KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: WellCare of Kentucky

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
19.1 QAPI Program	**Prior**			
The Contractor shall implement and operate a comprehensive QAPI program that assesses monitors, evaluates and improves the quality of care provided to Members.	Full - WellCare provided its 2013 Medicaid Quality Improvement (QI) Program Description and Appendices, and committee quarterly reports and minutes. WellCare's QAPI Program is described in the 2013 Medicaid Quality Improvement (QI) Program Description and Appendices. The purpose is stated as objective and systematic monitoring and evaluation of quality and accessibility of care and identification and implementation of strategies for improvement. Committee minutes and quarterly reports provide documentation that the MCO has conducted monitoring and evaluation of quality of care and has implemented a range of quality initiatives.	Full	Includes review of MCO Report #84 QAPI Program Description WellCare provided its 2014 Medicaid Quality Improvement (QI) Program Description and Appendices, and quality committees' quarterly reports and minutes. WellCare's QAPI Program is described in the 2014 Medicaid Quality Improvement (QI) Program Description and Appendices. The purpose is stated as objective and systematic monitoring and evaluation of quality and accessibility of care and identification and implementation of strategies for improvement. Committee minutes and quarterly reports provide documentation that the MCO has conducted monitoring and evaluation of quality of care and has implemented a range of quality initiatives.	
The program shall also have processes that provide for the evaluation of	Full- WellCare's processes for evaluating access to and continuity of care, health care outcomes and services	Full	WellCare's processes for evaluating access to and continuity of care, health care	

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access to care, continuity of care, health care outcomes, and services provided or arranged for by the Contractor.	are outlined in the QI Program Description, Utilization Management (UM) Description, Case and Disease Management Program Descriptions, Patient Safety Plan and policies and procedures, and the QI Work Plan. Access to care is monitored via Geo Access mapping and appointment availability surveys (Primary Care Providers (PCPs), pediatricians and vendor services), grievances, and utilization metrics. WellCare conducted member and provider satisfaction surveys. Member satisfaction was assessed using the CAHPS Health Plan survey. WellCare reported that the baseline 2013 CAHPS results for adults exceed the Medicaid mean for 67% of adult measures and 56% of child measures exceeded identified benchmarks. The MCO reported Provider Satisfaction Survey results. The survey was approved by DMS and assessed satisfaction on a wide range of measures including helpfulness of plan staff in obtaining referrals for BH Services. Measures are reported for all provider types as well as separately for PCP and BH providers. When asked about any special surveys, WellCare		outcomes and services are outlined in the QI Program Description, Utilization Management (UM) Description, Case and Disease Management Program Descriptions, Patient Safety Plan and policies and procedures, and the QI Work Plan. Access to care is monitored via Geo Access mapping and appointment availability surveys (Primary Care Providers (PCPs), pediatricians and vendor services), grievances, and utilization metrics. WellCare conducted member and provider satisfaction surveys. Member satisfaction was assessed using the CAHPS Health Plan survey. In the Q4 QI Work Plan, page 17, WellCare reported that for the 2014 Adult CAHPS, rates exceeded the Quality Compass Mean in eight of the eight areas with benchmarks assessed and exceeded the 75th percentile benchmark in six of the eight areas with benchmarks assessed. For the child CAHPS measures, results exceeded the Quality Compass mean in seven of the eight areas with benchmarks assessed and exceeded the 75th percentile	

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	indicated that BH Adult and Child Satisfaction Surveys were conducted in 2013. The results were provided in spreadsheet format. WellCare first reported HEDIS in 2013. WellCare also reported baseline rates for the 2012 KY Health Outcomes performance measures. HEDIS results for CY 2013 show the MCO exceeded the 50th percentile for40% of reported measures and the 75th percentile for 9% of reported measures. The current target is to achieve or exceed the 75th percentile. The QI Work Plan indicates that WellCare conducted Drug Utilization Review initiatives. These were continued in 2014: 1) Injectable Antipsychotics: Risperdal Consta and Invega Sustenna 2) Suboxone Decision Tool 3) Use of Narcotic Containing Cough and Cold Products. 4) ADHD Medication Use in Children 5) Use of Inappropriate HIV Regimens Additionally, ongoing monitoring also includes, but is not limited to, adverse events, quality of care concerns, administrative services, case management/disease management enrollment and outcomes, health risk assessments, EPSDT services,		benchmark in four of the eight areas with benchmarks assessed. The Q4 QI Work Plan report, on page 17, the MCO reported Provider Satisfaction Survey results. Overall satisfaction with WellCare of KY was 74.6% which is a 12% increase from 2013.The survey was approved by DMS and assessed satisfaction on a wide range of measures including helpfulness of MCO staff in obtaining referrals for BH Services. Measures are reported for all provider types as well as separately for PCP and BH providers. BH Adult (MHSIP) and Child (YSS-F) Satisfaction Surveys were conducted in 2014. Results were shared with the CMHCs, DMS, and DBH during the quarter. WellCare reported HEDIS and the Healthy Kentuckians (HK) Performance Measures in 2014. Analysis of measurement year (MY) 2013 results will be available in the 2014 QI Evaluation scheduled for March, 2015. Interim HEDIS results for MY 2014 are contained in the Q4 QI Work Plan report, page 75, and the HK Performance	

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	and behavioral health services hotline calls.		Measures results on page 101. The Q4 QI Work Plan, page 135, indicates that WellCare conducted Drug Utilization Review (DUR) initiatives during the dispensing process to identify the need for additional utilization criteria (i.e., Point of Service (POS) edits, Utilization Management (UM) criteria) to drive appropriate medication management. Additionally, ongoing monitoring also includes, but is not limited to, adverse events, quality of care concerns, administrative services, case management/disease management enrollment and outcomes, health risk assessments, Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) services, and behavioral health services hotline calls.	
The Contractor's QI structures and processes shall be planned, systematic and clearly defined.	Full - WellCare's QI structure is well defined in the QI Program Description, UM Program Description, Patient Safety Plan and policies and procedures. Comprehensive descriptions of structure and processes including staff responsible, committees, resources, goals, utilization monitoring, monitoring of services, safety are provided. The QI Work Plan	Full	WellCare's QI structure is well defined in the QI Program Description, UM Program Description, Patient Safety Plan and Policies and Procedures. Comprehensive descriptions of structure and processes including staff responsible, committees, resources, goals, utilization monitoring,	

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	includes activities that are clearly defined.		monitoring of services, safety are provided. The QI Work Plan includes activities that are clearly defined.	
The Contractor's QI activities shall demonstrate the linkage of QI projects to findings from multiple quality evaluations, such as the EQR annual evaluation, opportunities for improvement identified from the annual HEDIS indicators and the consumer and provider surveys, internal surveillance and monitoring, as well as any findings identified by an accreditation body.	Full - The QI Work Plan and committee minutes demonstrate that quality initiatives are developed and implemented based on data analysis of a variety of quality indicators. The QI Work Plan includes a goal related to participation and few deficient findings for the EQR 2013 annual review and implementation of corrective actions as identified. The Work Plan states that the corrective action plans were submitted for all areas scored less than substantial compliance. 2013 provided the first full year of data for HEDIS, utilization and other metrics. Wellcare monitored the top 10 diagnosis for inpatient services and readmission rates. WellCare implemented a transitional care program to reduce readmission rates and an initiative for members with high readmission rates. The QI work plan describes the expansion of the UM onsite transitional program from 1 to 9 onsite nurses. Behavioral health readmissions are also being	Full	The QI Work Plan and committee minutes demonstrate that quality initiatives are developed and implemented based on data analysis of a variety of quality indicators. The QI Work Plan includes a goal related to participation with DMS/External Quality Review (EQR) activities, few deficient findings for the 2014 Annual Compliance Review, and implementation of corrective actions. The QI Work Plan states that the corrective action plans were submitted for all areas that scored less than substantial compliance. WellCare reported HEDIS and HK Performance Measures data. The Q4 QI Work Plan, on page 115, describes work on readmissions with the top 20 Kentucky hospitals. Wellcare monitored the top 10 diagnoses for inpatient services and readmission rates.	

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	monitored. Monitoring indicated that behavioral health provider availability for routine and urgent care decreased, although post-discharge availability improved. WellCare established the Behavioral Health Advisory Committee. Topics discussed included: an outpatient treatment program for sexual offenders, development of clinical criteria, holding meetings with providers, and high ED utilizers for BH diagnoses. The QI Work Plan describes an EPSDT database used to monitor gaps in care for members who are in need of EPSDT services. Provider Relations Representatives conduct academic detailing visits to distribute the gap reports and HEDIS toolkits. The plan continues to distribute periodicity letters to members and conducts-- via Centralized Telephonic Outreach-- education and assistance scheduling appointments. The plan identified priorities to be Emergency Department (ED) use, behavioral health medications, tobacco use and obesity. The proposed Performance Improvement Projects (PIPs) address these priority areas. The MCO continues to monitor the top 5 ED diagnoses and established a multidisciplinary team to address		WellCare continued a transitional care program to reduce readmission rates and an initiative for members with high readmission rates. Additionally, behavioral health (BH) readmissions continue to be monitored. The Q4 QI Work Plan, page 67, describes an EPSDT database ("KY-CHCHUP") used to monitor gaps in care for members who are in need of EPSDT services. Provider Relations representatives conduct academic detailing visits to distribute the gap reports and HEDIS toolkits to educate providers. The MCO continues to distribute periodicity letters to members and conducts-- via Centralized Telephonic Outreach-- education and assistance scheduling appointments. The Q4 QI Work Plan, page 33, indicates that a program to provide integrated case management to members with Serious Mental Illness (SMI) plus 5 or more chronic medical conditions continued in 2014 and was monitored by the Utilization Management Medical Advisory Committee (UMAC) and the Quality Improvement	

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	inappropriate ED utilization. WellCare reported positive results for ED diversion as a result of triage by the 24/7 NurseLine. During the onsite interview, WellCare indicated that CM follows up on NurseLine calls. WellCare initiated a pilot program on April 15, 2013 to provide integrated case management to members with Serious Mental Illness (SMI) in combination with 5 or more chronic medical conditions. The MCO collaborated with its largest Independent Physician Association (IPA), Kentucky Primary Care Associates (KPCA) in an effort to engage providers to more closely monitor behavioral health conditions. WellCare provides data for pharmacy and BH hospitalizations for KPCA panel members. Ongoing meetings to develop action plans and systems for monitoring are organized by the MCO. The number of licensed BH case managers increased in 2013 and 157 members received complex case management services in 2013. In 2013, WellCare continued to experience low rates for timely Health Risk Assessment (HRA) completion for pregnant women with a rate of completion within 30 days of enrollment of 15.7% for pregnant members. WellCare reported that a new vendor was		Committee (QIC) semi-annually. The Q4 QI Work Plan, page 28, describes an Autism initiative the MCO instituted, forming collaborative partnerships with community-based organizations that serve members with autism to plan, organize, and coordinate initiatives and strategies to assist members. The Q4 QI Work Plan, page 127, indicates that the MCO uses the "ELIZA" Computer Based program to complete the Health Risk Assessments (HRAs). The MCO initiated 32,855 HRAs and completed 6,455 (19.8%). Of the total completed, 6,162 were for non-pregnant members. There were 293 HRAs completed for pregnant members. The MCO outreached 94 of those pregnant members within 30 days. The MCO enrolled 8,297 members in Case Management (CM) and 55,665 in Disease Management (DM). WellCare continued to use HRAs to identify obese members and smokers and disseminated educational material to those members. Members with obesity and	

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	hired and the ELIZA computer based program would be used to complete HRAs. WellCare reported using HRAs to identify obese members and smokers and disseminating educational material to those members. Members with obesity and smokers are enrolled in CM where appropriate. During the onsite interview, WellCare reported working in collaboration with the DPH on quit smoking initiatives. WellCare monitored PCP/Pediatrician after-hours telephone availability which revealed that 58.9% of PCPs and 72.4% of pediatricians returned after hours phone calls within 30 minutes. The MCO reported that providers who remain non-compliant after second audit receive a CAP. WellCare experienced an appeals overturn rate of 62.8% for Member Appeals. The internal goal for the overturn rate was 50%. During 2013, the YTD overturn rate increased to 82.28 %. The top 3 appeal categories are tracked and were Care Core Supplies, BH Impact Plus and BH Inpatient, and pharmacy. Minutes demonstrate discussion of appeals and grievances at UMAC meetings. The committee suggested that a root cause analysis be conducted.		smokers are enrolled in CM where appropriate. During the onsite interview, WellCare reported working in collaboration with the Department of Public Health (DPH) on tobacco cessation initiatives. The Q4 QI Work Plan, page 5, describes WellCare's monitoring PCP/Pediatrician after-hours telephone availability. This revealed that of those audited, 57.8% were compliant with after-hours phone availability standards. The Provider Relations team and the Network Integrity Department continued to work with Network Physicians on this issue. WellCare closed 963 member appeals in 2014 and experienced an appeal overturn rate of 79.8%, 17 percentage points above 2013. The internal goal for the overturn rate was 50%. The top appeal categories are tracked and were Care Core Supplies, Consult with Services, BH Inpatient, and Durable Medical Equipment (DME) (Q4 QI Work Plan, page 22). Minutes demonstrate discussion of appeals and grievances at UMAC meetings.	

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	During the onsite interview, WellCare stated that the majority of appeal overturns were related to incomplete information received for the initial authorization, causing a denial and submission of additional documentation upon appeal, resulting in overturn of the initial decision. Also, WellCare described an issue related to confusion on appropriate documentation needed for authorization of psychiatric testing by the Kentucky Department of Behavioral Health (DBH). WellCare also reported that the Appeals department worked on process flows to combine and streamline the Grievance and Appeals processes. The 2013 Quality Improvement Program Evaluation was due for review and approval by the MCO's quality committees (UMAC, QMAC, and QIC) in March 2014. This is due to DMS with the Q2 2014 quarterly reports. **Recommendation for WellCare** WellCare should continue to monitor and address the appeals overturn rate. **MCO Response:** WellCare will continue to monitor and address the appeals overturn rate as appropriate.		The 2013 Quality Improvement Program Evaluation is due for review and approval by the MCO's quality committees (UMAC, Quality and Member Access Committee (QMAC), and QIC in March 2015. This report is due to DMS with the Q2 2014 quarterly reports.	
The QAPI program shall be developed	Full- Minutes from QMAC meetings on March 29,	Full	QMAC meetings were held on 3/26/14,	

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in collaboration with input from Members.	2013, June 6, 2013, September 18, 2013 and December 13, 2013 (draft) demonstrate review of the first member CAHPS survey results.		6/4/14, 9/11/14 and 12/4/14. Membership included 12 Community members, including the Chair. Minutes show evidence of substantive review of the QI program and processes.	
The Contractor shall maintain documentation of all member input; response; conduct of performance improvement activities; and feedback to Members.	Full - The plan provided QMAC Committee minutes for meetings held on March 29, 2013, June 6, 2013, September 18, 2013 and December 13, 2013 (draft minutes).	Full	The QMAC Committee minutes document member input and response in areas including, but not limited to, the QI Program Description and Evaluation, Network Adequacy and Availability assessment, Member Satisfaction reports, Community Engagement, Innovative Programs and Member Materials.	
The Contractor shall have or obtain within 2-4 years and maintain National Committee for Quality Assurance (NCQA) accreditation for its Medicaid product line.	NA - In 2013, WellCare began preparations for its first NCQA accreditation survey. A team was assembled and began meeting quarterly. Additionally, mock audits have been conducted.	Full	WellCare was awarded a three year "Commendable" accreditation effective 9/2/14.	
The Contractor shall provide the Department a copy of its current certificate of accreditation together with a copy of the complete survey report every three years including the scoring at the category, Standard, and	NA - Not applicable, as the first accreditation survey will be held on July 28, 2014. Documentation is due to NCQA by June 10, 2014. Preparations and an internal deadline of April 2014 for documents was seen in the December 16, 2013 QI meeting minutes. The QI Work Plan includes quarterly meetings by the NCQA Team	Full	WellCare submitted the certificate of accreditation and a copy of the complete survey report to the Department in September 2014.	

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element levels, as well as NCQA recommendations, as presented via the NCQA Interactive Survey System (ISS): Status, Summarized & Detailed Results, Performance, Performance Measures, Must Pass Results Recommendations and History.	and mock audit during Q2 2013. The team reviewed recommendations for improvement and conducted activities to meet identified gaps.			
Annually, the Contractor shall submit the QAPI program description document to the Department for review.	Full - The 2013 QI Program Description was approved internally in Q1 2013 (3/28/2013). The BOD approved the document in Q2 2013 (6/20/2013).	Full	The QAPI Program Description was submitted to the Department for review.	
The Contractor shall integrate Behavioral Health indicators into its QAPI program and include a systematic, ongoing process for monitoring, evaluating, and improving the quality and appropriateness of Behavioral Health Services provided to Members.	Full - The 2013 QI Work Plan evidences initiation of a pilot program to provide integrated case management to members with Serious Mental Illness (SMI) and with ≥ 5 chronic medical conditions. As of Q4 2013, 59 members were enrolled. As noted previously, WellCare collaborated with Kentucky Primary Care Associates on engaging providers to more closely monitor behavioral health conditions and also reported the 2013 HEDIS behavioral health measures, including Follow-up After Inpatient Admission for MDD and Monitoring of Children Prescribed ADHD Medications. WellCare submitted documentation related to data	Full	The Q4 2014 QI Work Plan, page 64, evidences continued integrated case management for members with Serious Mental Illness (SMI) and with ≥ 5 chronic medical conditions [4th Q QI Work Plan Report pg 33). Additionally, the MCO maintains a BH Case Management Program. 5689 members were referred to the program during the year (Q4 QI Work Plan, page 33). BH admissions and readmissions continue to be monitored. WellCare submitted results of adult and child BH satisfaction survey results to DMS.	

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	collected annually to monitor the exchange of information between physical and behavioral health providers; appropriate diagnosis, treatment and referral of behavioral conditions seen in primary care; appropriate psychopharmacological medication prescribing; access and follow-up for members with coexisting physical and behavioral conditions; and preventive behavioral health care programs. WellCare reported results related to BH indicators in monitoring providers for compliance with medical record documentation standards, including: consultations from BH providers in the medical record and reviewed (24.3%). WellCare submitted data for the HEDIS BH measures: Diabetes Screening and Monitoring for Members with Schizophrenia. WellCare initiated a PH/BH PIP focusing on PCP prescribing of behavioral health medications for children.		WellCare submitted data for the HEDIS BH measures, including Diabetes Screening and Monitoring for Members with Schizophrenia. The MCO is contracted with "MD2U", which delivers primary care for chronic and acute illnesses for home-bound or home-limited members who have difficulty traveling to a doctor's office. Services provided include BH care. Additionally the "WellCall" Home-Based Care Model for High-Risk members includes BH services. As a result of State Plan Amendments passed in 201 allowing a wider variety of BH practitioners to serve Kentucky Medicaid, the MCO contracted with all 14 CMHCs and more than 600 individual providers and continues to monitor for additional contracting opportunities across the state. Other BH initiatives included: BH staff members were trained in suicide prevention as part of the Suicide to Zero Program; key metrics and BH provider performance profiles were created by the	

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			MCO, BH network access & availability were monitored; BH Clinical Practice Guidelines were included in the regular review conducted by the MCO; member appeals related to BH services were monitored and revealed that BH Inpatient was one of the top 3 categories of appeals; BH providers were included in the MCO's monitoring of compliance with medical record documentation standards; BH care issues are included in Quality of Care monitoring activities; the BH Services Hotline was monitored for quality of service delivered to members; and BH medications are included in the Pharmacy QI program.	
The Contractor shall collect data, and monitor and evaluate for improvements to physical health outcomes resulting from behavioral health integration into the Member's overall care.	Full - WellCare reported a QI activity related to Coordination of Care Between Medical and Behavioral Health with a goal of collecting data around this issue. WellCare initiated integrated case management efforts (physical health and behavioral health). After analyzing claims data, a pilot with 64 members who had a BH diagnosis and ≥ 5 chronic medical conditions was conducted. A clinical software system was created to monitor this effort. Home visits to perform comprehensive assessments and develop care plans are planned.	Full	As described above, WellCare continues to collect data, analyze and monitor, and evaluate for improvements in the care provided by its network of providers and facilities relative to BH. This includes the integrated case management program, monitoring admissions and readmissions, developing and reviewing clinical practice guidelines, and monitoring BH providers' compliance with medical record standards.	

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	In Q2 2013, WellCare developed protocols for medical case managers to make referrals to behavioral health case management following hospitalization for suicide or drug overdose. Additionally, protocols have been developed for behavioral health referrals to medical case management.		Additionally, the BH staff underwent suicide prevention training.	
19.2 Annual QAPI Review				
The Contractor shall annually review and evaluate the overall effectiveness of the QAPI program to determine whether the program has demonstrated improvement in the quality of care and service provided to Members. The Contractor shall modify, as necessary, the QAPI Program, including Quality Improvement policies and procedures; clinical care standards; practice guidelines and patient protocols; utilization and access to Covered Services; and treatment outcomes to meet the needs of Members. The Contractor shall prepare a written report to the Department, detailing the annual review and shall include a review of completed and	Full- WellCare indicated that the 2013 Quality Improvement Program Evaluation was in process during Q1 2014 and was scheduled for review and approval by the quality committees (UMAC, QMAC, QIC) at the March 2014 quarterly meetings. The report is due to DMS with the Q2 2014 quarterly reports (July 2014). The 2012 QI Program Evaluation was submitted to DMS as required.	Full	The 2013 QI Program Evaluation was approved by the UMAC, QMAC and QIC. The 2014 QI Program Evaluation is scheduled for review at the March 2015 meetings.	

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continuing QI activities that address the quality of clinical care and service; trending of measures to assess performance in quality of clinical care and quality of service; any corrective actions implemented; corrective actions which are recommended or in progress; and any modifications to the program. There shall be evidence that QI activities have contributed to meaningful improvement in the quality of clinical care and quality of service, including preventive and behavioral health care, provided to Members. The Contractor shall submit this report as specified by the Department.				
21.3 External Quality Review				
The Contractor shall provide information to the EQRO as requested to fulfill the requirements of the mandatory and optional activities required in 42 CFR Parts 433 and 438.	Full - WellCare submitted the requested documentation and fully cooperated with the onsite process for the annual compliance review, the Performance Improvement Project (PIP) proposals and reports, and has participated in EQRO focused studies as requested.	Full	WellCare submitted the requested documentation and fully cooperated with the onsite process for the Annual Compliance Review, conducts and reports Performance Improvement Projects (PIPs), and has participated in EQRO focused studies and validation studies as requested.	
The Contractor shall cooperate and	Full - Per above for comment for 21.3.	Full	Per above for comment for 21.3.	

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participate in the EQR activities in accordance with protocols identified under 42 CFR 438, Subpart E. These protocols guide the independent external review of the quality outcomes and timeliness of, and access to, services provided by a Contractor providing Medicaid services. In an effort to avoid duplication, the Department may also use, in place of such audit, information obtained about the Contractor from a Medicare or private accreditation review in accordance with 42 CFR 438.360.				
21.4 EQR Administrative Reviews				
The Contractor shall assist the EQRO in competing all Contractor reviews and evaluations in accordance with established protocols previously described.	Full - WellCare actively participated in both PIP and Performance Measure validation.	Full	WellCare actively participates in all mandatory and optional EQR activities conducted on behalf of DMS.	
The Contractor shall assist the Department and the EQRO in identification of Provider and Member information required to carry out annual, external independent reviews of the quality outcomes and timeliness	Full - WellCare provided all documentation necessary for the Annual Compliance Reviews in 2013 and 2014, the 2013 Technical Report production, and records for focused studies as requested.	Full	WellCare provided all documentation necessary for the Annual Compliance Reviews in 2014 and 2015, the 2014 Technical Report production, and records, data and documentation for focused studies, validation studies, PIPs, and	

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of on-site or off-site medical chart reviews. Timely notification of Providers and subcontractors of any necessary medical chart review shall be the responsibility of the Contractor.			Performance Measure Validation.	
21.5 EQR Performance				
If during the conduct of an EQR by an EQRO acting on behalf of the Department, an adverse quality finding or deficiency is identified, the Contractor shall respond to and correct the finding or deficiency in a timely manner in accordance with guidelines established by the Department and EQRO. The Contractor shall:	Full - The 2013 EQR compliance review findings were received by the plan and corrective actions were planned and implemented. WellCare worked with DMS and IPRO on recommended PIP revisions.	Full	The 2014 Annual Compliance Review findings were received by the MCO and corrective actions were planned and implemented. WellCare proactively submitted a formal corrective action plan with its responses to the 2014 findings.	
A. Assign a staff person(s) to conduct follow-up concerning review findings;	Full- The QI Work Plan reveals that a staff member was assigned to follow-up on the Annual Compliance Review findings.	Full	The 2014 QI Work Plan demonstrates that a staff member was assigned to follow-up on the Annual Compliance Review findings.	
B. Inform the Contractor's Quality Improvement Committee of the final findings and involve the committee in the development, implementation and monitoring of the corrective action plan; and	Full- The QIC description indicates that the committee is responsible for monitoring and ensuring compliance of QI Program activities with regulatory and contractual standards.	Full	The QIC description indicates that the committee is responsible for monitoring and ensuring compliance with regulatory and contractual standards.	

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C. Submit a corrective action plan in writing to the EQRO and Department within 60 days that addresses the measures the Contractor intends to take to resolve the finding. The Contractor's final resolution of all potential quality concerns shall be completed within six (6) months of the Contractor's notification.	Full- The QI work plan indicates that the corrective action plan for areas determined to be less than substantially compliant was developed and submitted. This is also incorporated in the QI Program Description. The Final Annual Compliance Review report details the CAPs.	Full	For 2014, this is evidenced in the corrective action plans (CAPs) that WellCare provided with its responses to the 2014 Annual Compliance Review findings and described in the 2014 QI Work Plan under "EQRO Audit". The CAPs were approved by DMS and are being implemented.	
D. The Contractor shall demonstrate how the results of the External Quality Review (EQR) are incorporated into the Contractor's overall Quality Improvement Plan and demonstrate progressive and measurable improvement during the term of this contract; and	Full- Per above for comment for 21.5.	Full	Addressed in the 2014 QI Program Description, Activities to Fulfill the Scope, Objectives. Implementation as described above.	
E. If Contractor disagrees with the EQRO's findings, it shall submit its position to the Commissioner of the Department whose decision is final.	Full- The plan submitted a letter to the Department of Medicaid Services dated September 27, 2013 detailing its position.	Full	For 2014, WellCare was permitted to submit responses to the preliminary findings. These were reviewed by the EQRO, IPRO and DMS and final determinations made. As noted above, WellCare developed and implemented CAPs where necessary.	
19.3 QAPI Plan				

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall have a written QAPI work plan that	Full - The plan submitted the 2013 Quality Assessment and Performance Improvement (QAPI) Work Plan with quarterly updates.	Full	Evidenced in the 2014 QI Work Plan with quarterly updates (Report #17).	
outlines the scope of activities and	Full - The QAPI Work Plan addresses activities conducted/continued during CY 2013. In addition to those initiated in 2012, the following were added: Performance Improvement Projects (PIPs), NCQA Accreditation, Evaluation of QI Program, Innovative Programs, Health Risk Assessments, and additional Behavioral Health and Pharmacy Initiatives. WellCare deferred a Provider Recognition Program planned in 2012/2013 and the program description will be finalized in 2014.	Full	The 2014 QI Work Plan includes activities conducted/continued during calendar year (CY 2014), including detailed information and updates for each task.	
the goals,	Full - For each activity, a goal(s) and objective(s) is/are provided, many of which are quantitative.	Full	The 2014 QI Work Plan includes goal(s) and objective(s) for each activity, many of which are quantitative.	
objectives, and	Full -. For each activity, a goal(s) and objective(s) is/are provided, many of which are quantitative.	Full	The 2014 QI Work Plan includes goal(s) and objective(s) for each activity, many of which are quantitative.	
timelines for the QAPI program.	Full- Reporting timeframes for all QI Work Plan activities are included in the 2013 QI Work Plan, third column "Completion Timeframe" and are generally listed as quarterly.	Full	Reporting timeframes for all activities are included in the 2014 QI Work Plan under "Completion Timeframe".	
New goals and objectives must be set	Full- The plan has implemented several quality	Full	Addressed in the 2013 QI Evaluation,	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
at least annually based on findings from quality improvement activities and studies, survey results, Grievances and Appeals, performance measures and EQRO findings.	improvement activities as described in the 2013 QI Work Plan and has used HEDIS data and other indicators to update goals and objectives.		Program Impact and Recommendations. Demonstrated in the 2014 QI Work Plan, which provides goals and objectives and identifies previously identified issues.	
The Contractor is accountable to the Department for the quality of care provided to Members. The Contractor's responsibilities of this include, at a minimum: approval of the overall QAPI program and annual QAPI work plan;	Full- As evidenced in the March 28, 2013 QIC meeting minutes, the 2013 QI Program Description and Work Plan and the 2012 Quality Improvement Program Evaluation were approved by the QIC. The 2013 Medicaid Quality Improvement Program Description was approved by the Utilization Management Medical Advisory Committee on 3/27/13; reviewed by the Quality and Member Access Committee (QMAC) on 3/29/13, and approved by the Board of Directors on 6/20/13.	Full	Addressed in the 2014 QI Program Description, Authority, Scope, Role of the QI Department and in the Committee Descriptions for the Board of Directors and QIC. Evidenced in review and approval of the 2014 QI Program Description, 2014 QI Work Plan and QI Evaluation.	
designation of an accountable entity within the organization to provide direct oversight of QAPI;	Full - According to the QI Program Description, the Board of Directors is ultimately accountable for services provided to members, is responsible for oversight of the QI Program, and delegates monitoring and evaluation of the effectiveness of the Program to the Quality Improvement Committee (QIC). The Director of QI is responsible for day-to-day oversight.	Full	According to the 2014 QI Program Description, the Board of Directors is ultimately accountable for services provided to members and oversight of the QI Program, and delegates monitoring and evaluation of the effectiveness of the Program to the QIC. The Director of QI is responsible for day-to-day oversight.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
review of written reports from the designated entity on a periodic basis, which shall include a description of QAPI activities, progress on objectives, and improvements made;	Full - The 2013 QAPI Work Plan /QIC minutes include presentation and discussion of QI initiatives' activities and results.	Full	The 2014 QAPI Work Plan and QIC minutes include presentation and discussion of QI initiatives' activities and results.	
review on an annual basis of the QAPI program; and	Full - As evidenced in the March 28, 2013 QIC meeting minutes, the 2013 QI Program Description and Work Plan and the 2012 Quality Improvement Program Evaluation were approved by the QIC. The 2013 Medicaid Quality Improvement Program Description was approved by the Utilization Management Medical Advisory Committee on 3/27/13; reviewed by the Quality and Member Access Committee (QMAC) on 3/29/13, and approved by the Board of Directors on 6/20/13. The 2013 QI Program Evaluation is included in the QI Work Plan and QI Program Description and is scheduled for completion in Q1 2014.	Full	Addressed in the 2014 QI Program Description, Authority, Scope, Role of the QI Department and in the Committee Descriptions for the Board of Directors and QIC. Evidenced in review and approval of the 2013 QI Evaluation, 2014 QI Program Description and 2014 QI Work Plan.	
modifications to the QAPI program on an ongoing basis to accommodate review findings and issues of concern within the organization.	Full - The QI Work Plan includes quarterly updates to QAPI activities and modifications based on findings. As described previously, WellCare has implemented activities in priority areas. The 2012 QI Program Evaluation includes recommendations for activities and goals for 2013 based on prior findings.	Full	The 2014 QI Work Plan includes quarterly updates to QI activities, results and modifications based on findings. As described previously, WellCare has implemented a wide variety of activities in priority areas. The 2013 QI Program Evaluation includes Program Impact and Recommendations for	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			2014 based on prior findings.	
The Contractor shall have in place an organizational Quality Improvement Committee that shall be responsible for all aspects of the QAPI program.	Full - The QIC is described in the QI Program Description and meeting minutes demonstrate conduct of responsibilities. The Quality Improvement Committee responsibilities include providing general direction, oversight and approval of the QI activities and promoting the goals and objectives of the QI Program. The QIC is responsible for reviewing and revising the QI program Description, Annual QI Program Evaluation, and QI policies and procedures; monitoring and analyzing the QI program's progress towards goals; and recommending follow up action and improvement activities.	Full	The QIC is described in the 2014 QI Program Description and meeting minutes demonstrate conduct of responsibilities. The Quality Improvement Committee responsibilities include providing general direction, oversight and approval of the QI activities and promoting the goals and objectives of the QI Program. The QIC is responsible for reviewing and revising the QI program Description, Annual QI Program Evaluation, and QI policies and procedures; monitoring and analyzing the QI program's progress towards goals; and recommending follow up action and improvement activities.	
The committee structure shall be interdisciplinary and be made up of both providers and administrative staff. It should include a variety of medical disciplines, health professions and individual(s) with specialized knowledge and experience with Individuals with Special Health Care	Full- The QIC is chaired by the Medical Director. WellCare has recruited a local Kentucky Medical Director as documented in the MCO's organizational chart. WellCare staff members include: - President - Medical Director	Full	The QIC is chaired by the Kentucky Medical Director. Kentucky MCO representatives include: President, Medical Director, State Pharmacy Director, Field Health Services Director, QI Project Manager, Chief Operating Officer, Market Directors,	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Needs.	- State Pharmacy Director - Field Health Services Director - Director of Network Development - Director of Regulatory Affairs - Manager of Regional Operations - Human Resources Manager - Director of Hospital Contracting - Manager of Regional Operations - Manager of Foster Care, Adoption, Guardianship - Appeals Supervisor - Provider Relations Manager - All QI Staff - Other staff on an ad hoc basis WellCare Corporate participants represent a variety of roles and include senior staff for: QI, QM, BH Clinical Operations, Customer Service, Credentialing, Claims, Appeals and Grievances, UM, Clinical Care Management, Complaints, Disease Management, Enrollment, Compliance and Accreditation, QIC subcommittee chairpersons, and other ad hoc members. Network providers from a variety of specialties are represented via membership in the Utilization Management Medical Advisory Committee (UMAC) which reports to the QIC and oversees clinical QI, UM		Finance Director, Director of Network Development, Director of Regulatory Affairs, Manager of Regional Operations, Human Resources Manager, Director of Hospital Contracting, Manager of Foster Care, Adoption, and Guardianship, Appeals Supervisor, Provider Relations Manager, all QI staff and others as may be deemed appropriate by the QIC from time to time. WellCare Corporate representatives include: Vice President, Quality and Analytics, Chief Medical Officer, Behavioral Health Clinical Operations and Practice Senior Director, Customer Service Director, Credentialing Director, Claims Director, Appeals and Grievances Senior Director, UM Director, UM Medical Director, Senior Director of Clinical Care Management, Complaints Manager, Disease Management Director, Enrollment Director, Quality Compliance and Accreditation Director, chairs of all QIC subcommittees and other participants as needed. Network providers from a variety of specialties are represented via	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	and behavioral health activities. Additionally, providers are members of the Pharmacy and Therapeutics Committee and the Credentialing and Peer Review Committee.		membership in the UMAC, which reports to the QIC and oversees clinical QI, UM and behavioral health activities. Additionally, providers are members of the Pharmacy and Therapeutics Committee and the Credentialing and Peer Review Committee.	
The committee shall meet on a regular basis and activities of the committee must be documented; all committee minutes and reports shall be available to the Department upon request.	Full - The QIC meets at least quarterly. In 2013, the QIC met on March 28, 2013, June 25, 2013, July 9, 2013, September 23, 2013, and December 16, 2013. Minutes were provided for each meeting. Minutes were provided for UMAC meetings that occurred on March 29, 2013, June 6, 2013, September 18, 2013, and December 13, 2013. Committee minutes include thorough documentation of committee activities. Minutes are submitted to DMS with each quarterly report.	Full	The QIC meets at least quarterly. In 2014, the QIC met on March 31, May 28, June 15, June 25, September 23, October 10, and December 15, 2014. Minutes were provided for each meeting. Minutes were provided for UMAC meetings that occurred on January 24, March 27, April 7, May 19, June 3, June 4, June 12, June 25, September 18 and December 11, 2014. Committee minutes include thorough documentation of committee activities. Committee meeting minutes are submitted to DMS with each quarterly report.	
QAPI activities of Providers and	Full- QI and encounter requirements for	Full	QI and encounter requirements for	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Subcontractors, if separate from the Contractor's QAPI activities, shall be integrated into the overall QAPI program. Requirements to participate in QAPI activities, including submission of complete Encounter Records, are incorporated into all Provider and Subcontractor contracts and employment agreements. The Contractor's QAPI program shall provide feedback to the Providers and Subcontractors regarding integration of, operation of, and corrective actions necessary in Provider and Subcontractor QAPI activities.	subcontractors are stated in the Provider Manual, Section 9 Delegated Entities. The contract Delegation Addendum includes a schedule of delegated activities including those that address claims processing and quality improvement. Provider participation in the QI program is described in the Provider Manual, Section 3 Quality Improvement and is stated as a contractual requirement. Requirements for claims and encounters are described in Section 5 of the Provider Manual. Delegation oversight is described in the QI Program Description. Activities include pre-delegation assessment, annual evaluation, and review of quarterly reports. The QI Program Description indicates that providers participate in MCO QI activities via committee participation. Providers also collaborate with MCO QI activities (e.g., IPA collaboration on BH conditions) and through implementation of interventions.		subcontractors are delineated in the Provider Manual, Section 9 - Delegated Entities. The contract Delegation Addendum includes a schedule of delegated activities including those that address claims processing and quality improvement. Delegation oversight is described in the QI Program Description. Activities include pre-delegation assessment, annual evaluation, and review of quarterly reports. Provider participation in the QI program is described in the Provider Manual, Section 3 - Quality Improvement and is stated as a contractual requirement. Requirements for claims and encounters are described in Section 5 of the Provider Manual. The 2014 QI Program Description indicates that providers participate in MCO QI activities via committee participation. Providers also collaborate with MCO QI activities (e.g., Independent Practice Association (IPA) collaboration on BH conditions) and through implementation of	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			interventions.	
The Contractor shall integrate other management activities such as Utilization Management, Risk Management, Member Services, Grievances and Appeals, Provider Credentialing, and Provider Services in its QAPI program.	Full- The QI Program Description and committee meeting minutes document that representatives from operational units across the MCO and at a corporate level participate in QI committees, including but not limited to: UM, Risk Management, Customer Service, Appeals and Grievances, Credentialing and Provider Relations. The scope and objectives of the QI program, QI Work Plan, and committee meeting minutes and reports indicate a broad scope of QI activities, including monitoring of utilization metrics, grievances and appeals, provider surveys, customer service/call center metrics, and member and provider satisfaction surveys.	Full	The 2014 QI Program Description and committee meeting minutes document that representatives from operational units across the MCO and at the corporate level participate in QI committees, including but not limited to: UM, Risk Management, Customer Service, Appeals and Grievances, Credentialing and Provider Relations. The scope and objectives of the QI Program, QI Work Plan, and committee meeting minutes and reports indicate a broad scope of QI activities, including monitoring of utilization metrics, grievances and appeals, provider surveys, customer service/call center metrics, and member and provider satisfaction surveys.	
Qualifications, staffing levels and available resources must be sufficient to meet the goals and objectives of the QAPI program and related QAPI activities, including, but not limited to, monitoring and evaluation of Member's care and services, including the care and services of Members with special	Full- During the onsite interview, WellCare indicated that the QI Department was fully staffed including the medical director position, and that open positions relate to expansion of the department. This was evidenced in the organizational chart provided with the pre-onsite documentation. New positions for HEDIS Field Advisors have been added to enhance provider education activities.	Full	Addressed in the 2014 QI Program Description, Role of the Medical Director, Role of the BH Medical Director, Role of the Quality Improvement Department which descries the number and disciplines of staff dedicated to the QI Program. Evidenced in the 2014 QI Work Plan which	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
health care needs, use of preventive services, coordination of behavioral and physical health care needs, monitoring and providing feedback on provider performance, involving Members in QAPI initiatives and conducting performance improvement projects. Written documentation listing staffing resources, including total FTE's, percentage of time, experience, and roles shall be submitted to the Department upon request.			designates departments and individuals responsible for QI activities.	
The Contractor shall submit the QAPI work plan to the Department annually in accordance with a format and timeline specified by the Department.	New Requirement	Full	Evidenced in the quarterly reports. The 2014 QI Work Plan updates (Report #17) were submitted each quarter in 2014.	
19.4 QAPI Monitoring and Evaluation				
A. The Contractor, through the QAPI program, shall monitor and evaluate the quality of health care on an ongoing basis. Health care needs such as acute or chronic physical or behavioral conditions, high volume, and high risk, special needs populations, preventive care, and behavioral health shall be studied and prioritized for performance	Full - The QI Work Plan, committee meeting minutes and QI Evaluation demonstrate that WellCare maintains a QAPI program to monitor and evaluate the quality of clinical care on an ongoing basis, including acute and/or chronic physical and behavioral conditions, high volume (ED and readmissions), and high risk (SMI population readmission initiative), , special needs populations, preventive care, and behavioral health. The QI Evaluation includes analysis	Full	The 2014 QI Work Plan, committee meeting minutes and 2013 QI Evaluation demonstrate that WellCare maintains a QI/QAPI program to monitor and evaluate the quality of clinical care on an ongoing basis, including acute and/or chronic physical and behavioral conditions, high volume (ED and readmissions), and high risk (SMI population readmission initiative),	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
measurement, performance improvement and/or development of practice guidelines. Standardized quality indicators shall be used to assess improvement, assure achievement of at least minimum performance levels, monitor adherence to guidelines and identify patterns of over- and under-utilization. The measurement of quality indicators selected by the Contractor must be supported by valid data collection and analysis methods and shall be used to improve clinical care and services.	and recommendations for the following year. WellCare reported CAHPS, HEDIS, and KY Health Outcomes standardized quality indicators. Rates are benchmarked against national percentiles (HEDIS and CAHPS) or reviewed by DMS and the EQRO. Per the onsite interview, WellCare indicated that adherence to guidelines is monitored via HEDIS performance (e.g., preventive services, care for diabetes and asthma and pregnancy) and is described in the QI Evaluation. The QI Evaluation indicates that WellCare has monitored utilization for prenatal and postpartum visits, preventive care services, ED, readmissions, inpatient utilization. Additionally, the MCO initiated its first 2 PIPs (one for PH and one for BH) and submitted proposals for 2014 PIPs as directed by DMS and with ongoing evaluation by the EQRO, IPRO. The QI Evaluation document demonstrates evaluation of performance and action plans for improvement. As described previously, WellCare analyzed the high appeals overturn rates and acted accordingly.		special needs populations, preventive care, and behavioral health. The 2013 QI Evaluation includes analysis and recommendations for the following year. WellCare reported standardized quality indicators, including CAHPS, HEDIS, and HK Performance Measures. Rates are benchmarked against national percentiles (HEDIS and CAHPS) and/or reviewed by DMS and the EQRO. MCO Report #23 dated 4/28/14 and 7/30/14 list the Clinical Practice Guidelines reviewed and adopted. The MCO also provided the Evidence Based Guidelines for Practitioners sent to providers, dated 2/17/14. The 2013 QI Evaluation describes WellCare's PIP implementation and indicates that the MCO has monitored utilization for prenatal and postpartum visits, preventive care services, ED, readmissions, inpatient utilization.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			The 2013 QI Evaluation document demonstrates evaluation of performance and action plans for improvement.	
B. Providers shall be measured against practice guidelines and standards adopted by the Quality Improvement Committee.	Full- As demonstrated in the QI Evaluation and the WellCare of Kentucky Clinical Practice Guidelines Assessment as well as onsite interview, WellCare uses the annual HEDIS measurement to evaluate practitioner compliance against clinical practice guidelines. **Recommendation for WellCare** Though not required specifically, WellCare might consider a targeted assessment of a chosen CPG. For instance, during HEDIS data collection or medical records standards review, WellCare might assess key components for a CPG of interest, e.g., ADHD assessment and diagnosis or additional components of asthma management. **MCO Response:** WellCare acknowledges the recommendation made by the EQRO.	Full	As demonstrated in the 2013 QI Evaluation and the WellCare Clinical Practice Guidelines Assessment, the MCO uses the annual HEDIS rates to evaluate practitioner compliance against clinical practice guidelines. The 2014 QI Work Plan addresses practitioner compliance with CPG's using HEDIS measures focused on Diabetes in Adults, Asthma, Depression in Adults, and ADHD.	
Areas identified for improvement shall be tracked and corrective actions taken as indicated.	Full - The QI Work Plan and QI Evaluation, as well as committee meeting minutes, demonstrate tracking and corrective actions for areas identified in need of improvement. For example, in the Program Impact, accomplishments included, but were not limited to,	Full	The 2014 QI Work Plan, 2013 QI Evaluation, and committee meeting minutes demonstrate tracking of performance and corrective actions where needed.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	network adequacy, credentialing, improving member care gaps and patient safety, call center and BH Hotline performance, claims processing and establishing 12 regional HealthConnections Councils. Areas identified by WellCare for improvement included: identifying and addressing barriers to improvement for those metrics not meeting goals.		The 2013 QI Program was considered effective as the MCO achieved all of its QI objectives. The MCO indicated that the resources were adequate; however, additional staffing resources were identified for 2014 to further improve performance outcomes. Notable successes include: convened all committees that support the QI Program as required; achieved 100 % network adequacy in all urban and rural areas; conducted extensive oversight of delegated vendors; conducted Provider Workshops and Summits throughout the state; implemented activities aimed at improving member safety; established baseline HEDIS rates, CAHPS results and provider satisfaction results and identified actionable ways to improve results; implemented a HEDIS Member Incentive Program targeting improvement in annual dental visits; piloted a successful Coordinated Case Management program for members with high PH and BH needs and that resulted in 17% overall lower costs 17% in the Q1and 44% in Q2 2014;	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			established baseline rates for medical record standards and EPSDT documentation compliance; identified Health Hotline metrics for monitoring; processed 96.88% of clean claims within 30 days; and convened 12 regional member HealthConnections Councils. Areas of the 2013 QI Program not meeting goals were analyzed and barriers to improvement were identified and were integrated in the 2014 QI Work Plan. In addition, activities included in the 2013 QI Work Plan will continue in 2014 as appropriate and the QI Department added 2014 staff resources as described above.	
The effectiveness of corrective actions must be monitored until problem resolution occurs. The Contractor shall perform reevaluations to assure that improvement is sustained.	Full - The 2013 QI Program Description and QI Work Plan describe monitoring of delegated services and CAPs to resolution. For example, the high risk OB management provider was required to implement CAPs for policy and procedure gaps. Onsite, WellCare provided, Delegation Oversight Committee meeting minutes, CAP monitoring documents, communications with Alere, resolution letter and a copy of the corrected P/P under CAP.	Full	The 2014 QI Work Plan, 2013 QI Evaluation and committee meeting minutes demonstrate tracking and corrective actions for areas identified in need of improvement.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
C. The Contractor shall use appropriate multidisciplinary teams to analyze and address data or systems issues.	Full- The QI Program Description reveals that QI resources include: A VP of QI, Director of Field QI, a QI Coordinator, 2 QI Project Managers, 2 RN QI Specialists, as well as the Medical Director and BH Medical Director and committee members and MCO staff from other departments. During the onsite interview, WellCare indicated that the QI program was expanded to include additional field staff throughout the Kentucky regions.	Full	aThe2014 QI Program Description, Role of the QI Department indicates that QI resources include: a VP of QI & Analytics, Sr. Director of QI, Director of QI, 2 QI Managers, 2 QI Coordinators, 2 QI Project Managers, a QI Analyst, 4 RN QI Specialists, 8 HEDIS Advisors, and the Chief Medical Officer and BH Medical Director, as well as committee members and MCO staff from other departments.	
D. The Contractor shall submit to the Department upon request documentation regarding quality and performance improvement (QAPI) projects/performance improvement projects (PIPs) and assessment that relates to enrolled members.	Full - Baseline results for the 2013 PIPs and proposals for 2014 PIPs were submitted to DMS and the EQRO as required. Additionally, updates for the PIPs and other QI initiatives are found in the QI Work Plan.	Full	WellCare submitted two PIP proposals and baseline and interim reports for PIPs in progress as required.	
E. The Contractor shall develop or adopt practice guidelines that are disseminated to Providers and to Members upon request.	Full - WellCare submitted copies of CPGs that have been established. Additionally, the QI Evaluation describes the category (Chronic, Behavioral Preventive), the condition addressed, the clinical basis, date of most recent update, distribution to practitioners, relation to disease management and method of assessment as well as other CPGs and status (distribution, pending approval).	Full	WellCare submitted copies of CPGs that have been established. WellCare submitted quarterly Report #23 Evidenced Based Guidelines for Q1-Q4 2014. The 2014 QI Work Plan describes adoption and review of CPGs and monitoring	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			practitioner compliance with guidelines.	
The guidelines shall be based on valid and reliable medical evidence or consensus of health professionals;	Full- Per above for comments for 19.4 and also, per the QI Program Description, each CPG lists references, among them, American Heart Association, National Heart, Blood, and Lung Institute, NYC Department of Health and Mental Hygiene, US Preventive Services Task Force, NYU School of Medicine, American Society of Clinical Oncology, Centers for Disease Control.	Full	Per the 2014 QI Program Description, each CPG lists references, among them, American Heart Association, National Heart, Blood, and Lung Institute, NYC Department of Health and Mental Hygiene, US Preventive Services Task Force, NYU School of Medicine, American Society of Clinical Oncology, and Centers for Disease Control.	
consider the needs of Members;	Full - Guidelines adopted in 2013 include: Cancer, Diabetes in Children and Diabetes in Adults.	Full	Guidelines adopted in 2014 include: Cholesterol Management, Obesity in Adult, Obesity in Children, Osteoporosis, Alzheimer's Disease and Other Dementias, Fall Risk Assessment in Older Adults, HIV Antiretroviral Treatment, HIV Screening, Imaging for Low Back Pain, Pharyngitis, and Rheumatoid Arthritis.	
developed or adopted in consultation with contracting health professionals, and	Full - The QI Program Description notes that guidelines are developed with community physician input through the UMAC. UMAC committee minutes demonstrate participation of network physicians.	Full	The 2014 QI Program Description notes that guidelines are developed with community physician input through the UMAC. UMAC committee minutes demonstrate participation of network physicians and review of CPGs.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
reviewed and updated periodically.	Full - As described previously, the QI Evaluation delineates each CPG and the most recent update or approval status. The QI Program Description indicates that CPGs are reviewed and updated at least every 2 years.	Full	As described previously, the 2013 QI Evaluation delineates each CPG and the most recent update or approval status. The 2014 QI Program Description indicates that CPGs are reviewed and updated at least every 2 years.	
Decisions with respect to UM, member education, covered services, and other areas to which the practice guidelines apply shall be consistent with the guidelines.	Full - The QI Program Description notes that member education materials, benefits and coverage parameters are reviewed against guidelines annually. The QI Program Description, Appendix A Utilization Management Program Description indicates that UM decisions are based upon InterQual criteria and clinical practice guidelines but are also case specific. The QI Program Description states that the UMAC is responsible for reviewing and elevating utilization data to facilitate appropriate resource use; analyzing UM Inter-Rater Reliability data and making recommendations for improvement (where needed); annually reviewing and approving nationally-recognized and evidence-based medical necessity criteria and guidelines utilized by UM staff. Case Management Program Description (Appendix B	Full	The 2014 QI Program Description notes that member education materials, benefits and coverage parameters are reviewed against guidelines annually. The 2014 QI Program Description, Appendix A, Utilization Management Program Description indicates that UM decisions are based upon InterQual criteria and clinical practice guidelines but are also case specific. The UMAC is responsible for reviewing utilization data to facilitate appropriate resource use; analyzing UM Inter-Rater Reliability data and making recommendations for improvement (where needed); reviewing and approving nationally-recognized and evidence-based medical necessity criteria and guidelines utilized by UM staff.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	of QI Program Description) states that members will be provided with nationally-recognized and approved educational materials. Additionally, there are member versions of the CPGs, which, as described above, are based upon nationally-recognized sources.		Additionally, there are member versions of the CPGs, which are based upon nationally-recognized sources.	
19.5 Innovative Programs				
Contractor shall implement its innovative program as presented in the response to the RFP and report quarterly on its program to improve and reform the management of the pharmacy program as contained in the Contractor's response to the RFP.	Full- Innovative programs listed in the 2013 QI Work Plan include: - Obesity Disease Management Program: 3099 members enrolled. - Telemedicine with U of K: - Transitional Care Management Program: prevention of readmissions - Drug screening program: over-use of drug screening tests - DUR/(Suboxone Prior Authorization - High Risk Pregnancy program with member incentive for participation.	Full	Innovative programs listed in the 2014 QI Work Plan include: routine provider meetings; an obesity program; a telemedicine program; a transitional care management program for prevention of readmissions; a drug screening program; a high risk pregnancy program with member incentives; a Regional Member Engagement Center in Louisville, opened in July 2014 to provide face-to-face member services; an Emergency Department (ED) diversion program.	
20.1 Kentucky Outcomes Measures and HEDIS Measures				
The Contractor shall implement steps targeted at improvement for selected performance measures, identified in	Full - According to the 2013 QI Work Plan, WellCare analyzed baseline HEDIS baseline data in Q1 2013 and implemented interventions in Q3. Healthy Kentuckian	Full	The 2014 Work Plan, section XV HEDIS Outcomes and Preventive Health Measures includes objectives, goals, monitoring and	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Appendix N, in either the actual outcomes or processes used to affect those outcomes. Once performance goals are met, select measures may be retired and new measures, based on CMS guidelines and/or developed collaboratively with the Contractor, may be implemented, if either federal or state priorities change; findings and/or recommendations from the EQRO; or identification of quality concerns; or findings related to calculation and implementation of the measures require amended or different performance measures, the parties agree to amend the previously identified measures.	activities are documented in the Work Plan and outcome measures are reported in a document titled: 2012 Health Outcomes and 2013 Member Satisfaction. The QI Program Evaluation reports on all standardized measures, including HEDIS, KY Health Outcomes measures, and CAHPS survey measures under Clinical Initiatives and Indicators, State Clinical Performance Indicators, and Member Satisfaction. The Evaluation includes initiatives implemented, barrier analysis and recommendations/plans for 2013.		interventions taken by measure to improve performance. The 2013 QI Program Evaluation reports on all standardized measures, including HEDIS, HK Performance Measures, and CAHPS survey measures, including initiatives implemented, barrier analysis and recommendations/plans for 2014.	
Additionally, the Department, Contractor, and EQRO will review and evaluate the feasibility and strategy for rotation of measures requiring hybrid or medical record data collection to reduce the burden of measure production. The group may consider the annual HEDIS measure rotation schedule as part of this process.	NA- DMS, in collaboration with the EQRO, assesses the measure reporting requirements on an annual basis. Measure rotation has not been utilized to date.	Not Applicable	DMS has not chosen measures for rotation. In collaboration with the EQRO, DMS assesses the measure reporting requirements on an annual basis.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor in collaboration with the Department and the EQRO shall develop and initiate a performance measure specific to ISHCN.	Full- The KY Health Outcomes measure set includes indicators to assess access to care for ISHCN. WellCare reported these measures for the first time in 2013.	Full	The HK Performance Measures include indicators to assess access to care for ISHCN. WellCare reports rates for these measures.	
The Department shall assess the Contractor's achievement of performance improvement related to the health outcome measures. The Contractor shall be expected to achieve demonstrable and sustained improvement for each measure.	Full- Baseline rates for HEDIS, CAHPS, and the KY Health Outcomes measures were reported in 2013. Assessment of improvement cannot yet be evaluated. A report entitled 2012 Health Outcomes and 2013 Member Satisfaction provided the rates, relevant benchmarks, barrier analysis and interventions. WellCare stratified rates to extent feasible, as some measures had very small denominators. WellCare provided the results in a report entitled KY HEDIS 2013 Measure Stratification.	Full	The 2013 QI Evaluation shows trending and analysis of measures, including those not meeting MCO goals with recommendations for 2014. The 2013 HK Performance Measure and 2014 Member Satisfaction rates, relevant benchmarks, barrier analysis and interventions were presented.	
Specific quantitative performance targets and goals are to be set by the workgroup. The Contractor shall report activities on the performance measures in the QAPI work plan quarterly and shall submit an annual report after collection of performance data. The Contractor shall stratify the data to each measure by the Medicaid eligibility category, race, ethnicity,	Full- The Healthy Kentuckians Outcomes measures include performance targets/goals. WellCare reported all rates and provided a spreadsheet with rates for the performance measures stratified by race, ethnicity, gender, age, and category of aid.	Full	The HK Performance Measures include performance targets/goals. WellCare reported all rates and stratified the data by race, ethnicity, gender, age, and category of aid.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
gender and age to the extent such information has been provided by the Department to the Contractor. This information will be used to determine disparities in health care.				
20.2 HEDIS Performance Measures				
The Contractor shall be required to collect and report HEDIS data annually. After completion of the Contractor's annual HEDIS data collection, reporting and performance measure audit, the Contractor shall submit to the Department the Final Auditor's Report issued by the NCQA certified audit organization and an electronic (preferred) or printed copy of the interactive data submission system tool (formerly the Data Submission tool) by no later than August 31st.	Full- WellCare collected and reported baseline 2013 HEDIS data and submitted the Final Audit Report and the IDSS.	Full	Includes review of MCO Report #96 Audited HEDIS Reports. WellCare collected and reported 2014 HEDIS data and submitted the Final Audit Report and the IDSS to DMS. The following HEDIS measures ranked below the Quality Compass mean: Preventive Child Measures: Well Child Visits in the 15 Months; Well Child Visits Ages 3-6 Years; Adolescent Well Care Visits; Childhood Immunizations Combo 2; Lead Screening in Children; Weight Assessment and Counseling for Children and Adolescents: BMI, Nutrition, Physical Activity. Acute Care for Children: Testing for Children with Pharyngitis; Appropriate Treatment for Children with	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			URI. Preventive Care for Women: Cervical Cancer Screening; Chlamydia Screening; Postpartum Visits. Chronic Care for Adult: Beta blocker use after a Heart Attack; Imaging for Low Back Pain; Follow-up for Hospitalization for Mental Illness; measures of diabetes control. The following rates exceeded the mean: Controlling High Blood Pressure; Antidepressant Medication Management: Acute and Continuation Phases; Monitoring for Members on Persistent Medications; and measure for HgbA1c and LDL testing, nephropathy monitoring, and blood pressure control for members with diabetes. The following rates exceeded the 75th percentile: Preventive Care for Children: Children's and Adolescents' Access to PCPs; Annual Dental Visits; Immunizations for Adolescents. Preventive Care for Women: Timeliness of Prenatal Care; Frequency of	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Prenatal Care 81%+ Visits. Adult Preventive and Acute Care: Adults Access to Ambulatory Care; Appropriate Use of Antibiotics for Adults with Acute Bronchitis.	
In addition, for each measure being reported, the Contractor shall provide trending of the results from all previous years in chart and table format. Where applicable, benchmark data and performance goals established for the reporting year shall be indicated. The Contractor shall include the values for the denominator and numerator used to calculate the measures.	NA- Since this is the baseline measurement year for HEDIS reporting, no rate trending is possible. WellCare did benchmark its rates using Quality Compass, where applicable.	Full	Performance measure rates, including HEDIS, CAHPS, HK Performance Measures were trended and benchmarked as evidenced in the 2013 QI Evaluation, and other related reports.	
For all reportable Effectiveness of Care and Access/Availability of Care measures, the Contractor shall stratify each measure by Medicaid eligibility category, race, ethnicity, gender and age.	Full- As described previously, WellCare stratified measure rates by race/ethnicity, gender, age, and category of aid.	Full	WellCare submitted Report #96, which included data stratified by race/ethnicity, gender, age, and category of aid.	
Annually, the Contractor and the Department will select a subset of targeted performance from the HEDIS reported measures on which the Department will evaluate the	NA- To date, DMS has not chosen a subset of measures for evaluation. Annually DMS, in collaboration with the EQRO, evaluates the measures required for reporting.	Not Applicable	DMS has not chosen a subset of measures for evaluation. Annually in collaboration with the EQRO, DMS evaluates the measures required for	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Contractor's performance. The Department shall inform the Contractor of its performance on each measure, whether the Contractor satisfied the goal established by the Department, and whether the Contractor shall be required to implement a performance improvement initiative. The Contractor shall have sixty (60) days to review and respond to the Department's performance report.			reporting.	
The Department reserves the right to evaluate the Contractor's performance on targeted measures based on the Contractor's submitted encounter data. The Contractor shall have 60 days to review and respond to findings reported as a result of these activities.	NA - To date, DMS has not chosen a subset of measures for evaluation using MCO submitted encounter data.	Not Applicable	DMS has not chosen a subset of measures for evaluation using MCO submitted encounter data. Annually in collaboration with the EQRO, DMS evaluates the measures required for reporting.	
20.3 Accreditation of Contractor by National Accrediting Body				
A Contractor which holds current NCQA accreditation status shall submit a copy of its current certificate of accreditation with a copy of the complete accreditation survey report, including scoring of each category, standard, and	NA - WellCare is pursuing accreditation. As described previously, a team was formed and mock audits conducted.	Full	WellCare was awarded a three year "Commendable" accreditation effective 9/2/14 and submitted copies of its accreditation certificate and survey report to DMS in September 2014.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
element levels, and recommendations, as presented via the NCQA Interactive Survey System (ISS): Status. Summarized & Detailed Results, Performance, Performance Measures, Must Pass Results Recommendations and History to the Department in accordance with timelines established by the Department.				
If a Contractor has not earned accreditation of its Medicaid product through the National Committee for Quality Assurance (NCQA) Health Plan, the MCO shall be required to obtain such accreditation within two (2) to four (4) years from the effective date of this contract.	Full- NCQA Accreditation is in process for 2014, as described above and previously in this tool.	Full	WellCare was awarded a three year "Commendable" accreditation effective 9/2/14.	
20.4 Performance Improvement Projects (PIPs)				
The Contractor must ensure that the chosen topic areas for PIPs are not limited to only recurring, easily measured subsets of the health care needs of its Members. The selected PIPs topics must consider: the prevalence of a condition in the	Full- WellCare initiated 2013 PIPs based on DMS requirements – for physical health focusing on ED Utilization and for behavioral health focusing on use of psycho-active medications (ADHD meds) in children. The 2014 PIP topics are COPD and follow up after hospitalization for mental illness.	Full	Includes review of MCO Reports: #19 PIPs #90 PIP Proposal #92 PIP Measurement WellCare submitted two PIP proposals and reports (MCO Reports #90, #92) for all PIPs	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
enrolled population; the need(s) for a specific service(s); member demographic characteristics and health risks; and the interest of Members in the aspect of care/services to be addressed.			in progress. Topics are listed below and include both physical and behavioral health as required. Topic selection was approved by DMS and reviewed by IPRO. PIP Proposals – MCO PH: Preventing Postpartum Readmissions, Statewide Collaborative: Use of Antipsychotics in Children and Adolescents Baseline Reports – PH: Management of COPD, BH: Follow-Up for Hospitalization for Mental Illness Interim Reports – PH: Reducing ED Utilization, BH: Use of BH Medications in Children	
The Contractor shall continuously monitor its own performance on a variety of dimensions of care and services for Members, identify areas for potential improvement, carry out individual PIPs, undertake system interventions to improve care and services, and monitor the effectiveness of those interventions. The Contractor shall develop and implement PIPs to	Full - The PIP topics (described above) were selected in compliance with DMS requirements and approved by DMS. WellCare provided a rationale for each PIP topic based on review of literature and MCO data. WellCare adopted recommendations of the EQRO and DMS. Only baseline data has been reported to date. The PIP proposals and reports do not evidence any payments or incentives to a provider or provider group as an inducement to reduce or limit medically	Full	WellCare reported both baseline and interim measurements in 2014. As noted above, topic selection was approved for all PIPs. The PIP reports included a rationale for the selected topic supported by literature citations and data (national, Kentucky, MCO) as applicable.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
address aspects of clinical care and non-clinical services and are expected to have a positive effect on health outcomes and Member satisfaction. While undertaking a PIP, no specific payments shall be made directly or indirectly to a provider or provider group as an inducement to reduce or limit medically necessary services furnished to a Member. Clinical PIPs should address preventive and chronic healthcare needs of Members, including the Member population as a whole and subpopulations, including, but not limited to, Medicaid eligibility category, type of disability or special health care need, race, ethnicity, gender and age. PIPs shall also address the specific clinical needs of Members with conditions and illnesses that have a higher prevalence in the enrolled population. Non-clinical PIPs should address improving the quality, availability and accessibility of services provided by the Contractor to Members and Providers. Such aspects of service should include, but not be limited to, availability, accessibility, cultural	necessary services.			

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
competency of services, and complaints, grievances, and appeals.				
The Contractor shall develop collaborative relationships with local health departments, behavioral health agencies and other community based health/social agencies to achieve improvements in priority areas. Linkage between the Contractor and public health agencies is an essential element for the achievement of public health objectives.	Full- The 2013 QI Work Plan included a goal of conducting regional provider advisory councils. As of Q4 2013, WellCare reported that 11 Provider Workshops and Summits were conducted Statewide, were successful and will be continued in 2014. Additionally, the MCO formed collaborative partnerships with local health departments across Kentucky to identify community health needs, identify barriers and develop solutions to barriers. During the onsite interview, WellCare reported having collaborated on a grant to provide Farmer's Market vouchers at PCP sites ; working with community advocacy organizations; and plans in 2014 for BH forums to address a continuum of care for children with suicide attempts/ideation.	Full	Evidenced in 2014 QI Work Plan. WellCare hosted a meeting attended by leadership from 9 CMHCs and a Kentucky mental health organization to brainstorm barriers and plan associated interventions for the BH PIP related to use of BH meds for children. Community engagement activities included convening Regional Health Connections Council (HCC) meetings that include a broad variety of community stakeholders from across the state: Public Health Departments, non-profit Hospitals. Additionally, the MCO engaged community organizations like the Homeless and Housing Coalition and domestic violence organizations.	
The Contractor shall be committed to on-going collaboration in the area of service and clinical care improvements	Full - WellCare has fully cooperated with all DMS and EQRO initiatives and requests.	Full	WellCare has fully cooperated with DMS and IPRO on all EQRO tasks and projects.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
by the development of best practices and use of encounter data–driven performance measures.			Currently, all MCOs are collaborating on a statewide PIP focusing on the use of antipsychotics in children and adolescents. WellCare reported all required performance measures including HEDIS, CAHPS, and HK Performance Measures and monitors MCO-specific metrics.	
The Contractor shall monitor and evaluate the quality of care and services by initiating a minimum of two (2) PIPs each year, including one relating to physical health and one relating to behavioral health. However, the Contractor may propose an alternative topic(s) for its annual PIPs to meet the unique needs of its Members if the proposal and justification for the alternative(s) are submitted to and approved by the Department. Additionally, the Department may require Contractor to (i) implement an additional PIP specific to the Contractor; if findings from an EQR review or audit indicate the need for a PIP, or if directed by CMS; and (2) assist the Department in one annual	Full - As described previously, WellCare has reported baseline data for its 2013 PIPs and proposals for 2014 PIPs as directed. Topics were selected per requirements and approved by DMS. No DMS or EQRO-directed PIPs have been required. No statewide PIP has been initiated but one is planned for 2014. WellCare has provided data and medical records for EQRO focused studies.	Full	As described above, WellCare has developed and conducted two PIPs each year with full reports submitted annually and updates provided quarterly, as required.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
statewide PIP, if requested. In assisting the Department with implementation of an annual statewide PIP, the Contractor's participation shall be limited to providing the Department with readily available data from the Contractor's region. The Contractor shall submit reports on PIPs as specified by the Department.				
The Department has identified four clinical areas and non-clinical topics for PIPs as a baseline assessment of Medicaid members in Appendix M. – Per Region 3 contract OR The Department recognizes that the following conditions are prevalent in the Medicaid population in the Commonwealth and recommends that the Contractor considers the following topics for PIPs: diabetes, coronary artery disease screenings, colon cancer screenings, cervical cancer screenings, behavioral health, reduction in ED usage and management of ED services.	Full - As described previously, the PIP topics for 2013 and 2014 were chosen per requirements and approved.	Full	WellCare's PIP topics are consistent with those identified by DMS, address both PH and BH as required, and have been approved by DMS and reviewed by the EQRO, IPRO.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
– Per Other Regions contract				
The Contractor shall report on each PIP utilizing the template provided by the Department and must address all of the following in order for the Department to evaluate the reliability and validity of the data and the conclusions drawn:	Full - The 2013 PIP reports and 2014 proposals were submitted in the required format.	Full	In 2014, WellCare submitted proposals and baseline and interim reports using the required template and the updated template, as applicable.	
A. Topic and its importance to enrolled members;	Full - As described previously, WellCare supported its PIP topic selection in the PIP proposals.	Full	As described above, WellCare includes a well-developed rationale to support its PIP topic selection. The rationale generally includes literature references, national, Kentucky, and/or Medicaid statistics and MCO-specific data.	
B. Methodology for topic selection;	Full- WellCare used a review of literature, MCO-specific data and performance in the rationale for each PIP proposal.	Full	Per above.	
C. Goals;	Full- The baseline reports for the 2013 PIPs provide baseline rates and target rates/goals.	Full	WellCare establishes goals for each PIP indicator, such as national benchmarks or standards for meaningful improvement and supports the goal selection with a logical rationale.	
D. Data sources/collection;	Full - Data sources are fully described in the PIP reports and proposals. Many of the measures are	Full	WellCare fully and clearly describes the data sources for all PIP indicators, for both	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	based on HEDIS specifications.		standard measures (HEDIS) and MCO-developed measures.	
E. Intervention(s) – not required for projects to establish baseline; and	Full- The reports and proposals include planed and implemented interventions as well as initiation dates, where applicable.	Full	WellCare develops intervention strategies targeting providers, members and MCO systems and processes and uses varied approaches.	
F. Results and interpretations – clearly state whether performance goals were met, and if not met, analysis of the intervention and a plan for future action.	Full- The baseline reports for the 2013 PIPs were submitted and included baseline rates for outcome and process measures as well as discussion.	Full	WellCare reports PIP results clearly using tables, graphs, figures and narrative. Since WellCare has not yet reported a PIP final re-measurement, the Limitations, Lessons Learned, Next Steps sections of the PIP report are not yet required.	
The final report shall also answer the following questions and provide information on:				
A. Was Member confidentiality protected;	NA- No final reports due at this time, though the information on member confidentiality has been completed for the 2013 and 2014 PIPs.	Not Applicable	WellCare has not yet reported a PIP final re-measurement.	
B. Did Members participate in the performance improvement project;	NA- No final reports due at this time.	Not Applicable	WellCare has not yet reported a PIP final re-measurement.	
C. Did the performance improvement project include cost/benefit analysis or other consideration of	NA- No final reports due at this time, though the ED PIP does include some information on financial impact.	Not Applicable	WellCare has not yet reported a PIP final re-measurement.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
financial impact;				
D. Were the results and conclusions made available to members, providers and any other interested bodies;	NA- No final reports due at this time.	Not Applicable	WellCare has not yet reported a PIP final re-measurement.	
E. Is there an executive summary;	NA- No final reports due at this time.	Not Applicable	WellCare has not yet reported a PIP final re-measurement.	
F. Do illustrations – graphs, figures, tables – convey information clearly?	NA- No final reports due at this time, though WellCare provided graphs and results tables in its baseline reports.	Full	WellCare has not yet reported a PIP final re-measurement; however, as described above, baseline and interim results are reported clearly.	
Performance reporting shall utilize standardized indicators appropriate to the performance improvement area. Minimum performance levels shall be specified for each performance improvement area, using standards derived from regional or national norms or from norms established by an appropriate practice organization. The norms and/or goals shall be pre-determined at the commencement of each performance improvement goal and the Contractor shall be monitored for achievement of demonstrable	Full- WellCare adopted the revisions recommended by DMS and IPRO, although the BH Medication PIP indicator was limited to ADHD medications. This was reviewed and discussed by DMS and EQRO and is acceptable.	Full	WellCare's PIP indicators have included: HEDIS measures – Use of Antipsychotics in Children and Adolescents, Appropriate Management of COPD, Follow-Up for Hospitalization for Mental Illness, and Ambulatory Utilization: ED Visits. MCO- developed metrics include measures for postpartum readmissions and use of BH Medications in Children.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
and/or sustained improvement				
The Contractor shall validate if improvements were sustained through periodic audits of the relevant data and maintenance of the interventions that resulted in improvement. The timeframes for reporting:	NA- Only baseline rates for the 2013 PIPs are available at this time.	Not Applicable	In 2014, WellCare submitted only proposals, baseline, and interim measurements. No final measurements have occurred at this time. All reports were submitted timely.	
A. Project Proposal – due September 1 of each contract year. If PIP identified as a result of Department/EQRO review, the project proposal shall be due sixty (60) days after notification of requirement.	Full - 2013 and 2014 PIP proposals and reports were submitted timely in 2012 and 2013.	Full	In 2014, WellCare submitted only proposals, baseline, and interim measurements. No final measurements have occurred at this time. All reports were submitted timely.	
B. Baseline Measurement – due at a maximum, one calendar year after the project proposal and no later than September 1 of the contract year.	Full- The baseline reports for the 2013 PIPs were submitted timely.	Full	In 2014, WellCare submitted only proposals, baseline, and interim measurements. No final measurements have occurred at this time. All reports were submitted timely.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
C. 1st Remeasurement – no more than two calendar years after baseline measurement and no later than September 1 of the contract year.	NA- Only baseline measurements for the 2013 PIPs are available at this time.	Full	In 2014, WellCare submitted only proposals, baseline, and interim measurements. No final measurements have occurred at this time. All reports were submitted timely.	
D. 2nd Remeasurement – no more than one calendar year after the first remeasurement and no later than September 1 of the contract year.	NA- Only baseline measurements for the 2013 PIPs are available at this time.	Not Applicable	In 2014, WellCare submitted only proposals, baseline, and interim measurements. No final measurements have occurred at this time. All reports were submitted timely.	
20.5 Quality and Member Access Committee				
The Contractor shall establish and maintain an ongoing Quality and Member Access Committee (QMAC) composed of Members, individuals from consumer advocacy groups or the community who represent the interests of the Member population.	Full - The QI Program Description describes the Quality and Member Access Committee (QMAC). The committee is comprised of members, individuals from consumer advocacy groups or the community and this is supported in the documentation submitted by the MCO. The QMAC is responsible for representing the interests of members. The QMAC meets quarterly in Bowling Green and Lexington with teleconference	Full	The QI Program Description describes the QMAC. The committee is comprised of members, individuals from consumer advocacy groups or the community and this is supported in the documentation submitted by the MCO.	

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	access. Meeting minutes were provided for 3/29/2013, 6/6/2013, 9/18/2013, and 12/13/2013.		The QMAC is responsible for representing the interests of members. The QMAC meets quarterly in Bowling Green and Lexington with teleconference access. Meeting minutes were provided for March 26, June 4, September 11, December 4, 2014 Report #21 MCO Committee Activity for all four quarters was provided.	
Members of the Committee shall be consistent with the composition of the Member population, including such factors as aid category, gender, geographic distribution, parents, as well as adult members and representation of racial and ethnic minority groups. Member participation may be excused by the Department upon a showing by Contractor of good faith efforts to obtain Member participation. Responsibilities of the Committee shall include:	Full- The QMAC member roster shows that both WellCare staff and external representatives comprise the committee. External representatives include: community members as well as advocates for the homeless and youth and persons from the Center for Accessible Living and NAMI.	Full	The QMAC member roster shows that both WellCare staff and external representatives comprise the committee. External representatives include: community members as well as advocates for the homeless and youth and persons from the Center for Accessible Living and National Alliance for the Mentally Ill (NAMI).	
A. Providing review and comment on quality and access standards;	Full - QMAC minutes from 3/29/2013 (and subsequent meetings) indicate that the committee reviewed	Full	QMAC minutes from 3/26/2014 (and subsequent meetings) indicate that the	

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	network adequacy and appointment availability.		committee reviewed network adequacy and appointment availability.	
B. Providing review and comment on the Grievance and Appeals process as well as policy modifications needed based on review of aggregate Grievance and Appeals data;	Full - QMAC minutes indicated that the committee reviewed grievances and appeals at the meetings held on 6/6/2013, on 9/18/2013, and 12/13/2013.	Full	QMAC minutes from 3/26/2014 (and subsequent meetings) indicated that the committee reviewed grievances and appeals.	
C. Providing review and comment on Member Handbooks;	Full - Review of Member Handbooks is noted in the QI Program Description as a primary responsibility of the QMAC and is reflected in committee minutes of 3/29/2013.	Full	Review of Member Handbook is noted in the QI Program Description as a primary responsibility of the QMAC and is reflected in committee minutes.	
D. Reviewing Member education materials prepared by the Contractor;	Full - Review of member education materials is listed in the QI Program Description as a primary responsibility of the QMAC. The QMAC committee minutes include a review of a member OTC Brochure and website on 3/29/2013 and Member Newsletters on 6/6/2013. The Member Handbook and Provider Directory were reviewed previously.	Full	Review of member education materials is listed in the QI Program Description as a primary responsibility of the QMAC. The QMAC committee minutes include a review of the Member Newsletter and website on 3/26/2014 and Member Newsletters at each subsequent meeting. Substantive discussion is documented in the minutes.	
E. Recommending community outreach activities; and	Full - Recommending community outreach activities is listed in the QI Program Description as a primary responsibility of the QMAC.	Full	Recommending community outreach activities is listed in the QI Program Description as a primary responsibility of the QMAC.	

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	The QMAC was updated regarding community outreach activities at each quarterly meeting and outreach was discussed as reflected in minutes from those dates: 3/29/2013; 6/6/2013, 9/18/2013, and 12/13/2013.		The QMAC was updated regarding community outreach activities at each quarterly meeting and outreach was discussed as reflected in minutes from each meeting.	
F. Providing reviews of and comments on Contractor and Department policies that affect Members.	Full - Review of policies that affect members is listed in the QI Program Description as primary responsibilities of the QMAC. Discussion of network adequacy, access and availability, appeals and grievances, community engagement activities and cultural preferences is documented in the 2013 meeting minutes.	Full	Review of policies that affect members is listed in the QI Program Description as primary responsibilities of the QMAC. Discussion of network adequacy, access and availability, appeals and grievances, community engagement activities and cultural preferences is documented in the 2014 meeting minutes.	
The list of the Members participating with the QMAC shall be submitted to the Department annually.	Full- The QI Program Description notes that the list of QMAC members will be submitted to the Department annually. WellCare provided the committee roster as described previously.	Full	The QI Program Description notes that the list of QMAC members will be submitted to the Department annually. WellCare provided a list of the 2014 committee members as required by the contract. The list identifies the MCO staff that are members as well as a variety of community advocates by title/organization.	The 2014 QMAC committee roster which was submitted to IPRO prior to the onsite review identifies three committee members (Peggy Roark, Rachael Cartnell, and Sheina Murphy) as Community Members who are members enrolled with WellCare. Rachael Cartnell attended the QMAC meeting held March 26, 2014 and Peggy Roark attended all QMAC meetings during 2014. In addition, Peggy Roark served as chair of the committee during 2014.

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			The committee is comprised of 26 MCO staff members and 12 community advocates. ~~No MCO members were currently listed on the committee roster or as meeting attendees.~~ ~~**Recommendation for WellCare**~~ ~~The MCO should actively recruit for members to participate in the MCO.~~ **Final Review Determination** The review determination has been changed to Full.	Screenshots showing these members' eligibility with WellCare are attached as proof of members' enrollment with WellCare. The question of whether the 2014 QMAC roster includes WellCare members was not raised while the EQRO was on site and the documentation was unchanged from the 2013 review, which resulted in a finding of Full compliance with this contract requirement. WellCare's Community Advocacy team and the QMAC committee chair identify WellCare members who may be interested in serving as QMAC members and refer those members to the QI Coordinator, who outreaches those members with information about the QMAC and an invitation to join the committee. WellCare is also exploring opportunities for partnering with external community advocates to recruit WellCare members to the QMAC from the populations their organizations serve. The Plan believes the committee roster and the evidence of member enrollment demonstrate Full compliance with this contract requirement. The Plan respectfully

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
				requests that IPRO reconsider the review determination of Substantial.
20.8 Assessment of Member and Provider Satisfaction and Access				
The Contractor shall conduct an annual survey of Members' and Providers' satisfaction with the quality of services provided and their degree of access to services. The member satisfaction survey requirement shall be satisfied by the Contractor participating in the Agency for Health Research and Quality's (AHRQ) current Consumer Assessment of Healthcare Providers and Systems survey ("CAHPS") for Medicaid Adults and Children, administered by an NCQA certified survey vendor.	Full - In 2013, the CAHPS surveys were administered by an NCQA-certified survey vendor. Results were provided in the report 2012 Health Outcomes and 2013 Member Satisfaction.	Full	In 2014, the adult and child CAHPS surveys were administered by an NCQA-certified survey vendor. Results were provided in the report 2013 Health Outcomes and 2014 Member Satisfaction.	
The Contractor shall provide a copy of the current CAHPS survey tool to the Department.	Full - WellCare provided documentation of DMS approval for the CAHPS survey tools.	Full	WellCare provided documentation of submission of the survey results to DMS in August 2014.	
Annually, the Contractor shall assess the need for conducting special surveys to support quality/performance improvement initiatives that target	Full - WellCare reported having conducted adult and child oral health survey. The MCO provided reports of the results during the onsite review.	Full	In addition to the CAHPS surveys, WellCare conducted BH satisfaction surveys for adults and children.	

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
subpopulations perspective and experience with access, treatment and services.	WellCare reported having conducted behavioral health satisfaction survey for adults and children. Documentation of DMS approval for both surveys was provided, as well as the results in spreadsheet format.		Additionally, upon closure of a case, WellCare conducts a case management satisfaction survey.	
To meet the provider satisfaction survey requirement the Contractor shall submit to the Department for review and approval the Contractor's provider satisfaction survey tool.	Full- WellCare indicated that a Provider Satisfaction Survey was conducted in April 2013 and the results submitted to DMS in August 2013.	Full	WellCare submitted the provider satisfaction survey results to DMS in August 2014.	
The Department shall review and approve any Member and Provider survey instruments and shall provide a written response to the Contractor within fifteen (15) days of receipt.				
The Contractor shall provide the Department a copy of all survey results. A description of the methodology to be used in conducting the Provider or other special surveys, the number and percentage of the Providers or Members to be surveyed, response rates and a sample survey instrument, shall be submitted to the Department along with the findings and interventions conducted or planned.	Full- WellCare provided documentation of DMS approval of its surveys and submitted reports of the results which included response rates.	Full	WellCare provided documentation of DMS approval of its surveys and submitted reports of the results which included response rates.	

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
All survey results must be reported to the Department, and upon request, disclosed to Members.	Full- CAHPS member survey results were reported in the document: 2012 Health Outcomes and 2013 Member Satisfaction.	Full	CAHPS member survey results were reported in the document: 2013 Health Outcomes and 2014 Member Satisfaction.	
37.5 QAPI Reporting Requirements The Contractor shall provide status reports of the QAPI program and work plan to the Department on a quarterly basis thirty (30) working days after the end of the quarter and as required under this section and upon request. All reports shall be submitted in electronic and paper format.	Full- WellCare submitted quarterly reports to DMS as required, including quality-related reports and the QI Work Plan updates.	Full	Evidenced by WellCare's quarterly updates to the 2014 QI Work Plan, Report #17 submitted to DMS each quarter in 2014.	

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: WellCare of Kentucky

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	96	0	0	0
Total Points	288	0	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average	**3.0**			

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review, may adversely affect the scoring of a requirement and result in possible sanctions by DMS.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement

Suggested Evidence

Documents

QI Program Description
QI Work Plan
Evidence of member involvement in development of QI program
Annual PIP proposals and summary reports
Quality Improvement Committee description, membership, meeting agendas and minutes
Committee description, membership, meeting agendas and minutes for QMAC
Clinical Practice Guidelines
Provider Manual
Provider Newsletters
Provider Committee minutes
Innovative Program description and status report

Reports

Annual QI Evaluation Report
HEDIS Final Audit Report and IDSS rates
Healthy Kentuckians Outcomes Measures Report
CAHPS Report
Provider Satisfaction Survey Report
NCQA Accreditation Certificate and ISS Survey Report or status of accreditation
Performance Measure Reporting
Evaluation, analysis and follow-up of performance measure results
Evaluation, analysis and follow-up of provider compliance with Clinical Practice Guidelines
Monitoring of consistent application of practice guidelines for utilization management, enrollee education, and coverage of service

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: WellCare of Kentucky

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
24. General Requirements for Grievances and Appeals				
The Contractor shall have an organized grievance system that shall include- a grievance process, an appeals process, and access for Members to a State fair hearing pursuant to KRS Chapter 13B.	Full-2013			
The Contractor shall provide to all Providers in the Contractor's network a written description of its grievance and appeal process and how providers can submit a grievance or appeal for a Member or on their own behalf. KAR 17:010 Section 4 (18)	Full-2013			
24.1 Grievance and Appeal Policies and Procedures				
The MCO shall have a timely and organized Grievance and Appeal Process with written policies and procedures for resolving Grievances filed by Members. The Grievance and Appeal Process shall address Members' oral and written grievances. The Grievance and Appeal Process shall be approved in writing by the Department prior to implementation and shall be conducted in accordance with 42 CFR 438 subpart F, 907 KAR 17:010 and other applicable CMS and Department requirements. These policies and procedures shall include, but not be limited to:	Full-2013			
A Member may file a grievance either orally or in writing with the Contractor within thirty (30) calendar days of the date of the event causing the dissatisfaction. The legal guardian of the Member for a minor or an incapacitated adult, a	Full-2013			

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
representative of the Member as designated in writing to the Contractor, or a service provider acting on behalf of the Member and with the Member's written consent, have the right to file a grievance on behalf of the Member. KAR 17:010 Section 4 (2), (4) (a) and Section 15 (1)				
A Member may file an appeal either orally or in writing of a Contractor action within thirty (30) calendar days of receiving the Contractor's notice of action. The legal guardian of the Member for a minor or an incapacitated adult, a representative of the Member as designated in writing to the Contractor, or a provider acting on behalf of the Member with the Member's written consent, have the right to file an appeal of an action on behalf of the Member. The Contractor shall consider the Member, representative, or estate representative of a deceased Member as parties to the appeal. KAR 17:010 Section 4 (4) (a), (5) , (6), and Section 15 (1)	Full-2013			
A. A process for evaluating patterns of grievances for impact on the formulation of policy and procedures, access and utilization;	New Requirement	Full	Addressed in C6GR-003 Medicaid Grievance Policy page 6, section 6.1 Reporting Procedures and C6GR003-PR-001 Kentucky Medicaid Procedure page 8 sections Reporting and Marketing/Trust Grievance Reporting – both documents state "track trend and report grievances, both internally and the appropriate state regulators, for the	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			purpose of identifying opportunities for improved care and/or service to enrollees" or "members." Grievance reports are provided to the Customer Service Quality Improvement Committee (CSQIC) and the Quality and Member Access Committee (QMAC). The CSQIC reports to the Quality Improvement Committee (QIC). The requirement is also addressed in C7AP-035-Pr-001 Kentucky Member Appeals Process, page 18, section 6 Reporting Requirements. The Medicaid QI Evaluation includes analysis, barriers and recommendations related to grievances. For example, the Business Process Improvement Work Group for Balance Billing has addressed reducing the number of providers billing members. WellCare has reminded members to present their ID card at each visit.	
B. Procedures for maintenance of records of grievances separate from medical case records and in a manner which protects the confidentiality of Members who file a grievance or appeal;	New Requirement	Full	C6GR-003 Medicaid Grievance Policy page 5, section 5 Record Keeping Procedures meets the requirement. C7AP-035-Pr-001 Kentucky Member Appeals Process, page 19, section 7 meets the requirement.	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
C. Ensure individuals who make decisions on grievances and appeals were not involved in any prior level of review;	Full-2014		Includes Member Grievance Random, Member Grievance Quality and Member Appeal file review results	
D. If the grievance involves a Medical Necessity determination, ensure that the grievance and appeal is heard by health care professionals who have the appropriate clinical expertise;	Full-2014		Includes Member Grievance Random, Member Grievance Quality and Member Appeal file review results	
E. Process for informing Members, orally and/or in writing, about the MCO's Grievance and Appeal Process by making information readily available at the MCO's office, by distributing copies to Members upon enrollment; and by providing it to all subcontractors at the time of contract or whenever changes are made to the Grievance and Appeal Process;	Full-2013			
F. Provide assistance to Members in filing a grievance if requested or needed;	Full-2013			
G. Include assurance that there will be no discrimination against a Member solely on the basis of the Member filing a grievance or appeal;	Full-2013			
The Contractor shall ensure that punitive action is not taken against a Member or a service provider who requests an expedited resolution or supports a Member's expedited appeal. 42 CFR 438.410 (b)	Full-2013			

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
H. Include notification to Members in the Member Handbook regarding how to access the Cabinet's ombudsmen's office regarding grievances, appeals and hearings;	Full-2013			
I. Provide oral or written notice of the resolution of the grievance in a manner to ensure ease of understanding;	Full-2014		Includes Member Grievance Random and Member Grievance Quality file review results	
J. Provide for an appeal of a grievance decision if the Member is not satisfied with that decision;	New Requirement	Full	C6GR-003 Medicaid Grievance Policy pages 3-4, section 4 Grievance Processing and Resolution Procedures, Member Handbook pages 60-66 and C7AP-035-Pr-001 Kentucky Member Appeals Process (entire document) – all 3 documents meet the requirement.	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
K. Provide for continuation of services, if appropriate, while the appeal is pending; The Contractor shall continue the Member's benefits if all of the following are met: (1) the Member or the service provider files a timely appeal of the Contractor action or the Member asks for a state fair hearing within 30 days from the date on the Contractor notice of action; (2) the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; (3) the services were ordered by an authorized service provider; (4) the time period covered by the original authorization has not expired; and (5) the Member requests extension of the benefits. 42 CFR 438.420	Full-2013			
The Contractor shall provide benefits until one of the following occurs: (1) The Member withdraws the appeal; (2) Fourteen (14) days have passed since the date of the resolution letter, provided the resolution of the appeal was against the Member and the Member has not requested a state fair hearing or taken any further action; (3) The Cabinet issues a state fair hearing decision adverse to the Member; (4) The time period or service limits of a previously authorized service has expired.	Full-2013			

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
42 CFR 438.420 KAR 17:010 Section 4 (14)				
If the final resolution of the appeal is adverse to the Member, that is, the Contractor's action is upheld, the Contractor may recover the cost of the services furnished to the Member while the appeal was pending, to the extent that services were furnished solely because of the requirements of this section and in accordance with the policy in 42 CFR 431.230(b). 42 CFR 438.420	Full-2013			
If the Contractor or the Cabinet reverses a decision to deny, limit, or delay services, and these services were not furnished while the appeal was pending, the Contractor shall authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires. If the Contractor or the Cabinet reverses a decision to deny, limit or delay services and the Member received the disputed services while the appeal was pending, the Contractor shall pay for these services. 42 CFR 438.424	Full-2013			
L. Provide expedited appeals relating to matters which could place the Member at risk or seriously compromise the Member's health or well-being;	Full-2013			

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
If the Contractor denies a request for an expedited resolution of an appeal, it shall: (1) transfer the appeal to the thirty (30) day timeframe for standard resolution, in which the thirty (30) day period begins on the date the Contractor received the original request for appeal; and (2) make reasonable efforts to give the Member prompt oral notice of the denial, and follow up with a written notice within two-calendar days. The Contractor shall document in writing all oral requests for expedited resolution and shall maintain the documentation in the case file. KAR 17:010 Section 4 (16)				
M. Provide written notice of the appeal decision;	Full-2013			
N. Provide for the right to request a hearing under KRS Chapter 13B; and	Full-2013			

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
O. Provide for continuation of services, if appropriate, while the hearing is pending. The Contractor shall continue the Member's benefits if all of the following are met: (1) the Member or the service provider files a timely appeal of the Contractor action or the Member asks for a state fair hearing within 30 days from the date on the Contractor notice of action; (2) the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; (3) the services were ordered by an authorized service provider; (4) the time period covered by the original authorization has not expired; and (5) the Member requests extension of the benefits. 42 CFR 438.420	Full-2013			
The Contractor shall provide benefits until one of the following occurs: (1) The Member withdraws the appeal; (2) Fourteen (14) days have passed since the date of the resolution letter, provided the resolution of the appeal was against the Member and the Member has not requested a state fair hearing or taken any further action; (3) The Cabinet issues a state fair hearing decision adverse to the Member; (4) The time period or service limits of a previously authorized service has expired.	Full-2013			

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
KAR 17:010 Section 4 (14) 42 CFR 438.420				
If the final resolution of the appeal is adverse to the Member, that is, the Contractor's action is upheld, the Contractor may recover the cost of the services furnished to the Member while the appeal was pending, to the extent that services were furnished solely because of the requirements of this section and in accordance with the policy in 42 CFR 431.230(b). 42 CFR 438.420	Full-2013			
If the Contractor or the Cabinet reverses a decision to deny, limit, or delay services, and these services were not furnished while the appeal was pending, the Contractor shall authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires. If the Contractor or the Cabinet reverses a decision to deny, limit or delay services and the Member received the disputed services while the appeal was pending, the Contractor shall pay for these services. 42 CFR 438.424	Full-2013			
All grievance or appeal files shall be maintained in a secure and designated area and be accessible to the Department or its designee, upon request, for review. Grievance or appeal files shall be retained for ten (10) years following the final decision by the Contractor, an administrative hearing officer,	Full-2014			

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
judicial appeal, or closure of a file, whichever occurs later.				
The Contractor shall have procedures for assuring that files contain sufficient information to identify the grievance or appeal, the date it was received, the nature of the grievance or appeal, notice to the Member of receipt of the grievance or appeal, all correspondence between the Contractor and the Member, the date the grievance or appeal is resolved, the resolution, the notices of final decision to the Member, and all other pertinent information.	Substantial - This requirement is addressed in the aforementioned policies and procedures and includes record keeping sections that specify inclusion of the date and copies of the appeal or grievance, notice of determination and any other notices related to the appeal. They also include notice of determination or resolution and date of determination or resolution of appeals and grievances in the files. The Medicaid Grievance Policy (C7GR-003) notes that acknowledgment letters are listed in grievance record keeping but do not appear in the Kentucky Member Appeals Process (C7AP-035-PR-001). Onsite, WellCare provided page 19 of P/P C7Ap-035-PR-001-Kentucky Member Appeals Process-New which had been updated 2/19/2014 to include "Record Keeping" with a list of required documents, including appeals acknowledgement letters. <u>Grievance and Appeal File Review</u> As described above, all files reviewed	Full	C6GR-003 Medicaid Grievance Policy page 5, section 5 Record Keeping Procedures and C7AP-035-Pr-001 Kentucky Member Appeals Process, page 19, section 7 meet the requirement.	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	contained all required documentation, including date received, nature of grievance or appeal, timely acknowledgement, all correspondence between the MCO and member, date of resolution, the resolution, the decision notice, and all other pertinent information. **Recommendation for WellCare** The updated policy addresses this requirement and its implementation will be reviewed during the next compliance review. **MCO Response:** C7AP-035-PR-001-Kentucky Member Appeals Process was updated to specifically include appeals acknowledgment letter under "Record Keeping" with a list of other required documents.			
Documentation regarding the grievance shall be made available to the Member, if requested.	Full-2013			
Grievance File Review				
Within five (5) working days of receipt of the grievance, the Contractor shall provide the grievant with written notice that the grievance has been received and the expected date of its	Full-2013		Includes Member Random and Member Quality Grievance file review results	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
resolution. KAR S 17:010 Section 4 (2) (a)				
The investigation and final Contractor resolution process for grievances shall be completed within thirty (30) calendar days of the date the grievance is received by the Contractor and shall include a resolution letter to the grievant that shall include: all information considered in investigating the grievance; findings and conclusions based on the investigation; and the disposition of the grievance. KAR 17:010 Section 4 (2) (b)	Full-2014		Includes Member Random and Member Quality Grievance file review results	
The Contractor may extend by of up to fourteen (14) calendar days if the Member requests the extension, or the Contractor determines that there is need for additional information and the extension is in the Member's interest. For any extension not requested by the Member, the Contractor shall give the Member written notice of the reason for the extension within two working days of the decision to extend the timeframe. 42 CFR 438.408 (c)	Full-2014		Includes Member Random and Member Quality Grievance file review results	
Appeal File Review				
Within five working days of receipt of the appeal, the Contractor shall provide the Member with written notice that the appeal has been received and the expected date of its resolution. The Contractor shall confirm in writing receipt of oral appeals, unless the Member or the service provider	Full-2013		Includes Member Appeal file review results	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
requests an expedited resolution. KAR 17:010 Section 4 (10) (a) and (b)				
The Contractor has thirty (30) calendar days from the date the initial oral or written appeal is received by the Contractor to resolve the appeal. KAR 17:010 Section 4 (7)	Full-2013		Includes Member Appeal file review results	
The Contractor may extend the thirty (30) day timeframe by fourteen (14) calendar days if the Member requests the extension, or the Contractor determines that there is need for additional information, and the extension is in the Member's interest. For any extension not requested by the Member, the Contractor shall give the Member written notice of the extension and the reason for the extension within two working days of the decision to extend the timeframe. KAR 17:010 Section 4 (11) and (12)	Full-2013		Includes Member Appeal file review results	
The Contractor shall provide the Member or the Member's representative a reasonable opportunity to present evidence of the facts or law, in person as well as in writing. 42 CFR 438.406 (b) (2)	Full-2013		Includes Member Appeal file review results	
The Contractor shall provide the Member or the representative the opportunity, before and during the appeals process, to examine the Member's case file, including medical or clinical records (subject to HIPAA requirements),	Full-2013		Includes Member Appeal file review results	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
and any other documents and records considered during the appeals process. The Contractor shall include as parties to the appeal the Member and his or her representative, or the legal representative of a deceased Member's estate. 42 CFR 438.406 (a) (3) (4)				
For all appeals, the Contractor shall provide written notice within the thirty (30) calendar-day timeframe for resolutions to the Member or the provider, if the provider filed the appeal. The written notice of the appeal resolution shall include, but not be limited to, the following information: 1) the results of the resolution process; (2) the date it was completed. KAR 17:010 Section 4 (13) (a) 42 CFR 438.408 (d) (2) and (e)	Full-2013		Includes Member Appeal file review results	
The written notice of the appeal resolution for appeals not resolved wholly in favor of the Member shall include, but not be limited to, the following information: (1) the right to request a state fair hearing and how to do so; (2) the right to request receipt of benefits while the state fair hearing is pending, and how to make the request; and (3) that the Member may be held liable for the cost of continuing benefits if the state fair hearing decision upholds the Contractor's action. 42 CFR 438.408 (e) (2)	Full-2013		Includes Member Appeal file review results	
Expedited Appeals File Review				

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall resolve the appeal within three working days of receipt of the request for an expedited appeal. In addition to written resolution notice, the Contractor shall also make reasonable efforts to provide and document oral notice. KAR 17:010 Section 4 (14) (c)	Full-2013		Includes review results for Member Appeals if expedited	
The Contractor may extend the timeframe by up to fourteen (14) calendar days if the Member requests the extension, or the Contractor demonstrates to the Department that there is need for additional information and the extension is in the Member's interest. For any extension not requested by the Member, the Contractor shall give the Member written notice of the reason for the delay. KAR 17:010 Section 4 (14) (d) and (15)	Full-2013		Includes review results for Member Appeals if expedited	
The Contractor shall inform the Member of the limited time available to present evidence and allegations in fact or law. 42 CFR 438.406 (b) (2)	Full-2014		Includes review results for Member Appeals if expedited	
24.2 State Hearings for Members				
A Member shall exhaust the internal Appeal process with the Contractor prior to requesting a State Fair Hearing. A Member may request a State Fair Hearing within forty-five (45) days of the final appeal decision by the Contractor as provided for in 907 KAR 17:010. A Member may request a State Fair Hearing for an Action taken by the Contractor that denies or limits an authorization of a requested service or	Full-2013			

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
reduces, suspends, or terminates a previously authorized service. The Member's request for a State Fair Hearing must include a copy of the Contractor's final appeal decision. Failure of the Contractor to comply with the State Fair Hearing requirements of the state and federal Medicaid law in regard to an Action taken by the Contractor or to appear and present evidence will result in an automatic ruling in favor of the Member.				
27.9 Provider Grievances and Appeals				
The Contractor shall implement a process to ensure that all appeals from Providers are reviewed. A Provider shall have the right to file an appeal with the Contractor regarding provider payment or contractual issues. Appeals received from Providers that are on the Member's behalf with requisite consent of the Member are deemed Member appeals and not subject to this Section. Contractor shall log Provider appeals in a written record with the following details: date, nature of appeal, identification of the individual filing the appeal, identification of the individual recording the appeal, disposition of the appeal, corrective action required and date resolved. Provider grievances or appeals shall be resolved within thirty (30) calendar days. If the grievance or appeal is not resolved within thirty (30) days, the Contractor shall request a fourteen (14) day extension from the Provider. If the Provider requests the extension, the extension shall be approved by the Contractor. The Contractor shall ensure that there is no discrimination against a Provider solely on the grounds that the Provider filed an appeal or is making an	Full-2013		Includes file review summary results for Provider Grievances and Provider Appeals Includes review of MCO Reports: #27 Grievance Activity #28 Appeal Activity #29 Grievances and Appeals Narrative (see Quarterly Desk Audit results)	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
informal grievance. The Contractor shall monitor and evaluate Provider grievances and appeals. The Contractor shall submit quarterly reports to the Department regarding the number, type and outcomes of Provider grievances and appeals. A Provider does not have standing to request a State Fair Hearing for appeals that fall under the scope of this Section.				
27. 10 Other Related Processes				
The Contractor shall provide information specified in 42 CFR 438.10(g)(1) about the grievance system to all service providers and subcontractors at the time they enter into a contract.	Full-2013			
37.8 Grievance and Appeal Reporting Requirements				
The Contractor shall submit to the Department on a quarterly basis the total number of Member Grievances and Appeals and their disposition. The report shall be in a format approved by the Department and shall include at least the following information: A. Number of Grievances and Appeals, including expedited appeal requests; B. Nature of Grievances and Appeals; C. Resolution; D. Timeframe for resolution; and E. QAPI initiatives or administrative changes as a result of analysis of Grievances and Appeals.	New Requirement	~~Substantial~~ Full	Includes review of MCO Reports: #27 Grievance Activity #28 Appeal Activity #29 Grievances and Appeals Narrative (see Quarterly Desk Audit results) C6GR-003-PR-001 Kentucky Medicaid Grievance Procedure page 6 section Reporting meets the requirement. MCO Reports #27, 28 and 29 reported quarterly. The volume of grievances related to the	WellCare will report specific actions taken in response to analysis of grievances, specific actions taken regarding Participating Providers Billing Members, and an assessment of the effectiveness of those actions. WellCare will document specific data in Report #29, including the number of grievances received during the quarter, the number resolved during the quarter, and the percentage of grievances resolved within 30 days, as well as comparison to the previous quarter. In addition, this data is currently and will continue to be reported quarterly in Report #17 Quality Assessment and

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			Participating Provider Billing Member category increased from quarter to quarter from Q1 to Q3 2014. The volume of grievances in this category decreased in Q4. Quarterly reports show approximately 80% of pharmacy-related appeals were overturned in 2014. The total number of pharmacy-related appeals has increased, particularly expedited appeal requests. The high overturn rate was discussed during the onsite review. WellCare partly attributed the high rate to meeting the turnaround time for rendering an authorization (2 business days). Many denials have resulted from lack of sufficient information submitted by the provider to approve the requested service and not receiving additional information within the timeframe needed to render a timely decision. In response, the MCO has placed articles in provider newsletters and provided provider education to reinforce the information needed to expedite a decision. IPRO findings are communicated to the MCO in the quarterly desk audit reports.	Performance Improvement Work Plan. This data is also presented quarterly to the QMAC. The 80% overturn rate of pharmacy-related appeals can be directly attributed to insufficient documentation initially submitted by providers to approve the requested service. Appeals documents consistently contain more information than the documents submitted with initial authorization requests due to the longer turn-around time for appeals. This additional time for obtaining information and processing appeals allows WellCare to overturn denials and approve services for our members once WellCare has received sufficient documentation, as occurred in the approximately 80% of pharmacy-related appeals that were overturned in 2014. WellCare will continue to provide provider education to reinforce provider understanding of the prior authorization requirements and process. The pharmacy appeals department makes multiple attempts to obtain any missing information that is needed and documents attempts to obtain additional information by recording the date, time, person spoken with, and outcome of call in WC Toolbox.

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			Recommendation for DMS and WellCare IPRO recommendations regarding grievance reports include: DMS and WellCare should discuss this report at the reporting meeting. Actions taken by the MCO in response to analysis of grievances should be more specific. Issues identified in one quarter should be updated in subsequent quarters until resolved. Narrative report (#29) should include total # of grievances received, total # resolved and # and percent of grievances resolved within 30 days of receipt. IPRO has suggested that WellCare assess the effectiveness of its actions and implement revised or new actions to address the increase in grievances related to Participating Provider Billing Member. IPRO recommendations regarding appeal reports include: WellCare should analyze and report its findings for the high rate of overturned denials for pharmacy services, as well as any actions taken in	WellCare agrees with the use of the option of extending a case up to 14 additional days to try to obtain any needed information when the extension is in the member's interest and includes this option as a step in our current process at the discretion of the pharmacist reviewing the case. WellCare currently uses an extension in select cases when pharmacy-related requests lack sufficient documentation and additional information is pending. The decision to use an extension is left up to the discretion of the pharmacist reviewing the case to decide if more information is needed. They base this decision on a comparison of review criteria against the documentation the provider has submitted and determine if any additional information would change the outcome of the case. WellCare is currently working with the Department of Medicaid Services to ensure that WellCare fully understands the State report specifications and that data submitted meets the Department's needs and expectations. WellCare has requested that the Department provide clarification as to the specific qualitative analysis the Department would like MCOs to include in the reporting templates as currently the

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			response to the findings. In addition, WellCare may want to consider use of an extension in select cases when pharmacy-related requests lack sufficient documentation and additional information is pending. The DMS/MCO contract does allow for an extension of up to 14 additional days, if the Contractor justifies a need for additional information and the extension is in the member's interest. **Final Review Determination** The review determination is changed to Full.	report specifications for Report #29 do not include this information.
The Department or its contracted agent may conduct reviews or onsite visits to follow up on patterns of repeated Grievances or Appeals. Any patterns of suspected Fraud or Abuse identified through the data shall be immediately referred to the Contractor's Program Integrity Unit.	New Requirement	Full	C12SIU-FWA-001 Fraud Waste and Abuse Policy, pages 5-6 section iv. Investigative Actions includes "provider onsite audits", "data analysis" and "clinical reviews". Page 3 section A Role of the Special Investigations Units (SIU) states that the Grievance Department is part of the SIU. C6GR-003 Medicaid Grievance Policy page 6 section 6 Reporting Procedures states that all grievances are reported	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			monthly, quarterly and annually and analyzed to identify outstanding issues and adverse trends. C6GR-003 Medicaid Grievance Policy page 10 contains the Workflow Diagram which details the process for investigating potential fraud and abuse complaints received through Customer Service, mail, fax, email, voice mail or by phone.	

Final Findings

Grievance System

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	6	0	0	0
Total Points	18	0	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average	3.0			

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review, may adversely affect the scoring of a requirement and result in possible sanctions by DMS.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action

Final Findings

Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Grievance System
Suggested Evidence

Documents

Policies/procedures for:

- Grievances including handling of quality-related cases
- Appeals
- State hearings
- Maintenance of grievance records

QI Committee minutes or other documentation demonstrating investigation, evaluation, analysis and follow-up of aggregated grievance and appeal data
Process for evaluating patterns of grievances

Reports

Quarterly reports of grievances and appeals

File Review

Member and Provider grievance files for a sample of files selected by EQRO
Member and Provider appeal files for a sample of files selected by EQRO
QI Committee minutes or other documentation demonstrating investigation and any action taken for individual grievance and appeal files selected for review by the EQRO

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: WellCare of Kentucky

Final Findings

Health Risk Assessment (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
34.1 Health Risk Assessment (HRA)				
The Contractor shall have programs and processes in place to address the preventive and chronic physical and behavioral healthcare needs of its population. The Contractor shall implement processes to assess, monitor, and evaluate services to all subpopulations, including but not limited to, the on-going special conditions that require a course of treatment or regular care monitoring, Medicaid eligibility category, type of disability or chronic conditions, race, ethnicity, gender and age.	Full-2013			
The Contractor shall conduct initial health screening assessments including mental health and substance use disorders screenings, of new Members who have not been enrolled in the prior twelve (12) month period, for the purpose of assessing the Member's need for any special health care needs within ninety (90) days of Enrollment. If the Contractor has a reasonable belief a Member is pregnant, the Member shall be screened within thirty (30) days of Enrollment, and if pregnant, referred for appropriate prenatal care.	Minimal - Addressed in P/P 06CS-037 Medicaid New Enrollee Welcome Calls Addendum C, which outlines procedures specific to Kentucky new enrollee welcome calls, and processes for addressing members' preventive and chronic health care needs. The addendum notes that initial screening will be conducted for members not enrolled in prior 12 months within 90 days of enrollment and 30 days for members believed to be pregnant, who will be referred for appropriate prenatal care. The outlined procedure indicates that a welcome call is attempted within 30-90 days of enrollment. The welcome call includes an assessment of demographics, health and behavioral health status, and need for care management or other services. The plan submitted data tracking completed HRAs within contract timeframes; fourth quarter completion rates 2013 were 56.8% for non pregnant members within 90 days and 45.7% completion within 30 days for	Substantial	Includes HRA file review results C6CS-037 Medicaid New Enrollee Welcome Calls is compliant and states that the MCO's vendor will conduct up to 6 welcome call attempts within 30 days of a new member's effective date. A paper copy of the HRA is included in each Welcome Packet. For members without phone access, an Unable to Contact letter is sent to the member with instructions to call the MCO to complete an HRA. It is noted that few of the files reviewed included 6 contact attempts or an Unable to Contact letter, however most files pre-dated the date of the policy changes (11/12/14). In follow-up to the two recommendations by DMS after last year's review, WellCare reported that the addition of an "on hold" message was considered, however, since it	WellCare is amending our process to revise the current methodology for identification of new members for HRA outreach to be included in the file sent to the vendor so that the vendor is notified of retroactively enrolled members in need of HRA follow-up.

Final Findings

Health Risk Assessment (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	pregnant members. During the onsite, it was identified that WellCare forwards to the vendor the 834 file received from DMS that may contain members with a future enrollment date. The plan has instructed the vendor to utilize the 'Insert Date' instead of the 'Enrollment Date.' This results in the vendor contacting the member prior to their enrollment date. The plan indicated low completion rates of the HRA sent to the member with the welcome packet. The Quarterly Report # 79 currently does not include any responses received from the HRAs included in the welcome packet. HRA File Review Of 30 files reviewed, only 2 files had completed HRAs. 13/30 files showed evidence of multiple attempts, via Welcome packet and telephone outreach, to complete an HRA. The plan indicated that many members do not have a valid telephone number on file. **Recommendation for WellCare** For members with an invalid telephone number, the MCO should conduct additional mailings to encourage completion of an HRA. The MCO/vendor should ensure that all attempts to reach the member are documented. **MCO Response:** The Plan has developed a		would not apply to all callers, the MCO did not implement this recommendation. Regarding invalid addresses and phone numbers, WellCare has instituted the use of an Unable to Contact letter as described above. In addition, care managers reach out to member PCPs and other providers, such as pharmacy, DME to obtain correct contact information. Contact information is also verified during member services calls, care management calls, etc. HRA File Review Results A total of 25 files were reviewed. 25/25 files included evidence of a timely initial outreach attempt. 22/25 files included timely follow-up attempts when the initial attempt was unsuccessful. Follow-up in one file was not applicable (member completed HRA at first attempt) and two files were retro enrollments identified greater than 90 days from enrollment. For these 2 files, only a Welcome Packet was sent; no follow-up attempts were made. The MCO explained that in the case of a retro enrollment, the member would not show up on the file provided to the vendor for follow-up. **Recommendation for WellCare** Follow-up attempts to complete an HRA should be made for all new members, regardless of when the member is identified. As these members may not be included in	

Final Findings

Health Risk Assessment (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	corrective action plan to correct this deviation. The Plan will develop and distribute an unable to contact letter accompanied with a paper HRA to members identified as having an invalid phone number on a monthly basis and ensure this contact attempt is documented in the Plan's system. Please refer to the document, CAP_3_Tool_HRA_2014. <u>DMS Recommendation:</u> WellCare should add the following to its CAP for HRA follow-up: - Add an "On Hold" reminder message for HRA completion to educate the members of the need to complete and offer an extension to press to complete the HRA on the phone or to have one mailed. - Add "scrubbing"/ checking of addresses and phone numbers with failed contact attempts – look for changes on DMS files, contact the PCP or other providers that the member has seen, contact the member's pharmacy of record, conduct internet searches.		the file provided to the vendor, the MCO may need to create another process for notifying the vendor of retro enrollments needing follow-up contacts.	
The Contractor agrees to make all reasonable efforts to contact new Members in person, by telephone, or by mail to have Members complete the initial health screening questionnaire and the survey instrument for both substance use and mental health disorders.	Minimal - P/P 06CS-037 indicates welcome call attempted in 30-90 days, if not reached attempt to leave message and a paper HRA included in member welcome packet, which members are asked to complete and return to WellCare. The plan's agreement with their vendor, Eliza, was	Substantial	Includes HRA file review results The components of the HRA differ for the paper version of the HRA and the telephone script (ELIZA). For example, the script does not include information on prior	WellCare has initiated a corporate-wide program to standardize one HRA for use across all markets, with implementation tentatively scheduled for 4th quarter 2015. The Plan has also received an inquiry from DMS regarding the

Final Findings

Health Risk Assessment (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	submitted and includes 3 rounds of outbound calls with 6 attempts for busy/no answers. A new Member Welcome Kit is distributed containing an HRA with instructions for completion and a return envelope. A member with no telephone is flagged in CareConnects, a Member Services system that is used for inbound calls. HRA File Review Of 30 files reviewed, only 2 files had completed HRAs. 13/30 files showed evidence of multiple attempts, via Welcome packet and telephone outreach, to complete an HRA. The plan indicated that many members do not have a valid telephone number on file. **Recommendation for WellCare** For members with an invalid telephone number, the MCO should conduct additional mailings to encourage completion of an HRA. The MCO/vendor should ensure that all attempts to reach the member are documented. **MCO Response:** The Plan has developed a corrective action plan to correct this deviation. The Plan will develop and distribute an unable to contact letter accompanied with a paper HRA to members identified as having an invalid phone number on a monthly basis and ensure this contact attempt is documented in the Plan's		hospitalizations or recent ER visits. The MCO should ensure that both tools are consistent and that pertinent information is collected. Information regarding hospitalizations and ER visits, for example, is helpful for determining a member's potential need for care management, disease management or other services. Another difference identified between the paper tool and script relates to offering to schedule a PCP visit. The paper HRA requests that the member enters their PCP name and indicate when last visited, but does not ask if the member requires assistance. The telephone script includes an offer of assistance. The MCO explained that upon review of completed paper HRAs, members would be contacted as needed for follow-up including offering assistance in scheduling an appointment. It was suggested that WellCare consider inserting language in the Member Handbook related to assistance in scheduling an appointment. The Handbook already includes a section "Getting Started" that advises the member to schedule a visit within 90 days of enrollment. Offering assistance in scheduling an appointment could be added to this section. HRA File Review Results 10/25 members contacted completed an	possibility of implementing one HRA questionnaire across all Kentucky MCOs. An offer of assistance in scheduling an initial PCP visit will be added to the Member Handbook during the next revision. This will also be added to the Preventive Health Guide, which is distributed to all new members.

Final Findings

Health Risk Assessment (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	system. Please refer to the document, CAP_3_Tool_HRA_2014.		HRA. All 10 HRAs were provided for review. Required components were addressed. One member was offered but declined care management services. **Recommendation for WellCare** HRA tools should be consistent regardless of the contact method used and should contain essential information for assessing the member's potential needs. The MCO should include an offer of assistance in scheduling an initial PCP visit in the paper HRA and/or include this information in the Member Handbook. **Recommendation for DMS** DMS may want to consider developing, in consultation with the MCOs, either: a standardized HRA tool for use across MCOs, or a list of minimally required contents for MCO-specific HRA tools. DMS may also consider specifying in the MCO contract, the minimum number of outreach attempts and the types of methods to be used, such as at least 3 outreach attempts using at least 2 different methods.	
Information to be collected shall include demographic information, current health and behavioral health status to determine the Member's need for care management, disease management,	Full-2014		Includes HRA file review results	

Final Findings

Health Risk Assessment (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
behavioral health services and/ or any other health or community services.				
The Contractor shall use appropriate healthcare professionals in the assessment process.	Full-2014			
Members shall be offered assistance in arranging an initial visit to their PCP for a baseline medical assessment and other preventative services, including an assessment or screening of the Members potential risk, if any, for specific diseases or conditions, including substance use and mental health disorders.	Full-2014			
The Contractor shall submit a quarterly report on the number of new Member assessments; number of assessments completed; number of assessments not completed after reasonable effort; number of refusals.	Full-2013		Includes review of MCO Report #79 Health Risk Assessments	

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: WellCare of Kentucky

Health Risk Assessment

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	0	2	0	0
Total Points	0	4	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.0**		

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review, may adversely affect the scoring of a requirement and result in possible sanctions by DMS.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Final Findings

Health Risk Assessment

Suggested Evidence

Documents

Policies/procedures for:

- Initial health screening assessment (including initial health screening tool)

File Review

File review of a sample of cases selected by the EQRO

Reports

Quarterly reports on the number of new member assessments; number of assessments completed; number of assessments not completed after reasonable effort; number of refusals (MCO Report #79)

Evidence of monitoring of health screening assessment completion rates, and follow-up actions to increase completion rates

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: November 1, 2014 – December 31, 2014
MCO: WellCare of Kentucky

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
27.2 Provider Credentialing and Recredentialing				
In compliance with 907 KAR 1:672 and federal law, the Contractor shall document the procedure, which shall comply with the Department's current policies and procedures, for credentialing and recredentialing of providers with whom it contracts or employs to treat members. This documentation shall include, but not be limited to,	Full-2013			
defining the scope of providers covered,	Full-2013			
the criteria and the primary source verification of information used to meet the criteria,	Full-2013			
the process used to make decisions and the extent of delegated credentialing and recredentialing arrangements.	Full-2013			
The Contractor shall have a process for receiving input from participating providers regarding credentialing and recredentialling of providers.	Full-2013			
Those providers accountable to a formal governing body for review of credentials shall include physicians; dentists, advanced registered nurse practitioners, audiologist, CRNA, optometrist, podiatrist, chiropractor, physician assistant, and other licensed or certified practitioners.	Full-2013			
Providers required to be recredentialed by the Contractor per Department policy are physicians, audiologists, certified registered nurse anesthetists, advanced registered nurse practitioners, podiatrists,	Full-2014			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
chiropractors and physician assistants. However, if any of these providers are hospital-based, credentialing will be performed by the Department.				
The Contractor shall be responsible for the ongoing review of provider performance and credentialing as specified below:				
A. The Contractor shall verify that its enrolled network Providers to whom members may be referred are properly licensed in accordance with all applicable Commonwealth law and regulations, and have in effect such current policies of malpractice insurance as may be required by the Contractor.	Full-2013			
B. The process for verification of Provider credentials and insurance, and any additional facts for further verification and periodic review of Provider performance, shall be embodied in written policies and procedures, approved in writing by the Department.	Full-2013			
C. The Contractor shall maintain a file for each Provider containing a copy of the Provider's current license issued by the Commonwealth and such additional information as may be specified by the Department.	Full-2013			
D. The process for verification of Provider credentials and insurance shall be in conformance with the Department's policies and procedures. The Contractor shall meet requirements under KRS 295.560 (12) related to credentialing. The Contractor's enrolled providers shall complete a credentialing application in	Full-2013			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
accordance with the Department's policies and procedures.				
The process for verification of Provider credentials and insurance shall include the following:				
A. Written policies and procedures that include the Contractor's initial process for credentialing as well as its re-credentialing process that must occur, at a minimum, every three (3) years;	Full-2013			
B. A governing body, or the groups or individuals to whom the governing body has formally delegated the credentialing function;	Full-2013			
C. A review of the credentialing policies and procedures by the formal body;	Full-2013			
D. A credentialing committee which makes recommendations regarding credentialing;	Full-2013			
E. Written procedures, if the Contractor delegates the credentialing function, as well as evidence that the effectiveness is monitored;	Full-2013			
F. Written procedures for the termination or suspension of Providers; and	Full-2013			
G. Written procedures for, and the implementation of, reporting to the appropriate authorities serious quality deficiencies resulting in suspension or termination of a provider.	Full-2013			
The contractor shall meet requirements under KRS 205.560(12) related to credentialing. Verification of	Full-2013 (policy/procedure) Substantial -2014 (file review)	Full	Includes Credentialing file review summary results	

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
the Providers credentials shall include the following:	Credentialing File Review Twenty credentialing files were reviewed: 10 PCP credentialing files and 10 Specialist credentialing files. Specialist Files: 1 file – license expired after license verification, but before credentialing decision. MCO noted that license expiration dates are tracked for all providers monthly, with providers notified of expiring licenses and providers with expired licenses removed from the network. **Recommendation for WellCare** The files for PCPs and Specialists were consistent. For most files, the most recent attestation date did not match the date on the attestation included within the file. Copies of the most up to date documentation should be maintained in the respective files. The MCO should ensure that the practitioner's license is in effect at the time of the credentialing decision. **MCO Response:** WellCare uses the Council for Affordable Quality		This requirement is addressed in WellCare's Credentialing Program Description. Credentialing File Review Results Twenty credentialing files were reviewed: 10 initial credentialing files (5 PCP credentialing files, 5 Specialist credentialing files) 10 recredentialing files (5 PCP recredentialing files, 5 Specialist recredentialing files) 2 of 20 files (one Family Practitioner and another Family Practitioner/Emergency Medicine specialist) did not contain evidence that WellCare checked for the provider's clinical privileges and good performance at the hospital designated by the provider as the primary admitting facility. Instead, the two files contained a screenshot of the results of a provider search from hospitals' website showing that the provider was found in the hospital web directory. During the interview, WellCare disclosed that they follow NCQA guidelines for credentialing, and that verifying clinical privilege and good performance through the web directory was sufficient as per these guidelines. WellCare's credentialing files were in good order and demonstrate that WellCare follows	

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Health Care (CAQH) uniform Credentialing Application. The most recent Attestation date appears on the top left corner of page 1 of the application and not on an actual "Attestation" document. Use of the Attestation date from Page 1 of the CAQH application is an acceptable NCQA and industry credentialing practice. For the most part, the actual signed Attestation document included within the CAQH application will always be outdated. Credentialing Policy and Procedure documents will be amended to clarify use of the CAQH Attestation Date. WellCare conducts random quality audits on completed credentialing files to ensure all verifications have been included and are timely at the time of the Credentialing decision.		a process that is consistent with their contract requirements. In addition, WellCare's recredentialing files indicate that providers in the sample were all recredentialed well within the 3 year timeframe.	
A. A current valid license or certificate to practice in the Commonwealth of Kentucky.	Full-2013			
B. A Drug Enforcement Administration (DEA) certificate and number, if applicable;	Full-2013			
C. Primary source of graduation from medical school and completion of an appropriate residency, or accredited nursing, dental, physician assistant or vision	Full-2013			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
program, as applicable; if provider is not board certified.				
D. Board certification if the practitioner states on the application that the practitioner is board certified in a specialty;	Full-2013			
E. Professional board certification, eligibility for certification, or graduation from a training program to serve children with special health care needs under twenty-one (21) years of age;	Full-2013			
F. Previous five (5) years work history;	Full-2013			
G. Professional liability claims history;	Full-2013			
H. Clinical privileges and performance in good standing at the hospital designated by the Provider as the primary admitting facility, for all providers whose practice requires access to a hospital, as verified through attestation;	Full-2013			
I. Current, adequate malpractice insurance, as verified through attestation;	Full-2013			
J. Documentation of revocation, suspension or probation of a state license or DEA/BNDD number;	Full-2013			
K. Documentation of curtailment or suspension of medical staff privileges;	Full-2013			
L. Documentation of sanctions or penalties imposed by Medicare or Medicaid;	Full-2013			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
M. Documentation of censure by the State or County professional association; and	Full-2013			
N. Most recent information available from the National Practitioner Data Bank.	Full-2013			
The provider shall complete a credentialing application that includes a statement by the applicant regarding:				
A. The ability to perform essential functions of the positions, with or without accommodation;	Full-2013			
B. Lack of present illegal drug use;	Full-2013			
C. History of loss of license and felony convictions;	Full-2013			
D. History of loss or limitation of privileges or disciplinary activity;	Full-2013			
E. Sanctions, suspensions or terminations imposed by Medicare or Medicaid; and	Full-2013			
F. Applicant attests to correctness and completeness of the application	Full-2013			
Before a practitioner is credentialed, the Contractor shall verify information from the following organizations and shall include the information in the credentialing files:				
A. National practitioner data bank, if applicable;	Full-2013			
B. Information about sanctions or limitations on licensure from the appropriate state boards applicable	Full-2013			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
to the practitioner type; and				
C. Other recognized monitoring organizations appropriate to the practitioner's discipline.	Full-2013			
At the time of credentialing, the Contractor shall perform an initial visit to potential providers, as it deems necessary and as required by law.	Substantial - WellCare's 2013 Credentialing Program Description states that as part of the initial credentialing process site inspection evaluations (SIE) are required for the office of primary care physicians (PCPs) and Obstetrician and Gynecology offices. Re-credentialing SIE's are required for PCP offices. C6CR-PR-027 states that SIEs are performed in conjunction with member complaints and unaccredited facility without State or Federal SIE for initial credentialing and re-credentialing. Per WellCare, language was amended in the 2014 Credentialing Program Description: Site visits are only conducted for Kentucky providers as the result of our complaint monitoring process. This modification was outside the review period. **Recommendation for WellCare**	Full	WellCare's 2014 Credentialing Program Description states that as part of the initial credentialing and recredentialing process site inspection evaluations (SIEs) shall be required in accordance with state regulations as described in detail in the Credentialing policies. Based on an email from DMS, on site reviews are not required, but should be used if deemed necessary by WellCare or required by NCQA. WellCare's Credentialing Policy states that WellCare shall monitor to ensure PCPs are meeting PCP responsibilities through member grievances, access and availability surveys, over and under-utilization of services report; and perform onsite inspections and face-to-face education as necessary. Corporate Policy and Procedures, Health Services Area, Credentialing, page 20 states that SIEs are performed in conjunction with the member complaint monitoring process when the member complaints threshold is met or exceeded.	

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Policies/procedures should be consistent regarding the requirement for a site inspection. P/Ps provided indicate site visits are required, however, in practice they are conducted as deemed necessary. **MCO Response:** Policy verbiage update was completed in 2014. Therefore, the updated documents fell outside of the review period (2013). Policy verbiage updates will be reflected appropriately for the 2014 review period.			
The Contractor shall document a structured review to evaluate the site against the Contractor's organizational standards and those specified by this contract.	Full-2013			
The Contractor shall document an evaluation of the medical record documentation and keeping practices at each site for conformity with the Contractors organizational standards and this contract.	Full-2013			
The Contractor shall have formalized recredentialing procedures. The Contractor shall formally recredential its providers at least every three (3) years. The Contractor shall comply with the Department's recredentialing policies and procedures. There shall be evidence that before making a recredentialing decision, the Contractor has verified information about sanctions or limitations on practitioner from:	Full-2013		Includes Recredentialing file review summary results	

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
A. A current license to practice;	Full-2013			
B. The status of clinical privileges at the hospital designated by the practitioner as the primary admitting facility;	Full-2013			
C. A valid DEA number, if applicable;	Full-2013			
D. Board certification, if the practitioner was due to be recertified or become board certified since last credentialed or recredentialed;	Full-2013			
E. Five (5) year history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the practitioner; and	Full-2013			
F. A current signed attestation statement by the applicant regarding:	Full-2013			
1. The ability to perform the essential functions of the position, with or without accommodation;	Full-2013			
2. The lack of current illegal drug use;	Full-2013			
3. A history of loss, limitation of privileges or any disciplinary action; and	Full-2013			
4. Current malpractice insurance.	Full-2013			
There shall be evidence that before making a recredentialing decision, the Contractor has verified information about sanctions or limitations on practitioner from :	Full-2013			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
A. The national practitioner data bank;	Full-2013			
B. Medicare and Medicaid;	Full-2013			
C. State boards of practice, as applicable; and	Full-2013			
D. Other recognized monitoring organizations appropriate to the practitioner's specialty.	Full-2013			
The Contractor will use the format provided in Appendix H to transmit the listed provider credentialing elements to the Department. A Credentialing Process Coversheet will be generated per provider. The Credentialing Process Coversheet will be submitted electronically to the Department's fiscal agent.	Full-2013			
The Contractor shall establish ongoing monitoring of provider sanctions, complaints and quality issues between recredentialing cycles, and take appropriate action.	Full-2013			.
The Contractor shall have written policies and procedures for the initial and on-going assessment of organizational providers with whom it intends to contract or which it is contracted. Providers include, but are not limited to, hospitals, home health agencies, free-standing surgical centers, residential treatment centers and clinics.	Full-2013			
At least every three (3) years, the Contractor shall confirm the provider is in good standing with state and federal regulating bodies, including the Department,	NA- C6CR-001 notes that recredentialing is required every three years (36 months) as per			

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Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
and, has been accredited or certified by the appropriate accrediting body and state certification agency or has met standards of participation required by the Contractor.	NCQA and URAC standards. This policy details the MCO's recredentialing standards and methodology. File review was not applicable for this review period.			
The Contractor shall have policies and procedures for altering conditions of the practitioners participation with the Contractor based on issues of quality of care and services.	Full-2013			
The Contractor shall have procedures for reporting to the appropriate authorities, including the Department, serious quality deficiencies that could result in a practitioner's suspension or termination.	Full-2014			
If a provider requires review by the Contractor's credentialing Committee, based on the Contractor's quality criteria, the Contractor will notify the Department regarding the facts and outcomes of the review in support of the State Medicaid credentialing process.	Full-2014			
The Contractor shall use the provider types summaries listed at: http://chfs.ky.gov/dms/provEnr/Provider+Type+Summaries.htm	Full-2013			
28.1 Network Providers to be Enrolled				
The Contractor's Network shall include Providers from throughout the provider community. The Contractor	Full-2013			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
shall comply with the any willing provider statute as described in 907 KAR 1:672 and KRS 304.17A-270. Neither the Contractor nor any of its Subcontractors shall require a Provider to enroll exclusively with its network to provide Covered Services under this Contract as such would violate the requirement of 42 CFR Part 438 to provide Members with continuity of care and choice. The Contractor shall enroll at least one (1) Federally Qualified Health Center (FQHC) into its network if there is a FQHC appropriately licensed to provide services in the region or service area and at least one teaching hospital. In addition the Contractor shall enroll the following types of providers who are willing to meet the terms and conditions for participation established by the Contractor: physicians, psychiatrists, advanced practice registered nurses, physician assistants, free-standing birthing centers, dentists, primary care centers including, home health agencies, rural health clinics, opticians, optometrists, audiologists, hearing aid vendors, speech therapists, physical therapists, occupational therapists, private duty nursing agency, pharmacies, durable medical equipment suppliers, podiatrists, renal dialysis clinics, ambulatory surgical centers, family planning providers, emergency medical transportation provider, non-emergency medical transportation providers as specified by the Department, other laboratory and x-ray providers, individuals and clinics providing Early and Periodic Screening, Diagnosis, and Treatment services, chiropractors, community mental health centers,				

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
psychiatric residential treatment facilities, hospitals (including acute care, critical access, rehabilitation, and psychiatric hospitals), local health departments, and providers of EPSDT Special Services. The Contractor shall also enroll Psychologists, Licensed Professional Clinical Counselors, Licensed Marriage and Family Therapists, Licensed Psychological Practitioners, Behavioral Health Multi-Specialty Groups, Certified Peer Support Providers, Certified Parental Support Providers, and Licensed Clinical Social Workers. The Contractor may also enroll other providers, which meet the credentialing requirements, to the extent necessary to provide covered services to the Members. Enrollment forms shall include those used by the Kentucky Medicaid Program as pertains to the provider type. The Contractor shall use such enrollment forms as required by the Department. The Department will continue to enroll and certify hospitals, nursing facilities, home health agencies, independent laboratories, preventive health care providers, FQHC, RHC and hospices. The Medicaid provider file will be available for review by the Contractor so that the Contractor can ascertain the status of a Provider with the Medicaid Program and the provider number assigned by the Kentucky Medicaid Program.				
Providers performing laboratory tests are required to be certified under the CLIA. The Department will	Full-2013			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
continue to update the provider file with CLIA information from the OSCAR file provided by the Centers for Medicare and Medicaid Services for all appropriate providers. This will make laboratory certification information available to the Contractor on the Medicaid provider file.				
The Contractor shall have written policies and procedures regarding the selection and retention of the Contractor's Network. The policies and procedures regarding selection and retention must not discriminate against providers who service high-risk populations or who specialize in conditions that require costly treatment or based upon that Provider's licensure or certification.	Full-2013			
If the Contractor declines to include individuals or groups of providers in its network, it shall give affected providers written notice of the reason for its decision.	Full-2013			
The Contractor must offer participation agreements with currently enrolled Medicaid providers who have received electronic health record incentive funds who are willing to meet the terms and conditions for participation established by the Contractor.	Full-2014			
28.2 Out-of-Network Providers				
The Department will provide the Contractor with a streamlined enrollment process to assign provider numbers for Out-of-network providers. Only out-of-network hospitals and physicians are allowed to complete the Registration short form in emergency situations. The Contractor shall, in a format specified	Full-2014			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
by the Department report all out-of-network utilization by Members.				
28.3 Contractor's Provider Network				
The Contractor may enroll providers in their network who are not participating in the Kentucky Medicaid Program. Providers shall meet the credentialing standards described in Provider Credentialing and Re-Credentialing of this Contract and be eligible to enroll with the Kentucky Medicaid Program. A provider joining the Contractor's Network shall meet the Medicaid provider enrollment requirements set forth in the Kentucky Administrative Regulations and in the Medicaid policy and procedures manual for fee-for-service providers of the appropriate provider type. The Contractor shall provide written notice to Providers not accepted into the network along with the reasons for the non-acceptance. A provider cannot enroll or continue participation in the Contractor's Network if the provider has active sanctions imposed by Medicare or Medicaid or SCHIP, if required licenses and certifications are not current, if money is owed to the Medicaid Program, or if the Office of the Attorney General has an active fraud investigation involving the Provider or the Provider otherwise fails to satisfactorily complete the credentialing process. The Contractor shall obtain access to the National Practitioner Database as part of their credentialing process in order to verify the Provider's eligibility for network participation. Federal Financial Participation is not available for amounts expended for providers excluded by Medicare, Medicaid, or SCHIP, except for	Full-2014			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Emergency Medical Services.				
28.4 Enrolling Current Medicaid Providers				
The Contractor will have access to the Department Medicaid provider file either by direct on-line inquiry access, by electronic file transfer, or by means of an extract provided by the Department. The Medicaid provider master file is to be used by the Contractor to obtain the ten-digit provider number assigned to a medical provider by the Department, the Provider's status with the Medicaid program, CLIA certification, and other information. The Contractor shall use the Medicaid Provider number as the provider identifier when transmitting information or communicating about any provider to the Department or its Fiscal Agent The Contractor shall transmit a file of Provider data specified in this Contract for all credentialed Providers in the Contractor's network on a monthly basis and when any information changes.	Full-2014			
28.5 Enrolling New Providers and Providers not Participating in Medicaid				
A medical provider is not required to participate in the Kentucky Medicaid Program as a condition of participation with the Contractor's Network. If a potential Provider has not had a Medicaid number assigned, the Contractor will obtain all data and forms necessary to enroll within the Contractor's Network, and include the required data in any transmission of the provider file information with the exception of the Medicaid Provider number.	Full-2014			

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Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
28.6 Termination of Network Providers or Subcontractors				
A. The Contractor shall terminate from participation any Provider who (i) engages in an activity that violates any law or regulation and results in suspension, termination, or exclusion from the Medicare or Medicaid program; (ii) has a license, certification, or accreditation terminated, revoked or suspended; (iii) has medical staff privileges at any hospital terminated, revoked or suspended; or (iv) engages in behavior that is a danger to the health, safety or welfare of Members.	Full-2014			
The Department shall notify the Contractor of suspension, termination, and exclusion actions taken against Medicaid providers by the Kentucky Medicaid program within three business days via e-mail. The Contractor shall terminate the Provider effective upon receipt of notice by the Department.	Not Reviewed	Full	This is addressed in C7PR-015 Termination of Existing Providers, page 18.	
The Contractor shall notify the Department of termination from Contractor's network taken against a Provider within three business days via email. The Contractor shall indicate in its notice to the Department the reason or reasons for which the PCP ceases participation.	Full-2014			
The Contractor shall notify any Member of the Provider's termination provided such Member has received a service from the terminated Provider within the previous six months. Such notice shall be mailed within 15 days of the action taken if it is a PCP and	Not Reviewed	Full	This is addressed in C7PR-015 Termination of Existing Providers, page 18.	

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Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
within 30 days for any other Provider.				
B. In the event a Provider terminates participation with the Contractor, the Contractor shall notify the Department of such termination by Provider within five business days via email. In addition, the Contractor will provide all terminations monthly, via the Provider Termination Report as referenced in Appendix K. The Contractor shall indicate in its notice to the Department the reason or reasons for which the PCP ceases participation.	Full-2014			
The Contractor shall notify any Member of the Provider's termination provided such Member has received a service from the terminating Provider within the previous six months. Such notice shall be mailed the later of the following: (i) 30 days prior to the effective date of the termination or (ii) within 15 days of receiving notice.	Not Reviewed	Full	This is addressed in C7PR-015 Termination of Existing Providers, page 18.	
C. The Contractor may terminate from participation any Provider who materially breaches the Provider Agreement with Contractor and fails to timely and adequately cure such breach in accordance with the terms of the Provider Agreement.	Not Reviewed	Full	This is addressed in C7PR-015 Termination of Existing Providers, page 16.	
The Contractor shall notify any Member of the Provider's termination provided such Member has received a service from the terminating Provider within the previous six months. Such notice shall be mailed the later of the following: (i) within 15 days of providing notice or (ii) 30 days prior to the effective date of the termination.	Not Reviewed	Full	This is addressed in C7PR-015 Termination of Existing Providers, page 18.	

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	7	0	0	0
Total Points	21	0	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average	3.0			

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review, may adversely affect the scoring of a requirement and result in possible sanctions by DMS.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing
Suggested Evidence

Documents

Policies and Procedures for:

- Enrollment of network providers
- Enrollment of out-of-network providers
- Provider Credentialing and Recredentialing including delegated credentialing
- Monitoring of provider sanctions, complaints and quality issues between recredentialing cycles
- Altering conditions of participation
- Termination/Suspension of providers
- Initial and ongoing assessment of organizational providers

Credentialing Committee description, membership, meeting agendas and minutes

Reports

Reports of oversight of delegated credentialing
Reports to DMS and/or other authorities of serious quality issues that could result in provider suspension or termination
Sample provider file report of provider credentialing for DMS Fiscal Agent
Sample reports to DMS of cases where a provider requires review by the Credentialing Committee

File Review

Sample of Credentialing and Recredentialing files for varied provider types selected by the EQRO

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: WellCare of Kentucky

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
27.3 Primary Care Provider Responsibilities				
A primary care provider (PCP) is a licensed or certified health care practitioner, including a doctor of medicine, doctor of osteopathy, advanced practice registered nurse (including a nurse practitioner, nurse midwife and clinical specialist), physician assistant, or clinic (including a FQHC, primary care center and rural health clinic), that functions within the scope of licensure or certification, has admitting privileges at a hospital or a formal referral agreement with a provider possessing admitting privileges, and agrees to provide twenty-four (24) hours per day, seven (7) days a week primary health care services to individuals. Primary care physician residents may function as PCPs. The PCP shall serve as the member's initial and most important point of contact with the Contractor. This role requires a responsibility to both the Contractor and the Member. Although PCPs are given this responsibility, the Contractors shall retain the ultimate responsibility for monitoring PCP actions to ensure they comply with the Contractor and Department policies.	Full-2013			
Specialty providers may serve as PCPs under certain circumstances, depending on the Member's needs. The decision to utilize a specialist as the PCP shall be based on agreement among the Member or family, the specialist, and the Contractor's medical director. The Member has the right to Appeal such a decision in the formal Appeals process.	Substantial - Member Handbook and C7ND MD-001 Network Development.: Addendum H Kentucky states: "Specialty providers may serve as PCPs under certain circumstances, depending on the Member's needs. The decision to utilize a specialist as the PCP shall be based on agreement among the Member or family, the specialist, and the Company's medical direction".	Full	This requirement is addressed in the Member Handbook and Network Development: Addendum H.	

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Policy C7AP-035 addresses member's right to appeal this decision. The date on the policy is revised 3/5/14 and was not in effect during 2013. **Recommendation for WellCare** Policy should be updated to address the member's right to appeal. The revised policy addresses this requirement but was not in effect in 2013. **MCO Response:** WellCare has revised this policy.			
The Contractor shall monitor PCP's actions to ensure he/she complies with the Contractor's and Department's policies including but not limited to the following:				
A. Maintaining continuity of the Member's health care;	Full-2013			
B. Making referrals for specialty care and other Medically Necessary services, both in and out of network, if such services are not available within the Contractor's network;	Full-2013			
C. Maintaining a current medical record for the Member, including documentation of all PCP and specialty care services;	Full-2013			
D. Discussing Advance Medical Directives with all Members as appropriate;	Full-2013			
E. Providing primary and preventative care, recommending or arranging for all necessary preventive	Full-2013			

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
health care, including EPSDT for persons under the age of 21 years;				
F. Documenting all care rendered in a complete and accurate medical record that meets or exceeds the Department's specifications; and	Full-2013			
G. Arranging and referring members when clinically appropriate, to behavioral health providers.	Full-2013			
Maintaining formalized relationships with other PCPs to refer their Members for after-hours care, during certain days, for certain services, or other reasons to extend their practice. The PCP remains solely responsible for the PCP functions (A) through (G) above.	Full-2013			
The Contractor shall ensure that the following acceptable after-hours phone arrangements are implemented by PCPs in Contractor's Network and that the unacceptable arrangements are not implemented:				
A. Acceptable				
(1) Office phone is answered after hours by an answering service that can contact the PCP or another designated medical practitioner and the PCP or designee is available to return the call within a maximum of thirty (30) minutes;	Full-2013			
(2) Office phone is answered after hours by a recording directing the Member to call another number to reach the PCP or another medical practitioner whom the Provider has designated to return the call within a maximum of thirty (30) minutes; and	Full-2013			

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
(3) Office phone is transferred after office hours to another location where someone will answer the phone and be able to contact the PCP or another designated medical practitioner within a maximum of thirty (30) minutes.	Full-2013			
B. Unacceptable				
(1) Office phone is only answered during office hours;	Substantial - Policy C6NI-002 Provider Appointment Accessibility and After-Hours Coverage Addendum J includes the following: "The Contractor considers the following arrangements to be unacceptable: 1. Office phone is only answered during office hours **Recommendation for WellCare** Include acceptable and unacceptable office phone requirements in the Provider Manual. **MCO Response:** Page 23 of the Provider Manual lists coverage requirements. Recommended additions to Provider Manual have been submitted for next update.	Full	This requirement is addressed in full on page 20 of the Provider Appointment Accessibility and After-Hours Coverage Policy.	
(2) Office phone is answered after hours by a recording that tells Members to leave a message;	Substantial - Policy C6NI-002 Provider Appointment Accessibility and After-Hours Coverage Addendum J includes the following: "The Contractor considers the following	Full	This requirement is addressed in full on page 20 of the Provider Appointment Accessibility and After-Hours Coverage Policy.	

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	arrangements to be unacceptable: 1. Office phone is answered after hours by a recording that tells Members to leave a message. **Recommendation for WellCare** Include acceptable and unacceptable office phone requirements in the Provider Manual. **MCO Response:** Page 23 of the Provider Manual lists coverage requirements. Recommended additions to Provider Manual have been submitted for next update.			
(3) Office phone is answered after hours by a recording that directs Members to go to the emergency room for any services needed; and	Substantial - Policy C6NI-002 Provider Appointment Accessibility and After-Hours Coverage Addendum J includes the following: "The Contractor considers the following arrangements to be unacceptable: 1. Office phone is answered after hours by a recording that directs Members to go to the emergency room for any services needed. **Recommendation for WellCare** Include acceptable and unacceptable office phone requirements in the	Full	This requirement is addressed in full on page 20 of the Provider Appointment Accessibility and After-Hours Coverage Policy.	

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Provider Manual. **MCO Response:** Page 23 of the Provider Manual lists coverage requirements. Recommended additions to Provider Manual have been submitted for next update.			
(4) Returning after-hours calls outside of thirty (30) minutes.	Substantial - Policy C6NI-002 Provider Appointment Accessibility and After-Hours Coverage Addendum J includes the following: "The Contractor considers the following arrangements to be unacceptable: 1. Returning after-hours calls outside of thirty (30) minutes. **Recommendation for WellCare** Include acceptable and unacceptable office phone requirements in the Provider Manual. **MCO Response:** Page 23 of the Provider Manual lists coverage requirements. Recommended additions to Provider Manual have been submitted for next update.	Full	This requirement is addressed in full on page 20 of the Provider Appointment Accessibility and After-Hours Coverage Policy.	
28.7 Provider Program Capacity Demonstration				
The Contractor shall assure that all covered services are as accessible to Members (in terms of timeliness,	Full-2013			

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
amount, duration, and scope) as the same services as are available to commercial insurance members in the Contractor's Region; and that no incentive is provided, monetary or otherwise, to providers for the withholding from Members of medically necessary services.				
The Contractor shall make available and accessible facilities, service locations, and personnel sufficient to provide covered services consistent with the requirements specified in this section.	Full-2013			
Emergency medical services shall be made available to Members twenty-four (24) hours a day, seven (7) days a week. Urgent care services by any provider in the Contractor's Program shall be made available within 48 hours of request. The Contractor shall provide the following:	Full-2013			
A. Primary Care Provider (PCP) delivery sites that are: no more than thirty (30) miles or thirty (30) minutes from Members in urban areas, and for Members in non-urban areas, no more than forty-five (45) minutes or forty-five (45) miles from Member residence; with a member to PCP (FTE) ratio not to exceed 1500:1; and with appointment and waiting times, not to exceed thirty (30) days from date of a Member's request for routine and preventive services and forty-eight (48) hours for Urgent Care.	Full-2013		Includes review of MCO Report #12A Geo Access Network Reports & Maps (see Quarterly Desk Audit results)	
B. Specialty care in which referral appointments to specialists shall not exceed thirty (30) days for routine care or forty-eight (48) hours for Urgent Care; except for Behavioral Health Services for which emergency care with crisis stabilization must be provided within twenty-four	Full-2013			

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
(24) hours, urgent care which must be provided within forty-eight (48) hours, services may not exceed fourteen (14) days post discharge from an acute Psychiatric Hospital and sixty (60) days for other referrals.				
C. In addition to the above, the Contractor shall include in its network Specialists designated by the Department in no fewer number than 25% of the Specialists enrolled in the Department's Fee-for-Service program by region; and include sufficient pediatric specialists to meet the needs of Members younger than 21 years of age. Access to Specialists shall not exceed 60 miles or 60 minutes. In the event there are less than 5 qualified Specialists in a particular region, the 25% shall not apply to that region.	Full-2013		Includes review of MCO Report #12A Geo Access Network Reports & Maps (see Quarterly Desk Audit results)	
D. Immediate treatment for Emergency Care at a health facility that is most suitable for the type of injury, illness or condition, regardless of whether the facility is in Contractor's Network.	Full-2013			
E. Access to hospital care shall not exceed 30 miles or 30 minutes of a Member's residence in an urban area, or 60 minutes of a Member's residence in a non-urban area, with the exception of Behavioral Health Services and physical rehabilitative services where access shall not exceed 60 miles or 60 minutes.	Full-2013		Includes review of MCO Report #12A Geo Access Network Reports & Maps (see Quarterly Desk Audit results)	
F. Access for general dental services shall not exceed 60 miles or 60 minutes. Any exceptions shall be justified and documented by the Contractor. Appointment and waiting times shall not exceed 3 weeks for regular appointments and 48 hours for urgent care.	Full-2013		Includes review of MCO Report #12A Geo Access Network Reports & Maps (see Quarterly Desk Audit results)	
G. Access for general vision, laboratory and radiology	Full-2013		Includes review of MCO Report #12A Geo	

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
services shall not exceed 60 miles or 60 minutes. Any exceptions shall be justified and documented by the Contractor. Appointment and waiting times shall not exceed 30 days for regular appointments and 48 hours for Urgent Care.			Access Network Reports & Maps (see Quarterly Desk Audit results)	
H. Access for Pharmacy services shall not exceed 60 miles or 60 minutes or the delivery site shall not be further than 50 miles from the Member's residence. The Contractor is not required to provide transportation services to Pharmacy services.	Full-2014		Includes review of MCO Report #12A Geo Access Network Reports & Maps (see Quarterly Desk Audit results)	
The Contractor shall attempt to enroll the following Providers in its network as follows:				
A. Teaching hospitals;	Full-2014			
B. FQHCs and rural health clinics;	Full-2013			
C. The Kentucky Commission for Children with Special Health Care Needs; and	Full-2014			
D. Community Mental Health Centers	Full-2013			
If the Contractor is not able to reach agreement on terms and conditions with these specified providers, it shall submit to the Department, for approval, documentation which supports that adequate services and service sites as required in this Contract shall be provided to meet the needs of its Members without contracting with these specified providers.	Full-2014			
In consideration of the role that Department for Public Health, which contracts with the local health departments play in promoting population health of the				

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
provision of safety net services, the Contractor shall offer a participation agreement to the Department of Public Health for local health department services. Such participation agreements shall include, but not be limited to, the following provisions:				
A. Coverage of the Preventive Health Package pursuant to 907 KAR 1:360.	Full-2014			
B. Provide reimbursement at rates commensurate with those provided under Medicare.	Full-2014			
The Contractor may also include any charitable providers which serve Members in the Contractor Region, provided that such providers meet credentialing standards.	Full-2014			
The Contractor shall demonstrate the extent to which it has included providers who have traditionally provided a significant level of care to Medicaid Members. The Contractor shall have participating providers of sufficient types, numbers, and specialties in the service area to assure quality and access to health care services as required for the Quality Improvement program as outlined in Management Information Systems. If the Contractor is unable to contract with these providers, it shall submit to the Department, for approval, documentation which supports that adequate services and service sites as required in the Contract shall be available to meet the needs of its Members.	Full-2013			
28.8 Provider Network Adequacy				
The Contractor shall submit information in accordance with Appendix G that demonstrates that the Contractor	Full-2013		Includes review of MCO Report #12A Geo Access Network Reports & Maps (see	

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
has an adequate network that meets the Department's standards in Section 28.7. The MCO shall notify the Department, in writing, of any anticipated network changes that may impact network standards herein.			Quarterly Desk Audit results)	
The Contractor shall update this information to reflect changes in the Contractor's Network on an annual basis, or upon request by the Department.	Full-2013			
28.9 Expansion and/or Changes in the Network				
If at any time, the Contractor or the Department determines that its Contractor Network is not adequate to comply with the access standards specified above for 95% of its Members, the Contractor or Department shall notify the other of this situation and within 15 business days the Contractor shall submit a corrective action plan to remedy the deficiency. The corrective action plan shall describe the deficiency in detail, including the geographic location and specific regions where the problem exists, and identify specific action steps to be taken by the Contractor and time- frames to correct the deficiency.	Full-2013		Includes review of MCO Report #13 Access & Delivery Network Narrative (see Quarterly Desk Audit results)	
In addition to expanding the service delivery network to remedy access problems, the Contractor shall also make reasonable efforts to recruit additional providers based on Member requests. When Members ask to receive services from a provider not currently enrolled in the network, the Contractor shall contact that provider to determine an interest in enrolling and willingness to meet the Contractor's terms and conditions.	Full-2014			
30.1 Medicaid Covered Services				

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall provide, or arrange for the provision of, the Covered Services listed in Appendix I to Members in accordance with the Contract standards, and according to the Department's regulations, state plan, policies and procedures applicable to each category of Covered Services. The Contractor shall be required to provide Covered Services to the extent services are covered for Members at the time of Enrollment.	Full-2013			
The Contractor shall ensure that the care of new enrollees is not disrupted or interrupted. The Contractor shall ensure continuity of care for new Members receiving health care under fee for service prior to enrollment in the Plan. Appendix I shall serve as a summary of currently Covered Services that the Contractor shall be responsible for providing to Members. However, it is not intended, nor shall it serve as a substitute for the more detailed information relating to Covered Services which is contained in applicable administrative regulations governing Kentucky Medicaid services provision (907 KAR Chapter 1 and 907 KAR 3:005) and individual Medicaid program services manuals incorporated by reference in the administrative regulations.	Full-2013			
After the Execution Date and the adjustment for ACA compliance, to the extent a new or expanded Covered Service is added by the Department to Contractor's responsibilities under this Contract, ("New Covered Service") the financial impact of such New Covered Service will be evaluated from an actuarial perspective by the Department, and Capitation Rates to be paid to Contractor hereunder will be adjusted accordingly to 12.2				

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
and 39.16 herein. The determination that a Covered Service is a New Covered Service is at the discretion of the Department. At least ninety (90) days before the effective date of the addition of a New Covered Service, the Department will provide written notice to Contractor of any such New Covered Service and any adjustment to the Capitation Rates herein as a result of such New Covered Service. This notice shall include: (i) an explanation of the New Covered Service; (ii) the amount of any adjustment to Capitation Rates herein as a result of such New Covered Service; and (iii) the methodology for any such adjustment.				
The Contractor may provide, or arrange to provide, services in addition to the services described in Attachment I, provided quality and access are not diminished, the services are Medically Necessary health services and cost-effective. The cost for these additional services shall not be included in the Capitation Rate. The Contractor shall notify and obtain approval from Department for any new services prior to implementation. The Contractor shall notify the Department by submitting a proposed plan for additional services and specify the level of services in the proposal.	Full-2014			
Any Medicaid service provided by the Contractor that requires the completion of a specific form (e.g., hospice, sterilization, hysterectomy, or abortion), the form shall be completed according to the appropriate Kentucky Administrative Regulation (KAR). The Contractor shall require its Subcontractor or Provider to retain the form in the event of audit and a copy shall be submitted to the Department upon request.	Full-2014			

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall not prohibit or restrict a Provider from advising a Member about his or her health status, medical care, or treatment, regardless of whether benefits for such care are provided under the Contract, if the Provider is acting within the lawful scope of practice.	Full-2013			
If the Contractor is unable to provide within its network necessary medical services covered under Appendix I, it shall timely and adequately cover these services out of network for the Member for as long as Contractor is unable to provide the services in accordance with 42 CFR 438.206. The Contractor shall coordinate with out-of-network providers with respect to payment. The Contractor will ensure that cost to the Member is no greater than it would be if the services were provided within the Contractor's Network.	Full-2013			
A Member who has received Prior Authorization from the Contractor for referral to a specialist physician or for inpatient care shall be allowed to choose from among all the available specialists and hospitals within the Contractor's Network, to the extent reasonable and appropriate.	Full-2014			
32.3 Emergency Care, Urgent Care and Post Stabilization Care				
Emergency Care shall be available to Members 24 hours a day, seven days a week. Urgent Care services shall be made available within 48 hours of request. Post Stabilization Care services are covered and reimbursed in accordance with 42 CFR 422.113(c) and 438.114(c).	Full-2013			
32.4 Out-of-Network Emergency Care				

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall provide, or arrange for the provision of Emergency Care, even though the services may be received outside the Contractor's Network, in compliance with 42 CFR 438.114.	Full-2013			
Payment for Emergency Services covered by a non-contracting provider shall not exceed the Medicaid fee-for service rate as required by Section 6085 of the Deficit Reduction Act of 2005.	Full-2014			.
30.2 Direct Access Services				
The Contractor shall make Covered Services available and accessible to Members as specified in Appendix I. The Contractor shall routinely evaluate Out-of-Network utilization and shall contact high volume providers to determine if they are qualified and interested in enrolling in the Contractor's network. If so, the Contractor shall enroll the provider as soon as the necessary procedures have been completed. When a Member wishes to receive a direct access service or receives a direct access service from an Out-of-Network Provider, the Contractor shall contact the provider to determine if it is qualified and interested in enrolling in the network. If so, the Contractor shall enroll the provider as soon as the necessary enrollment procedures have been completed.	Full-2014			
The Contractor shall ensure direct access and may not restrict the choice of a qualified provider by a Member for the following services within the Contractor's network:				
A. Primary care vision services, including the fitting of eye-glasses, provided by ophthalmologists, optometrists	Full-2013			

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
and opticians;				
B. Primary care dental and oral surgery services and evaluations by orthodontists and prosthodontists;	Full-2013			
C. Voluntary family planning in accordance with federal and state laws and judicial opinion;	Full-2013			
D. Maternity care for Members under 18 years of age;	Full-2013			
E. Immunizations to Members under 21 years of age;	Full-2013			
F. Sexually transmitted disease screening, evaluation and treatment;	Full-2013			
G. Tuberculosis screening, evaluation and treatment;	Full-2013			
H. Testing for Human Immunodeficiency Virus (HIV), HIV-related conditions, and other communicable diseases as defined by 902 KAR 2:020;	Full-2013			
I. Chiropractic services; and	Full-2013			
J. Women's health specialists.	Full-2013			
32.6 Voluntary Family Planning				
The Contractor shall ensure direct access for any Member to a Provider, qualified by experience and training, to provide Family Planning Services, as such services are described in Appendix I to this Contract. The Contractor may not restrict a Member's choice of his or her provider for Family Planning Services. Contractor must assure access to any qualified provider of Family Planning Services without requiring a referral from the PCP.	Full-2013			
The Contractor shall maintain confidentiality for Family	Full-2014			

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Planning Services in accordance with applicable federal and state laws and judicial opinions for Members under eighteen (18) years of age pursuant to Title X, 42 CFR 59.11, and KRS 214.185. Situations under which confidentiality may not be guaranteed are described in KRS 620.030, KRS 209.010 et. seq., KRS 202A, and KRS 214.185.				
All information shall be provided to the Member in a confidential manner. Appointments for counseling and medical services shall be available as soon as possible with in a maximum of 30 days. If it is not possible to provide complete medical services to Members less than 18 years of age on short notice, counseling and a medical appointment shall be provided right away preferably within 10 days. Adolescents in particular shall be assured that Family Planning Services are confidential and that any necessary follow-up will assure the Member's privacy.	New Requirement	Full	The Provider Appointment Accessibility and After-Hours Policy addresses the requirements regarding appointments for counseling and medical services. The Member Handbook informs members that they have the right to have their privacy protected and their records kept private.	

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: WellCare of Kentucky

Quality Assessment and Performance Improvement: Access

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	6	0	0	0
Total Points	18	0	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average	3.0			

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review, may adversely affect the scoring of a requirement and result in possible sanctions by DMS.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Final Findings

Quality Assessment and Performance Improvement: Access
Suggested Evidence

Documents

Policies/procedures for:

- PCP responsibilities
- Provider hours of operation and availability, including after-hours availability
- Provider program capacity requirements
- Access and availability standards
- Emergency care, urgent care and post stabilization care
- Out-of-network emergency care
- Direct access services
- Voluntary family planning
- Referral for non-covered services
- Referral and assistance with scheduling for specialty health care services

Process for monitoring of provider compliance with hours of operation and availability, including after-hours availability
Process for monitoring of provider compliance with PCP responsibilities
Sample provider contracts – one per provider type
Provider Manual
Benefit Summary (covered/non-covered services)
Corrective action plan submitted to DMS for inadequate access, if applicable

Reports

Monitoring and follow-up of provider compliance with hours of operation and availability, including after-hours availability
Monitoring of provider compliance with PCP responsibilities
Geo Access network reports and maps (MCO Report #12A) for:

- Primary care
- Specialty care

Final Findings

- Emergency care
- Hospital care
- General dental services
- General vision, laboratory and radiology services
- Pharmacy services

Access and delivery network narrative reports (MCO Report #13)
Evidence of evaluation, analysis and follow-up related to provider program capacity reports
Reports of Out-of-Network Utilization
Evidence of evaluation, analysis and follow-up related to out-of-network utilization monitoring

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MCO: WellCare of Kentucky

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Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
20.6 Utilization Management				
The Contractor shall have a comprehensive UM program that reviews services for Medical Necessity and that monitors and evaluates on an ongoing basis the appropriateness of care and services.	Full-2013			
A written description of the UM program shall outline the program structure and include a clear definition of authority and accountability for all activities between the Contractor and entities to which the Contractor delegates UM activities.	Full-2013			
The description shall include the scope of the program;	Full-2013			
the processes and information sources used to determine service coverage;	Full-2013			
clinical necessity, appropriateness and effectiveness;	Full-2013			
policies and procedures to evaluate care coordination, discharge criteria, site of services, levels of care, triage decisions and cultural competence of care delivery;	Full-2013			
processes to review, approve, and deny services as needed, particularly but not limited to the EPSDT program.	Full-2013			
The UM program shall be evaluated annually, including an evaluation of clinical and service outcomes.	Full-2013			
The UM program evaluation along with any changes	Full-2013			

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
to the UM program as a result of the evaluation findings, will be reviewed and approved annually by the Medical Director or the QI Committee.				
The Contractor shall adopt Interqual, Milliman or other nationally recognized standards and criteria for Medical Necessity review which shall be approved by the Department.	Full-2013			
The Contractor shall include appropriate physicians and other providers in Contractor's Network in the review and adoption of Medical Necessity criteria.	Full-2013			
The Contractor shall have in place mechanisms to check the consistency of application of review criteria.	Full-2013			
The written clinical criteria and protocols shall provide for mechanisms to obtain all necessary information, including pertinent clinical information, and consultation with the attending physician or other health care provider as appropriate.	Full-2013		Includes UM file review results	
The Medical Director shall supervise the UM program and shall be accessible and available for consultation as needed. Decisions to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a physician who has appropriate clinical expertise in treating the Member's condition or disease.	Full-2013		Includes UM file review results	
The reason for the denial shall be cited.	Full-2013		Includes UM file review results	

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Physician consultants from appropriate medical and surgical specialties shall be accessible and available for consultation as needed.	Full-2013			
The Medical Necessity review process shall be timely and shall include a provision for expedited reviews in urgent decisions.	Full-2013			
A. The Contractor shall submit its request to change any prior authorization requirement to the Department for review.	Full-2013			
B. For the processing of requests for initial and continuing authorization of services, the Contractor shall require that its subcontractors have in place written policies and procedures and have in effect a mechanism to ensure consistent application of review criteria for authorization decisions.	Full-2013			
C. In the event that a Member or Provider requests written confirmation of an approval, the Contractor shall provide written confirmation of its decision within 3 working days of providing notification of a decision if the initial decision was not in writing. The written confirmation shall be written in accordance with Member Rights and Responsibilities.	Full-2013			
D. The Contractor shall have written policies and procedures that show how the Contractor will monitor to ensure clinical appropriate overall continuity of care.	Full-2013			
E. The Contractor shall have written policies and	Full-2013			

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
procedures that explain how prior authorization data will be incorporated into the Contractor's overall Quality Improvement Plan.				
F. The Contractor shall only provide coverage for randomized and controlled Phase III and Phase IV clinical trials.	New Requirement	~~Non-Compliance~~ Not Applicable	~~This requirement was not addressed in documents provided for review. At the onsite review, WellCare staff explained that this requirement is not included in the MCO's current contract with DMS. In follow-up, IPRO examined the contracts and amendments provided by DMS. While this requirement is not included in the core contract, it was added in the First Amendment to the Medicaid Managed Care Contract, effective 1/1/13 and signed in February 2013.~~ Final Review Determination After discussion with DMS, this requirement is considered Not Applicable.	The amendment executed in February 2013, amended Section 20.6 of the Medicaid Managed Care Contract to include "F. The Contractor shall only provide coverage for randomized and controlled Phase III and Phase IV clinical trials." This conflicts with Appendix I of the Managed Care Contract which specifies that "Services, including but not limited to drugs, that are investigational, mainly for research purposes or experimental in nature" are not covered under the Kentucky Medicaid Program. This amendment also expired in June 2014. We would also note that the Department has replied publicly to questions submitted during a public comment period that coverage for Phase III and Phase IV clinical trials is not a covered benefit in the Medicaid Managed Care contracts effective 7/1/2015.
Each subcontract must provide that consistent with 42 CFR Sections 438.6(h) and 422.208, compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to a Member.	Full-2013			
The program shall identify and describe the mechanisms to detect under-utilization as well as	Full-2013			

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
over-utilization of services.				
The written program description shall address the procedures used to evaluate Medical Necessity, the criteria used, information sources, timeframes and the process used to review and approve the provision of medical services.	Full-2013			
The Contractor shall evaluate Member satisfaction (using the CAHPS survey) and provider satisfaction with the UM program as part of its satisfaction surveys.	Full-2013			
The UM program will be evaluated by DMS on an annual basis.	Full-2013		Includes review of MCO Report #59 Prior Authorizations (see Quarterly Desk Audit results)	
20.7 Adverse Actions Related to Medical Necessity or Coverage Denials				
The Contractor shall give the Member written notice of an Action related to medical necessity or coverage denials that meets the language and formatting requirements for Member materials, of any action (not just service authorization actions) within the timeframes for each type of action pursuant to 42 CFR 438.210(c). The notice must explain:	Full-2013			
(a) The action the Contractor has taken or intends to take;	Full-2013		Includes UM file review results	
(b) The reasons for the action in clear, non-technical language that is understandable by a layperson;	Full-2013		Includes UM file review results	

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
(c) The federal or state regulation supporting the action, if applicable;	New Requirement	Full	Includes UM file review results UM file review was deemed this year and not performed. This requirement is addressed in Appendix A Utilization Management Program Description, page 15.	
(d) The Member's right to appeal;	Full-2013		Includes UM file review results	
(e) The Member's right to request a State hearing;	Full-2013		Includes UM file review results	
(f) Procedures for exercising Member's rights to Appeal or file a Grievance;	Full-2013		Includes UM file review results	
(g) Circumstances under which expedited resolution is available and how to request it; and	Full-2013		Includes UM file review results	
(h) The Member's rights to have benefits continue pending the resolution of the Appeal, how to request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of these services.	Full-2013		Includes UM file review results	
20.8 Timeframe for Notice of Action Related to Medical Necessity or Coverage Denials				
The Contractor must give notice of an Action related to medical necessity or coverage denials at least: A. Ten (10) days before the date of Action when the Action is a termination, suspension, or reduction of a covered service authorized by the	Full-2013			

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Department, its agent or Contractor, except the period of advanced notice is shortened to 5 days if Member Fraud or Abuse has been determined.				
B. The Contractor must give notice by the date of the Action for the following:				
1. In the death of a Member;	Full-2013			
2. A signed written Member statement requesting service termination or giving information requiring termination or reduction of services (where he understands that this must be the result of supplying that information);	Full-2013			
3. The Member's admission to an institution where he is ineligible for further services;	Full-2013			
4. The Member's address is unknown and mail directed to him has no forwarding address;	Full-2013			
5. The Member has been accepted for Medicaid services by another local jurisdiction;	Full-2013			
6. The Member's physician prescribes the change in the level of medical care;	Full-2013			
7. An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1, 1989;	Full-2013			
8. The safety or health of individuals in the facility would be endangered, the Member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or	Full-2013			

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
discharge is required by the member's urgent medical needs, or a Member has not resided in the nursing facility for thirty (30) days.				
C. The Contractor must give notice on the date of the Action when the Action is a denial of payment.	Full-2013			
D. The Contractor must give notice as expeditiously as the Member's health condition requires and within State-established timeframes that may not exceed two (2) business days following receipt of the request for service, with a possible extension of up to fourteen (14) additional days, if the Member, or the Provider, requests an extension, or the Contractor justifies a need for additional information and how the extension is in the Member's interest.	Full-2013		Includes UM file review results	
If the Contractor extends the timeframe, the Contractor must give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a Grievance if he or she disagrees with that decision; and issue and carry out the determination as expeditiously as the Member's health condition requires and no later than the date the extension expires.	Full-2013		Includes UM file review results	
E. For cases in which a Provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice	Full-2013			

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
as expeditiously as the Member's health condition requires and no later than two (2) business days after receipt of the request for service.				
F. The Contractor shall give notice on the date that the timeframes expire when service authorization decisions not reached within the timeframes for either standard or expedited service authorizations. An untimely service authorization constitutes a denial and is thus and adverse action.	Full-2013			

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	1	0	0	0
Total Points	3	0	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average	3.0			

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review, may adversely affect the scoring of a requirement and result in possible sanctions by DMS.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
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Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS' Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management
Suggested Evidence

Documents

Policies/procedures for:

- Utilization management
- Review and adoption of medical necessity criteria
- Monitoring to ensure clinically appropriate overall continuity of care
- Incorporation of prior authorization data into QI plan

UM Program Description
Contracts with any subcontractors delegated for UM
Evidence of provider involvement in the review and adoption of medical necessity criteria
UM Committee description and minutes
Process for detecting under-utilization and over-utilization of services

Reports

UM Program Evaluation
Monitoring of consistent application of review criteria and any follow-up actions
CAHPS Report
Provider Satisfaction Survey Report

File Review

Sample of UM files selected by EQRO

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: WellCare of Kentucky

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
36. Program Integrity				
The Contractor shall have arrangements and policies and procedures that comply with all state and federal statutes and regulations including 42 CFR 438.608 and Section 6032 of the Federal Deficit Reduction Act of 2005, governing fraud, waste and abuse requirements.				
The Contractor shall develop in accordance with Appendix L, a Program Integrity plan of internal controls and policies and procedures for preventing, identifying and investigating enrollee and provider fraud, waste and abuse. If the Department changes its program integrity activities, the Contractor shall have up to six (6) months to provide a new or revised program. This plan shall include, at a minimum:	Full-2014			
A. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state standards;	Full-2013			
B. The designation of a compliance officer and a compliance committee that are accountable to senior management;	Full-2013			
C. Effective training and education for the compliance officer, the organization's	Full-2013			

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
employees, subcontractors, providers and members regarding fraud, waste and abuse;				
D. Effective lines of communication between the compliance officer and the organization's employees;	Full-2013			
E. Enforcement of standards through disciplinary guidelines;	Full-2013			
F. Provision for internal monitoring and auditing of the member and provider;	Full-2013			
G. Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the Contractor's contract;	Full-2013			
H. Provision for internal monitoring and auditing of Contractor and its subcontractors; if issues are found Contractor shall provide corrective action taken to the Department;	Full-2013			
I. Contractor shall be subject to on-site review; and comply with requests from the department to supply documentation and records;	Full-2013			
J. Contractor shall create an account receivables process to collect outstanding debt from members or providers; and provide monthly reports of activity and collections to the	Full-2013			

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
department;				
K. Contractor shall provide procedures for appeal process;	Full-2013			
L. Contractor shall comply with the expectations of 42 CFR 455.20 by employing a method of verifying with member whether the services billed by provider were received by randomly selecting a minimum sample of 500 claims on a monthly basis;	Full-2014			
M. Contractor shall create a process for card sharing cases;	Full-2014			
N. Contractor shall run algorithms on Claims data and develop a process and report quarterly to the Department all algorithms run, issues identified, actions taken to address those issues and the overpayments collected;	Full-2013		Includes review of MCO Report #75 SUR Algorithms	
O. Contractor shall follow cases from the time they are opened until they are closed; and	Full-2013			
P. Contractor shall attend any training given by the Commonwealth/Fiscal Agent or other Contractor's organizations provided reasonable advance notice is given to Contractor of the scheduled training.	Full-2013			
The plan shall be made available to the	Full-2013			

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Department for review and approval.				
9.1 Administration/Staffing				
The Contractor shall provide the following functions that shall be staffed by a sufficient number of qualified persons to adequately provide for the member enrollment and services provided.				
B. A Compliance Director whose responsibilities shall be to ensure financial and programmatic accountability, transparency and integrity. The Compliance Director shall maintain current knowledge of Federal and State legislation, legislative initiatives, and regulations relating to Contractor and oversee the Contractor's compliance with the laws and Contract requirements of the Department. The Compliance Director shall also serve as the primary contact for and facilitate communications between Contractor leadership and the Department relating to Contract compliance issues. The Compliance Director shall also oversee Contractor implementation of and evaluate any actions required to correct a deficiency or address noncompliance with Contract requirements as identified by the Department.	Full-2013			

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Q, A Program Integrity Coordinator who shall coordinate, manage and oversee the Contractor's Program Integrity unit to reduce fraud and abuse of Medicaid services.	Full-2013			
37.15 Ownership and Financial Disclosure				
The Contractor agrees to comply with the provisions of 42 CFR 455.104. The Contractor shall provide true and complete disclosures of the following information to Finance, the Department, CMS, and/or their agents or designees, in a form designated by the Department (1) at the time of each annual audit, (2) at the time of each Medicaid survey, (3) prior to entry into a new contract with the Department, (4) upon any change in operations which affects the most recent disclosure report, or (5) within thirty-five (35) days following the date of each written request for such information:	Full-2013		Includes review of individual disclosures	
A. The name and address of each person with an ownership or control interest in (i) the Contractor or (ii) any Subcontractor or supplier in which the Contractor has a direct or indirect ownership of five percent (5%) or more, specifying the relationship of any listed persons who are related as spouse,	Full-2013		Includes review of individual disclosures	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
parent, child, or sibling;				
B. The name of any other entity receiving reimbursement through the Medicare or Medicaid programs in which a person listed in response to subsection (a) has an ownership or control interest;	Full-2013		Includes review of individual disclosures	
C. The same information requested in subsections (a) and (b) for any Subcontractors or suppliers with whom the Contractor has had business transactions totaling more than $25,000 during the immediately preceding twelve-month period;	Full-2013		Includes review of individual disclosures	
D. A description of any significant business transactions between the Contractor and any wholly-owned supplier, or between the Contractor and any Subcontractor, during the immediately preceding five-year period;	Full-2013		Includes review of individual disclosures	
E. The identity of any person who has an ownership or control interest in the Contractor, any Subcontractor or supplier, or is an agent or managing employee of the Contractor, any Subcontractor or supplier, who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the services program under Title XX of the Act, since the inception of those	Full-2013		Includes review of individual disclosures	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
programs;				
F. The name of any officer, director, employee or agent of, or any person with an ownership or controlling interest in, the Contractor, any Subcontractor or supplier, who is also employed by the Commonwealth or any of its agencies; and	Full-2013		Includes review of individual disclosures	
G. The Contractor shall be required to notify the Department immediately when any change in ownership is anticipated. The Contractor shall submit a detailed work plan to the Department and to the DOI during the transition period no later than the date of the sale that identifies areas of the contract that may be impacted by the change in ownership including management and staff.	Full-2013			
State Contract, Appendix L				
ORGANIZATION: The Contractor's Program Integrity Unit (PIU) shall be organized so that:				
A. Required Fraud, Waste and Abuse activities are conducted by staff that shall with separate authority to direct PIU activities and functions specified in this Appendix on a continuous and ongoing basis;	Full-2013			

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
B. Written policies, procedures, and standards of conduct that demonstrate the organization's commitment to comply with all applicable federal and state regulations and standards;	Full-2013			
C. The unit establishes, controls, evaluates and revises Fraud, Waste and Abuse detection, deterrent and prevention procedures to ensure compliance with Federal and State requirements;	Full-2013			
C. Adequate staff shall be assigned to the PIU to enable them to conduct the functions specified in this Appendix on a continuous and on-going basis; and staffing shall consist of a compliance officer, auditing and clinical staff;	Full-2013			
D. The staff consists of a compliance officer in addition to auditing and clinical staff;	Full-2013			
E. The unit prioritizes work coming into the unit to ensure that cases with the greatest potential program impact are given the highest priority. Allegations or cases having the greatest program impact include cases involving:	Full-2013			
(1) Multi-State fraud or problems of national scope, or Fraud or Abuse crossing partnership boundaries;	Full-2013			

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
(2) High dollar amount of potential overpayment; or	Full-2013			
(3) Likelihood for an increase in the amount of Fraud or Abuse or enlargement of a pattern.	Full-2013			
F. Ongoing education is provided to Contractor staff on Fraud, Waste and Abuse trends including CMS initiatives; and	Full-2013			
G. Contractor attends any training given by the Commonwealth/Fiscal Agent, its designees or other Contractor's organizations provided reasonable advance notice is given to Contractor of the scheduled training.	Full-2013			
FUNCTION: The Contractor and/or Contractor's PIU shall:	Full-2013			
A. Prevent Fraud, Waste and Abuse by identifying vulnerabilities in the Contractor's program including identification of Member and Provider Fraud, Waste and Abuse and taking appropriate action including but not limited to the following: (1) Recoupment of overpayments; (2) Changes to policy; (3) Dispute resolution meetings; and (4) Appeals.	Full-2013			

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
B. Proactively detect incidents of Fraud, Waste and Abuse that exist within the Contractor's program through the use of algorithms, investigations and record reviews;	Full-2013			
C. Determine the factual basis of allegations concerning Fraud or Abuse made by Members, Providers and other sources;	Full-2013			
D. Initiate appropriate administrative actions to collect overpayments;	Full-2013			
E. Refer potential Fraud, Waste and Abuse cases to the OIG with copy to the Department) for preliminary investigation and possible referral for civil and criminal prosecution and administrative sanctions;	Full-2013			
F. Initiate and maintain network and outreach activities to ensure effective interaction and exchange of information with all internal components of the Contractor as well as outside groups;	Full-2013			
G. Make and receive recommendations to enhance the ability of the Parties to prevent, detect and deter Fraud, Waste or Abuse;	Full-2013			
H. Provide for prompt response to detected offenses and for development	Full-2013			

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
of corrective action initiatives relating to the Contractor's contract;				
I. Provide for internal monitoring and auditing of Contractor and its subcontractors; and supply the Department with quarterly reports or as-requested basis on its activity or ad hocs as necessary;	Full-2014			
J. Being subject to on-site review and fully comply with requests from the Department to supply documentation and records;	Full-2014			
K. Create an accounts receivable process to collect outstanding debt from members or providers and providing monthly reports of activity and collections to the Department;	Full-2013		Includes review of MCO Report #71 Provider Outstanding Account Receivables	
L. Allow the Department to collect and retain any overpayments if the Contractor has not taken appropriate action to collect the overpayment after 180 days;	New Requirement	Full	This requirement is addressed in the Kentucky Fraud Waste and Abuse Policy – Overpayment Requirements.	
M. Conduct continuous and on-going reviews of all MIS data including Member and Provider Grievances and Appeals for the purpose of identifying potentially fraudulent acts;	Full-2014			
N. Conduct regularly post-payment audits	Full-2013			

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
of Provider billings, investigate payment errors, produce printouts and queries of data and report the results of their work to the Department;				
O. Conduct onsite and desk audits of Providers and report the results, including identified overpayments and recommendations to the Department;	Full-2014			
P. Locally maintain cases under investigation for possible Fraud, Waste or Abuse activities and provide these lists and entire case files to the Department and OIG upon demand;	Full-2013			
Q. Designate a contact person to work with investigators and attorneys from the Department and OIG;	Full-2013			
R. Ensure the integrity of PIU referrals to the Department and shall not subject referrals to the approval of the Contractor's management or officials;	Full-2013			
S. Comply with the expectations of 42 CFR 455.20 by employing a method of verifying with a Member whether the services billed by Provider were received by randomly selecting a minimum sample of 500 claims on a monthly basis;	Full-2014		Includes review of MCO Report #73 Explanation of Member Benefits (EOMB)	
T. Run algorithms on billed claims data over a time span sufficient to identify	Full-2013		Includes review of MCO Report #75 SUR Algorithms	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
potential fraudulent billing patterns and develop a process and report quarterly or as otherwise requested to the Department all algorithms, issues identified, actions taken to address those issues and the overpayments collected;				
U. Collect administratively from Members for overpayments that were declined prosecution, for Medicaid Program Violations (MPV);	Full-2013			
V. Comply with the program integrity requirements set forth in 42 CFR 438.608 and provide policies and procedures to the Department for review and approval;	Full-2013			
W. Report to the Department any Provider denied enrollment by Contractor for any reason, including those contained in 42 CFR 455.106, within 5 days of the enrollment denial;	Full-2014			
X. Recover overpayments from Providers and identify Providers for pre-payment review as a result of the Provider's activities;	Full-2013			
Y. Comply with the program integrity requirements of the Patient Protection and Affordable Care Act as directed by the Department; and	Full-2013			
Z. Correct any weaknesses, deficiencies,	Full-2014			

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
or noncompliance items identified as a result of a review or audit conducted by the Department, CMS, or by any other State or Federal Agency or agents thereof that has oversight of the Medicaid program. Corrective action shall be completed the earlier of 30 calendar days or the timeframes established by Federal and state laws and regulations.				
PATIENT ABUSE: Incidents or allegations concerning physical or mental abuse of Members shall be immediately reported to the Department for Community Based Services in accordance with state law and with copy to the Department and OIG.	Full-2014			
COMPLAINT SYSTEM: The Contractor's PIU shall operate a system to receive, investigate and track the status of Fraud, Waste and Abuse complaints from Members, Providers and all other sources which may be made against the Contractor, Providers or Members. The system shall contain the following:				
A. Upon receipt of a complaint or other indication of potential Fraud or Abuse, the Contractor's PIU shall conduct a preliminary inquiry to determine the validity of the complaint;	Full-2013			

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
B. The PIU should review background information and MIS data; however, the preliminary inquiry should not include interviews with the subject concerning the alleged instance of Fraud or Abuse;	Full-2013			
C. If the preliminary inquiry results in a reasonable belief that the complaint does not constitute Fraud or Abuse, the PIU should not refer the case to OIG; however, the PIU shall take whatever remedial actions may be necessary, up to and including, administrative recovery of identified overpayments;	Full-2013			
D. If the preliminary inquiry results in a reasonable belief that Fraud or Abuse has occurred, the PIU shall refer the case and all supporting documentation to the OIG, with a copy to the Department;	Full-2013			
E. The OIG will review the referral and attached documentation, make a determination and notify the PIU as to whether the OIG will investigate the case or return it to the PIU for appropriate administrative action;	Full-2013			
F. If in the process of conducting a preliminary review, the PIU suspects a violation of either criminal Medicaid Fraud statutes or the Federal False Claims Act, the PIU shall immediately notify the OIG with a copy to the	Full-2013			

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Department of their findings and proceed only in accordance with instructions received from the OIG;				
G. If the OIG determines that it will keep a case referred by the PIU, the OIG will conduct a preliminary investigation, gather evidence, write a report and forward information to the Department, the PIU, or if warranted, to the Attorney General's Medicaid Fraud Control Unit, for appropriate actions;				
H. If the OIG opens an investigation based on a complaint received from a source other than the Contractor, the OIG will, upon completion of the preliminary investigation, provide a copy of the investigative report to the Department, the PIU, or if warranted, to MFCU, for appropriate actions;				
I. If the OIG investigation results in a referral to the MFCU and/or the U.S. Attorney, the OIG will notify the Department and the PIU of the referral. The Department and the PIU shall only take actions concerning these cases in coordination with the law enforcement agencies that received the OIG referral;				
J. Upon approval of the Department, Contractor shall suspend Provider payments in accordance with Section	Full-2013			

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
6402 (h)(2) of the Affordable Care Act pending investigation of credible allegation of fraud; these efforts shall be coordinated through the Department;				
K. Upon completion of the PIU's preliminary review, the PIU shall provide the Department and the OIG a copy of their investigative report, which shall contain the following elements:	Full-2014			
(1) Name and address of subject,	Full-2013		Includes Program Integrity file review results	
(2) Medicaid identification number,	Full-2013		Includes Program Integrity file review results	
(3) Source of complaint,	Full-2013		Includes Program Integrity file review results	
(4) State the complaint/allegation,	Full-2014		Includes Program Integrity file review results	
(5) Date assigned to the investigator,	Full-2013		Includes Program Integrity file review results	
(6) Name of investigator,	Full-2013		Includes Program Integrity file review results	
(7) Date of completion,	Full-2014		Includes Program Integrity file review results	
(8) Methodology used during investigation,	Full-2013		Includes Program Integrity file review results	
(9) Facts discovered by the investigation	Full-2014		Includes Program Integrity file	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
as well as the full case report and supporting documentation,			review results	
(10) Attach all exhibits or supporting documentation,	Full-2014		Includes Program Integrity file review results	
(11) Include recommendations as considered necessary, for administrative action or policy revision,	Full-2013		Includes Program Integrity file review results	
(12) Identify overpayment, if any, and recommendation concerning collection;	Full-2013		Includes Program Integrity file review results	
(13) Any other elements identified by CMS for fraud referral.	New Requirement	Full	This requirement is addressed in the Fraud Waste and Abuse Policy.	
L. The Contractor's PIU shall provide the OIG and the Department a quarterly Member and Provider status report of all cases including actions taken to implement recommendations and collection of overpayments, or case information shall be made available to the Department upon request;	Full-2013		Includes review of MCO Report #76 Provider Fraud Waste Abuse Report and #77 Member Fraud Waste Abuse Report	
M. The Contractor's PIU shall maintain access to a follow-up system which can report the status of a particular complaint or grievance process or the status of a specific recoupment; and	Full-2013			
N. The Contractor's PIU shall assure a Grievance and Appeal process for Members and Providers in accordance with 907 KAR 1:671.	Full-2013			

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
REPORTING: The Contractor's PIU shall report on a quarterly basis in a narrative report format all activities and processes for each investigative case (from opening to closure) to the Department. If any employee or subcontractor employee of the Contractor discovers or is made aware of an incident of possible Member or Provider Fraud, Waste or Abuse, the incident shall be immediately reported to the PIU Coordinator. The Contractor's PIU shall immediately report all cases of suspected Fraud, Waste, Abuse or inappropriate practices by Subcontractors, Members or employees to the Department and the OIG.	Full-2013		Includes review of MCO Report #76 and Report #77	
The Contractor is required to report the following data elements to the Department and the OIG on a quarterly basis, in an excel format:	Full-2013		Includes review of MCO Report #76 and Report #77	
(1) PIU Case number;	Full-2013		Includes review of MCO Report #76 and Report #77	
(2) OIG Case number (if one has been assigned);	N/A - Reports 76 and 77 show reporting, however, the OIG case number is not a field included on the template provided by Kentucky for these reports. **Recommendation for DMS** DMS should consider revising the report templates for reports 76 and 77 to include the OIG case number.		Includes review of MCO Report #76 and Report #77	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
(3) Provider/Member name;	Full-2013		Includes review of MCO Report #76 and Report #77	
(4) Provider/Member number;	Full-2013		Includes review of MCO Report #76 and Report #77	
(5) Date complaint received by Contractor;	Full-2013		Includes review of MCO Report #76 and Report #77	
(6) Source of complaint, unless the complainant prefers to remain anonymous;	Full-2013		Includes review of MCO Report #76 and Report #77	
(7) Date opened and name of PIU investigator assigned;	Full-2013		Includes review of MCO Report #76 and Report #77	
(8) Summary of complaint;	Full-2013		Includes review of MCO Report #76 and Report #77	
(9) Is complaint substantiated or not substantiated (Y or N answer only under this column);	N/A - Reports 76 and 77 show reporting, however, this requirement is not included on the template provided by Kentucky for these reports. **Recommendation for DMS** DMS should consider revising the report templates for reports 76 and 77 to include this requirement.		Includes review of MCO Report #76 and Report #77	
(10) PIU action taken and date (only provide the most current update);	Full-2013		Includes review of MCO Report #76 and Report #77	
(11) Amount of overpayment (if any) and time span;	Full-2013		Includes review of MCO Report #76 and Report #77	
(12) Administrative actions taken to resolve findings of completed cases;	Full-2013		Includes review of MCO Report #76 and Report #77	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
(13) The overpayment required to be repaid and overpayment collected to date;	Full-2013		Includes review of MCO Report #76 and Report #77	
(14) Describe sanctions/withholds applied to Providers/Members, if any;	Full-2013		Includes review of MCO Report #76 and Report #77	
(15) Provider/Members appeal regarding overpayment or requested sanctions. List the date an appeal was requested, date the hearing was held, the date and decision of the final order;	Full-2013		Includes review of MCO Report #76 and Report #77	
(16) Revision of the Contractor's policies to reduce potential risk from similar situations with a description of the policy recommendation, implemented revision and date of implementation; and	Full-2013		Includes review of MCO Report #76 and Report #77	
(17) Make MIS system edit and audit recommendations as applicable.	Full-2013		Includes review of MCO Report #76 and Report #77	
AVAILABILITY AND ACCESS TO DATA: The Contractor shall:				
A. Gather, produce, and maintain records including, but not limited to, ownership disclosure for all Providers and subcontractors, submissions, applications, evaluations, qualifications, member information, enrollment lists, grievances, Encounter data, desk reviews, investigations, investigative supporting documentation, finding	Full-2013			

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
letters and subcontracts for a period of 5 years after contract end date;				
B. Regularly report enrollment, Provider and Encounter data in a format that is useable by the Department and the OIG;	Full-2014			
C. Backup, store or be able to recreate reported data upon demand for the Department and the OIG;	Full-2013			
D. Permit reviews, investigations or audits of all books, records or other data, at the discretion of the Department or the OIG, or other authorized federal or state agency; and, shall provide access to Contractor records and other data on the same basis and at least to the same extent that the Department would have access to those same records;	Full-2014			
E. Produce records in electronic format for review and manipulation by the Department and the OIG;	Full-2014			
F. Allow designated Department staff read access to ALL data in the Contractor's MIS systems;	Full-2014			
G. Provide the Contractor's PIU access to any and all records and other data of the Contractor for purposes of carrying out the functions and responsibilities specified in this Contract;	Full-2014			

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
H. Fully cooperate with the Department, OIG, the United States Attorney's Office and other law enforcement agencies in the investigation of Fraud or Abuse cases; and	Full-2013			

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: WellCare of Kentucky

Program Integrity

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	2	0	0	0
Total Points	6	0	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average	**3.0**			

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review, may adversely affect the scoring of a requirement and result in possible sanctions by DMS.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Final Findings

Program Integrity
Suggested Evidence

Documents

Policies/Procedures for:

- post payment audits
- internal monitoring and auditing
- preventive actions
- annual ownership and financial disclosure

Program Integrity Plan including related policies and procedures
Program Integrity training program and evidence of training for Compliance Officer, staff, providers, subcontractors and members
Program Integrity Unit description including Compliance Officer position description
Program Integrity Committee description and minutes
Documentation of annual disclosure of ownership and financial interest including owners/directors, subcontractors and employees
Provider contract provisions for FWA
Vendor contract provisions for FWA

Reports

Evidence of PIU preventive actions and ongoing monitoring of MIS data
Monthly state reporting
Quarterly Program Integrity Reports

File Review

Program Integrity files for a random sample of cases chosen by EQRO
ADO files selected by EQRO

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: WellCare of Kentucky

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
4.3 Delegations of Authority				
The Contractor shall oversee and remain accountable for any functions and responsibilities that it delegates to any Subcontractor. In addition to the provision set forth in Subcontracts, Contractor agrees to the following provisions.				
A. There shall be a written agreement that specifies the delegated activities and reporting responsibilities of the Subcontractor and provides for revocation of the delegation or imposition of other sanctions if the Subcontractor's performance is inadequate.	Full-2013		Includes review results for each subcontractor	
B. Before any delegation, the Contractor shall evaluate the prospective subcontractor's ability to perform the activities to be delegated.	Full-2014		Includes review results for each subcontractor	
C. The Contractor shall monitor the Subcontractor's performance on an ongoing basis and subject the Subcontractor to a formal review at least once a year.	Full-2014		Includes review results for each subcontractor	
D. If the Contractor identifies deficiencies or areas for improvement, the Contractor and the Subcontractor shall take corrective action.	Full-2014		Includes review results for each subcontractor	
E. If the Contractor delegates selection of providers to another entity, the Contractor retains the right to approve, suspend, or terminate any provider selected by that Subcontractor.	Full-2013		Includes review results for each subcontractor	
F. The Contractor shall assure that the Subcontractor is in compliance with the requirement in 42 CFR 438.	Full-2014			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
6.1 Subcontractor Indemnity				
Except as otherwise provided in this Contract, all Subcontracts between the Contractor and its Subcontractors for the provision of Covered Services, shall contain an agreement by the Subcontractor to indemnify, defend and hold harmless the Commonwealth, its officers, agents, and employees, and each and every Member from any liability whatsoever arising in connection with this Contract for the payment of any debt of or the fulfillment of any obligation of the Subcontractor.	Full-2013		Includes review results for each subcontractor	
Each such Subcontractor shall further covenant and agree that in the event of a breach of the Subcontract by the Contractor, termination of the Subcontract, or insolvency of the Contractor, each Subcontractor shall provide all services and fulfill all of its obligations pursuant to the Subcontract for the remainder of any month for which the Department has made payments to the Contractor, and shall fulfill all of its obligations respecting the transfer of Members to other Providers, including record maintenance, access and reporting requirements all such covenants, agreements, and obligations of which shall survive the termination of this Contract and any Subcontract.	Full-2013		Includes review results for each subcontractor	
6.2 Requirements				
The Contractor may, with the approval of the Department, enter into Subcontracts for the provision of various Covered Services to Members or other services that involve risk-sharing, medical management,	Full-2013		List subcontractors contracted with the MCO and type of service provided	

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
or otherwise interact with a Member. Such Subcontractors must be eligible for participation in the Medicaid program as applicable. Each such Subcontract and any amendment to such Subcontract shall be in writing, and in form and content approved by the Department. The Contractor shall submit for review to the Department a template of each type of such Subcontract referenced herein. The Department may approve, approve with modification, or reject the templates if they do not satisfy the requirements of this Contract. In determining whether the Department will impose conditions or limitations on its approval of a Subcontract, the Department may consider such factors as it deems appropriate to protect the Commonwealth and Members, including but not limited to, the proposed Subcontractor's past performance. In the event the Department has not approved a Subcontract referenced herein prior to its scheduled effective date, Contractor agrees to execute said Subcontract contingent upon receiving the Department's approval. No Subcontract shall in any way relieve the Contractor of any responsibility for the performance of its duties pursuant to this Contract. The Contractor shall notify the Department in writing of the status of all Subcontractors on a quarterly basis and of the termination of any approved Subcontract within ten (10) days following termination.				
The Department's subcontract review shall assure that all Subcontracts:				
A. Identify the population covered by the Subcontract;	Full-2013		Includes review results for each	

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			subcontractor	
B. Specify the amount, duration and scope of services to be provided by the Subcontractor;	Full-2013		Includes review results for each subcontractor	
C. Specify procedures and criteria for extension, renegotiation, and termination;	Full-2013		Includes review results for each subcontractor	
D. Specify that Subcontractors use only Medicaid enrolled providers in accordance with this Contract;	Full-2013		Includes review results for each subcontractor	
E. Make full disclosure of the method of compensation or other consideration to be received from the Contractor;	Full-2013		Includes review results for each subcontractor	
F. Provide for monitoring by the Contractor of the quality of services rendered to Members in accordance with the terms of this Contract;	Full-2013		Includes review results for each subcontractor	
G. Contain no provision that provides incentives, monetary or otherwise, for the withholding from Members of Medically Necessary Covered Services;	Full-2013		Includes review results for each subcontractor	
H. Contain a prohibition on assignment, or on any further subcontracting, without the prior written consent of the Department;	Full-2013		Includes review results for each subcontractor	
I. Contain an explicit provision that the Commonwealth is the intended third-party beneficiary of the Subcontract and, as such, the Commonwealth is entitled to all remedies entitled to third-party beneficiaries under law;	Full-2013		Includes review results for each subcontractor	
J. Specify that Subcontractor where applicable, agrees to submit Encounter Records in the format specified by the Department so that the Contractor can meet the	Full-2013		Includes review results for each subcontractor	

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Department's specifications required by this Contract;				
K. Incorporate all provisions of this Contract to the fullest extent applicable to the service or activity delegated pursuant to the Subcontract, including, without limitation,	Full-2013			
(1) the obligation to comply with all applicable federal and Commonwealth law and regulations, including, but not limited to, KRS 205:8451-8483, all rules, policies and procedures of Finance and the Department, and all standards governing the provision of Covered Services and information to Members,	Full-2013		Includes review results for each subcontractor	
(2) all QAPI requirements,	Full-2013		Includes review results for each subcontractor	
(3) all record keeping and reporting requirements,	Full-2013		Includes review results for each subcontractor	
(4) all obligations to maintain the confidentiality of information,	Full-2013		Includes review results for each subcontractor	
(5) all rights of Finance, the Department, the Office of the Inspector General, the Attorney General, Auditor of Public Accounts and other authorized federal and Commonwealth agents to inspect, investigate, monitor and audit operations,	Full-2013		Includes review results for each subcontractor	
(6) all indemnification and insurance requirements, and	Full-2013		Includes review results for each subcontractor	
(7) all obligations upon termination;	Full-2013		Includes review results for each subcontractor	

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
L. Provide for Contractor to monitor the Subcontractor's performance on an ongoing basis including those with accreditation: the frequency and method of reporting to the Contractor; the process by which the Contractor evaluates the Subcontractor's performance; and subjecting it to formal review according to a periodic schedule consistent with industry standards, but no less than annually;	Full-2013		Includes review results for each subcontractor	
M. A Subcontractor with NCQA/URAC or other national accreditation shall provide the Contractor with a copy of its' current certificate of accreditation together with a copy of the survey report.	Substantial - This requirement is addressed in the Delegation Oversight Policy as well as the Delegation Oversight Entity Monitoring Procedure. Documentation was provided that shows certification and survey reports for the subcontracted entities. WellCare noted that during the audit, subcontractors are required to submit accreditation certificates and survey reports. **Recommendation for WellCare** Wellcare should include in the Delegation addendum the requirement for the subcontractor to provide accreditation certificates and survey reports to the MCO. **MCO Response:** Subcontractors are required to submit accreditation certificates and reports. This element is included in the delegation audit tool. The contract requires the subcontractor to	Full	This requirement is addressed in the Delegation Addendum. The Plan submitted copies of accreditation certificates for the following subcontractors: VerifPoint/CreDENTALs Services, Inc - NCQA University of KY Hospital – Joint Commission Ashland Hospital – Joint Commission Care Core National, LLC– NCQA, URAC Health Information Line – NCQA Alere Health Improvement Company – NCQA Advanced Medical Reviews – URAC St. Jude Children's Research Hospital – Joint Commission Jennie Stuart Medical Center, Inc – Joint Commission InfoMedia Group Inc. – URAC	

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	provide copy of its current accreditation and copy of survey report but does not prescribe methodology. Network contractors in the Kentucky market and corporate contractors will execute delegation amendments to include the following language "A Subcontractor with NCQA/URAC or other national accreditation shall provide the Contractor with a copy of its' current certificate of accreditation together with a copy of the survey report" by December 31, 2014.		Vanderbilt University Medical Center - NCQA	
N. Provide a process for the Subcontractor to identify deficiencies or areas of improvement, and any necessary corrective action.	Full-2013		Includes review results for each subcontractor	
O. The remedies up to, and including, revocation of the subcontract available to the Contractor if the Subcontractor does not fulfill its obligations.	Full-2013		Includes review results for each subcontractor	
P. Contain provisions that suspected fraud and abuse be reported to the contractor.	Full-2013		Includes review results for each subcontractor	
Section 6.2 requirements would be applicable to Subcontractors characterized as Risk Arrangements. Section 6.2 requirements shall not apply to Subcontracts for administrative services or other vendor contracts that do not impact Members.	Full-2013			
6.3 Disclosure of Subcontractors				
The Contractor shall inform the Department of any Subcontractor providing Covered Services which	Full-2013			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
engages another Subcontractor in any transaction or series of transactions, in performance of any term of this Contract, which in one fiscal year exceeds the lesser of $25,000 or five percent (5%) of the Subcontractor's operating expense.				
6.4 Remedies				
Finance shall have the right to invoke against any Subcontractor any remedy set forth in this Contract, including the right to require the termination of any Subcontract, for each and every reason for which it may invoke such a remedy against the Contractor or require the termination of this Contract.				

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: WellCare of Kentucky

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	1	0	0	0
Total Points	3	0	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average	3.0			

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review, may adversely affect the scoring of a requirement and result in possible sanctions by DMS.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services Suggested Evidence

Documents

List of subcontractors including type(s) of services provided and date of initial delegation
Contract with each subcontractor
Accreditation certificate and report for each subcontractor
Policies and procedures for subcontractor oversight
Subcontractor Oversight Committee description, meeting agendas and minutes
Documentation of ongoing oversight of subcontractors including follow-up
List of subcontractors terminated during the period of review
Evidence of DMS notification of all new subcontractors and terminated subcontractors
Evidence of disclosure of subcontractor activity to DMS

Reports

Pre-delegation evaluation report for new subcontractors
Periodic, formal evaluation reports for each subcontractor, including those with accreditation
Subcontractor certificate of accreditation and survey report

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: WellCare of Kentucky

Draft Final Findings

Case Management/Care Coordination *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
1. Definitions				
Care Coordination means the integration of all processes in response to a Member's needs and strengths to ensure the achievement of desired outcomes and the effectiveness of services.				
Care Management System includes a comprehensive assessment and care plan care coordination and case management services. This includes a set of processes that arrange, deliver, monitor and evaluate care, treatment and medical and social services to a member.				
Care Plan means written documentation of decisions made in advance of care provided, based on a Comprehensive Assessment of a Member's needs, preference and abilities, regarding how services will be provided. This includes establishing objectives with the Member and determining the most appropriate types, timing and supplier(s) of services. This is an ongoing activity as long as care is provided.				
Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the client's health and human service needs. It is characterized by advocacy, communication, and resource management and promotes quality and cost-effective interventions and outcomes.				
Children with Special Health Care Needs means Members who have or are at increased risk for chronic physical,				

Draft Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally and who may be enrolled in a Children with Special Health Care Needs program operated by a local Title V funded Maternal and Child Health Program.				
CHIPRA means the Children's Health Insurance Program Reauthorization Act of 2009 which reauthorized the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act. It assures that State is able to continue its existing program and expands insurance coverage to additional low-income, uninsured children.				
Comprehensive Assessment means the detailed assessment of the nature and cause of a person's specific conditions and needs as well as personal resources and abilities. This is generally performed by an individual or a team of specialists and may involve family, or other significant people. The assessment may be done in conjunction with care planning.				
34.2 Care Management System				
As part of the Care Management System, Contractor shall employ care coordinators and case managers to arrange, assure delivery of, monitor and evaluate basic and comprehensive care, treatment and services to a Member.	Full-2013			
Members needing Care Management Services shall be identified through the health risk assessment, evaluation of Claims data, Physician referral or other mechanisms	Full-2013		Includes review of MCO Report #79 HRAs (see Quarterly Desk Audit results)	

Draft Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
that may be utilized by the Contractor.				
The Contractor shall develop guidelines for Care Coordination that will be submitted to the Department for review and approval. The Contractor shall have approval from the Department for any subsequent changes prior to implementation of such changes.	Full-2013			
Care coordination shall be linked to other Contractor systems, such as QI, Member Services and Grievances.	Full-2014			
34.3 Care Coordination				
The care coordinators and case managers will work with the primary care providers as teams to provide appropriate services for Members.	Full-2014			
Care coordination is a process to assure that the physical and behavioral health needs of Members are identified and services are facilitated and coordinated with all service providers, individual Members and family, if appropriate, and authorized by the Member.				
The Contractor shall identify the primary elements for care coordination and submit the plan to the Department for approval.	Full-2013			
The Contractor shall identify a Member with special health care needs, including but not limited to Members identified in Member Services. A Member with special health care needs shall have a Comprehensive Assessment completed upon admission to a Care Management program. The Member will be referred to	Full-2013			

Draft Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Care Management. Guidelines for referral to the appropriate care management programs shall be pre-approved by the Department. The guidelines will also include the criteria for development of Care Plans. The Care Plan shall include both appropriate medical, behavioral and social services and be consistent with the Primary Care Provider's clinical treatment plan and medical diagnosis.				
The Contractor shall first complete a Care Coordination Assessment for these Members the elements of which shall comply with policies and procedures approved by the Department.	Full-2013		Includes review results for Care Coordination and Complex Case Management files	
The Care Plan shall be developed in accordance with 42 CFR 438.208.	Full-2013		Includes review results for Care Coordination and Complex Case Management files	
The Contractor shall develop and implement policies and procedures to ensure access to care coordination for all DCBS clients. The Contractor shall track, analyze, report, and when indicated, develop corrective action plans on indicators that measure utilization, access, complaints and grievances, and services specific to the DCBS population.	Minimal - Addressed in the 2013 CM Program Description and P/P C7CM MD-4.8. Quantitative performance measures include: 1. Member perception of health at discharge from case management as evidenced by an increased score in the 12-Item Short Form Health Survey (SF-12) 2. Case Management Satisfaction Survey 3. Readmission Reduction 4. Gap in care closure 5. ED utilization reduction	Full	Addressed in Kentucky DCBS/DAIL Service Plan Process, which outlines the process to consistently review DCBS and DAIL Services Plans for all members entering into case management services and medically fragile members. Addressed in Kentucky Foster Care Service Utilization Review, which outlines the process to consistently review and report on the Kentucky Foster Care members' utilization of behavioral health (BH) and medical services, focusing on the utilization of	

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Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	WellCare provided the following rationale for not producing reports that are DCBS-specific: (see Measurement of utilization DCBS.docx) "WellCare reviews complaints, grievances and appeals for all members. The review continues to indicate that there are no material differences between the DCBS population and the general population of the membership. WellCare includes DCBS members in the materials reported through the Quality Utilization Management Committee, the Quality Member and Access Committee and the Quality Improvement Committee. Reports separating the DCBS (KHK) population have been included in this review". Onsite, WellCare provided the results of grievance and appeals for the DCBS population that was used as a comparison to the rest of the membership. **Recommendation for WellCare** WellCare should track, analyze, report, and when indicated, develop corrective action plans on indicators that measure utilization, access, and satisfaction with		highest levels of care. 2014 Reports #65 & #66 were submitted to DMS as required. The MCO provided SCM Audit Tool template for CCM Audit and Tool Description. Evidenced in Outpatient Service Numbers for Foster Care Report. The MCO submitted a CAP document (CAP_10_Tool_CM_CC_2014), to demonstrate how they are addressing the deficiency observed from last year's audit. This document was discussed in detail during the onsite interview. In order to meet the deficiency observed in tracking, analyzing and reporting on the DCBS population, the MCO has implemented the following: A monthly review of DCBS member utilization of services, focusing on utilization of inpatient, acute, sub-acute and PRTF level of care and single case agreements with for specialized services (DMS Report# 20). A monthly review of DCBS member utilization of services, focusing on	

Draft Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	care and services specific to the DCBS population. **MCO Response:** A CAP has been submitted to correct identified deficiencies. Please refer to the document CAP_10_Tool_CM_CC_2014.		utilization of inpatient, acute, sub-acute and PRTF level of care to occur with DCBS Central Office leadership. Monthly review of DCBS member complaints and grievances with analysis of trends and specific issues (DMS Report # 20). The MCO's Member Engagement will conduct DCBS member satisfaction surveys at the termination of case management services, to assess satisfaction with care and service. Since all DCBS members are automatically entered into the Case Management system, the MCO is able to track their status as well as the members in CM. The MCO also indicated that they are working on a Policy and Procedure document for the monthly review of services utilized by DCBS members.	
Members, Member representatives and providers shall be provided information relating to care management services, including case management, and information on how to request and obtain these services.	Full-2013			
35.1 Individuals with Special Health Care Needs (ISHCN)				

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Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
ISHCN are persons who have or are at high risk for chronic physical, developmental, behavioral, neurological, or emotional condition and who may require a broad range of primary, specialized medical, behavioral health, and/or related services. ISCHN may have an increased need for healthcare or related services due to their respective conditions. The primary purpose of the definition is to identify these individuals so the Contractor can facilitate access to appropriate services.				
As per the requirement of 42 CFR 438.208, the Department has defined the following categories of individuals who shall be identified as ISHCN. The Contractor shall have written policies and procedures in place which govern how Members with these multiple and complex physical and behavioral health care needs are further identified.	Full-2013			
The Contractor shall have an internal operational process, in accordance with policy and procedure, to target Members for the purpose of screening and identifying ISHCN's.	Full-2013			
The Contractor shall assess each member identified as ISHCN in order to identify any ongoing special conditions that require a course of treatment or regular care monitoring. The assessment process shall use appropriate health professionals.	Full-2013			
The Contractor shall employ reasonable efforts to identify ISHCN's based on the following populations: Children in/or receiving Foster Care or adoption	Full-2013		Includes review of MCO Report #20 Utilization of Subpopulations and ISHCN (see Quarterly Desk Audit results)	

Draft Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
assistance; Blind/Disabled Children under age 19 and Related Populations eligible for SSI; Adults over the age of 65; Homeless (upon identification); individuals with chronic physical health illnesses; individuals with chronic behavioral health illnesses; and children receiving EPSDT Special Services.				
The Contractor shall develop and distribute to ISHCN Members, caregivers, parents and/or legal guardians, information and materials specific to the needs of the member, as appropriate. This information shall include health educational material as appropriate to assist ISHCN and/or caregivers in understanding their chronic illness.	Full-2013			
The Contractor shall have in place policies governing the mechanisms utilized to identify, screen, and assess individuals with special health care needs.	Full-2013			
The Contractor will produce a treatment plan for enrollees with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring.	Full-2013			
The Contractor shall develop practice guidelines and other criteria that consider that needs of ISHCN and provide guidance in the provision of acute and chronic physical and behavioral health care services to this population.	Full-2013			
35.2 DCBS and DAIL Protection and Permanency Clients				
Members who are adult guardianship clients or foster	Full-2014		Includes review results for DCBS Service	

Draft Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
care children shall be identified as ISHCN and shall be enrolled in the Contractor through a service plan that will be completed on each such Member by DCBS and Department for Aging and Independent Living (DAIL) prior to being enrolled with the Contractor. The service plan will be completed by DCBS or DAIL and forwarded to the Contractor prior to Enrollment and will be used by DCBS and or DAIL and the Contractor to determine the individual's medical needs and identify the need for placement in case management. The Contractor shall be responsible for the ongoing care coordination of these members whether or not enrolled in case management to ensure access to needed social, community, medical and behavioral health services. A monthly report of Foster Care Cases shall be sent to Department thirty (30) days after the end of each month.			Plans and DCBS Claims/Case Management files	
35.3 Adult Guardianship Clients				
Upon Enrollment with the Contractor, each adult in Guardianship shall have a service plan prepared by DAIL. The service plan shall indicate DAIL level of responsibility for making medical decisions for each Member. If the service plan identifies the need for case management, the Contractor shall work with Guardianship staff and/or the Member, as appropriate, to develop a case management care plan.	Full-2013			
35.4 Children in Foster Care				

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Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Upon Enrollment with the Contractor, each child in Foster Care shall have a service plan prepared by DCBS. DCBS shall forward a copy of the service plan to the Contractor on each newly enrolled Foster Care child. No less than monthly, DCBS staff shall meet with Contractor's staff to identify, discuss and resolve any health care issues and needs of the child as identified in the service plan. Examples of these issues include needed specialized Medicaid Covered Services, community services and whether the child's current primary and specialty care providers are enrolled in the Contractor's Network.	Full-2014		Includes review results for DCBS Service Plans files	
If DCBS service plan identifies the need for case management or DCBS staff requests case management for a Member, the foster parent and/or DCBS staff will work with Contractor's staff to develop a case management care plan.	Full-2014		Includes review results for DCBS Service Plans files	
The Contractor will consult with DCBS staff before the development of a new case management care plan (on a newly identified health care issue) or modification of an existing case management care plan.	Full-2014		Includes review results for DCBS Service Plans files	
The DCBS and designated Contractor staff will sign each service plan to indicate their agreement with the plan. If the DCBS and Contractor staff cannot reach agreement on the service plan for a Member, information about that Member's physical health care needs, unresolved issues in developing the case management plan, and a summary of resolutions discussed by the DCBS and	Full-2014		Includes review results for DCBS Service Plans files	

Draft Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Contractor staff will be forwarded to the designated county DCBS worker. That DCBS staff member shall work with the designated Contractor representative and a designated Department representative, if needed, to agree on a service plan. If agreement is not reached through mediation, the service plan shall be referred to the Department for resolution through the appeals process.				
35.5 Children Receiving Adoption Assistance				
Upon Enrollment with the Contractor, each Member receiving adoption assistance shall have a service plan prepared by DCBS. The process for enrollment of children receiving adoption assistance shall follow that outlined for Children in Foster Care.	Full-2014			
32. 9 Pediatric Sexual Abuse Examination				
Contractor shall have Providers in its network that have the capacity to perform a forensic pediatric sexual abuse examination. This examination must be conducted for Members at the request of the DCBS.	Full-2014			
32.8 Pediatric Interface				
School-Based Services provided by schools are excluded from Contractor coverage and are paid by the Department through fee-for-service Medicaid.				
Preventive and remedial services as contained in 907 KAR 1:360 and the Kentucky State Medicaid Plan provided by the Department of Public Health through	Full-2013			

Draft Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
public health departments in schools by a Physician, Physician's Assistant, Advanced Registered Nurse Practitioner, Registered Nurse, or other appropriately supervised health care professional are included in Contractor coverage. Services provided under a child's IEP should not be duplicated. However, in situations where a child's course of treatment is interrupted due to school breaks, after school hours or during summer months, the Contractor is responsible for providing all Medically Necessary Covered Services to eligible Members.				
Services provided under HANDS shall be excluded from Contractor coverage.				
Pediatric Interface Services includes pediatric concurrent care as mandated by the ACA. The Contractor shall simultaneously provide palliative hospice services in conjunction with curative services and medications for pediatric patients diagnosed with life-threatening/terminal illnesses.	New Requirement	Full	Addressed in Policy and Procedure C7CM MD 4.7 Developmental Disabilities; Addendum C: Kentucky – Pediatric Interface and Policy and Procedure C7CM MD-4.8 Individuals with Special Health Care Needs; Addendum D: Kentucky and Pediatric Hospice; Addendum G-Kentucky states the recipients under the age of twenty-one (21) eligible for hospice benefits are eligible to receive curative treatment in relation to their terminal illness concurrently with hospice services. However, these do not address medications for pediatric patients diagnosed with life-	WellCare has added the contract language regarding "medications for pediatric patients diagnosed with life-threatening/terminal illnesses" to its Policies and Procedures.

Draft Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			threatening/terminal illnesses. **Recommendation for WellCare** WellCare should add the contract language regarding "medications for pediatric patients diagnosed with life-threatening/terminal illnesses" to its Policies and Procedures.	
37.11 DCBS and DAIL Service Plans Reporting				
Thirty (30) days after the end of each quarter, the Contractor shall submit a quarterly report detailing the number of service plan reviews conducted for Guardianship, Foster and Adoption assistance Members outcome decisions, such as referral to case management, and rationale for decisions.	Full-2013		Includes review of MCO Reports #65 Foster Care and #66 Guardianship (see Quarterly Desk Audit results)	

Draft Final Findings

Case Management/Care Coordination

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	2	0	0	0
Total Points	6	0	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average	3.0			

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review, may adversely affect the scoring of a requirement and result in possible sanctions by DMS.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Draft Final Findings

Case Management/Care Coordination
Suggested Evidence

Documents

Policies/Procedures for:

- Identification of members for care management services
- Care coordination
- Comprehensive Assessment including guidelines for referral to care management programs
- Care Plan including criteria for care plan development
- ISHCN including identification, screening and assessment
- DCBS and DAIL clients
- Coordination of care for children receiving school-based services
- Pediatric sexual abuse examination
- Measurement of utilization, access, complaint and grievance, and services for DCBS population.

Case manager and care coordinator position descriptions
Evidence of dissemination of information to members, member representatives and providers relating to care management services
Evidence of monitoring effectiveness of case management
Evidence of tracking, analysis, reporting and interventions for indicators measuring utilization, access, complaints and grievances, and services for DCBS population
Evidence of dissemination of information and materials specific to the needs of the ISHCN member
Evidence of practice guidelines or other criteria considering the needs of ISHCN

Reports

Monthly/quarterly reports of service plan reviews conducted for DCBS and DAIL clients
Monthly reports of Foster Care cases

File Review

Care Coordination and Complex Case Management files for a random sample of cases selected by EQRO

Draft Final Findings

DCBS Service Plans for a sample of cases selected by EQRO

DCBS Claims/Case Management files for a random sample of cases selected by EQRO

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MCO: WellCare of Kentucky

Final Findings

Enrollee Rights and Protection: Enrollee Rights *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
22.6 Member Rights and Responsibilities				
The Contractor shall have written policies and procedures that are designed to protect the rights of Members and enumerate the responsibilities of each Member. A written description of the rights and responsibilities of Members shall be included in the Member information materials provided to new Members.	Full-2013			
A copy of these policies and procedures shall be provided to all of the Contractor's Network Providers to whom Members may be referred. In addition, these policies and procedures shall be provided to any Out-of-Network Provider upon request from the Provider.	Full-2014			
The Contractor's written policies and procedures that are designed to protect the rights of Members shall include, without limitation, the right to:				
A. Respect, dignity, privacy, confidentiality and nondiscrimination;	Full-2013			
B. A reasonable opportunity to choose a PCP and to change to another Provider in a reasonable manner;	Full-2013			
C. Consent for or refusal of treatment and active participation in decision choices;	Full-2013			
D. Ask questions and receive complete information relating to the Member's medical condition and treatment options, including specialty care;	Full-2013			
E. Voice Grievances and receive access to the Grievance process, receive assistance in filing an Appeal, and receive a state fair hearing from the Contractor and/or	Full-2013			

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
the Department;				
F. Timely access to care that does not have any communication or physical access barriers;	Full-2013			
G. Prepare Advance Medical Directives pursuant to KRS 311.621 to KRS 311.643;	Full-2013			
H. Assistance with Medical Records in accordance with applicable federal and state laws;	Full-2013			
I. Timely referral and access to medically indicated specialty care; and	Full-2013			
J. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.	Full-2013			
The Contractor shall also have policies addressing the responsibility of each Member to:				
A. Become informed about Member rights:	Full-2013			
B. Abide by the Contractor's and Department's policies and procedures;	Full-2013			
C. Become informed about service and treatment options;	Full-2013			
D. Actively participate in personal health and care decisions, practice healthy life styles;	Full-2013			
E. Report suspected Fraud and Abuse; and	Full-2013			
F. Keep appointments or call to cancel.	Full-2013			

Final Findings

Enrollee Rights and Protection: Enrollee Rights *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
22.2 Member Handbook				
The Contractor shall publish a Member Handbook and make the handbook available to Members upon enrollment, to be delivered to the Member within five (5) business days of Contractor's notification of Member's enrollment. Contractor is in compliance with this requirement if the Member's handbook is mailed within five (5) business days by a method that will not take more than three (3) days to reach the Member.	Full-2013			
The Member Handbook shall be available in English, Spanish and any other language spoken by five (5) percent of the potential enrollee or enrollee population.	Full-2013			
The Member Handbook shall be available in a hardcopy format as well as an electronic format online.	Full-2013			
The Contractor shall review the handbook at least annually and shall communicate any changes to Members in written form. Revision dates shall be added to the Member Handbook so that it is evident which version is the most current. Changes shall be approved by the Department prior to printing. The Department has the authority to review the Contractor's Member Handbook at any time.	Full-2013			
The handbook shall be written at the sixth grade reading comprehension level and shall include at a minimum the following information:	Full-2013			
A. The Contractor's Network of Primary Care Providers, including a list of the names, telephones numbers, and service site addresses of PCPs available for Primary Care Providers in the network listing. The network listing may	Full-2013			

Final Findings

Enrollee Rights and Protection: Enrollee Rights *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
be combined with the Member Handbook or distributed as a stand-alone document;				
B. The procedures for selecting a PCP and scheduling an initial health appointment;	Full-2013			
C. The name of the Contractor and address and telephone number from which it conducts its business; the hours of business; and the Member Services telephone number and twenty-four/seven (24/7) toll-free medical call-in system;	Full-2013			
D. A list of all available Covered Services, an explanation of any service limitations or exclusions from coverage and a notice stating that the Contractor will be liable only for those services authorized by the Contractor;	Full-2013			
E. Member rights and responsibilities including reporting suspected fraud and abuse;	Full-2013			
F. Procedures for obtaining Emergency Care and non-emergency after hours care. For a life-threatening situation, instructs Members to use the emergency medical services available or to activate emergency medical services by dialing 911;	Full-2013			
G. Procedures for obtaining transportation for both emergency and non-emergency situations;	Full-2013			
H. Information on the availability of maternity, family planning and sexually transmitted disease services and methods of accessing those services;	Full-2013			
I. Procedures for arranging EPSDT for persons under the age of 21 years;	Full-2013			

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
J. Procedures for obtaining access to Long Term Care Services;	Full-2013			
K. Procedures for notifying the Department for Community Based Services (DCBS) of family size changes, births, address changes, death notifications;	Full-2013			
L. A list of direct access services that may be accessed without the authorization of a PCP;	Full-2013			
M. Information about procedures for selecting a PCP or requesting a change of PCP and specialists; reasons for which a request may be denied; reasons a Provider may request a change;	Full-2013			
N. Information about how to access care before a PCP is assigned or chosen;	Full-2013			
O. A Member's right to obtain second opinion and information on obtaining second opinions related to surgical procedures, complex and/or chronic conditions;	Full-2013			
P. Procedures for obtaining Covered Services from non-network providers;	Full-2013			
Q. Procedures for filing a Grievance or Appeal. This shall include the title, address, and telephone number of the person responsible for processing and resolving Grievances and Appeals;	Full-2013			
R. Information about the Cabinet for Health and Family Services' independent ombudsman program for Members;	Full-2013			
S. Information on the availability of, and procedures for obtaining behavioral health/substance abuse health	Full-2013			

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
services;				
T. Information on the availability of health education services;	Full-2013			
U. Information deemed mandatory by the Department; and	Full-2013			
V. The availability of care coordination, case management and disease management provided by the Contractor.	Full-2013			
30.3 Second Opinions				
The Contractor shall provide for a second opinion related to surgical procedures and diagnosis and treatment of complex and/or chronic conditions within the Contractor's network, at the Member's request. The Contractor shall inform the Member, in writing, at the time of Enrollment, of the Member's right to request a second opinion.	Full-2013			
22.1 Required Functions				
The Contractor shall have a Member Services function that includes a call center which is staffed and available by telephone Monday through Friday 7 am to 7 pm Eastern Time (ET). The call center shall meet the current American Accreditation Health Care Commission/URAC-designed Health Call Center Standard (HCC) for call center abandonment rate, blockage rate and average speed of answer. If a Contractor has separate telephone lines for different Medicaid populations, the Contractor shall report performance for each individual line separately. The Department will inform the Contractor of any changes/updates to these URAC call center	Full-2013		Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results)	.

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
standards.				
The Contractor shall also provide access to medical advice and direction through a centralized toll-free call-in system, available twenty-four (24) hours a day, seven (7) days a week nationwide. The twenty-four/seven (24/7) call-in system shall be staffed by appropriately trained medical personnel. For the purposes of meeting this requirement, trained medical professionals are defined as physicians, physician assistants, licensed practical nurses (LPN), and registered nurses (RNs).	Full-2014			
The Contractor shall self-report their prior month performance in the three areas listed above, call center abandonment rate, blockage rate and average speed of answer, for their member services and twenty-four/seven (24/7) hour toll-free medical call-in system to the Department.	Full-2013		Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results)	.
Appropriate foreign language interpreters shall be provided by the Contractor and available free of charge and as necessary to ensure availability of effective communication regarding treatment, medical history, or health education. Member materials shall be provided and printed in each language spoken by five (5) percent or more of the Members in each county. The Contractor staff shall be able to respond to the special communication need of the disabled, blind, deaf and aged and effectively interpersonally relate with economically and ethnically diverse populations. The Contractor shall provide ongoing training to its staff and Providers on matters related to meeting the needs of economically disadvantaged and culturally diverse individuals.	Substantial - Foreign language interpreters are addressed in the Member Handbook. Staff training of cultural competency/considerations is included in the KY Medicaid New Hire – Facilitator Agenda provided. This requirement is addressed in the Provider Manual. Evidence of ongoing training of staff and providers was not evident in the documents provided.	Full	Provider Cultural Competency training is addressed in Policy C12PD-007 that the MCO distributes a summary of the Cultural Competency plan to network providers and how they may access the information on the WellCare website. Providers may request a hard copy of the CCP at no charge to the provider. KY Medicaid Provider Training Orientation addresses cultural competency compliance on slides 4, 10. Provider Cultural Competency KY Training Curriculum and WellCare Coporate Cultural	

Final Findings

Enrollee Rights and Protection: Enrollee Rights *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Recommendation for WellCare The MCO should provide evidence of ongoing training for staff and providers. **MCO Response:** The plan allows for refresher training as needed as well as team meetings which are utilized to deliver updates to content or newly established processes. Rosters/Signing sheets are/can be available upon request. DMS Recommendation: To be reviewed in 2015. WellCare should provide documentation of the training content and attendance for staff and providers.		Competency Program provided that address Provider performance monitoring. Annual Cultural Competency Training shows how the plan monitors and tracks employee's Cultural Competency Training.	
The Contractor shall require that all Service Locations meet the requirements of the Americans with Disabilities Act, Commonwealth and local requirements pertaining to adequate space, supplies, sanitation, and fire and safety procedures applicable to health care facilities. The Contractor shall cooperate with the Cabinet for Health and Family Services' independent ombudsman program, including providing immediate access to a Member's records when written Member consent is provided.	Full-2013			
The Contractor's Member Services function shall also be responsible for:				
A. Ensuring that Members are informed of their rights and responsibilities;	Full-2013			

Final Findings

Enrollee Rights and Protection: Enrollee Rights *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
B. Monitoring the selection and assignment process of PCPs;	Full-2013			
C. Identifying, investigating, and resolving Member Grievances about health care services;	Full-2013			
D. Assisting Members with filing formal Appeals regarding plan determinations;	Full-2013			
E. Providing each Member with an identification card that identifies the Member as a participant with the Contractor, unless otherwise approved by the Department;	Full-2013			
F. Explaining rights and responsibilities to members or to those who are unclear about their rights or responsibilities including reporting of suspected fraud and abuse;	Full-2013			
G. Explaining Contractor's rights and responsibilities, including the responsibility to assure minimal waiting periods for scheduled member office visits and telephone requests, and avoiding undue pressure to select specific Providers or services;	Full-2014			
H. Providing within five (5) business days of the Contractor being notified of the enrollment of a new Member, by a method that will not take more than three (3) days to reach the Member, and whenever requested by member, guardian or authorized representative, a Member Handbook and information on how to access services; (alternate notification methods shall be available for persons who have reading difficulties or visual impairments);	Full-2013			
I. Explaining or answering any questions regarding the	Full-2013			

Final Findings

Enrollee Rights and Protection: Enrollee Rights *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Member Handbook;				
J. Facilitating the selection of or explaining the process to select or change Primary Care Providers through telephone or face-to-face contact where appropriate. The Contractor shall assist members to make the most appropriate Primary Care Provider selection based on previous or current Primary Care Provider relationship, providers of other family members, medical history, language needs, provider location and other factors that are important to the Member. The Contractor shall notify members within thirty (30) days prior to the effective date of voluntary termination (or if Provider notifies Contractor less than thirty (30) days prior to the effective date, as soon as Contractor receives notice), and within fifteen (15) days prior to the effective date of involuntary termination if their Primary Care Provider leaves the Program and assist members in selecting a new Primary Care Provider;	Full-2013			
K. Facilitating direct access to specialty physicians in the circumstances of: (1) Members with long-term, complex health conditions; (2) Aged, blind, deaf, or disabled persons; and (3) Members who have been identified as having special healthcare needs and who require a course of treatment or regular healthcare monitoring. This access can be achieved through referrals from the Primary Care Provider or by the specialty physician being permitted to serve as the Primary Care Provider.	Full-2014			
L. Arranging for and assisting with scheduling EPSDT Services in conformance with federal law governing EPSDT for persons under the age of twenty-one (21)	Full-2014			

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
years;				
M. Providing Members with information or referring to support services offered outside the Contractor's Network such as WIC, child nutrition, elderly and child abuse, parenting skills, stress control, exercise, smoking cessation, weight loss, behavioral health and substance abuse;	Full-2014			
N. Facilitating direct access to primary care vision services; primary dental and oral surgery services, and evaluations by orthodontists and prosthodontics; women's health specialists; voluntary family planning; maternity care for Members under age 18; childhood immunizations; sexually transmitted disease screening, evaluation and treatment; tuberculosis screening, evaluation and treatment; and testing for HIV, HIV-related conditions and other communicable diseases; all as further described in Appendix I of this Contract;	Full-2014			
O. Facilitating access to behavioral health services and pharmaceutical services;	Full-2014			
P. Facilitating access to the services of public health departments, Community Mental Health Centers, rural health clinics, Federally Qualified Health Centers, the Commission for Children with Special Health Care Needs and charitable care providers, such as Shriner's Hospital for Children;	Full-2014			
Q. Assisting members in making appointments with Providers and obtaining services. When the Contractor is unable to meet the accessibility standards for access to Primary Care Providers or referrals to specialty providers, the Member Services staff function shall document and	Full-2013			

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
refer such problems to the designated Member Services Director for resolution;				
R. Assisting members in obtaining transportation for both emergency and appropriate non-emergency situations;	Full-2014			
S. Handling, recording and tracking Member Grievances properly and timely and acting as an advocate to assure Members receive adequate representation when seeking an expedited Appeal;	Full-2013			
T. Facilitating access to Member Health Education Programs;	Full-2014			
U. Assisting members in completing the Health Risk Assessment (HRA) as outlined in **Covered Services** upon any telephone contact; and referring Members to the appropriate areas to learn how to access the health education and prevention opportunities available to them including referral to case management or disease management; and	Full-2013			
V. The Member Services staff shall be responsible for making an annual report to management about any changes needed in Member Services functions to improve either the quality of care provided or the method of delivery. A copy of the report shall be provided to the Department.	Full-2014			
30.4 Billing Members for Covered Services				
The Contractor and its Providers and Subcontractors shall not bill a Member for Medically Necessary Covered Services with the exception of applicable co-pays or other cost sharing requirements provided under this contract. Any Provider who knowingly and willfully bills a Member	Full-2013			

Final Findings

Enrollee Rights and Protection: Enrollee Rights *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
for a Medicaid Covered Service shall be guilty of a felony and upon conviction shall be fined, imprisoned, or both, as defined in Section 1128B(d)(1) 42 U.S.C. 1320a-7b of the Social Security Act. This provision shall remain in effect even if the Contractor becomes insolvent.				
However, if a Member agrees in advance in writing to pay for a Non-Medicaid covered service, then the Contractor, the Contractor's Provider, or Contractor's Subcontractor may bill the Member. The standard release form signed by the Member at the time of services does not relieve the Contractor, Providers and Subcontractors from the prohibition against billing a Medicaid Member in the absence of a knowing assumption of liability for a Non-Medicaid covered Service. The form or other type of acknowledgement relevant to the Medicaid Member liability must specifically state the services or procedures that are not covered by Medicaid.	Full-2014			
22.9 Choice of Providers				
Dual Eligible Members, Members who are presumptively eligible, disabled children, and foster care children are not required to have a PCP. All other Members in the MCO must choose or have the Contractor select a PCP for their medical home.	Full-2013			
The Contractor shall have two processes in place for Members to choose a PCP: (A) a process for Members who have SSI coverage but are not Dual Eligible Members, and (B) a process for other Members.	Full-2013			
23.4 PCP Changes				
The Contractor shall have written policies and procedures	Full-2013			

Final Findings

Enrollee Rights and Protection: Enrollee Rights *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
for allowing Members to select or be assigned to a new PCP when such change is mutually agreed to by the Contractor and Member, when a PCP is terminated from coverage, or when a PCP change is as part of the resolution to an Appeal.				
The Contractor shall allow the Members to select another PCP within ten (10) days of the approved change or the Contractor shall assign a PCP to the Member if a selection is not made within the timeframe.	Full-2013			
A member shall have the right to change the PCP 90 days after the initial assignment and once a year regardless of reason, and at any time for any reason as approved by the Member's Contractor. The Member may also change the PCP if there has been a temporary loss of eligibility and this loss caused the Member to miss the annual opportunity, if Medicaid or Medicare imposes sanctions on the PCP, or if the Member and/or the PCP are no longer located in the Contractor's Region.	Full-2013			
The Member shall also have the right to change the PCP at any time for cause. Good cause includes the Member was denied access to needed medical services; the Member received poor quality of care; and the Member does not have access to providers qualified to treat his or her health care needs. If the Contractor approves the Member's request, the assignment will occur no later than first day of the second month following the month of the request.	Full-2013			
PCPs shall have the right to request a Member's Disenrollment from his/her practice and be reassigned to a new PCP in the following circumstances: incompatibility of the PCP/patient relationship or inability to meet the	Full-2013			

Final Findings

Enrollee Rights and Protection: Enrollee Rights *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
medical needs of the Member.				
PCPs shall not have the right to request a Member's Disenrollment from their practice for the following: a change in the Member's health status or need for treatment; a Member's utilization of medical services; a Member's diminished mental capacity; or, disruptive behavior that results from the Member's special health care needs unless the behavior impairs the ability of the PCP to furnish services to the Member or others. Transfer requests shall not be based on race, color, national origin, handicap, age or gender. The Contractor shall have authority to approve all transfers.	Full-2013			
The initial Provider must serve until the new Provider begins serving the Member, barring ethical or legal issues. The Member has the right to a grievance regarding such a transfer. The Provider shall make the change for request in writing. Member may request a PCP change in writing, face to face or via telephone.	Full-2013			
30.5 Referrals for Services not Covered by Contractor				
When it is necessary for a Member to receive a Medicaid service that is outside the scope of Covered Services provided by the Contractor, the Contractor shall refer the Member to a provider enrolled in the Medicaid fee-for-service program. The Contractor shall have written policies and procedures for the referral of Member for Non-Covered services that shall provide for the transition to a qualified health care provider and, where necessary, assistance to Members in obtaining a new Primary Care Provider. The Contractor shall submit any desired changes to the established written referral policies and procedures to the Department for review and approval.	Full-2013			

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: WellCare of Kentucky

Enrollee Rights and Protection: Enrollee Rights

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	1	0	0	0
Total Points	3	0	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average	3.0			

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review, may adversely affect the scoring of a requirement and result in possible sanctions by DMS.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Final Findings

Enrollee Rights and Protection: Enrollee Rights
Suggested Evidence

Documents

Policies/Procedures for:

- Member rights and responsibilities
- Member Handbook
- Choice of providers
- PCP changes
- Referral for non-covered services provided by FFS Medicaid providers
- Second Opinions
- Required member services functions including, but not limited to, call center and medical call-in system
- Cost Sharing

Member Handbook including any separate inserts or materials
Sample Member newsletters and other informational materials
Sample Provider newsletters and other informational materials
Provider Manual or evidence demonstrating that policies/procedures related to member rights and responsibilities are communicated to providers

Reports

Census information on common ethnicities and languages other than English spoken by 5% or more of the enrolled population in a county
Annual Member Services Report
Call center metrics
Medical call-in system metrics

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: WellCare of Kentucky

Final Findings

Enrollee Rights and Protection: Member Education and Outreach (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.206, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
22.3 Member Education and Outreach				
The Contractor shall develop, administer, implement, monitor and evaluate a Member and community education and outreach program that incorporates information on the benefits and services of the Contractor's Program to its Members. The Outreach Program shall encourage Members and community partners to use the information provided to best utilize services and benefits.	Full-2013			
Creative methods should be used to reach Contractor's Members and community partners. These will include but not be limited to collaborations with schools, homeless centers, youth service centers, family resource centers, public health departments, school-based health clinics, chamber of commerce, faith-based organizations, and other appropriate sites.	Full-2013			
The Contractor shall submit an annual outreach plan to the Department for review and approval. The plan shall include the frequency of activities, the staff person responsible for the activities and how the activities will be documented and evaluated for effectiveness and need for change.	Full-2013			
22.4 Outreach to Homeless Persons				
The Contractor shall assess the homeless population by implementing and maintaining a customized outreach plan for Homeless Persons population, including victims of domestic violence.	Full-2013			

Final Findings

Enrollee Rights and Protection: Member Education and Outreach (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.206, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The plan shall include: (A) utilizing existing community resources such as shelters and clinics; and (B) Face-to-Face encounters.	Full-2013			
The Contractor will not provide a differentiation of services for Members who are homeless. Victims of domestic violence should be a target for outreach as they are frequently homeless. Assistance with transportation to access health care may be provided via bus tokens, taxi vouchers or other arrangements when applicable.	Full-2014			
22.5 Member Information Materials				
All written materials provided to Members, including marketing materials, new member information, and grievance and appeal information shall be geared toward persons who read at a sixth-grade level,	Full-2014			
be published in at least a 14-point font size, and	Full-2014			
shall comply with the Americans with Disabilities Act of 1990 (Public Law USC 101-336).	Full-2014			
Font size requirements shall not apply to Member Identification Cards.	Full-2014			
Braille and audiotapes shall be available for the partially blind and blind.	Full-2014			
Provisions to review written materials for the illiterate shall be available.	Full-2014			
Telecommunication devices for the deaf shall be available.	Full-2014			
Language translation shall be available if five (5) percent	Full-2014			

Final Findings

Enrollee Rights and Protection: Member Education and Outreach (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.206, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
of the population in any county has a native language other than English.				
Materials shall be updated as necessary to maintain accuracy, particularly with regard to the list of participating providers.	Full-2014			
All written materials provided to Members, including forms used to notify Members of Contractor actions and decisions, with the exception of written materials unique to individual Members, unless otherwise required by the Department shall be submitted to the Department for review and approval prior to publication and distribution to Members.	Full-2014			
In addition all Member materials concerning behavioral health, with the exception of written materials unique to individual Members, shall be submitted to DBHDID's Director of the Division of Developmental Health for approval prior to publication and distribution to Members.	New Requirement	Not Applicable	DMS has instructed WellCare to submit materials to DMS and the State will submit to DBHDID as needed.	
28.12 Cultural Consideration and Competency				
The Contractor shall participate in the Department's effort to promote the delivery of services in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The Contractor shall address the special health care needs of its members needing culturally sensitive services. The Contractor shall incorporate in policies, administration and service practice the values of: recognizing the Member's beliefs; addressing cultural differences in a competent manner; fostering in staff and Providers attitudes and interpersonal communication	Full-2014			

Final Findings

Enrollee Rights and Protection: Member Education and Outreach (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.206, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
styles which respect Member's cultural background.				
The Contractor shall communicate such policies to Subcontractors.	Full-2014			

Final Findings

Enrollee Rights and Protection: Member Education and Outreach

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	***Only 1 element scored and is Not Applicable***			
Total Points				

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average				

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review, may adversely affect the scoring of a requirement and result in possible sanctions by DMS.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Final Findings

Enrollee Rights and Protection: Member Education and Outreach
Suggested Evidence

Documents

Member and Community Education Outreach Plan
Outreach plan for homeless persons
Member Handbook
Member informational materials
Policies/procedures for promoting delivery of services in a culturally competent manner and evidence of communicating these policies/procedures to subcontractors

Reports

Reports of outreach activities

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: WellCare of Kentucky

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
33.3 General Behavioral Health Requirements				
The Department requires the Contractor's provision of behavioral health services to be recovery and resiliency focused. This means that services will be provided to allow individuals, or in the case of, a minor, family or guardian, to have the greatest opportunities for decision making and participation in the individual's treatment and rehabilitation plans.	Full-2013			
33.4 Covered Behavioral Health Services				
The Contractor shall assure the provision of all Medically Necessary Behavioral Health Services for Members. These services are described in Appendix I.	Full-2013			
All Behavioral Health services shall be provided in conformance with the access standards established by the Department. When assessing Members for BH Services, the Contractor and its providers shall use the DSM-V classification. The Contractor may require use of other diagnostic and assessment instrument/outcome measures in addition to the DSM-V.	Full-2013			
Providers shall document DSM-V diagnosis and assessment/outcome information in the Member's medical record.	Full-2013			
33.5 Behavioral Health Provider Network				
The Contractor must emphasize access to services, utilization management, assuring the services authorized are provided, are medically necessary and produce positive health outcomes. The Department and DBHDID	Full-2013			

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
will coordinate on the requirement of data collection and reporting to assure that state and federal funds utilized in financing behavioral health services are efficiently utilized and meet the overall goals of health outcomes.				
The Contractor shall utilize ICD-9/10 coding and DSM-V classification for Behavioral Health billings.	Full-2013			
The Contractor shall provide access to psychiatrists, psychologists, and other behavioral health service providers.	Full-2013			
Community Mental Health Centers (CMHCs) located within the Contractor service region shall be offered participation in the Contractor provider network.	Full-2013			
To the extent that non-psychiatrists and other providers of Behavioral health services may also be provided as a component of FQHC and RHC services, these facilities shall be offered the opportunity to participate in the Behavioral Health network. FQHC and RHC providers can continue to provide the same services they currently provide under their licenses.	Full-2013			
The Contractor shall ensure accessibility and availability of qualified providers to all Members.	Full-2014			
The Contractor shall maintain a Member education process to help Members know where and how to obtain Behavioral Health Services.	Full-2013			
The Contractor shall permit Members to participate in the selection of the appropriate behavioral health individual practitioner(s) who will serve them and shall	Full-2013			

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
provide the Member with information on accessible in-network Providers with relevant experience.				
33.6 Behavioral Health Services Hotline				
The Contractor shall have an emergency and crisis Behavioral Health Services Hotline staffed by trained personnel twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, toll-free throughout the Contractor's region.	Full-2014			
Crisis hotline staff must include or have access to qualified Behavioral Health Services professionals to assess, triage and address specific behavioral health emergencies.	Full-2013			
Emergency and crisis Behavioral Health Services may be arranged through mobile crisis teams. Face to face emergency services shall be available twenty-four (24) hours a day, seven (7) days a week.	Full-2013			
It is not acceptable for an intake line to be answered by an answering machine.	Substantial - Availability of crisis line with 24 hour, 7 days per week staffing is addressed by P/P CBCS 062 Customer Service Crisis Policy and Member Handbook, Bluegrass Regional MH-HR Board Inc. Emergency Services Manual Chapter 2 and 3. However, a policy specifically prohibiting answering machines is not addressed by the documents provided. Onsite, WellCare provided: - Bluegrass Training Checklist - P/P C6CS-121 Behavioral Health Customer	Full	The requirement is addressed in KY 2014 Work Plan, Health Integrated contract page 5, Crisis Line Training-non-clinical staff, and C7BH 002-PR-001 Behavioral Health 24-7 Crisis Hotline.	

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Service Requirements - P/P C6CS-062 Customer Service Handling of Crisis Calls WellCare noted that the call statistics for the Crisis Hotline in the quarterly reports reflect "0" hold time. **Recommendation for WellCare** Although the hold time does reflect that calls are answered by a live person and there is no hold time, WellCare should add Kentucky-specific language to its P/Ps that states that intake lines will at no time be answered by an answering machine. **MCO Response:** WellCare has entered a contract with a new vendor-Health Integrated for period 1/1/14 forward. The scope of work now includes this language on page 5 item 6.1.			
The Contractor shall ensure that the toll-free Behavioral Health Services Hotline meets the following minimum performance requirements for all Contractor Programs and Service Areas:	Full-2013		Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results)	
A. Ninety-nine percent (99%) of calls are answered by the fourth ring or an automated call pick-up system;	Full-2013		Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results)	
B. No incoming calls receive a busy signal;	Full-2013		Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results)	

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
C. At least eighty percent (80%) of calls must be answered by toll-free line staff within thirty (30) seconds measured from the time the call is placed in queue after selecting an option;	Full-2013		Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results)	
D. The call abandonment rate is seven percent (7%) or less;	Full-2013		Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results)	
E. The average hold time is two (2) minutes or less; and	Substantial - Hotline MCO Reports in the 2013 Medicaid QI Work Plan (page 55) indicate that Average Hold Time is Not Applicable as Behavioral Health callers are not placed on hold. However, Step 3 of the Crisis Call Process document (page 1) directs staff to place the Crisis Call on hold unless the member asks otherwise not to be placed on hold. The monthly call center metric spreadsheets provided do not appear to measure Average Hold Time (separate Average Speed of Answer and Highest Maximum Delay metrics are measured). Onsite, WellCare noted that the call statistics for the Crisis Hotline in the quarterly reports reflect "0" hold time. The Step Action Procedure: Concurrent – Behavioral Health Crisis Hotline lists all types of calls: Emergent: In Danger, High Risk, and Mod-	Minimal	Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results) Health Integrated – ECM 22260 contract (page 5) addresses requirement. MCO Report #11 shows average hold time not reported in any month for 2014. This requirement scored minimal because the MCO did not address the same recommendation from the prior review. **Recommendation for WellCare** The MCO should report average hold time as required. **Recommendation for DMS** DMS should update report #11 to	A corrective action plan (CAP) has been developed and is attached. The CAP includes updating policies, procedures, and other documents related to hold time for the Behavioral Health Hotline, as well as a request for DMS to update the template for Report #11 to include the metric "average hold time" for the Behavioral Health Hotline.

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Low Risk and for each, it states to "stay on the phone line and verify contact with (agency)." While the Crisis Call Transfer Script states "the CSR will immediately and briefly place the caller on hold…). **Recommendation for WellCare** WellCare should clarify the P/P regarding placing members on hold for Crisis or other BH inquiries and continue to report the on hold times quarterly. **MCO Response:** WellCare has entered a contract with a new vendor-Health Integrated for period 1/1/14 forward. The scope of work now includes this language on page 5 in item 6.1-H.		include hold times as a reporting requirement.	
F. The system can immediately connect to the local Suicide Hotline's telephone number and other Crisis Response Systems and have patch capabilities to 911 emergency services.	Substantial - Hotline metrics in QI Work Plan (page 55) indicate numerous calls transferred to suicide hotline each quarter. Crisis Call Process documents ability of patch capabilities to 911 emergency services. Additionally, WellCare provided the Step Action Procedure: Concurrent-Behavioral Health Crisis Hotline. This process directs the rep to contact 911, the CMHC Mobile Unit. Policies do not address immediate connection to local Suicide Hotline or other Crisis Response Systems.	Full	C7BH 002-PR-001 addresses immediately connecting to and having patch capabilities to 911 emergency services. C7BH-002 addresses connection to local Suicide Hotline and other Crisis Response Systems as well as patch capabilities to 911 emergency services. Also addressed in Health Integrated-ECM 22260 contract (page 5).	

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Recommendation for WellCare WellCare should add a specific notation to P/P C6CS-062 (or other relevant policy that describes the Hotline) that the Wellcare Hotline can patch directly to the local Suicide Hotline's telephone number and other Crisis Response Systems. **MCO Response:** WellCare has entered a contract with a new vendor-Health Integrated for period 1/1/14 forward. The scope of work now includes this language on page 5 in item 6.1 item K.			
The Contractor may operate one hotline to handle emergency and crisis calls and routine Member calls.	Full-2014			
The Contractor cannot impose maximum call duration limits and shall allow calls to be of sufficient length to ensure adequate information is provided to the Member.	Minimal - Call duration limits not addressed by documents provided. Onsite, WellCare referred the reviewer to the P/P C6CS-062, however, the policy addresses Customer Service Handling of Crisis Calls. WellCare also referenced the monthly call metrics by employee. Call duration ranged from 1 minute to 3:48 minutes. **Recommendation for WellCare** WellCare should include an explicit statement that there is no maximum call duration limit imposed and all calls will be of sufficient length to ensure adequate information is provided to the member.	Substantial	C6CS 121 Behavioral Health Customer Service Requirements addresses call duration limits. Requirement should also be addressed in the contract between WellCare and its subcontractor, Health Integrated. Contract language only states that "All calls will be properly dispositioned". **Recommendation for WellCare** WellCare should include an explicit statement in its contract with Health Integrated that there is no maximum call duration limit imposed and all calls will be of sufficient length to ensure adequate information is provided to the	An amendment to the Health Integrated contract has been completed (see attached contract change request). Subsection 6 to Section 6.7c was added to include the following specific language: "6. Vendor shall not impose maximum call duration limits and shall allow calls to be of sufficient length to ensure adequate information is provided to the member."

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	MCO Response: WellCare has entered a contract with a new vendor-Health Integrated for period 1/1/14 forward. This is addressed in the Health Integrated Scope of Work 6.1 item H (page 5 of document). A CAP has been submitted; please refer to the document CAP_15_Tool_BH Services_2014.		member.	
Hotline services shall meet Cultural Competency requirements and provide linguistic access to all Members, including the interpretive services required for effective communication.	Full-2014			
The Behavioral Health Services Hotline may serve multiple Contractor Programs if the Hotline staff is knowledgeable about all of the Contractor Programs. The Behavioral Health Services Hotline may serve multiple Service Areas if the Hotline staff is knowledgeable about all such Service Areas, including the Behavioral Health Provider Network in each Service Area.	Substantial - Addressed in C6CS-121 Behavioral Health Customer Service Requirements. While document includes information on the different contractor programs, it is not specified whether all of the Hotline staff are trained and knowledgeable about all of the contractor programs, and also knowledgeable about all of the behavioral health provider networks in each Service Area. Onsite, WellCare provided the Bluegrass Orientation Checklist which listed Kentucky-specific mental health regulations. In addition, P/P C6CS-062 indicates that there is a dedicated crisis line phone number for Kentucky Medicaid. **Recommendation for WellCare** Policy should address staff knowledge of	Minimal	Contract with Health Integrated addresses staff knowledge of various components of a contractor's programs, such as covered services, provider network, non-emergency transportation. The contract does not address service of multiple service areas. The MCO provides state-specific training. This requirement scored minimal because the MCO did not address the same recommendation from the prior review. **Recommendation for WellCare** Evidence of full compliance with this requirement would include information	A corrective action plan (CAP) has been developed that includes the development of training materials for Health Integrated staff and the provision of training for the Health Integrated team on Kentucky-specific components, as well as an update to the Health Integrated contract to include a requirement of ongoing training related to Kentucky-specific components. The CAP is attached.

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	multiple contractor programs and multiple service areas. **MCO Response:** WellCare has entered a contract with a new vendor-Health Integrated for period 1/1/14 forward. The scope of work now includes this language in 6.7 item A		regarding whether the Hotline serves multiple MCO Programs/product lines and/or multiple MCO Service Areas or if there are dedicated staff for each. Additionally, if multiple Programs/Service Areas are served by a single Hotline, evidence that the Hotline staffs are knowledgeable about the various Programs, Provider Networks, and Service Areas, in particular, those related to Kentucky Medicaid.	
The Contractor shall conduct on-going quality assurance to ensure these standards are met.	Full-2013			
The Contractor shall monitor its performance against the Behavioral Health Services Hotline standards and submit performance reports summarizing call center performance as indicated.	Full-2013		Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results)	
If Department determines that it is necessary to conduct onsite monitoring of the Contractor's Behavioral Health Services Hotline functions, the Contractors responsible for all reasonable costs incurred by Department or its authorized agent(s) relating to such monitoring.				
33.7 Coordination between the Behavioral Health Provider and the PCP				
The Contractor shall require, through contract provisions, that PCPs have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and	Full-2013			

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
disorders. PCPs may provide any clinically appropriate Behavioral Health Services within the scope of their practice. Such screening and evaluation procedures shall be submitted to the Department and DBHDID for approval. The Contractor will work directly with DBHDID to introduce the evidence based tool Screening, Brief Intervention, Referral, and Treatment (SBRIT) in appropriate PCP settings.				
The Contractor shall provide training to network PCPs on how to screen for and identify behavioral health disorders, the Contractor's referral process for Behavioral Health Services and clinical coordination requirements for such services. The Contractor shall include training on coordination and quality of care such as behavioral health screening techniques for PCPs and new models of behavioral health interventions.	Full-2014			
The Contractor shall develop policies and procedures and provide to the Department for approval regarding clinical coordination between Behavioral Health Service Providers and PCPs.	Full-2013		Includes BH/PH Care Coordination review summary results	
The Contractor shall require that Behavioral Health Service Providers refer Members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the Member's or the Member's legal guardian's consent. Behavioral Health Providers may only provide physical health care services if they are licensed to do so. This requirement shall be specified in all Provider Manuals.	Full-2014			

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall require that behavioral health Providers send initial and quarterly (or more frequently if clinically indicated) summary reports of a Members' behavioral health status to the PCP, with the Member's or the Member's legal guardian's consent. This requirement shall be specified in all Provider Manuals.	Full-2013			
33.8 Follow-up after Hospitalization for Behavioral Health Services				
The Contractor shall require, through Provider contract provision, that all Members receiving inpatient behavioral health services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge.	Full-2013			
The outpatient treatment must occur within seven (7) days from the date of discharge.	Full-2013			
The Contractor shall ensure that Behavioral Health Service Providers contact Members who have missed appointment within twenty-four (24) hours to reschedule appointments.	Full-2013			
33.9 Court-Ordered Services				
"Court-Ordered Commitment" means an involuntary commitment of a Member to a psychiatric facility for treatment that is ordered by a court of law pursuant to Kentucky statutes.				
The Contractor must provide inpatient psychiatric services to Members under the age of twenty-one (21) and over the age of sixty-five (65), up to the annual limit, who have been ordered to receive the services by a court	Full-2014			

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
of competent jurisdiction under the provisions of KRS 645, Kentucky Mental Health Act of The Unified Juvenile Code and KRS 202A, Kentucky Mental Health Hospitalization Act.				
The Contractor cannot deny, reduce or controvert the Medical Necessity of inpatient psychiatric services provided pursuant to a Court ordered commitment for Members under the age of twenty-one (21) or over the age of sixty-five (65). Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.	Full-2014			
33.10 Continuity of Care Upon Discharge From a Psychiatric Hospital				
The Contractor shall coordinate with providers of behavioral health services, and state operated or state contracted psychiatric hospitals and nursing facilities regarding admission and discharge planning, treatment objectives and projected length of stay for Members admitted to the state psychiatric hospital.	Full-2013			
The Contractor shall enter into a collaborative agreement with the state operated or state contracted psychiatric hospital assigned to their region in accordance with 908 KAR 3:040 and in accordance with federal Olmstead law. At a minimum the agreement shall include responsibilities of the Behavioral Health Service Provider to assure continuity of care for successful transition back into community-based supports.	Full-2014			
In addition, the Contractor Behavioral Health Service	Full-2014			

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Providers shall participate in quarterly Continuity of Care meetings hosted by the state operated or state contracted psychiatric hospital.				
The Contractor shall ensure the Behavioral Health Service Providers assign a case manager prior to or on the date of discharge and provide basic, targeted or intensive case management services as medically necessary to Members with severe mental illness and co-occurring developmental disabilities who are discharged from a state operated or state contracted psychiatric facility or state operated nursing facility for Members with severe mental illness.	Full-2013			
The Case Manager and other identified behavioral health service providers shall participate in discharge planning meetings to ensure compliance with federal Olmstead and other applicable laws. Appropriate discharge planning shall be focused on ensuring needed supports and services are available in the least restrictive environment to meet the Member's behavioral and physical health needs, including psychosocial rehabilitation and health promotion.	Full-2014			
Appropriate follow up by the Behavioral Health Service provider shall occur to ensure the community supports are meeting the needs of the Member discharged from a state operated or state contracted psychiatric hospital.	Full-2014			
The Contractor shall ensure the Behavioral Health Service Providers assist Members in accessing free or discounted medication through the Kentucky Prescription Assistance Program (KPAP) or other similar assistance programs.	Full-2013			

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
33.11 Program and Standards				
Appropriate information sharing and careful monitoring of diagnosis, treatment, and follow-up and medication usage are especially important when Members use physical and behavioral health systems simultaneously. The Contractor shall:				
A. Establish guidelines and procedures to ensure accessibility, availability, referral and triage to effective physical and behavioral health care, including emergency behavioral health services, (i.e. Suicide Prevention and community crisis stabilization);	Full-2013			
B. Facilitate the exchange of information among providers to reduce inappropriate or excessive use of psychopharmacological medications and adverse drug reactions;	Full-2013			
C. Identify a method to evaluate the continuity and coordination of care, including member-approved communications between behavioral health care providers and primary care providers;	Full-2014			
D. Protect the confidentiality of Member information and records; and	Full-2013			
E. Monitor and evaluate the above, which shall be a part of the Quality Improvement Plan.	Full-2013			
The Department and DBHDID shall monitor referral patterns between physical and behavioral providers to evaluate coordination and continuity of care. Drug utilization patterns of psychopharmacological				

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
medications shall be closely monitored. The findings of these evaluations will be provided to the Contractor.				

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MCO: WellCare of Kentucky

Final Findings

Behavioral Health Services

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	2	1	2	0
Total Points	6	2	2	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.0**		

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review, may adversely affect the scoring of a requirement and result in possible sanctions by DMS.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Final Findings

Behavioral Health Services
Suggested Evidence

Documents

Policies/procedures for:

- Behavioral Health services
- Clinical coordination between BH services providers and PCPs
- BH provider program capacity requirements
- BH services hotline
- Court-ordered services
- Case management services for members including discharge planning
- Accessing free or discounted medication

Benefit Summary (covered/non-covered BH services)
Provider Manual
Sample PCP contract
Sample BH provider contract
Process for educating members of where and how to obtain BH services
Process for monitoring compliance with hotline requirements
Process for educating PCPs of BH services/requirements
Evidence of training of PCPs regarding BH services/requirements
Sample participation agreement with CMHCs
Sample collaborative agreement with state operated or state contracted psychiatric hospitals
Process for coordination of services for members committed by court of law to the state psychiatric hospital
Guidelines/procedures ensuring accessibility, availability, referral and triage including emergency BH services
Process for facilitating the exchange of pharmaceutical information among providers
Process for evaluating continuity and coordination of care among providers
QI Plan

Final Findings

Process for monitoring BH providers participation in quarterly Continuity of Care meetings hosted by the state operated or state contracted psychiatric hospital.

Reports

Reports of access and availability of BH providers
Provider program capacity/program mapping reports
Evidence of monitoring of compliance with hotline requirements
Evidence of ensuring follow-up after hospitalization for BH services
Evidence of monitoring compliance with BH standards

File Review

BH/PH Coordination files for a random sample of cases chosen by EQRO

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MCO: WellCare of Kentucky

Final Findings

Pharmacy Benefits (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
31.1 Pharmacy Requirements				
The Contractor shall provide pharmacy benefits in accordance with this section in addition to other requirements specified in this contract. Pharmacy benefit requirements shall include, but not be limited to:				
A. State-of-the-art, online and real-time rules-based point-of-sale (POS) Claims processing services with prospective drug utilization review including an accounts receivable process;	Full-2013			
B. Retrospective utilization review services;	Full-2013			
C. Formulary and non-formulary services, including prior authorization services;	Full-2013		Includes review of MCO Reports #39 Monthly Formulary Management and #59 Prior Authorizations (see Quarterly Desk Audit Reports)	
D. Pharmacy provider relations and call center services, in addition to Provider Services specified elsewhere;	Full-2014			
E. Seamless interfaces with the information systems of the Commonwealth and as needed, any related vendors; and	Full-2013			
F. Coverage for all drugs for which a federal rebate is available and has been provided by DMS.	New Requirement	Substantial	Addressed in C20 RX-136 Preferred Drug List. This was revised 3/16/15 during the onsite review. Earlier version presented in pre-onsite documentation with date of 10/29/13 does not address this requirement.	WellCare has finalized the revised policy.

Final Findings

Pharmacy Benefits (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Recommendation for WellCare The MCO should finalize the revised policy.	
31.2 Formulary and Non-Formulary Services				
The Contractor shall maintain a preferred drug list and make information available to pharmacy providers and Members the co-pay tiers or other information as necessary.	Full-2014			
The Contractor shall provide information to its pharmacy providers regarding the Preferred Drug List (PDL) for Medicaid Members via posting on the web and other relevant means of communication. This list updated by the Contractor throughout the year shall reflect changes in the status of a drug or to the addition of new drugs, as required.	Full-2014			
The Contractor shall utilize a Pharmacy and Therapeutics Committee (P&T Committee). The P&T Committee shall meet in Kentucky periodically throughout the calendar year as necessary and make recommendations to the Contractor for changes to the drug formulary. The P&T Committee shall be considered an advisory committee to a public body and thereby making it subject to the Open Meetings Law. The Contractor shall give prior notice to the Department of the time, date and location of the P&T Committee meetings.	Full-2014			
31.3 Pharmacy Claims Administration				
The Contractor shall process, adjudicate, and pay	Full-2014			

Final Findings

Pharmacy Benefits (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
pharmacy Claims for Members via an online real-time POS system, including voids and full or partial adjustments. The Contractor shall maintain prospective drug utilization review edits and apply these edits at the POS. The Contractor shall be responsible for processing components required for paper Claims.				
The Contractor maintains, through an online system, appropriate accounts receivable (A/R) records for the Commonwealth to systematically track adjustments, recoupments, manual payments and other required identifying A/R and Claim information.	Full-2013			
The Contractor shall interface with the Commonwealth's information systems to provide data and other information, as needed, to properly administer the pharmacy benefit program.	Full-2013			
31.4 Pharmacy Rebate Administration				
The Patient and Affordable Care Act (PPACA) signed into law in March 2010 require states to collect CMS level rebates on all Medicaid MCO utilization. In order for the Department to comply with this requirement the Contractor shall be required to submit NDC level information including J-code conversions consistent with CMS requirements. The Department will provide this Claims level detail to manufacturers to assist in dispute resolutions. However, since the Department is not the POS Claims processor,	Full-2014			

Final Findings

Pharmacy Benefits (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
resolutions of unit disputes are dependent upon cooperation of the Contractor. The Contractor shall assist the Department in resolving drug rebate disputes with the manufacture. The Contractor also shall be responsible for rebate administration for pharmacy services provided through other settings such as physician services.				
37.12 Prospective Drug Utilization Review Report				
The Contractor shall perform Prospective Drug Utilization Review (Pro-DUR) at the POS. They also provide Retrospective Drug Utilization Review (Retro-DUR) services by producing multiple reports for use by the Department.	Full-2013		Includes review of the following MCO Reports: #40A Top 50 Psych Drugs by Quantity Reimbursed #40B Top 50 Psych Drugs by Reimbursement #42A Top 50 Prescribers by Reimbursement #42B Top 50 Prescribers of Controlled Drugs by Reimbursement #42C Top 50 BH Prescribers by Reimbursement #43 Top 50 Controlled Drugs by Quantity Reimbursed #44 Top 50 Drugs by MCO Reimbursement #45A Top 50 Drugs by Quantity #45B Top 50 Non PDL Drugs by Reimbursement (see Quarterly Desk Audit Reports)	

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: WellCare of Kentucky

Pharmacy Benefits

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	0	1	0	0
Total Points	0	2	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.0**		

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review, may adversely affect the scoring of a requirement and result in possible sanctions by DMS.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Final Findings

Pharmacy Benefits
Suggested Evidence

Documents

Policies/procedures for:

- Pharmacy benefit requirements
- Structure of pharmacy program
- Pharmacy claims administration
- Pharmacy rebate administration
- Prospective and retrospective drug utilization review
- Pharmacy restriction program

Preferred Drug List
Listing of drugs requiring prior authorization
Pharmacy & Therapeutics Committee description, membership, meeting agendas and minutes
Process for informing members and pharmacy providers of preferred drug list and related information
Process for evaluating the impact of the pharmacy program on members
Prior authorization process

Reports

Pharmacy reports