.	Monthly	Y	Y	Y	**Key Elements** • Data is pulled for the Enterprise Data Warehouse for IDD specific members based on current level of care who are receiving residential services (T2016). • The total number of days used is calculated on a monthly basis for each member • Total days is then compared to the same month in the previous year to look for any member who has had a decrease in total days. o Prior year IDD members o Current year IDD members o Prior year Paid Claims o Current year Paid Claims o Unique members impacted o Days impacted o Total savings

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
						• Each member days fewer received is multiplied by the corresponding tier rate to create a potential monthly savings and summarized by tier. **System Description** • Data is pulled from the Enterprise Data Warehouse using Teradata for IDD specific members in the reporting period. **Submission Format** • All data is combined and the final report is submitted in excel format matching state reporting requirements.
19. IDD Program Report	Implementation report of status for network development, claims processing, issues, grievance and appeals, Member management, person centered service plan (PCSP) turnaround times, provider outreach and critical incidents.	Monthly	Y	Y	Y	
20. Home and Community Based Services (HCBS) PCSP Report	Report of any fluctuation in plans of care by HCBS, HCBS-TC and WORK programs for Members and units.	Quarterly	Y	Y	Y	**Key Elements** • Quarterly, POC data from previous quarter is extracted from Centene's internal database and transferred Sunflower's internal database. ○ POC data based on state requirements for POC services for HCBS, HCBS-TC and WORK program. • Utilizing data housed within Sunflower's internal database, current reporting POC quarter data is compared to previous reporting POC quarter to determine fluctuations for each member.

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
						• Member data is broken down by waiver type to show o Total units of increase o Unduplicated members with HCBS POC increases o Average units of increase per member per month **System Description** • HCBS, HCBS-TC and WORK program plan of care data is housed within the Centene's internal database after services inputted through TruCare management system. **Submission Format** • All data is combined and the final report is submitted in excel format matching state reporting requirements.
21. Extraordinary Funding	Report of status of persons reimbursed with extraordinary funding, authorizations for extraordinary funding, review date, approvals and denials with explanation and dates of communication to the community service provider of the status of extraordinary funding.	Quarterly	**Y**	**Y**	**Y**	**Key Elements** • Quarterly, Extraordinary funding members are reviewed internal to determine qualification • Member specific information including the following are collected: o Request Date o Medicaid ID o Assessment status o Review date o Decision (approve or deny) o Denial reason (if request denied) o Provider o Date of notification **System Description**

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
						• Member information is input and returned through TruCare management system **Submission Format** • All data is combined and the final report is submitted in excel format matching state reporting requirements.
22. KanCare LTSS Oversight Report	Hiring status report of service coordination positions, service coordination turnover rate, caseloads, LTSS enrollment, and service coordination contacts for Members, annual reviews and Money Follows the Person (MFP) referrals.	Monthly	Y	Y	Y	**Key Elements** • Each section is determined by the following and housed within excel: • LTSS Care Coordinator Positions o HR provides a monthly report on this section with exception of average, high, and low case load sizes, in which regional medical management managers pull case load sizes. • LTSS o Specific members identified on the 834 • LTSS Care Coordination Contacts o New Member Initial • LTSS Care Coordination Contacts o Transition Members • LTSS Care Coordination Contacts o On-going members • LTSS Care Coordination Contacts o Annual Reviews • Money Follows the Person. o Medical Management department tracks total number MFP members.

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
						System Description – N/A **Submission Format** • All data is combined and the final report is submitted in excel format matching state reporting requirements.
23. RADAC Referral Reporting	Report that includes names of Members referred, date of referral, date of initial contact, first date of service, CONTRACTOR(S) service coordinator name, last service coordinator contact, service coordination hours provided, Medicaid services being provided including primary, secondary and others, examples of referrals made, housing status, employment status, SUD treatment, connection to behavioral health services and any barriers in contact or service provision.	Monthly	Y	Y	Y	**Key Elements** • Data is collected through Intensive Case Management Services from RADAC regarding any member in need of case management services. • Member specific information including the following is collected: o Date of referral o Date of initial contact o Date of first service o MCO Care coordinator name o Last CC contact o Case management hours provided o Medicaid services being actively provided o Referrals o Housing status o Employment status o SUD Treatment o Connection to mental health services o Barriers in contact/service provision **System Description** – N/A **Submission Format**

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
						• All data is combined and the final report is submitted in excel format matching state reporting requirements.
24. Screening, Brief Intervention and Referral to Treatment (SBIRT) Summary Billing reporting	Screening, Brief Intervention and Referral to Treatment (SBIRT) Summary Billing reporting including number of Members screened, number of units billed, total dollar amount claimed, and number of claims received.	Quarterly	Y	Y	Y	**Key Elements** • Data is pulled from the Enterprise Data Warehouse using Teradata for all members who have received the following SBIRT services: o H0049 o H0050 o 99408 o 99409 • Member's age is calculated based on the date of service to break into specified age ranges of adult or adolescent. • Member's county of residence is captured to break down the report into specific regions. • Members receiving a service are totaled and broken down by quarter service was received (unduplicated). • Members are totaled by specific service (duplicated) with the total units and total amounts paid. **System Description** • Data is pulled from the Enterprise Data Warehouse using Teradata for members receiving SBIRT services within the reporting period. **Submission Format** • All data is combined and the final report is submitted in excel format matching state reporting requirements.

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
25. Value Added Benefits	Utilization report of Member population type plan benefits offered beyond the State Plan services.	Monthly	Y	Y	Y	**Key Elements** • Data is collected for any service provided to members as a value add along with the amount associated with • Member eligibility information will be determined by the level of care present at the date of service on the 834 file • Members will be broken down by waiver type for all value added services each year • 2017 included services such as: o Dental visits for adults o CentaAccount debit cards o Start Smart o Boys & Girls club o Practice dental visits for IDD members o Home visits o E-Learning for mental wellness o Pharmacy consultation o Frail & Elderly incontinence supplies o Adopt-a-school program o Smoking cessation o Lodging & Meals for inpatient care o Respite care o Weight management program o Disease management o In-home telemonitoring o Farmers market vouchers **System Description** • Data is pulled tracked through multiple source

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
						○ Internal claims system ○ Internal Member connections **Submission Format** • All data is combined and the final report is submitted in excel format matching state reporting requirements.
26. In Lieu of Report	Report of Medicaid allowable services and non-Medicaid services provided to the following populations: • Members on waiting list for C waiver who receive waiver-like services • Members that need additional waiver or different Medicaid services • Members eligible for Medicaid that require a non-Medicaid service regardless of waiver status	Monthly	Y	Y	Y	**Key Elements** • Members eligibility is determined based on the 834 file level of care • Claims data is pulled for members receiving: ○ Waiver services over the benefit limit allowed in the program ○ Waiver services from a waiver they are not currently eligible for ○ Waiver services when they are not eligible for a waiver ○ Services that are non-covered by Medicaid • Specific information for each service received during the reporting period is captured including: ○ Month incurred ○ Medicaid ID ○ Waiver type ○ Procedure provided ○ Procedure description ○ Per unit value ○ Total units used during the month ○ Value of service ○ Avoided procedure ○ Avoided procedure description

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
						○ Avoided unites ○ Cost avoided ○ Rationale for approval of In Lieu of Service **System Description** • Data is pulled from the Enterprise Data Warehouse using Teradata for dates of service in the reporting period. **Submission Format** • Final report is submitted in excel format matching state reporting requirements.
27. Geographic Mapping Reports (Geo-Access)	Geographic mapping report detailing single and multiple provider locations by category, modality(for example, xxx), region and county to include: • Urban/suburban • Densely settled • Rural/frontier Report must include separate maps for adult and pediatric populations and specify that at a minimum report must include the following: physicians, including specialists; vision; dental; hospitals; pharmacies; behavioral health Providers; and LTSS, per 42 CFR 438.68 requirements. In	Quarterly	**Y**	**Y**	**Y**	**Key Elements** • Sunflower Geo Network Report Analysis ○ Includes a pdf that describes the individual parts of the GEO and write-up of changes to network since last submission • Sunflower Geo Physical and BH Summary Table ○ Includes a pdf giving a one-sheet view of the specialties that have required maps • Sunflower GeoAccess Maps ○ Includes pdf of Maps, Accessibility Summaries, Accessibility Details, and hospital provider lists as described in Geo-Access Reporting Requirements document • Sunflower GeoAccess Summary Tables ○ Includes an excel workbook describing HCBS waiver providers and specialties without maps as described in Geo-Access Reporting Requirements document

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
	addition, this report must include analysis of any provider gaps and corrective actions for remediation of gaps.					**System Description** • Portico; Vendor data extracts (Portico); EDW (Member Data) • Golden • Teradata SQL Assistant • Microstrategy • Quest Analytics (Geocoding, Map Generation, Adequacy calculations and pages) **Submission Format** • All data is combined and the final report is submitted in excel format matching state reporting requirements.

28. Network Adequacy (Provider Network Report)	The CONTRACTOR(S) must provide reports for Medicaid /CHIP populations. These electronic reports must be in Excel and list all Providers' names and addresses, including primary care Providers (PCPs), LTSS Providers, and specialists per the State-provided report template. Providers must have an indicator for open/closed panels and include the number of Members assigned to each provider and provider's maximum caseload. This will be a full file replacement per quarter.	Quarterly	Y	Y	Y	**Key Elements**
						• Network Adequacy
						  o Includes Facilities and Individual Providers Par or Termed within the Calendar Year
						• Terminated Providers
						  o Includes Facilities and Individual Providers Par or Termed within Previous Years
						Both the Network Adequacy and Terminated providers include the following provider specific information:
						• Provider Name
						• KMAP ID
						• NPI
						• KS Provider Type
						• KS Specialty
						• County
						• Street Address
						• City/State/Zip
						• Credentialed

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
						• Panel Status • Effective Date • Term Date • Special Needs Accommodated • Panel Capacity Panel Count • Adult or Pediatric **System Description** • Portico; Vendor data extracts (Portico) • Golden • Teradata SQL Assistant • Microstrategy • Quest Analytics (Geocoding, Map Generation, Adequacy calculations and pages) **Submission Format** • All data is combined and the final report is submitted in excel format matching state reporting requirements.

29. Network Adequacy Utilization	Report with Providers by National Provider Identifier/Tax Identification Number (NPI/TIN), Total Paid, Total Claims (Header) and Total Members. Include both claim and Member counts by month. Must include separate reporting for adult and pediatric populations and specify that at a minimum report must include the following: physicians, including specialists; vision; dental;	Quarterly	**Y**	**Y**	**Y**	**Key Elements**
						• Paid claims data is pulled for all providers during the reporting period
						• The claims are pulled for all providers based on NPI and TIN
						  ○ Billing Provider Name
						  ○ Billing NPI
						  ○ Billing TIN
						  ○ Rendering Provider Name
						  ○ Rendering NPI
						  ○ Rendering TIN
						• A distinct claim count and unique member count is returned for each month

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
	hospitals; pharmacies; behavioral health Providers; and LTSS, per 42 CFR 438.68 requirements.					**System Description** • Data is pulled from the Enterprise Data Warehouse using Teradata for dates of service in the reporting period. • All subcontractor data is delivered via SFTP in excel **Submission Format** • Final report is submitted in excel format matching state reporting requirements.
30. Consumer Assessment of Healthcare Providers and Systems (CAHPS) Report	Analysis report of audited CAHPS results including but not limited to the CAHPS adult survey, CAHPS child survey and the CAHPS children with chronic conditions survey using the most current CAHPS version specified by the National Committee for Quality Assurance (NCQA). Track and trend all aspects of the survey including mitigation plans.	Annually	Y	Y	Y	**Key Elements** • Each survey contains a summary report which provides a summary of the following: o Survey o Scoring o Demographic information on respondents o Analysis of strengths/opportunities. • An individual "tabs" report is included which provides data on responses per each question to include demographic details related to responses of each survey question. **System Description** • Data is returned using MORPACE for the reporting period **Submission Format** • All data is combined and the final report is submitted via PDF matching reporting requirements.

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
31. HEDIS Annual Reporting	Analysis report of audited HEDIS results. Track and trend all aspects of the survey including mitigation plans. The State may also request interim HEDIS reports each quarter to assess MCO performance throughout the year.	Annually and upon State request, quarterly	Y	Y	Y	**Key Elements** • Audit Review Table is provided annually providing final rates for both administrative and hybrid along with additional data on each measure to include numerator, denominator and exclusions. • Each individual measure is then broken out to show specific criteria **System Description** • Data is returned using Inovalon for the reporting period **Submission Format** • All data is combined and the final report is submitted via excel matching reporting requirements.
32. Staffing Contingency Plan Updates	Staffing contingency plan to include but not limited to the following: • Replacement of personnel before or after signing of contract process • Allocation process of additional resources in response to inability to meet any performance standard • Staff replacement process to include time frames	Annually	Y	Y	Y	**Key Elements** • The Staffing Contingency plan for Sunflower health plan was developed by Sunflower HR in conjunction with corporate standards used nationwide by Centene. • Key elements include the following: o Backup resources outlined for every department o Emergency contingent staff procurement o Other strategy Sunflower HR would engage in the event of staffing emergency **System Description** – N/A **Submission Format**

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
	• Replacement/additions onboarding process to include Kansas Contract emphasis					• All data is combined and the final report is submitted via excel matching reporting requirements.
33. 5% Ownership Report	Written report of any person or corporation that has 5% or more ownership or controlling interest in the entity. Report must include financial statements of identified persons.	Annually	Y	Y	Y	**Key Elements** • Specific information identified for all managing employees of Sunflower along with the Board of Directors **System Description** – N/A **Submission Format** • All data is combined and the final report is submitted via PDF matching reporting requirements.
34. Continuity of Business Operations Plan	Business continuity report that includes (at minimum): • Recovery of business functions, business units, business processes, human resources, and technology infrastructure • Core business processes • Maintenance of updated disaster recovery plans and procedures • Plan for replacement of personnel	Annually	Y	Y	Y	**Key Elements** • Data is captured through our Annual Plan Maintenance / Refresh • Key elements of the plan include: o Activation Process o Recovery checklist o Business line Recovery specific tasks o Key contacts o Plan specifics by location **System Description** • Data is housed in our Enterprise Wide Business Continuity Software Tool (Fusion) • Legacy tool was Living Disaster Recovery Planning System (LDRPS)

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
	Please note that if approved plan is unchanged from previous year, a certification from the year prior must be submitted.					**Submission Format** • All data is combined and the final report is submitted via PDF matching reporting requirements.
35. Member Handbook Updates	Summary of updates to Member/new Member handbook. Summary to include verification of handbook review.	Annually	Y	Y	Y	**Key Elements** • All manual changes are submitted by SME. • All changes then reviewed by Member Education Advisory Council • Changes then submitted to state for approval. • Submissions are emailed to the state, usually in Word or PDF format. **System Description** – N/A **Submission Format** • All manual changes are compiled into a final manual that is submitted via PDF
36. Organizational Charts	Organization chart with quarterly changes noted and a focus on key positions and care coordination, including positions that have direct contact with Members.	Quarterly	Y	Y	Y	**Key Elements** • This is a manually updated report based upon our structure at the time for the quarter reporting. • The report contains the following information: o Current vacancies for all KS based positions o Current vacancies in care management o Detailed organizational chart highlighting all key state contacts. **System Description** • The system used for this is Microsoft Visio

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
						Submission Format • All data is combined and submitted from the local Human Resources Manager. The final report is submitted in an excel format matching state reporting requirements.
37. Security Plan Updates	Summary of any updates to the Security Plan.	Annually	Y	Y	Y	**Key Elements** • The security roadmap contains all systems used and the security/safeguards associated with each. **System Description** • Security Policies and standards are maintained in Compliance 360 • Assessments and Pen Tests are confidential and not generally available **Submission Format** • All data is combined and the final report is submitted via PDF matching reporting requirements.
38. Insolvency Plan	Insolvency plan that includes provisions for dividing the cash reserves, capital and surplus requirement among plan Providers in the event of insolvency.	Annually	Y	Y	Y	**Key Elements** • Insolvency Plan is located in the company's policy and procedure warehouse, reviewed and confirmed annually. **System Description** – N/A **Submission Format** • All data is combined and the final report is submitted via PDF matching reporting requirements.

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
39. Performance Bond	Written assurance stating the required performance bond will be submitted no later than forty-five (45 days) after contract signing.	Annually	Y	Y	Y	**Key Elements** • Performance Bond is renewed annually and updated as required by current contract requirements. **System Description** – N/A **Submission Format** • A PDF copy of the bond is submitted
40. Children and Youth with Special Health Care Needs (CYSHCN)	Summary of CYSHCN who receives Medicaid coverage who require a health care plan. Report to include: • Date of birth (DOB) • Policy (ID)	Monthly	Y	Y	Y	**Key Elements** • Members eligible are generated from the most current 834 file delivered from the state. • Member specific details are input to include: o Medicaid Number o First Name o Last Name o Date of Birth o Gender o PCP o Enrollment date o Authorizations o Case management status o Case manager name o Case manager phone o KDHE Care Plan o Kan Be Healthy screenings **System Description**

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
						• Golden6 to query database EDIREPP to find the correct 834 eligibility files • Golden6 to query database AMIMID69 to locate the correct CYSHCN members from the 834 eligibility file found in step 1. • Use Teradata to query database EDW for member details Authorizations are manually pulled and entered into the report **Submission Format** • All data is combined and the final report is submitted in an excel format matching state reporting requirements.
41. Health Risk Assessments Report	Number of completed health risk assessments, as well as a summary and analysis of the information collected as it pertains to chronic conditions, preventive care, prenatal care referrals including the month a pregnant Member was identified and screened, and relevant demographic and regional information. Report to include: • Number of Members screened • Number of Members refusing screen	Quarterly	Y	Y	Y	**Key Elements** • Member specific HRAs, HRS, county and member population information pulled directly from our enterprise data warehouse and TruCare systems. • Data pulled includes the following: o Members eligible o Health Screenings completed o Members with chronic conditions o Members pregnant o Attempted screenings not completed **System Description** • Information is pulled directly from EDW using Teradata and our TruCare system **Submission Format** • All data is combined and the final report is submitted in an excel format matching state reporting requirements.

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
	• Number of Members unable to contact for screen • Number of Members referred for an HRA • Number of Members with an HRA completed • Number of Members refusing an HRA • Number of Members with an HRA completed telephonically or in-person					
42. Health Insurance Portability and Accountability Act (HIPAA) Monthly Summary	Notification report of all impermissible HIPAA uses and disclosures to include those that do not rise to the level of a HIPAA breach that require formal notification of the individual and HHS.	Monthly	Y	Y	Y	**Key Elements** • The report information is manually extracted for any HIPAA incidents to include the following: o Case number o Date of occurrence o Notice date o Description of incident o Member Name o Status (open/closed) o Date closed **System Description** • The data for the HIPAA monthly is manually entered into Compliance 360 (Archer beginning 12/1/17) and stored there.

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
						Submission Format • All data is combined and the final report is submitted in an excel format matching state reporting requirements.
43. Hysterectomies and Sterilizations Report	Report demonstrating compliance with 42 CFR 441 Subpart F and completion of consent forms.	Quarterly	Y	Y	Y	**Key Elements** • Members who have received one of the 52 specific procedures are listed. • The following member specific data is pulled for each procedure received: o Member Name o Date of Birth o Paid date of claim o Medicaid ID o Date of service o Procedure code o Procedure description **System Description** • Data is pulled from the Enterprise Data Warehouse using Teradata for dates of service in the reporting period. **Submission Format** • All data is combined and the final report is submitted in an excel format matching state reporting requirements.
44. Community Transitions	Monthly report of participants transitioning from an institutional setting and details of their	Monthly	Y	Y	Y	**Key Elements** • To Be Determined based off of KDHE required reporting template.

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
	program participation. Institutional setting will include, but not limited to, Nursing Facility, Nursing Facility for Mental Health, State and Private Intermediate Care Facilities (ICFs), State Hospitals, Psychiatric Residential Treatment Facilities (PRTFs) and other Psychiatric Impatient Settings.					**System Description** • To Be Determined based off of key elements required reporting template **Submission Format** • All data is combined and the final report is submitted matching state reporting requirements.

45. Pay for Performance 2017	Report listing the KanCare Pay for Performance reporting measures.	Quarterly	**Y**	**P** (current issues regarding both MDS and Authentic are data)	**Y**	**Key Elements**
						• Performance measures are determined each year by the state.
						• P4P rates for each measure are inputted into appropriate sections within the state P4P template
						• Each measure is broken down by quarter to show the progress
						  o Numerator (completed)
						  o Denominator (eligible)
						  o Percentage
						
						System Description
						• HEDIS data extracted from QSI backend database OFLQSIDP007 for current HEDIS year.
						  o Rates derived from most current QSI run for reporting period
						
						• Non-HEDIS measures data provided external data source
						  o 2017 P4P Measures

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.

						• MDS
						  ○ Rates derived provided by KDADS
						• Authenticare
						  ○ Rates derived provided by KDADS
						• Encounters
						  ○ Claims paid and encounters submitted data is ran
						  ▪ Each vendor submits a report to Sunflower of total claims paid in each month and the total number of encounters submitted within 30 days of the paid date
						  ▪ Vendor data include LogistiCcare, Envolve Vision, Envolve Dental, and Envolve Pharmacy
						  ▪ Rate is derived based on specifications
						  ○ All encounters for reporting quarter that were submitted and received a response during the reporting period with a paid date before end of reporting quarter
						  ▪ Rate is derived based on specifications
						
						Submission Format
						• All data is combined and the final report is submitted in an excel format matching state reporting requirements.

46. Serious Emotional Disturbances (SED) Waiver Performance Measures-Quarterly	Report of performance measures specific to the SED Waiver. The report shall include:
	• Grievance resolution timeframe
	• Paid claims not resulting in recoupment
		Quarterly	Y	Y	Y	**Key Elements**
						• Claims data is pulled for members eligible for the SED waiver that fall into one of the following categories:
						  ○ Service Provision before Eligibility
						  ○ 90 Day review of Plan of Care Verification
						  ○ Plan of care reflects change in need of verification
						  ○ Payments for services no on Plan of Care

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
	• Claims verified to have paid according to the service plan					○ Outside of range (budgeted units received fall below 65% or above 135%) **System Description** • Data is pulled from the Enterprise Data Warehouse using Teradata for dates of service in the reporting period **Submission Format** • All data is combined into 5 separate excel reports submitted matching the state reporting requirements.
47. Standard Terms and Conditions (STCs) Quarterly Report	Activity report on marketing, outreach and advocacy for Standard Terms and Conditions.	Quarterly	Y	Y	Y	**Key Elements** • The report includes a narrative of all the plan's activities performed during the reporting period in regards to: ○ Marketing activities ○ Outreach activities ○ Advocacy activities **System Description** – N/A **Submission Format** • All data is combined and the final report is submitted in a word format matching state reporting requirements.
48. Foster Care Reporting	Summary of all children in foster care, by population code with CONTRACTOR(S), current address and mental health diagnosis along with an indicator if the child has high needs.	Monthly	Y	Y	Y	**Key Elements** • Member specific data is pulled from the eligibility file ○ Members who are in the pop codes of 60, 62, 63 and 65 for the reporting month are included along with the following specific member information: ▪ Medicaid ID

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
						▪ Last Name ▪ First Name ▪ Street address ▪ City ▪ State ▪ Date of Birth ▪ Pop Code • The appropriate member diagnosis codes are pulled from claims data **System Description** • Data is pulled from the Enterprise Data Warehouse using Teradata for dates of service in the reporting period. • The contractor information is pulled from the scripts file for the reporting month. **Submission Format** • All data is combined and the final report is submitted in an excel format matching state reporting requirements.
49. Member Outreach and Educational Offerings Report	Summary of Member outreach and educational offerings. Report to include: • Number of attendees • Types of activities including meetings, presentations, coalition involvement, and	Quarterly	**Y**	**Y**	**Y**	**Key Elements** • All information maintained within the marketing event tracking spreadsheet for the current reporting period. • The following information is included within the report: o Event Date o Event Name o Event Time o Event Location o Approximate Attendance

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
	recovery focused events and tip sheets • Demonstration of outreach for priority populations					○ Target Audience ○ Member/Provider **System Description** – N/A **Submission Format** • All data is combined and the final report is submitted in an excel format matching state reporting requirements.
50. WORK Allocation Report	Detail listing containing one line per participant listing the participant's monthly allocation amount as showing in the patient pay liability (PPL) Web Portal and include Participant PPL ID number; Participant Medicaid number; Participant First Name; Participant Last Name; Month Start Date; Month End Date; Monthly Allocation; Unallocated Amount; Allocated Amount; Total Spent Amount including Total spent on prior authorization (PA) services, Total spent on alternative services, Total reimbursements; Total Swept Amount; Monthly Allocation Balance.	Monthly	**Y**	**Y**	**Y**	**Key Elements** • A summary containing total members served along with the total amounts utilized for all served members is included • Member specific data is included within the report containing: ○ Medicaid ID ○ First and Last Name ○ Month start date ○ Month end date ○ Total Monthly allocation ○ Monthly unallocated ○ Monthly allocated ○ Monthly spent on alternative services ○ Monthly spent on PA services – self directed ○ Monthly spent on PA services – agency directed ○ Total monthly reimbursements ○ Total monthly spent from carryover ○ Total monthly spent ○ Total remaining allocation ○ Total remaining carryover ○ Total swept

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
						○ Monthly worker compensation paid ○ Monthly fiscal management fee **System Description** • Member specific information is maintained by TILRC **Submission Format** • All data is combined and the final report is submitted in an excel format matching state reporting requirements.
51. WORK Enrollment End Date Report	Detail listing containing one line for each participant in the program and list the enrollment start and end dates (if applicable) that have been entered by the participant's ILC or Case Manager into the PPL Web Portal and include: Participant PPL ID; Participant First Name; Participant Last Name; Enrollment Begin Date; Enrollment End Date.	Monthly	Y	Y	Y	**Key Elements** • A summary containing total number of consumers enrolled along with the total complaints and grievances is included • Member specific data is included within the report containing: ○ Member first name ○ Member last name ○ Enrollment begin date ○ Enrollment end date ○ Enrollment status ○ Care coordinator first name ○ Care coordinator last name ○ ILC Agency ○ ILC first name ○ ILC last name ○ Monthly complaints and grievances **System Description** • Member specific information is maintained by TILRC

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
						Submission Format • All data is combined and the final report is submitted in an excel format matching state reporting requirements.
52. WORK Good to Go (GTG) Report	Detail listing containing one line for each participant/provider association in the Web Portal to include: • Participant Patient Pay Liability (PPL) ID • Participant First Name • Participant Last Name • Participant GTG Status • Provider PPL ID • Provider Name • Provider First Name • Provider Last Name • Provider Type • Provider GTG Status • Participant Provider Checklist Status Independent Living Counselor (ILC) First Name • ILC Last Name • Assessment CONTRACTOR(S) First Name	Monthly	Y	Y	Y	**Key Elements** • A summary containing total number of PCS service providers along with wage and employment information is included • Member specific data is included within the report containing: o First name o Last name o Member GTG status o Provider number o Provider Name o Provider first name o Provider last name o Provider type o Provider GTG status o Total spent on alternative services o Total paid for agency supports o Average agency hourly rate o Highest agency hourly rate o Lowest agency hourly rate o Total paid for individuals providing PA supports o Total PA Gross wages o Total PA taxes o Average PA Wage Paid o Highest PA Wage paid o Lowest PA Wage paid o Total PA service hours billed 1st – 15th of reporting month

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
	• Assessment CONTRACTOR(S) Last Name					○ Total PA service hours billed 16th – 31st of reporting month **System Description** • Member specific information is maintained by TILRC **Submission Format** • All data is combined and the final report is submitted in an excel format matching state reporting requirements.
53. WORK ILC Billing Audit File	Audit file of ILC billing submitted during reporting quarter.	Quarterly	Y	Y	Y	**Key Elements** • Member specific data is included within the report: ○ Last name ○ First name ○ Medicaid ID ○ Provider agency ○ Provider of ILC services ○ Date of service (DOS) ○ Units billed for DOS **System Description** • Data is pulled from the Enterprise Data Warehouse using Teradata for all claims received in the reporting period. **Submission Format** • All data is combined and the final report is submitted in an excel format matching state reporting requirements.
54. WORK Participant Funds Summary Reports	Detail listing containing one line per participant summarizing their monthly allocations for the	Quarterly	Y	Y	Y	**Key Elements** • Member specific data is included within the report containing: ○ Medicaid ID

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
	month(s) the report is run and the participant's carryover and overflow information. The reports are cumulative and include: • Participant PPL ID • Participant Medicaid Number • Participant First Name • Participant Last Name • Sum of Monthly Allocations • Total Unallocated • Total Allocated • Total Spent (Total spent on prior authorization services, Total spent on alternative services, Total reimbursements) • Total Swept • Total Monthly Allocations Balance • Carryover Budget • Carryover Unallocated • Carryover Allocated • Carryover Spent • Carryover Balance • Overflow Budget • Overflow Unallocated					○ First name ○ Last name ○ Sum of monthly allocations ○ Total unallocated ○ Total allocated ○ Total spent on PA services ○ Total spent on Alternative services ○ Total reimbursements ○ Total carryover spent ○ Total spent ○ Total swept ○ Total monthly allocation balance ○ Total carryover fund balance ○ Total worker compensation paid ○ Total Fiscal management fees paid **S System Description** • Member specific information is maintained by TILRC **Submission Format** • All data is combined and the final report is submitted in an excel format matching state reporting requirements.

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
	• Overflow Allocated					
55. Annual CONTRACTOR(S) Evaluation Report	Detail of the annual review of the Quality Assessment and Performance Improvement (QAPI) program. The report, at a minimum, to include: • Summary and review of completed and continuing quality improvement activities that address the quality of clinical care and services • Trending and analysis of performance measures of quality of clinical care and services • Recommended corrective actions that are implemented or in progress • Modifications to the QAPI program	Annually by end of first quarter following the year being evaluated.	Y	Y	Y	**Key Elements** • The evaluation describes analysis done on multiple QI components throughout the year, interventions, barriers, and results. • The evaluation also describes committee structure, committee responsibilities, QI team composition, and provides details on work done by health plan to impact Quality for the members served. **System Description** • Data comes from various reports and surveys completed throughout the measurement year and utilized for analysis to determine effectiveness of current strategies, opportunities for improvement, barriers, and allow for strategy to be re-aligned with continuous Quality Improvement focus. **Submission Format** • Annual evaluation provided as a PDF and includes a narrative and data utilized • All data is combined and the final report is submitted matching state reporting requirements.
56. Performance Improvement Projects	Updates for all Performance Improvement Projects (PIPs) that have been approved by the State.	Quarterly	Y	Y	Y	**Key Elements** HPV Vaccination. • Section A – C

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
	Reports must be submitted on the approved State form and include: • Rationale for conducting the PIP and its impact on the KanCare program • Objective quality indicators to be used in assessing PIP effectiveness • Baseline assessment and goals/benchmarks for improvement • Implementation of system interventions to achieve improvement • Evaluation and barrier analysis of the effectiveness of the interventions • Planning and initiation of activities for increasing or sustaining improvement Reporting the results of each project to the State.					○ Data extracted from QSI backend database OFLQSIDP007 from measure Immunization of Adolescents (IMA) ○ Rates derived based on requirements from report specifications • Section D – F ○ Interventions and outreach tracked from events completed ▪ Interventions include phone outreach, mailers, and webinars ○ Data derived from track sheets based on requirements from report specifications • Vaccination and intervention data inputted into appropriate section within the state HPV PIP template matching state reporting requirements. **System Description** • Data is pulled from QSI backend database • Data is also tracked on spreadsheets **Submission Format** • All data is combined and the final report is submitted in an excel format matching state reporting requirements.
57. Quality Assessment and Performance	Executive summary of annual quality assessments and performance improvement efforts	Semi-annually	**Y**	**Y**	**Y**	**Key Elements** • QAPI work plan is provided as PDF with key deliverables including: ○ Reports

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
Improvement Work Plan	and results. Report to include all changes, providing the substantive nature of each and the impetus of each (e.g., responsive to a review finding, update to an NCQA standard, etc.); and separately provide substantive updates on each area of the QAPI plan.					○ Work plans ○ Surveys ○ PIPs ○ Audits ○ Any other analysis with notation review timeframe for specific committee or submission to state. • This report is utilized to ensure deliverables are completed on time for submission to the appropriate committees and the state. • There is no data typically included. **System Description** • Data comes from various reports and surveys completed throughout the measurement year and utilized for analysis to determine effectiveness of current strategies, opportunities for improvement, barriers, and allow for strategy to be re-aligned with continuous Quality Improvement focus. **Submission Format** • All data is combined and the final report is submitted matching state reporting requirements.
58. Standard Services Preauthorization Decisions Report	Total number of standard pre-authorizations: 0–5 days,6–14 days, more than14 days, and total number of expedited pre-authorizations: 1 day, 2–3 days	Monthly	Y	Y	Y	**Key Elements** • Monthly report is ran based on drugs that would fall in PDL and clinical pharmacy and state provided J-codes for physician administered datasets for authorizations. • Prior authorization turnaround time is based off received date compared to completion date. • PDL and Clinical Pharmacy data is submitted to Sunflower monthly from Envolve and data is transformed into state reporting

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
						template along with Sunflower's data output for physician administered data. • PDL, Clinical Pharmacy and Clinical Physician administered Pas are broken down as follows: o Received by Fax o Received by Phone o Received by Auto PA o Received by Web o Received by Other o Total Received o Approved o Denied o Pending o Cancelled o Approved by state o Denied by state o Average time to process o Initial PA requests exceeding 24 hours **System Description** • Data is housed within Envolve Pharmacy Solution database for PDL and Clinical Pharmacy PAs. • Physician Administered data is held within Sunflower's internal database. **Submission Format** • Final report is submitted in excel format matching state reporting requirements.

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
59. Turnaround Time (TAT) Prior Authorization Report [Standard Services Preauthorization Decision Report (Service Authorizations, Service Denials, and Pending Service Authorizations)]	Summary of TAT to be stratified by program and population. Report to include: • Number of authorization requests • Hours approved and denied • Reasons for denial • Approved units • Paid units • Percent paid to approved units • Total number of pre-authorizations	Quarterly	Y	Y	Y	**Key Elements** • The Utilization Management designee pulls the scheduled report containing required specified information for Nursing Facilities, Inpatient, Outpatient, LTSS and Behavioral health authorizations. o Authorizations received o Authorizations approved o Authorizations denied o Authorizations pending o Expedited authorizations o TAT for all authorizations o Authorizations outside the 14 day TAT **System Description** • Data is housed within Micro Strategy, an internal data warehouse. **Submission Format** • The data is imported to the appropriate template and reviewed by the UM Manager and a Behavioral Health designee prior to submission. • The finalized report is submitted in excel format matching state reporting requirements.
60. Provider Manual Updates	Summary report of updates to provider manual. Summary to include verification of manual review.	Annually	Y	Y	Y	**Key Elements** • All manual changes are submitted by SME. • All changes then reviewed by Provider Education Advisory Council • Changes then submitted to state for approval. • Submissions are emailed to the state, usually in Word or PDF format.

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
						System Description – N/A **Submission Format** • Final approvals are saved and archived within a tracking spreadsheet. • All manual changes are compiled into a final manual that is submitted via PDF.

61. Utilization of Services by Service Type and Average Service Utilization	Utilization report to include:
	• Members receiving any services
	• Total number of all service units paid
	• Grand total amount paid
	• Average number of hours per Member
	• Average amount paid per Member
	• Drug utilization to include
	  ○ Total number of units of each dosage form
	  ○ Strength and package size by NDC of each covered outpatient drug
		Monthly	**Y**	**Y**	**Y**	**Key Elements**
						• Monthly report is ran based on drugs that would fall in PDL and clinical pharmacy and state provided J-codes for physician administered datasets for paid claims.
						• PDL and Clinical Pharmacy data is submitted to Sunflower monthly from Envolve and data is transformed into state reporting template along with Sunflower's data output for physician administered data.
						• Data received from Envolve is transformed and inputted in the state reporting format.
						
						System Description
						• Data is housed within Envolve Pharmacy Solution database for PDL and Clinical Pharmacy PAs.
						• Physician Administered data is held within Sunflower's internal database.
						
						Submission Format
						• Final report is submitted in excel format matching state reporting requirements.

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
	administered to Members					
62. Final Independently Audited Financial Statements	The CONTRACTOR(S) shall submit to the State Annual Audited Financial Statements as they become available and no later than June 1st. The CONTRACTOR(S) shall submit to the Kansas Insurance Department the results of an annual audit performed by an independent certified public accountant and to authorize the Kansas Insurance Department (KID) to share this information with other State agencies as required. The CONTRACTOR(S) shall authorize the independent accountant to allow representatives of the State, including the KID, upon written request, to verify the audit report. The CONTRACTOR(S), the CONTRACTOR(S)' parent company, and all non-provider SUBCONTRACTOR(S) that are not	Annually	Y	Y	Y	**Key Elements** • Independent public auditors are engaged annually to perform an audit of the annual NAIC financial report. • The independent audit and related statements are provided to the KID as required in the KID's annual Health Entities Checklist. **Source Description** • The sources of information for our statutory statements are: o ERP system PeopleSoft, our investment tracking software Clearwater o Statutory filing software eFreedom. • A separate external audit in accordance with GAAP would be a new external audit requirement which would be fulfilled if required. **Submission Format** • Final report is submitted in PDF format.

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
	affiliated with the CONTRACTOR(S) will provide the results of an annual audit performed by an independent Certified Public Accountant and to authorize the CONTRACTOR(S) to share this information with the State. The CONTRACTOR(S) shall authorize the independent accountant to allow representatives of the State, upon written request, to verify the audit report.					
63. Financial Package - Monthly Edition	Generally Accepted Accounting Principles (GAAP) financial report of the KanCare program to be submitted by the CONTRACTOR(S) monthly. Details around the Title XIX and Title XXI programs are required. The State provided financial reporting template includes several tabs for input including a Medical Loss Ratio (MLR) report, restated financial report covering a two-year period and a SUBCONTRACTOR(S) report detailing various components of payments made to SUBCONTRACTOR(S). Also	Monthly	Y	Y	Y	**Key Elements** • The report is completed to adhere to all financial requirements. • Specific monthly and year to date financial information includes the following: o Full Revenue Report o Deliveries and Hepatitis C specific revenue o Other Revenues / Other Income o Pay for Performance Report o Medical Loss Ratio Report o Combined Income and Expense Report o Capitation and Fee For Service Subcontractor Expenses **Source Description** • The sources of information for the financial package are: o ERP system PeopleSoft

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
	included in the template are quarterly reporting requirements such as reconciliation between National Association of Insurance Commissioners (NAIC) and GAAP reports.					○ Claims system - Amisys. **Submission Format** • The monthly financial package is completed and submitted in the excel format provided by the state.
64. Health Insurance Provider Fee (HIPF_ form 8963	Copy of IRS form 8963 as submitted to Internal Revenue Service (IRS). Revisions to the form to be submitted within 10 days of IRS submission.	Annually	Y	Y	Y	**Key Elements** • The Form is completed and submitted in the IRS format as required **System Description** – N/A **Report Submission** • A copy of the IRS form is submitted via PDF.
65. Quarterly KID NAIC Financial Report	Quarterly Reports must be filed. These reports shall be on the form prescribed by the NAIC for HMOs and shall be submitted to the State on or before May 15 (covering first quarter of current year), August 15 (covering second quarter of current year) and November 15 (covering third quarter of current year). Each quarterly report shall also contain an income statement	Quarterly	Y	Y	Y	**Key Elements** • The quarterly financial statements are provided to the KID as required in the KID's annual Health Entities Checklist. **System Description** • The sources of information for our statutory statements are: ○ ERP system PeopleSoft, our investment tracking software Clearwater ○ Statutory filing software eFreedom. **Submission Format** • Final report is submitted in PDF format.

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
	detailing the CONTRACTOR(S)' quarterly and year-to-date revenues earned and expenses incurred as a result of the CONTRACTOR(S)' participation in the KanCare program. The second quarterly report (submitted on August 15) shall include the MLR report completed on an accrual basis that includes an actuarial certification of the claims payable (reported and unreported) and, if any, other actuarial liabilities reported. The actuarial certification shall be prepared in accordance with NAIC guidelines. The CONTRACTOR(S) shall also submit a reconciliation of the MLR report to the second quarterly NAIC report. Statement of Financial Position-Assets -- Total Cash, Total Reimbursement Funds, Total Investments, Total Other Assets, Total Current Assets, Net Fixed Assets, Liabilities and Equity --					

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
	Total Current Liabilities, Total Liabilities, Total Equity. For Providers licensed as CONTRACTOR(S) by the Kansas Insurance Department (KID): Copies of financial reports and financial solvency reports as outlined in Section 5.13.1.F to be submitted to the KID pursuant to the T-XIX Manage Care Interagency Agreement as well as any additional reports or information required by KDHE or its sister agency, the KID. For non-CONTRACTOR(S) licensed Providers and for those providing services for Title-XXI Members, income and expense statements specific to the contracted program(s) will be required semi-annually, for the six-month period of January to June, and July to December of each contract period.					
66. Inventory Management	Summary report of all claim types received and processed.	Monthly	**Y**	**Y**	**Y**	**Key Elements**

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
Analysis by Claim Type						• The total claims received for the month are totaled along with the amount paid. • Of all received claims the number of claims denied along with the total amount denied is totaled. • The data is captured for claims falling into the following categories: o Hospital Inpatient o Hospital Outpatient o Pharmacy o Dental o Vision o Non Emergent Medical Transportation o Medical (physical health not otherwise specified) o Nursing Facilities o Home and Community Based Services o Behavioral Health **System Description** • Data is pulled from the Enterprise Data Warehouse using Teradata for all claims received in the reporting period. • Vendor specific data is delivered via SFTP. **Submission Format** • Final report is compiled and submitted in excel format matching state reporting requirements.
67. Input Type Control Listings	Summary report of number of claims submitted via web, paper and batch.	TBD	**Y**	**Y**	**Y**	**Key Elements** • Claims received for the month are totaled based on one of the following categories:

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
						○ Web (web portal) ○ Paper (CDMS) ○ Batch **System Description** • Data is pulled from our AMIOWN data warehouse using Golden. **Submission Format** • Final report is compiled and submitted in excel format matching state reporting requirements.
68. Records of Non-processable Claims	Summary report of incomplete claims lacking information to be processed.	TBD	Y	Y	Y	**Key Elements** • A rejected claims report is ran for the month and all claims received are categorized into one of the following: ○ Invalid member date of birth ○ Invalid member ○ Invalid provider ○ Member not valid at date of service ○ Invalid diagnosis ○ Invalid procedure ○ Invalid future date ○ Original claim number required ○ Claim exceeded maximum 97 service line limit ○ Attending provider required ○ ICD9 is mandated for this date of service ○ ICD10 is mandated for this date of service ○ Other

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
						System Description • Data is pulled from Micro Strategy, an internal reporting system containing claims data. **Submission Format** • Final report is compiled and submitted in excel format matching state reporting requirements.
69. Exception Reports of Claims in Suspense in a Particular Processing Location for More Than a User-specified Number of Days	Tracking report of claims routed to different departments for adjudication.	TBD	Y	Y	Y	**Key Elements** • To Be Determined based off of KDHE required reporting template. **System Description** • To Be Determined based off of key elements required reporting template **Submission Format** • All data is combined and the final report is submitted matching state reporting requirements.
70. Electronic Submission Statistics (as defined by the State)	Reports of unsuccessful transmissions and claims/encounters and adjustments, errors or rejections.	TBD	Y	Y	Y	**Key Elements** • Report includes encounter specific information including: o Claim Number o MMIS Number o Provider NPI o Submission file name o Submission file create date o Response file name o HP Processed date

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
						○ Encounter status **System Description** • Data is pulled from ENCPOST using MS SQL Server for all encounter related information **Submission Format** • All data is combined and the final report is submitted in an excel or flat file format matching state reporting requirements.
71. Reports of Unsuccessful Transmissions and Claims/Encounters and Adjustments Errors or Rejections	Summary report to include: • Claim filing is within time limit for filing • Logical dates of services (e.g., valid dates, not future dates) • Service consistency with place of service/type of service • Units/number of services performed is consistent with the span of time for the procedure	TBD	Y	Y	Y	**Key Elements** • Report includes claim and encounter specific information including: ○ Claim Number ○ MMIS Number ○ Claim date of service ○ Claim paid date ○ Claim paid units ○ Provider NPI ○ Submission file name ○ Submission file create date ○ Response file name ○ HP Processed date ○ Encounter status **System Description** • Data is pulled from ENCPOST using MS SQL Server for all encounter related information

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
						Submission Format • All data is combined and the final report is submitted in an excel or flat file format matching state reporting requirements.
72. Timely Claims Processing	Claims report to include: • Percent of claims processed within thirty (30) days • Percent of claims processed within sixty (60) days • Percent of claims processed within ninety (90) days	TBD	Y	Y	Y	**Key Elements** • All claims received within a month captured for the reporting period. • The days to process a claim are calculated based on the day difference between date received and date paid PLUS one to account for the actual day received. • The total claims paid for each stratification is then divided by the total claim count to reach a percent of claims processed with the days specified. • Validated excluded claims are removed from all calculations. • Claims are broken down into 3 criteria for specific claim TAT o Clean claims o Non-clean claims o All claims **System Description** • Data is pulled from the Enterprise Data Warehouse using Teradata for all claims received within a given month. **Submission Format** • All data is combined and the final report is submitted in an excel format matching state reporting requirements.
73. Top Claims Denial Reasons	Report of the highest percentage for each denial reason.	TBD	Y	Y	Y	**Key Elements** • The total claim lines denied for the month are totaled and then each denial reason code is totaled separately.

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
						• The total claim lines denied for each denial reason are then divided by the total claim line count to reach a percent of claims denied. • The data is captured for claims falling into the following categories: o Hospital Inpatient o Hospital Outpatient o Pharmacy o Dental o Vision o Non Emergent Medical Transportation o Medical (physical health not otherwise specified) o Nursing Facilities o Home and Community Based Services o Behavioral Health **System Description** • Data is pulled from the Enterprise Data Warehouse using Teradata for all claims denied within a given month. **Submission Format** • All data is combined and the final report is submitted in an excel format matching state reporting requirements.
74. Encounter Submission Report	Summary report of encounters, voids and replacements, as well as held encounter reasons.	Weekly	Y	Y	Y	**Key Elements** • Report includes encounter specific information including: o Claim Number o MMIS Number o Provider NPI o Submission file name

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
						○ Submission file create date ○ Response file name ○ HP Processed date ○ Encounter status **System Description** • Data is pulled from ENCPOST using MS SQL Server for all encounter related information **Submission Format** • All data is combined and the final report is submitted in an excel or flat file format matching state reporting requirements.
75. Pended Claims Report	Claims reports of pended claims to include pend reason codes.	As Needed	Y	Y	Y	**Key Elements** • Claims received during the reporting period that are in a PEND status are all returned • The specific pended reason codes are returned for all 6 separate adjudication reasons • A distinct claim count is returned for each specific pend code **System Description** • Data is pulled from the Enterprise Data Warehouse using Teradata for all claims pended within a given month. **Submission Format** • Final report is compiled and submitted in excel format matching state reporting requirements.

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
76. KDHE Unified Log	Report is a log of all known provider, claims, Third Party Liability (TPL), and eligibility issues. The electronic file is shared with the CONTRACTOR(S) weekly and the MCO provides a status update each week until the issue is closed.	Weekly	Y	Y	Y	**Key Elements** • Members and/or providers may contact the state directly with possible issues which are then forwarded on the health plan. • These issues are worked until resolution and the log tracks all stages of the process. The report includes the following: o Issue Source (MCO Manager, KDHE, Claims Project) o Date Identified o Petitioner Type o Petitioner Name o Member ID (required for member specific issues) o Issue Description o Issue Update info o Provider Type o Issue Type o Status o Resolution Date **System Descriptions** – N/A **Submission Format** • The excel workbook is sent to the state weekly to be loaded into their internal system which generates an Internal ID number.
77. KanCare Claims Resolutions Log	The KanCare Claims Resolutions Log contains a list of items that are currently in process for the fiscal agent and the CONTRACTOR(S). It provides a brief explanation of the issue and	As Needed	Y	Y	Y	**Key Elements** • The excel workbook contains a list of any Global issue that may affect the plan along with any state policy changes to track the implementation process. The report will include the following information: o Date Added

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
	any updates with regard to needed system modifications and/or claims projects that need to be queued up for claims adjustments. The Providers have the option to submit corrected claims to expedite reprocessing or to wait for claims to be reprocessed systematically. If the system has not yet been corrected/updated, a date for reprocessing/adjusting claims will be determined once the system correction/update has been made.					○ Affected Area ○ Comments ○ DXC System status ○ MCO System status ○ DXC/MCO Preprocessing completion date ○ MCO Overpayment/Underpayment **System Descriptions** – N/A **Submission Format** • The excel workbook is sent to the state as needed.
78. Encounter Resolutions Log (CONTRACTOR(S))	Report to list all encounter data issues and resolution dates.	TBD	Y	Y	Y	**Key Elements** • This is a list of issues that we are currently facing regarding encounters. **System Description** • Any data is based off research that is found in our Encounter Data Warehouse. **Submission Format** • The excel workbook is sent to the state as needed.
79. Problem Notification	Notification of any issue within its span of control that may jeopardize or is jeopardizing the	TBD	Y	Y	Y	**Key Elements** • Upon the discovery of any problem that may affect any scheduled exchanges between Sunflower and the state, providers or

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
	availability and performance of all systems functions and the availability of information in said systems to include Issues affecting scheduled exchanges of data between the CONTRACTOR(S) and the State and/or its agents. Notification to include impact to critical path processes such as enrollment management and claims submission processes. Notification may be submitted via phone, fax and/or electronic mail within one (1) hour of such discovery.					members the following information will be submitted to the state in a word document: o Brief description of the problem o Date notification sent to the state o Period of time during which the problem occurred o Date and time the plan became aware of the problem o Detailed description of the problem o Information about critical processes that were affected and the number claims/providers impacted o Name and number of the person the state should contact regarding questions/concerns o Information regarding any type of notices that have been prepared **System Description** – N/A **Submission Format** • The word document is sent to the state as soon as a problem is identified.
80. CONTRACTOR(S) Daily Encounter Submission Report (CLM-0123-D Secured File Transfer Protocol (SFTP))	Report of daily encounter submissions.	TBD	**Y**	**Y**	**Y**	**Key Elements** • This is a report that is sent to us by the state. • Included is the information after the state loads encounter files and what should have been on the attestation. • Daily this report is reviewed to what was submitted on the attestation. • If our attestation is incorrect, we review and determine what caused this and send in a corrected attestation.

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
						System Description – N/A **Submission Format** • The corrected word document is returned to the state as needed
81. CONTRACTOR(S) Front End Billing (FEB) Pending File Report	Summary report of pending FEB files.	TBD	Y	Y	Y	**Key Elements** • To Be Determined based off of KDHE required reporting template. **System Description** • To Be Determined based off of key elements required reporting template **Submission Format** • All data is combined and the final report is submitted matching state reporting requirements.
82. New-Rejected and Accepted Claims	Report of number of FEB claims that were accepted and rejected per week. At a minimum, the report should contain: • Claim type • CONTRACTOR(S)/ SUBCONTRACTOR(S) • Number of claims accepted • Number of claims rejected • Total number of claims • Percentage of claims accepted	TBD	Y	Y	Y	**Key Elements** • To Be Determined based off of KDHE required reporting template. **System Description** • To Be Determined based off of key elements required reporting template **Submission Format** • All data is combined and the final report is submitted matching state reporting requirements.

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
	• Percentage of claims rejected					
83. Acceptance of FEB-Related Files	Report indicating when the FEB-related files were loaded into the system.	TBD	Y	Y	Y	**Key Elements** • To Be Determined based off of KDHE required reporting template. **System Description** • To Be Determined based off of key elements required reporting template **Submission Format** • All data is combined and the final report is submitted matching state reporting requirements.
84. Submission of Pre-Adjudicated Claim Copies	Report indicating when the pre-adjudicated claim copies were sent to the State.	TBD	Y	Y	Y	**Key Elements** • To Be Determined based off of KDHE required reporting template. **System Description** • To Be Determined based off of key elements required reporting template **Submission Format** • All data is combined and the final report is submitted matching state reporting requirements.
85. Submission of Pre-Adjudicated Claim Copies	Report of submissions of claims copies prior to adjudication.	TBD	Y	Y	Y	**Key Elements** • To Be Determined based off of KDHE required reporting template. **System Description**

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
						• To Be Determined based off of key elements required reporting template **Submission Format** • All data is combined and the final report is submitted matching state reporting requirements.
86. Death Data Match Reports-Providers Report	This report contains a list of Providers whose records were updated with a date of death. CONTRACTOR(S) is expected to review the information and end date the CONTRACTOR(S) program eligibility with the provider's date of death.	Monthly	Y	Y	Y	**Key Elements** • To Be Determined based off of KDHE required reporting template. **System Description** • To Be Determined based off of key elements required reporting template **Submission Format** • All data is combined and the final report is submitted matching state reporting requirements.
87. Death Data Match Reports-Encounters After Date of Death (DOD) Report	This report contains a list of encounter claims in MMIS with dates of service after the provider's DOD. After retrieving this report, the CONTRACTOR(S) should follow their internal process for recouping the claims. Once the claim has been recouped, the encounter would be voided from MMIS.	Monthly	Y	Y	Y	**Key Elements** • To Be Determined based off of KDHE required reporting template. **System Description** • To Be Determined based off of key elements required reporting template **Submission Format** • All data is combined and the final report is submitted matching state reporting requirements.

sunflower health plan

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
88. New-Monthly Claims Processing Reporting	Claims report to include: • Percentage of claims paid • Percentage of claims denied • Average days to process (electronic and paper) • Processed less than thirty (30) days • Processed greater than thirty (30) days	Monthly	Y	Y	Y	**Key Elements** • All claims received within a month captured for the reporting period are broken down by claim type. o Hospital Inpatient o Hospital Outpatient o Pharmacy o Dental o Vision o Non Emergent Medical Transportation o Medical (physical health not otherwise specified) o Nursing Facilities o Home and Community Based Services o Behavioral Health • The total claims paid and total claims denied are broken apart to show the percentage total for both categories. • The average TAT for a claim is calculated based on the day difference between date received and date paid PLUS one to account for the actual day received. • The total claims processed for each claim type are shown based on the following categories: o Average TAT o Average TAT for Paid claims o Average TAT for Denied claims o Claims 31 – 60 days o Claims 61 – 90 days

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
						○ Claims over 90 days ○ Total pended claims ○ Average age of an unprocessed claim **System Description** • Data is pulled from the Enterprise Data Warehouse using Teradata for all claims received within a given month. **Submission Format** • All data is combined and the final report is submitted in an excel format matching state reporting requirements.
89. New-Monthly Claims Processing Reporting - Timely Filing Statistics	Claims report to include: • Number of requests received • Number of requests completed • Average business days to complete • Top three reasons for timely filing bypass requests	Monthly	Y	Y	Y	**Key Elements** • To Be Determined based off of KDHE required reporting template. **System Description** • To Be Determined based off of key elements required reporting template **Submission Format** • All data is combined and the final report is submitted matching state reporting requirements.
90. New-Monthly Accounts Receivables (ARs) Collections	Accounts receivables report to include: • Number of ARs assigned for collection • Number of new ARs assigned for the month	Monthly	Y	Y	Y	**Key Elements** • To Be Determined based off of KDHE required reporting template. **System Description** • To Be Determined based off of key elements required reporting template

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
	• CONTRACTOR(S) referral amount • Total dollars collected					**Submission Format** • All data is combined and the final report is submitted matching state reporting requirements.
91. New-Adjustment or Corrected Claim Reporting	Claim report to include: • Number of ARs assigned for collection • Number of new ARs assigned for the month • CONTRACTOR(S) referral amount total dollars collected	Monthly	Y	Y	Y	**Key Elements** • All claims received within a month captured for the reporting period are broken down by claim type. o Hospital Inpatient o Hospital Outpatient o Pharmacy o Dental o Vision o Non Emergent Medical Transportation o Medical (physical health not otherwise specified) o Nursing Facilities o Home and Community Based Services o Behavioral Health • Any claim that is adjusted either up or down is captured based on the service sequence of the claim and the paid amount difference. • The total claims adjusted for each claim type are shown based on the following categories: o Claims adjusted up o Dollar amount adjusted up o Percentage adjusted up o Claims adjusted down o Dollar amount adjusted down o Percent adjusted down

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
						○ Total claims adjusted ○ Total dollar amount adjusted ○ Total percent adjusted ○ Amount adjusted 1 – 10 times **System Description** • Data is pulled from the Enterprise Data Warehouse using Teradata for all claims received within a given month. **Submission Format** • All data is combined and the final report is submitted in an excel format matching state reporting requirements.
92. Electronic Health Screen Report	A report that includes the names of and the cumulative number of Members for whom the plan has completed a health screen via a data review.	Annual	Y	Y	Y	**Key Elements** • To Be Determined based off of KDHE required reporting template. **System Description** • To Be Determined based off of key elements required reporting template **Submission Format** • All data is combined and the final report is submitted matching state reporting requirements.
93. Service Coordination Caseload Report	Report to include: • Number of Members enrolled in service coordination by stratification level		Y	Y	Y	**Key Elements** • To Be Determined based off of KDHE required reporting template. **System Description**

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
	• Number of completed PCSP's within required timeframes • Number of reassessments • Number of telephonic contacts • Number of face-to-face contacts • Number of Members per waiver and per level of care • Number of Members no longer in need of LTSS					• To Be Determined based off of key elements required reporting template **Submission Format** • All data is combined and the final report is submitted matching state reporting requirements.

94. Advance Pay Collection Referral Report	Report includes information regarding outstanding accounts receivable that have been referred to the CONTRACTOR(S) for collection.	Monthly	**Y**	**Y**	**Y**	**Key Elements**
						• Information is received from KDHE regarding any provider with an advance pay balance.
						• Provider claims are reviewed and collection checks are determined.
						• Specific provider information is tracked including:
						  ○ Sent from KDHE
						  ▪ Referral Date
						  ▪ AR Number
						  ▪ Provider Name
						  ▪ FEIN
						  ▪ KMAP ID
						  ▪ Advance Pay Balance
						  ○ Populated by MCO
						  ▪ Collection Amount

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
						▪ Collection Date ▪ Check Number ▪ Check Amount ▪ Date Refund sent to KDHE **System Description** • Data is pulled from our claims system, AMISYS **Submission Format** • KDHE and MCO data is combining into an excel tracking spreadsheet that is returned to the state.
95. HCBS Provider Qualifications and Training Status	Provider qualifications and training records for all participating HCBS Providers that include qualification status and content of training, date(s) and participants.	Annual	Y	Y	Y	**Key Elements** • To Be Determined based off of KDHE required reporting template. **System Description** • To Be Determined based off of key elements required reporting template **Submission Format** • All data is combined and the final report is submitted matching state reporting requirements.
96. Schedule and Annual Report of	A schedule of all trainings offered to Participating Providers, including in-person, internet	Annual	Y	Y	Y	**Key Elements** • To Be Determined based off of KDHE required reporting template.

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
Provider Training Sessions	based and other remote access trainings. The CONTRACTOR(S) shall provide an annual report which reflects the completion of these training sessions over the calendar year.					**System Description** • To Be Determined based off of key elements required reporting template **Submission Format** • All data is combined and the final report is submitted matching state reporting requirements.
97. Cultural Competency Plan	The Plan must include how the CONTRACTOR(S) ensures that care and services are delivered in a culturally competent manner, training, goals and an annual assessment of the plan.	90 days post contract award and Annually thereafter	Y	Y	Y	**Key Elements** • To Be Determined based off of KDHE required reporting template. **System Description** • To Be Determined based off of key elements required reporting template **Submission Format** • All data is combined and the final report is submitted matching state reporting requirements.
98. Monitoring and Notification of Provider Qualifications	Describes how network provider licensure will be verified for all provider types on an ongoing basis and the timelines for notification to the State when issues are identified.	90 days before the start of the Contract Year	Y	Y	Y	**Key Elements** • To Be Determined based off of KDHE required reporting template. **System Description** • To Be Determined based off of key elements required reporting template **Submission Format**

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
						• All data is combined and the final report is submitted matching state reporting requirements.
99. Non-Participating Provider Report	Number of non-participating Providers utilized, provider type, provider specialty and rationale for using in lieu of a contracted network provider.	Quarterly	Y	Y	Y	**Key Elements** • To Be Determined based off of KDHE required reporting template. **System Description** • To Be Determined based off of key elements required reporting template **Submission Format** • All data is combined and the final report is submitted matching state reporting requirements.
100. Member Advisory Committee	Describes the plan for the Member Advisory Committee.	Annually	Y	Y	Y	**Key Elements** • To Be Determined based off of KDHE required reporting template. **System Description** • To Be Determined based off of key elements required reporting template **Submission Format** • All data is combined and the final report is submitted matching state reporting requirements.
101. Member Advisory Committee	Summarizes activity of Member Advisory Committee.	Quarterly	Y	Y	Y	**Key Elements** • To Be Determined based off of KDHE required reporting template.

Report Name	Reporting Description	Frequency	Report Available Y/N/P	Data Available Y/N/P	Data Dictionary Y/N	Data Details - key elements, system description, submission format, etc.
						System Description • To Be Determined based off of key elements required reporting template **Submission Format** • All data is combined and the final report is submitted matching state reporting requirements.