



**KY EQRO ANNUAL REVIEW**  
**March 2014**  
**Period of Review: January 1, 2013 – December 31, 2013**  
**MCO: WellCare of Kentucky**

**Final Report 7/31/2014**

**Quality Assessment and Performance Improvement: Measurement and Improvement**  
*(See Final Page for Suggested Evidence)*

| State Contract Requirements<br>(Federal Regulation 438.236, 438.240)  | Prior Results & Follow-Up  | Review<br>Determination | Comments (Note: For any element that<br>deviates from the requirements, an<br>explanation of the deviation must be<br>documented in the Comments section)  | Health Plan's and DMS'<br>Responses and Plan of Action |
|---|--|-------------------------|--|--|
| <b>19.1 QAPI Program</b>  |  |                         |  |  |
| The Contractor shall implement and operate a comprehensive QAPI program that assesses monitors, evaluates and improves the quality of care provided to Members.                             | Full - The plan's comprehensive QAPI Program is outlined in the 2012 Medicaid Quality Improvement (QI) Program Description and Appendices, and its purpose is described as including objective and systematic monitoring and evaluation of quality and accessibility of care and also to identify and implement strategies for improvement. Committee minutes, quarterly reports and onsite staff provided evidence that the plan is monitoring and evaluating quality of care and has implemented a range of quality initiatives. | Full                    | WellCare provided its 2013 Medicaid Quality Improvement (QI) Program Description and Appendices, and committee quarterly reports and minutes.<br><br>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.<br><br>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 access to care, continuity of care, health care outcomes, and services provided or arranged for by the Contractor. | Full - The plan's processes for evaluating access to care, continuity of care, health care 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 ongoing evaluation is further described in the QI Work Plan.  | Full                    | WellCare's processes for evaluating access to and continuity of care, health care outcomes and services are outlined in the QI Program Description, Utilization Management (UM) Description, Case and Disease Management Program Descriptions, Patient Safety Plan and   |  |



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|  | <p>Documents describe plan monitoring of access to care with Geo Access mapping and appointment availability surveys (Primary Care Providers (PCPs), Pediatricians and vendor services), grievances, and utilization metrics. The plan is currently conducting member and provider satisfaction surveys, and is planning to conduct behavioral health member satisfaction surveys. The plan has begun to monitor HEDIS data and utilization data, including readmissions for outcome and continuity. Ongoing monitoring described in documents 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, and behavioral health services hotline calls. The QI Work Plan indicates that the plan is monitoring atypical antipsychotic medication prescribing and narcotic polypharmacy as improvement activities are implemented.</p> |                         | <p>policies and procedures, and the QI Work Plan.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>When asked about any special surveys,</p> |  |



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|  |                           |                         | <p>WellCare indicated that BH Adult and Child Satisfaction Surveys were conducted in 2013. The results were provided in spreadsheet format.</p> <p>WellCare first reported HEDIS in 2013. WellCare also reported baseline rates for the 2012 KY Health Outcomes performance measures. HEDIS results for CY 2012 show the MCO exceeded the 50<sup>th</sup> percentile for 40% of reported measures and the 75<sup>th</sup> percentile for 9% of reported measures. The current target is to achieve or exceed the 75<sup>th</sup> percentile.</p> <p>The QI Work Plan indicates that WellCare conducted Drug Utilization Review initiatives. These were continued in 2014:</p> <ol style="list-style-type: none"> <li>1) Injectable Antipsychotics: Risperdal Consta and Invega Sustenna</li> <li>2) Suboxone Decision Tool</li> <li>3) Use of Narcotic Containing Cough and Cold Products.</li> <li>4) ADHD Medication Use in Children</li> <li>5) Use of Inappropriate HIV Regimens</li> </ol> <p>Additionally, ongoing monitoring also includes, but is not limited to, adverse</p> |   |



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|   |  |                         | events, quality of care concerns, administrative services, case management/disease management enrollment and outcomes, health risk assessments, EPSDT services, and behavioral health services hotline calls.  |   |
| The Contractor's QI structures and processes shall be planned, systematic and clearly defined.  | Full - The plan's QI structures and processes are well defined in the QI Program Description, UM Program Description, Patient Safety Plan and policies and procedures. These documents provide comprehensive descriptions of structure and processes including accountable staff, committees, resources, goals, utilization monitoring, monitoring of services, safety and other components of the QI Program. The QI Work Plan includes planned quality monitoring and activities that are 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 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 plan's QI Program Description indicates that quality initiatives are developed and implemented based on data analysis of multiple quality indicators and review of the complete range of services offered to members. Linkage of QI activities and evaluation findings are evident in the QI Work Plan and committee minutes.<br><br>The QI Work Plan notes a goal of participation and minimal findings for EQR annual review, but review findings have not yet been shared with the plan.       | 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.<br><br>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                | WellCare will continue to monitor and address the appeals overturn rate as appropriate. |



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|  | <p>The plan has begun to monitor HEDIS, utilization and other metrics. Based on readmission rates, the plan implemented a transitional care program for admitted members in the second quarter of 2012 to reduce readmission rates and a post discharge initiative for members with high readmission rates. Behavioral health readmissions are also being monitored.</p> <p>The QI Work Plan notes that EPSDT screening and participation rates and efforts to improve them through identifying members in need of services for providers and disseminating a "HEDIS Toolkit" that addresses children's preventive services. Other initiatives include internal training for provider relations representatives, and a booklet Guide to Preventive Care for new members.</p> <p>The plan is monitoring members who are non-compliant with services measured by HEDIS indicators, and the QI Work Plan documents that outreach calls are being conducted to members in need of services. A HEDIS toolkit was developed and distributed to providers. The HEDIS toolkit appears applicable to multiple HEDIS indicators, and includes preventive guidelines and coding guides.</p> <p>The plan identified priorities to be Emergency</p> |                         | <p>corrective action plans were submitted for all areas scored less than substantial compliance.</p> <p>2013 provided the first full year of data for HEDIS, utilization and other metrics.</p> <p>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.</p> <p>Behavioral health readmissions are also being monitored. Monitoring indicated that behavioral health provider availability for routine and urgent care decreased, although post-discharge availability improved.</p> <p>WellCare established the Behavioral Health Advisory Committee. Topics discussed included: an outpatient treatment program for sexual offenders, development of</p> |   |



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|  | <p>Department (ED) use, behavioral health medications, tobacco use and obesity; the plan began projects to address these priorities. The plan's proposed Performance Improvement Projects (PIPs) address these priority areas. The plan has also implemented monitoring of the top 5 ED diagnoses, and established a multidisciplinary team to address inappropriate ED utilization as per the QI Work Plan. Improvement interventions for ED utilization include promotion of the nurse line and newsletter and handbook information, and the PIP will address inappropriate ED utilization.</p> <p>As per the QI Work Plan, the plan is using HRAs to identify obese members and smokers, and disseminating educational materials. The plan implemented a smoking cessation program and is monitoring members who receive cessation materials.</p> <p>For behavioral health prescribing, the plan is working on behavioral health medication prescribing by PCPs. The plan has conducted pharmacist outreach and visits for prescribing practices, as described by onsite staff. The plan is also working on narcotic polypharmacy and antipsychotic polypharmacy, which the plan has identified as problems.</p> <p>The plan does document a low rate of timely Health</p> |                         | <p>clinical criteria, holding meetings with providers, and high ED utilizers for BH diagnoses.</p> <p>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.</p> <p>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.</p> <p>The MCO continues to monitor the top 5 ED diagnoses and established a multidisciplinary team to address inappropriate ED utilization. WellCare reported positive results for ED diversion</p> |   |



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|  | <p>Risk Assessment (HRA) completion for pregnant women. As per onsite staff, the plan has identified problems contacting members as a barrier, and is working on attempting contact on off-hours and seeking alternate phone numbers and identifying best practices for engagement.</p> <p>Quality improvement activities to address pregnant women, including postpartum outreach initiatives, are documented in the QI Work Plan and committee minutes.</p> <p>The plan is working on after-hours access in Region 8, which was identified as an opportunity, by working with hospitals and pediatric groups, informing members of pediatricians with after-hours office hours, reimbursing for office hours after 5 pm, and having navigators in emergency departments. The plan is also looking at after-hours access for Community Mental Health Centers (CMHCs). Individual practitioners who are non-compliant with appointment availability are re-audited and submit a Corrective Action Plan if still non-compliant.</p> <p>The plan reports a high rate of overturns in the QI Work Plan, particularly for pharmacy; the plan notes identification of a misrouting issue that affected timeliness of appeals that was addressed. The plan</p> |                         | <p>as a result of triage by the 24/7 NurseLine. During the onsite interview, WellCare indicated that CM follows up on NurseLine calls.</p> <p>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.</p> <p>The number of licensed BH case managers increased in 2013 and 157 members received complex case management services in 2013.</p> <p>In 2013, WellCare continued to experience low rates for timely Health Risk</p> |   |



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|  | <p>conducts internal meetings of Appeals, Claims, UM and Customer Service to address potential quality issues related to appeals as per the QI Work Plan and onsite staff. Appeals and grievances are discussed in UMAC as per committee minutes, and benchmarks for appeals and grievances were requested in the May 12, 2012 meeting and reported as 50% overturn rate in the next UMAC committee. This rate for general appeals was exceeded as of the 4<sup>th</sup> quarter 2012, and pharmacy appeal overturn rate was 76.5%.</p> <p><b>Recommendation for WellCare</b><br/>The plan should continue to monitor and address evaluation findings, including appeal overturns.</p> <p><b>MCO Response:</b> WellCare plans on continuing to monitor and address evaluation findings including appeal overturns.</p> |                         | <p>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 hired and the ELIZA computer based program would be used to complete HRAs.</p> <p>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.</p> <p>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.</p> <p>WellCare experienced an appeals overturn rate of 62.8% for Member Appeals. The internal goal for the overturn rate was</p> |   |



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|  |                           |                         | <p>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.</p> <p>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.</p> <p>The 2013 Quality Improvement Program Evaluation was due for review and</p> |   |



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|  |   |                         | <p>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.</p> <p><b><u>Recommendation for WellCare</u></b><br/>WellCare should continue to monitor and address the appeals overturn rate.</p> |   |
| <p>The QAPI program shall be developed in collaboration with input from Members.</p> | <p>Full - As per the QI Program Description, one of the plan's goals is to maintain a process for members to receive updates and provide recommendations for the QI Program. The program is evaluated annually to assess member participation in the QI and UM Programs. The plan has established a Quality and Member Access Committee (QMAC) with the purpose of representing the interest of members. The QMAC met on March 23, 2012, June 1, 2012, September 7, 2012 and December 7, 2012. Committee minutes reveal active review and discussion of the 2012 QI Program Evaluation, 2012 QI Work Plan updates, QI Program Evaluation, appeals and grievances, network adequacy and appointment availability, community engagement, the Member Handbook and member newsletters. The QI Program Description is available to members on request and a summary of the Annual Evaluation is published in member newsletters. The plan tracks member grievances and has a member survey (CAHPS) underway.</p> | <p>Full</p>             | <p>Minutes from QMAC meetings on March 29, 2013, June 6, 2013, September 18, 2013 and December 13, 2013 (draft) demonstrate review of the first member CAHPS survey results.</p>  |   |



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| 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 23, 2012, June 1, 2012, September 7, 2012 and December 7, 2012. These minutes record input and questions and concerns voiced by members. Summaries of QMAC meetings are included in QIC minute The plan's annual QI Evaluation is described in the Program Description as including an evaluation of member input. The plan tracks member grievances, including those related to usefulness of materials. | 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).  |   |
| 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 - The plan is preparing to submit for NCQA accreditation in 2014.   | Not Applicable       | 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.   |   |
| 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 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 | NA - The plan is preparing to submit for NCQA accreditation in 2014.   | Not Applicable       | 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 and mock audit during Q2 2013. The team reviewed recommendations for improvement and conducted activities to meet identified gaps. |   |



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| and History.  |   |                         |  |   |
| Annually, the Contractor shall submit the QAPI program description document to the Department for review by July 31 of each contract year.  | Full - The 2012 QI Program Description was developed and internally approved in the first quarter as per the QI Work Plan and the Description, which notes Board approval on 3/27/12. Submitted to DMS 7/30/12.   | 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).  |   |
| As the Contractor will provide Behavioral Health services, 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. | <p>Full - The QI Work Plan includes monitoring of behavioral health appeals and grievances, behavioral health hotline calls, behavioral health satisfaction surveys, behavioral health inpatient utilization (including length of stay, readmissions, pharmacy, polypharmacy, medications in children) and HEDIS measures relevant to behavioral health, such as follow-up after inpatient admission. HEDIS measures will not be available until June 2013.</p> <p>The QI Work Plan indicates that data will be collected annually to monitor the exchange of information between physical and behavioral health, appropriate diagnosis, treatment and referral of behavioral conditions seen in primary care; appropriate psychopharmacological medications, access and follow-up for members with coexisting physical and behavioral conditions; and preventive behavioral health care programs. These data were not available for review. Behavioral health and physical health are collaborating on a behavioral health PIP regarding the prescribing of behavioral health medications in</p> | Full                    | <p>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.</p> <p>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.</p> <p>WellCare submitted documentation related to data collected annually to monitor the exchange of information between physical and behavioral health providers; appropriate diagnosis,</p> |   |



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|   | children by PCPs.  |                         | <p>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%).</p> <p>WellCare submitted data for the HEDIS BH measures: Diabetes Screening and Monitoring for Members with Schizophrenia.</p> <p>WellCare initiated a PH/BH PIP focusing on PCP prescribing of behavioral health medications for children.</p> |   |
| 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 - Physical health and behavioral health case managers collaborate to coordinate care. The plan held meetings with behavioral health staff to review identified issues as per onsite staff. The QI Work Plan indicates that data will be collected annually to monitor the exchange of information between | 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).   |   |



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|  | <p>physical and behavioral health, appropriate diagnosis, treatment and referral of behavioral conditions seen in primary care; appropriate psychopharmacological medications, access and follow-up for members with coexisting physical and behavioral conditions; and preventive behavioral health care programs. These data were not available for review.</p> <p>Provider Relations representatives are currently working on facilitating behavioral health and physical health communication. Behavioral health case management activities are reported in the Work Plan. The plan reviewed PCP behavioral health medication prescribing in children by PCPs in developing their PIP proposal.</p> <p>The plan is working with DCBS on coordination for foster children, since medication may not follow the child, and they may be receiving psychotropics.</p> |                         | <p>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.</p> <p>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.</p> |   |
| <b>19.2 Annual QAPI Review</b>   |   |                         |   |   |
| 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, | Full - An annual review of the QAPI Program is referenced in the QI Program Description, which documents that a formal evaluation of the QI and UM Programs will be conducted annually and will include trending of measures, evaluation of outcomes, and identified actions/interventions to improve programs in the upcoming year. The Program Evaluation was   | 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   |   |



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| <p>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. The Contractor shall prepare a written report to the Department, detailing the annual review and shall include a review of completed and 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 by July 31 of each contract year.</p> | <p>drafted and submitted to the State as per the QI Work Plan in second quarter 2012.<br/>           The plan provided a statement that the 2012 QI Program Evaluation is in production and will be reviewed in committees in March 2013.</p> <p>The plan provided a November 2011-March 2012 QI Program Evaluation, which was limited due to plan's member enrollment start date of November 2011. The Evaluation includes analysis of member characteristics such as aid category and prevalent diagnoses, network adequacy, delegation oversight audits and corrective action plans, preliminary work on HEDIS and preventive health measures, Health Risk Assessment (HRA) completion results, members identified for or engaged in case management, disease management program enrollment, EPSDT outreach and screening and participation rate metrics and activities, clinical practice guideline adoption, quality of care grievances, inpatient and pharmacy utilization, appeals and grievances, call metrics. Recommendations for each area and goals for 2012 are included in the Evaluation.</p> |                         | <p>reports (July 2014).</p> <p>The 2012 QI Program Evaluation was submitted to DMS as required.</p>  |   |
| <b>21.3 External Quality Review</b>  |  |                         |  |   |



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| 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 - The plan provided information as requested for the annual compliance review, as well as Performance Improvement Project (PIP) proposals and revisions as requested. Participation in EQRO audit is listed as a goal in the QI Work Plan. The plan made staff available for interview during the onsite review as requested. | 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. |  |
| The Contractor shall cooperate and 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. | Full - The plan participated in the annual compliance review as described above, and participated in PIP proposals, revisions and conference calls as requested.   | Full                    | Per above for comment for 21.3.   |  |
| <b>21.4 EQR Administrative Reviews</b>  |  |                         |   |  |
| The Contractor shall assist the Department and the EQRO in identification of Provider and Member information required to carry out  | Full - Participation in EQRO audit is listed as a goal in the QI Work Plan, and the plan participated by providing requested provider and member information for review. Other medical chart reviews   | Full                    | WellCare provided all documentation necessary for the Annual Compliance Reviews in 2013 and 2014, the 2013 Technical Report production, and records   |  |



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| annual, external independent reviews of the quality outcomes and timeliness 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.  | have not yet been undertaken.   |                      | for focused studies as requested.  |   |
| The Contractor shall assist the EQRO in competing all Contractor reviews and evaluations in accordance with established protocols previously described.   | Full - Participation in EQRO audit is listed as a goal in the QI Work Plan, and the plan participated as described above. The plan assisted in PIP validation as described above.                   | Full                 | WellCare actively participated in both PIP and Performance Measure validation.   |   |
| <b>21.5 EQR Performance</b>   |   |                      |  |   |
| 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 EQR compliance review findings have not yet been received by the plan. The plan provided revisions to the PIP proposals as requested.  | 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. |   |
| A. Assign a staff person(s) to conduct follow-up concerning review findings;  | NA - EQR compliance review findings have not yet been provided to the plan. The QI Work Plan identifies the staff responsible for the EQR audit, though not specifically for follow-up of findings. | Full                 | The QI Work Plan reveals that a staff member was assigned to follow-up on the Annual Compliance Review findings.   |   |



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| 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   | NA - EQR compliance review findings have not yet been provided to the plan. 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 of QI Program activities with regulatory and contractual standards.  |   |
| 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. | NA - EQR compliance review findings have not yet been provided to the plan.<br><br><b>Recommendation for WellCare</b><br>The plan should consider including information regarding EQR findings and follow-up in policy and/or Work Plans.<br><br><b>MCO Response:</b> WellCare includes findings from EQRO audits on its QI Work Plan. This activity is in section XIX, "EQRO Audits" of the 2013 QI Work Plan. | 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. |   |
| 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   | NA - EQR compliance review findings have not yet been provided to the plan.   | Full                 | Per above for comment for 21.5.   |   |
| E. If contractor disagrees with the   | NA - EQR compliance review findings have not yet  | Full                 | The plan submitted a letter to the  |   |



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| EQRO's findings, it shall submit its position to the Commissioner of the Department whose decision is final. | been provided to the plan.   |                         | Department of Medicaid Services dated September 27, 2013 detailing its position.   |  |
| <b>19.3 QAPI Plan</b>  |  |                         |  |  |
| The Contractor shall have a written QAPI work plan that  | Full - The plan submitted the 2012 Quality Assessment and Performance Improvement (QAPI) Work Plan with quarterly updates through 2012 for review.   | Full                    | The plan submitted the 2013 Quality Assessment and Performance Improvement (QAPI) Work Plan with quarterly updates.  |  |
| outlines the scope of activities and   | Full - The QAPI work plan identifies activities that the plan will undertake in the focus areas of Network Adequacy and Appointment Availability, Guideline Development and Review, Member and Provider Satisfaction, Credentialing, Continuity and Coordination, Medical Record Review, Patient Safety, Operational Service, Utilization, Pharmacy, Members with Special Health Care Needs, Cultural Competency, Delegation Oversight, HEDIS and Preventive Health Measures, Kentucky Health Outcomes, Community Engagement, Provider Recognition, EQRO and State Audit and Program Evaluation. | 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. |  |
| the goals,   | Full - Each QI activity includes goals, many of which are quantitative.  | Full                    | For each activity, a goal(s) and objective(s) is/are provided, many of which are quantitative.   |  |
| objectives, and  | Full - Each QI activity includes objectives.   | Full                    | For each activity, a goal(s) and objective(s) is/are provided, many of which are   |  |



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|   |   |                         | quantitative.  |  |
| timelines for the QAPI program.   | Minimal - Reporting timeframes are included for many activities such as CAHPS, medical records standards review, guideline compliance monitoring, EPSDT, and performance measures. Baseline reporting is noted to begin in 2013 in the Work Plan. Other activities, such as "implement activities to decrease duplicate and contraindicated therapy use", do not have target timeframes, although status of initiatives is updated quarterly.<br><b>MCO Response:</b> Reporting timeframes for all QI Work Plan activities are included in the 2013 QI Work Plan. Please refer to the 2013 QI Work Plan, third column "Completion Timeframe". | 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.             |  |
| New goals and objectives must be set at least annually based on findings from quality improvement activities and studies, survey results, Grievances and Appeals, performance measures and EQRO findings. | NA - Although the plan has implemented several quality improvement activities and is monitoring HEDIS data and other indicators, goals and objectives have not yet been updated, since monitoring and activities were begun in 2012 and annual findings are not yet available.<br><br><b>Recommendation for WellCare</b><br>The plan should ensure goals and objectives are updated as data become available.<br><br><b>MCO Response:</b> WellCare plans on updating goals and  | Full                    | The plan has implemented several quality improvement activities as described in the 2013 QI Work Plan and has used HEDIS data and other indicators to update goals and objectives. |  |



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|   | objectives as more data becomes available.   |                      |  |   |
| 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 - The QI Program Description and Work Plans include documentation of approval by the Board of Directors and Quality Improvement Committee (QIC). The QIC minutes of October 31, 2011 document QIC approval of the 2011 QI Program Description and 2011 QI Work Plan, and QIC minutes of March 5, 2012 document QIC approval of the 2012 QI Program Description and 2012 QI 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.<br><br>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. |   |
| designation of an accountable entity within the organization to provide direct oversight of QAPI;   | Full - The plan's Board of Directors is ultimately accountable for services provided to members and is responsible for general oversight and direction of the QI Program as per the QI Program Description. The Board has delegated approval of QI activities such as monitoring and evaluation of outcomes and effectiveness of the Program and corrective action plans to the Quality Improvement Committee (QIC). Day to day oversight has been delegated to the Director of Quality Improvement. | 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.  |   |
| review of written reports from the designated entity on a periodic basis, which shall include a description of  | Full - The 2012 QAPI Work Plan includes quarterly updates on QAPI activities, reflecting activity status and progress toward goals. The Work Plan includes   | Full                 | The 2013 QAPI Work Plan /QIC minutes include presentation and discussion of QI initiatives' activities and results.  |   |



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| QAPI activities, progress on objectives, and improvements made;      | updates on network adequacy metrics, appointment availability, utilization metrics and grievances and appeals. The QI Work Plan includes documentation of numbers of quality of care concerns, though numbers are small and trends are not reported. QIC committee minutes reflect review of the QAPI Program Description and Work Plan, and reports from committees. Presentation of specific reports, such as grievance and appeals reports, utilization of services report, and delegation oversight report, is also documented in the QIC minutes. Presentations of quality improvement activities are also documented in QIC minutes. These presentations address activity status and include specific progress toward goals. |                         |   |   |
| review on an annual basis of the QAPI program; and                   | Full - The QIC reviewed the Quality Improvement Program Evaluation (November 2011-March 2012) on 8/17/12, as reflected in committee minutes. This Evaluation included plan activity from 11/1/11 to 3/31/12, after enrollment began. The Utilization Management Medical Advisory Committee (UMAC) approved the Evaluation on 8/9/12. The QI Program Evaluation is included in the QI Work Plan and QI Program Description.   | 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 |   |



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|   |   |                      | is scheduled for completion in Q1 2014.  |   |
| modifications to the QAPI program on an ongoing basis to accommodate review findings and issues of concern within the organization.               | Full - Although only a partial annual review was conducted, the QI Work Plan document updates in QAPI activities quarterly, and activities are implemented based on plan observations and findings. The plan has implemented activities in priority areas as noted above in section 19.1. The QI Program Evaluation includes recommendations for activities and goals for 2012 based on findings.   | 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.   |   |
| The Contractor shall have in place an organizational Quality Improvement Committee that shall be responsible for all aspects of the QAPI program. | Full - The Quality Improvement Committee (QIC) provides general direction, oversight and approval of the QI activities. The QIC promotes the goals and objectives of the QI Program through oversight and approval of plan QI activities, as per the QI Program Description. 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. QIC committee minutes reflect active engagement in these activities. | Full                 | The QIC is described in the QI Program Description and meeting minutes demonstrate conduct of responsibilities.<br><br>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  | Full - The QIC is chaired by the Medical Director (currently the interim Medical Director is based in   | Full                 | The QIC is chaired by the Medical Director. WellCare has recruited a local Kentucky  |   |



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| <p>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 Needs.</p> | <p>Tampa) and includes corporate and local plan senior staff representatives from various plan departments, including pharmacy, Health Services, Foster Care, Adoption and Guardianship, Appeals, Network and Provider Relations. The Behavioral Health Medical Director participates on the QIC, as well as the Behavioral Health QI Project Manager and the plan QI Project Manager. The plan has a designated Utilization Management Medical Advisory Committee (UMAC) that reports to the QIC and oversees clinical QI, UM and behavioral health activities. As per the QI Program Description and a separate UMAC description and membership roster that the plan provided, this committee is comprised of the plan (Interim) Medical Director and Behavioral Health Medical Director as well as providers representing Pediatrics, Family Practice, Behavioral Health and OB/GYN. Several regions are represented. UMAC committee minutes reflect active participation of network providers. Providers also have representation on the Pharmacy and Therapeutics Committee and the Credentialing and Peer Review Committee. The QI Work Plan notes that a Behavioral Health Integration Committee was initiated in the third quarter of 2012.</p> <p>Although experience with special needs populations is not specifically addressed in documents, onsite staff indicated the pediatrics representative had</p> |                         | <p>Medical Director as documented in the MCO's organizational chart.</p> <p>WellCare staff members include:</p> <ul style="list-style-type: none"> <li>- President</li> <li>- Medical Director</li> <li>- State Pharmacy Director</li> <li>- Field Health Services Director</li> <li>- Director of Network Development</li> <li>- Director of Regulatory Affairs</li> <li>- Manager of Regional Operations</li> <li>- Human Resources Manager</li> <li>- Director of Hospital Contracting</li> <li>- Manager of Regional Operations</li> <li>- Manager of Foster Care, Adoption, Guardianship</li> <li>- Appeals Supervisor</li> <li>- Provider Relations Manager</li> <li>- All QI Staff</li> <li>- Other staff on an ad hoc basis</li> </ul> <p>WellCare Corporate participants represent a variety of roles and include senior staff for: QI, QM, BH Clinical Operations, Customer Service, Credentialing, Claims,</p> |   |



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|   | <p>experience with special needs populations in work with Federally Qualified Health Centers (FQHC). The Quality and Member Access Committee includes representation from the Commission for Children with Special Health Care Needs, the Coalition for the Homeless and the Center for Accessible Living.</p>   |                         | <p>Appeals and Grievances, UM, Clinical Care Management, Complaints, Disease Management, Enrollment, Compliance and Accreditation, QIC subcommittee chairpersons, and other ad hoc members.</p> <p>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 and behavioral health activities. Additionally, providers are members of the Pharmacy and Therapeutics Committee and the Credentialing and Peer Review Committee.</p> |   |
| <p>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.</p> | <p>Full - As per the QI Program Description, the QIC meets at least quarterly. The QIC met October 31, 2011, March 5, 2012, May 18 2012, August 17 2012, and November 30, 2012. Minutes were provided for all of these meetings. Minutes were provided for UMAC meetings that occurred on October 26, 2011, November 4, 2011, February 23, 2012, May 10, 2012, August 9, 2012, October 31, 2012, and November 12, 2012. Committee minutes include thorough documentation of committee activities. Committee activity reports are provided to the Department quarterly.</p> | <p>Full</p>             | <p>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.</p>  |   |



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|  |   |                      | Minutes are submitted to DMS with each quarterly report.  |   |
| <p>QAPI activities of Providers and 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.</p> | <p>Full - Delegation oversight is outlined in the QI Program Description, and includes ongoing monitoring, corrective action or sanction as applicable and annual formal review. QIC committee minutes include reports from the Delegation Oversight Committee that document discussion of audits and monitoring of Corrective Action Plans; this is also documented in the QI Work Plan. The Provider Manual documents that providers are contractually obligated to participate in QI activities, and encounter data submission requirements are also in the Provider Manual. Delegated entities are included in the Provider Manual.</p> <p>Provider monitoring for compliance with guidelines and medical standards, particularly HEDIS rates, and tracking and trending of grievances are conducted by the plan, and provider interventions related to this monitoring are noted in the QI Work Plan. The QI Work Plan includes results of audits of appointment availability in the 4<sup>th</sup> quarter update, with plans for re-audit and ultimately Corrective Action Plan for non-compliant providers. The Work Plan also indicates that Corrective Action Plans may be required for quality of care concerns, although none were noted. The Work Plan documents active provider feedback (site visit)</p> | Full                 | <p>QI and encounter requirements for 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.</p> <p>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.</p> <p>Delegation oversight is described in the QI Program Description. Activities include pre-delegation assessment, annual evaluation, and review of quarterly reports.</p> <p>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.</p> |   |



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|   | for a quality of service complaint and for behavioral health providers' follow-up of members after hospitalization (Corrective Action Plan required). Providers are also given feedback based on other monitoring, such as prescribing practices, as per the QI Work Plan.   |                      |   |   |
| 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 - Representatives from Utilization Management (UM), Risk Management, Customer Services, Appeals and Grievances, Credentialing and Provider Relations are members of the QIC. Reports to the QIC reveal integration of quality activities conducted in other departments into the QAPI, including monitoring of utilization metrics, grievances and appeals, provider surveys, customer service calls, and member surveys. These activities are also included in the QI Work Plan. | 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.<br><br>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  | <b>MCO Response:</b> The QI Analyst position, two QI specialist positions, and Manager for Guardianship, Foster Care and Adoption have been filled. Please refer to the updated organizational chart. The three  | 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   |   |



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| activities. Such activities include, but are not limited to, monitoring and evaluation of Member's care and services, including those with special 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. | Patient Advocate positions are specific to Region 3 as per WellCare's Region 3 RFP response, which began outside of this audit review period. WellCare acknowledges that the Medical Director position is a critical position for the Plan. WellCare has been working with an executive search firm dedicated to recruiting the Medical Director position. We have interviewed five candidates and extended offers to two of those candidates but our offers were declined as they received counter offers from their employer.   |                         | 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.  |   |
| <b>19.4 QAPI Monitoring and Evaluation</b>   |   |                         |   |   |
| A. The Contractor, through the QAPI program, shall monitor and evaluate the quality of clinical 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 measurement,  | Full - As per the QI Program Description, the plan tracks, analyzes and trends quality indicators that reflect structure, processes and outcomes of care, and address both administrative and care system. HEDIS and CAHPS are part of the QAPI Program. The plan has implemented monitoring of several indicators. The plan began monitoring data for most HEDIS measures in 2012. The QI Work Plan and committee minutes reflect monitoring of customer service and other call metrics, grievances and appeals, and utilization | 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, |   |



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| <p>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.</p> | <p>metrics including pharmacy. The plan indicated onsite that a CAHPS survey and Provider Survey were scheduled for 2013. As per the Program Description and Work Plan, Access and availability are monitored through Geo Access and appointment availability surveys and call metrics.</p> <p>Trended data for complaints and grievances are also reviewed. Reports for complaints and grievances in committees are focused on number of grievances and type by broad category. Further analysis of type of grievance, and also for appeals, should be considered to inform interventions.</p> <p>As per the Program Description timely care post discharge is monitored for continuity of care, as are medical record documentation of consultation and appropriate transition between care levels. Annual member satisfaction surveys, investigation and peer review of quality concerns and provider satisfaction are also monitored. Ongoing monitoring of delegated services is conducted as well as per committee minutes and QI Work Plan.</p> <p><b><u>Recommendation for WellCare</u></b><br/> The plan should consider further evaluation of trends of member grievances and appeals.</p> |                         | <p>and behavioral health. The QI Evaluation includes analysis and recommendations for the following year.</p> <p>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.</p> <p>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.</p> <p>The QI Evaluation indicates that WellCare has monitored utilization for prenatal and postpartum visits, preventive care services, ED, readmissions, inpatient utilization.</p> <p>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.</p> |   |



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|   | <p><b>MCO Response:</b> WellCare plans on conducting further analysis of trends for member grievances and appeals.</p>  |                      | <p>The QI Evaluation document demonstrates evaluation of performance and action plans for improvement.</p> <p>As described previously, WellCare analyzed the high appeals overturn rates and acted accordingly.</p>  |   |
| <p>B. Providers shall be measured against practice guidelines and standards adopted by the Quality Improvement Committee.</p> | <p>The plan provided a statement that providers will be measured against practice guidelines and standards in conjunction with HEDIS. The QI Program Description indicates that the plan will conduct a review of provider compliance with two clinical practice guidelines annually. Practice guidelines will be evaluated for adherence in conjunction with HEDIS 2013. A HEDIS toolkit has been distributed to facilitate compliance with guidelines.</p> <p><b><u>Recommendation for WellCare</u></b><br/>           The plan should consider evaluation for adherence to guidelines beyond HEDIS measures in areas of concern. For example, the plan identifies diagnosis of behavioral health conditions in children by PCPs as an issue; monitoring appropriate diagnostic practices rather than HEDIS adherence measures could be useful to identify appropriate interventions.</p> <p><b>MCO Response:</b> WellCare acknowledges the recommendation.</p> | <p>Full</p>          | <p>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.</p> <p><b><u>Recommendation for WellCare</u></b><br/>           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.</p> | <p>WellCare acknowledges the recommendation made by the EQRO.</p> |



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| <p>Areas identified for improvement shall be tracked and corrective actions taken as indicated.</p>   | <p>Full - The QI program Description documents that interventions are developed based on findings of QI evaluations such as member satisfaction surveys, provider compliance with guidelines and medical record standards, and trending of complaints and grievances. The QI Work Plan notes identification of areas for improvement in appointment availability, behavioral health hotline responses, behavioral health outpatient follow-up, and other delegated services with Corrective Action Plans (CAPs) implemented and monitored. The QI Work Plan also documents tracking and trending of quality of care concerns, and implementation of Corrective Actions as needed. Provider site visits are also documented with corrective action implemented.</p> | <p>Full</p>          | <p>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, 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.</p> |   |
| <p>The effectiveness of corrective actions must be monitored until problem resolution occurs. The Contractor shall perform reevaluations to assure that improvement is sustained.</p> | <p>Full - The plan documented monitoring of delegated service CAPs to resolution; behavioral health provider CAPs for outpatient follow-up were monitored with re-audit to resolution. Provider monitoring processes are described in the QI Program Description and policies including the Quality of Care Policy C7QI-053.</p>   | <p>Full</p>          | <p>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.</p> <p>Onsite, WellCare provided, Delegation Oversight Committee meeting minutes, CAP monitoring documents, communications with Alere, resolution letter and a copy of the corrected P/P</p>   |   |



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|  |   |                         | under CAP.  |  |
| C. The Contractor shall use appropriate multidisciplinary teams to analyze and address data or systems issues.   | Full - Local QI staff includes a broad range of clinical and analytic staff, and the QIC and UMAC include multidisciplinary membership for review of data and system issues. The QI Program Description indicates that corporate staff conducts data collection and preliminary analysis. Behavioral health and plan staff are collaborating on the behavioral health PIP.                        | 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. |  |
| 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 - The plan submitted two Performance Improvement Project (PIP) proposals in 2012, and the QI Work Plan includes quarterly updates of PIP activity. The Work Plan also includes quarterly updates of other QI activities, including those related to EPSDT, pregnant women and maternal and infant death, and HEDIS measures.   | Full                    | Baseline results for the 2013 PIPs and proposals for 2014 PIPs were submitted to DMS and the EQRO as required.<br><br>Additionally, updates for the PIPs and other QI initiatives are found in the QI Work Plan.  |  |
| E. The Contractor shall develop or adopt practice guidelines that are disseminated to Providers and to Members upon request.   | Full - As per the QI Program Description, the plan adopts practice guidelines based on member needs and identified opportunity for improvement. Guidelines adopted in 2012 include guidelines relevant to prevalent chronic conditions (asthma, diabetes, and hypertension) and preventive and behavioral health guidelines. The QI Work Plan notes development and adoption of clinical practice | 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  |  |



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|  | <p>guidelines for Major Depressive Disorder, pediatric and adult pharyngitis, ADHD, lead screening, and multiple chronic conditions such as Congestive Heart Failure (CHF) and Chronic Obstructive Pulmonary Disease (COPD).</p> <p>Guidelines are disseminated to providers and members via newsletters and the plan website. The Work Plan notes that in the fourth quarter a provider newsletter included information on accessing behavioral health guidelines, The UMAC, which includes network physicians, reviewed and adopted clinical practice guidelines in 2012 as per committee minutes. The fourth quarter activity update of the QI Work Plan indicates that new members receive preventive care information based on American Academy of Pediatrics guidelines for well child care.</p> |                         | as well as other CPGs and status (distribution, pending approval).  |   |
| The guidelines shall be based on valid and reliable medical evidence or consensus of health professionals; | Full - As per the QI Program Description, guidelines are developed and reviewed based on nationally recognized evidence-based literature. Preventive Health Guidelines and Clinical Practice Guidelines are based on US Preventive Services Task Force (USPSTF), Centers for Disease Control and Prevention, American Academy of Pediatrics, American Diabetes Association and other national associations' evidence-based recommendations or guidelines. InterQual clinical guidelines provide primary decision support for UM decisions, and behavioral health guidelines from the   | 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. |   |



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|   | <p>American Psychiatric Association are also referenced in policy and the UM Program Description. The UM Program Description cites the use of guidelines from various other professional associations and agencies such as the American College of Physicians, American Diabetes Association, and American Academy of Pediatrics. The plan also develops proprietary clinical coverage guidelines using evidence-based literature, physician and other medical experts and other sources.</p>   |                         |   |   |
| consider the needs of Members;  | <p>Full - The QI Program Description notes that clinical practice guidelines are reviewed and adopted based on the plan's members' health care needs and identified opportunities for improvement. Guidelines adopted in 2012 include guidelines relevant to prevalent chronic conditions (asthma, diabetes, and hypertension) and preventive guidelines relevant to the plan's membership (obesity, lead, pediatric and perinatal preventive health). Behavioral health guidelines include depression and ADHD, as well as other behavioral health guidelines. For utilization review, guidelines are applied based on a member's needs as per the UM Program Description.</p> | Full                    | <p>Guidelines adopted in 2013 include: Cancer, Diabetes in Children and Diabetes in Adults.</p>   |   |
| developed or adopted in consultation with contracting health professionals, and | <p>Full - The QI Program Description notes that guidelines are developed with community physician input through the UMAC. UMAC committee minutes of 2/23/12, 5/10/12, 8/9/12 and 11/12/12 include</p>   | Full                    | <p>The QI Program Description notes that guidelines are developed with community physician input through the UMAC. UMAC committee minutes demonstrate</p> |   |



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|   | review and approval of clinical coverage and clinical practice guidelines, and network physicians participated in these meetings.  |                         | participation of network physicians.  |   |
| reviewed and updated periodically.  | Full - The QI Program Description indicates that clinical practice guidelines are reviewed and updated at least every two years. The UMAC minutes document review of clinical practice guidelines already in place, some of which were amended and some of which were not changed. Clinical practice guideline documents include original date and revision dates, and these provide evidence of ongoing review.   | Full                    | As described previously, the QI Evaluation delineates each CPG and the most recent update or approval status.<br><br>The 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 parameter are reviewed against guidelines annually. Disease Management and Case Management Programs educate members and promote self management with evidence-based clinical practice guidelines as per appendices to the QI Program Description, which describe these programs. UM decisions are based on InterQual clinical guidelines and evidence-based proprietary guidelines. Pediatric new member information includes new preventive care information based on American Academy of Pediatrics guidelines for well child care. The plan provided all clinical practice guidelines from 2012, and these include information sheets for members that reference the | Full                    | The QI Program Description notes that member education materials, benefits and coverage parameters are reviewed against guidelines annually.<br><br>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.<br><br>The QI Program Description states that the UMAC is responsible for reviewing and elevating utilization data to facilitate |   |



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|  | relevant guidelines and sources.  |                      | <p>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.</p> <p>Case Management Program Description (Appendix B of QI Program Description) states that members will be provided with nationally-recognized and approved educational materials.</p> <p>Additionally, there are member versions of the CPGs, which, as described above, are based upon nationally- recognized sources.</p> |   |
| <b>19.5 Innovative Programs</b>  |   |                      |  |   |
| 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. | Minimal - The plan highlighted work with the Kentucky Telehealth Network and University of Kentucky to expand needed services using telemedicine as an innovative program in the QI Work Plan submitted for review. A specific pharmacy program management reform innovative program as contained in the plan's response to the RFP was not described in the submitted documents, although the QI Work Plan documents that the plan is monitoring | Full                 | <p>Innovative programs listed in the 2013 QI Work Plan include:</p> <ul style="list-style-type: none"> <li>- Obesity Disease Management Program: 3099 members enrolled.</li> <li>- Telemedicine with U of K:</li> <li>- Transitional Care Management Program: prevention of readmissions</li> <li>- Drug screening program: over-use of drug screening tests</li> </ul>  |   |



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|   | <p>high volume, high cost medication and addressing antipsychotics and narcotic polypharmacy.</p> <p><b>MCO Response:</b> With the introduction and subsequent passage of HB1 that addresses pain management and use of opiate narcotics, 201 KAR 9:260 states: "The physician shall obtain and document a baseline drug screen". This legislation overrides any WellCare policy or program to require drug screening by physicians and it was found unnecessary to apply additional documentation from prescribers. However, WellCare continues to pay for the laboratory testing and reports regularly to the State on the number of screens performed by WellCare providers. In addition, as part of the Prior Authorization process, WellCare does require documentation for more frequent drug screens for members receiving treatment of opiate addiction to insure that patients are compliant with the medication and not using other opiate or controlled substances while in treatment. Please refer to the Suboxone Prior Authorization Form.</p> |                         | <ul style="list-style-type: none"> <li>- DUR/(Suboxone Prior Authorization</li> <li>- High Risk Pregnancy program with member incentive for participation.</li> </ul> |   |
| <b>20.1 Kentucky Outcomes Measures and HEDIS Measures</b>   |  |                         |   |   |
| The Contractor shall implement steps targeted at improvement for selected performance measures, identified in | Full - Although the QI Work Plan indicates baseline HEDIS and Healthy Kentuckian reporting in 2013, the plan initiated preliminary monitoring and activities for   | Full                    | According to the 2013 QI Work Plan, WellCare analyzed baseline HEDIS baseline data in Q1 2013 and implemented   |   |



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| <p>Appendix O, 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.</p> | <p>most of the HEDIS performance measures in 2012 to identify areas of opportunity. Although baseline data are not yet available, the plan has implemented activities relevant to the measures, including the Kentucky Outcomes measures, as documented in the Work Plan. Activities include targeted mailings for members in need of services, nurse outreach calls to noncompliant members (HEDIS Education and Screening Program), development of a toolkit for providers to identify and document preventive services and quality care relevant to the measures, development of specific clinical practice guidelines (e.g. depression management, pharyngitis), and development of the Patient Care Opportunity report, which identifies gaps in care, for providers. Since baseline data are not yet available to assess, actions based on meeting performance goals, such as retiring or amending measures, have not yet been discussed. Activities relevant to Healthy Kentuckian measures are also documented in the Work Plan.</p> |                         | <p>interventions in Q3. Healthy Kentuckian activities are documented in the Work Plan and outcome measures are reported in a document titled: 2012 Health Outcomes and 2013 Member Satisfaction.</p> <p>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.</p> |   |
| <p>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</p>  | <p>NA-Rotation of measures has not yet been discussed, as baseline data are not available.</p>   | <p>Not Applicable</p>   | <p>DMS, in collaboration with the EQRO, assesses the measure reporting requirements on an annual basis. Measure rotation has not been utilized to date.</p>  |   |



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| schedule as part of this process.  |   |                         |   |   |
| The Contractor in collaboration with the Department and the EQRO shall develop and initiate a performance measure specific to ISHCN.   | NA-Specifications for the measure Individuals with Special Health Care Needs "Children and Adolescents) Access and Preventive Care" have been distributed to the plan.                    | 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.   |   |
| 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.   | NA-baseline data are not yet available for health outcome measures.   | 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.<br><br>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. |   |
| 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 | NA-The plan has reported quarterly updates on activities related to the performance measures in the QI work Plan as noted above. Annual results and stratification are not yet available. | 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.  |   |



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| each measure by the Medicaid eligibility category, race, ethnicity, 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.  |   |                      |  |   |
| <b>20.2 HEDIS Performance Measures</b>   |   |                      |  |   |
| 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 31 <sup>st</sup> . | NA-The plan has not yet collected and reported HEDIS data (baseline year is HEDIS 2013, due June 2013, report August 31), but the QI Work Plan described preliminary data collection for most of the measures and activities in preparation for reporting are underway. | Full                 | WellCare collected and reported baseline 2013 HEDIS data and submitted the Final Audit Report and the IDSS.  |   |
| 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   | NA- HEDIS measures have not yet been reported.  | Not Applicable       | 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. |   |



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| reporting year shall be indicated. The Contractor shall include the values for the denominator and numerator used to calculate the measures.  |  |                      |   |   |
| 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.  | NA- HEDIS measures have not yet been reported. | Full                 | As described previously, WellCare stratified measure rates 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 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. | NA- HEDIS measures have not yet been reported. | Not Applicable       | 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. |   |
| The Department reserves the right to  | NA - measures have not been calculated from    | Not Applicable       | To date, DMS has not chosen a subset of   |   |



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| 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.  | encounter data.  |                      | measures for evaluation using MCO submitted encounter data.  |   |
| <b>20.3 Accreditation of Contractor by National Accrediting Body</b>  |  |                      |  |   |
| 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 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. | NA - The plan has not yet undergone the NCQA accreditation process. QIC minutes document planning for accreditation, including an accreditation workgroup, review of standards and mock audit. The plan provided a statement that submission for NCQA accreditation is planned for 2014. | Not Applicable       | WellCare is pursuing accreditation. As described previously, a team was formed and mock audits conducted.  |   |
| If a Contractor has not earned accreditation of its Medicaid product through the National Committee for Quality Assurance (NCQA ) Health Plan,  | NA The plan has not yet undergone the NCQA accreditation process, but planning is underway as noted above. The plan provided a statement that submission for NCQA accreditation is planned for   | Full                 | NCQA Accreditation is in process for 2014, as described above and previously in this tool.   |   |



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| the MCO shall be required to obtain such accreditation within two (2) to four (4) years from the effective date of this contract.  | 2014.  |                      |  |   |
| <b>20.4 Performance Improvement Projects (PIPs)</b>  |  |                      |  |   |
| 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 enrolled population; the need(s) for a specific service(s); member demographic characteristic and health risks; and the interest of Members in the aspect of care/services to be addressed. | Full - As noted in the QI Program Description, focused improvement studies are based on indicators and quality measurement processes that are relevant to the plan's membership. The plan chose two topic areas for Performance Improvement Projects (PIPs): Decreasing Inappropriate Emergency Department (ED) Utilization and Utilization of Behavioral Health Medications in Children. Both PIP proposals include a strong rationale that is based on published literature and data specific to the plan membership. Both topics are highly relevant to the plan's population, and represent areas that reflect barriers to appropriate care. | 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.       |   |
| 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   | Full - The PIP topics are based on observation of member characteristics and diagnoses associated with high ED utilization, and volume, cost and diagnoses associated with behavioral health medications in children. The plan reviewed prescribing patterns for behavioral health medication in children in more detail when it became available in early 2013 in order to further refine the PIP topic. The revision was not   | 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 |   |



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| <p>of those interventions. The Contractor shall develop and implement PIPs to 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 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,</p> | <p>available at the time of the review.</p> <p>Decreasing inappropriate ED utilization, which could be a reflection of primary care access issues, and improving prescribing practices for behavioral health medication in children would have a positive effect on member's outcomes. ED utilization affects the member population as a whole, and the plan noted behavioral health medications to be prevalent in children, as well as a high risk area of focus.</p> |                         | <p>date.</p> <p>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 necessary services.</p> |   |



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| availability, accessibility, cultural 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. | <p>Full - The QI Work Plan identifies that the plan partnered with various Public Health Departments in the Commonwealth as community health needs assessments were conducted, and partnered with Eastern Kentucky health departments on an asthma pilot program. The plan held meetings of Regional HealthConnections Councils, which include community and civic leaders, advocates and members. Meetings included discussion of community needs and resources, including needs of Health Departments. These meetings are documented in the QI Work Plan.</p> <p>The Work Plan also identifies collaboration with numerous homeless outreach organizations, shelters and coalitions, as well as domestic violence organizations, and monthly meetings with Community Mental Health Centers (CMHC). The QI Work Plan reflects collaboration with CMHCs on sharing data to track follow-up of inpatient admissions and readmissions. Onsite staff indicated that the plan had also been meeting regularly with Impact Plus providers in a clinical work group, and as per the QI Work Plan this group includes hospitals and CMHCs and is focused on coordination of care.</p> | Full                    | <p>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.</p> <p>Additionally, the MCO formed collaborative partnerships with local health departments across Kentucky to identify community health needs, identify barriers and develop solutions to barriers.</p> <p>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.</p> |   |



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| <p>The Department and the Contractor shall be committed to on-going collaboration in the area of service and clinical care improvements by the development of best practices and use of encounter data-driven performance measures.</p>  | <p>Full - The plan has submitted data and quality improvement activity updates in quarterly reports, and participated in collaborative calls with the Department and EQRO to discuss PIPs. PIP revisions were submitted as requested. The plan reviewed and commented on performance measure specifications, including State-specific performance measures, to ensure accurate reporting.</p> | <p>Full</p>          | <p>WellCare has fully cooperated with all DMS and EQRO initiatives and requests.</p>  |   |
| <p>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 statewide PIP, if requested. In assisting</p> | <p>Full - As noted above, the plan has initiated two PIPs, one related to physical health (Emergency Department Utilization) and one related to behavioral health (behavioral health medication in children). No other PIPs were proposed or required as of the time of the review. The plan submitted PIP proposals and revisions as requested,</p>  | <p>Full</p>          | <p>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.</p> <p>No DMS or EQRO-directed PIPs have been required.</p> <p>No statewide PIP has been initiated but one is planned for 2014.</p> <p>WellCare has provided data and medical records for EQRO focused studies.</p> |   |



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| 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 N.   | Full - The plan's chosen PIP topics were consistent with topics identified by the Department, and were approved by the Department.  | Full                    | As described previously, the PIP topics for 2013 and 2014 were chosen per requirements and approved.  |  |
| 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 plan submitted proposals on the template provided by the Department.   | Full                    | The 2013 PIP reports and 2014 proposals were submitted in the required format.  |  |
| A. Topic and its importance to enrolled members;   | Full - The topic and its importance to the plan's membership were well described in the submitted proposals.  | Full                    | As described previously, WellCare supported its PIP topic selection in the PIP proposals.   |  |
| B. Methodology for topic selection;  | Full - The PIP proposals include an overview of data that were evaluated to arrive at the selected topics. The behavioral health data used to arrive at the PIP topic for behavioral health medication in children were limited, and the plan indicated that they would | Full                    | WellCare used a review of literature, MCO-specific data and performance in the rationale for each PIP proposal.   |  |



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|   | re-evaluate behavioral health prescribing data to revise the PIP when data were available in February. As of the time of the review, the revised proposal had not yet been submitted.   |                      |  |   |
| C. Goals;   | NA-Goals for the ED utilization and behavioral health medications in children PIPs were deferred pending baseline data (2012 data, available in 2013) as noted in the proposals.  | Full                 | The baseline reports for the 2013 PIPs provide baseline rates and target rates/goals.  |   |
| D. Data sources/collection;   | Full - Data sources were identified for the ED utilization (claims, Kentucky ER Visit Report, nurse line vendor report, and the plan's case management ED high utilizer report) and behavioral health medications in children (pharmacy and medical claims and encounters) PIPs.  | Full                 | Data sources are fully described in the PIP reports and proposals. Many of the measures are based on HEDIS specifications.                       |   |
| E. Intervention(s) – not required for projects to establish baseline; and | Substantial - The plan included interventions relevant to the project topics in the project proposals. Interventions were to be clarified and specific to project objectives as per teleconference discussions with the EQR. As written, some of the interventions, such as provider-targeted outreach, lack detailed description.<br><br><b>Recommendation for WellCare</b><br>The plan should provide detailed descriptions of interventions in the next iteration of the PIP report. | Full                 | The reports and proposals include planned and implemented interventions as well as initiation dates, where applicable.                           |   |



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|   | <p><b>MCO Response:</b> At the time of this audit (3/4 – 3/6), clarifications to the PIP were not due to the EQRO. The updated PIP proposal was submitted to the EQRO on 3/20/13 for review. Please refer to the “BH PIP Emails with EQRP” document.</p> <p><b>I PRO Comments:</b> No change in review determination. At the time of the audit this was the status of the PIP. The revised PIP was due in February 2013. Reminders were sent 2/19 and 3/20.</p> |                      |  |   |
| 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. | NA-results of PIPs are not yet available.   | Full                 | The baseline reports for the 2013 PIPs were submitted and included baseline rates for outcome and process measures as well as discussion.        |   |
| The final report shall also answer the following questions and provide information on:  |   |                      |  |   |
| A. Was Member confidentiality protected;  | NA-Member confidentiality is addressed in the PIP proposals. The final report is not yet available.   | Not Applicable       | No final reports due at this time, though the information on member confidentiality has been completed for the 2013 and 2014 PIPs.               |   |
| B. Did Members participate in the performance improvement project?  | NA-The PIP is currently being implemented, and members will be a focus of interventions in the proposed PIPs. The final report is not yet available.  | Not Applicable       | No final reports due at this time.   |   |



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| C. Did the performance improvement project include cost/benefit analysis or other consideration of financial impact;  | NA- final report not yet available.   | Not Applicable          | No final reports due at this time, though the ED PIP does include some information on financial impact.  |   |
| D. Were the results and conclusions made available to members, providers and any other interested bodies;   | NA- final report not yet available.   | Not Applicable          | No final reports due at this time.   |   |
| E. Is there an executive summary;   | NA- final report not yet available.   | Not Applicable          | No final reports due at this time.   |   |
| F. Do illustrations – graphs, figures, tables – convey information clearly.   | NA- final report not yet available.   | Not Applicable          | No final reports due at this time, though WellCare provided graphs and results tables in its baseline reports.   |   |
| 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 predetermined at the commencement of each performance improvement goal and the Contractor shall be monitored for achievement of demonstrable | Minimal - The plan identified indicators in the project proposals, and indicators were standard (HEDIS) appropriate to the performance area for ED utilization. For the behavioral health medications in children project, the indicators chosen were developed by the plan, and would be improved by some clarification and increased specificity. It was unclear in the proposal how the indicators as written would address the objectives, specifically how the indicator would measure appropriate behavioral health medication prescribing. This was discussed with the plan on a conference call prior to the onsite review. The plan was to resubmit the behavioral health medication in children PIP proposal with | 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. |   |



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| and/or sustained improvement   | <p>clarified indicators subsequent to reviewing data in February. This revision had not been received as of the onsite review.</p> <p>As noted above, the plan has not yet established goals, and benchmarks (which may not be readily available for behavioral health medication in children) were not included in proposal rationales.</p> <p><b>MCO Response:</b> At the time of this audit (3/4 – 3/6), clarifications to the PIP were not due to the EQRO. The updated PIP proposal was submitted to the EQRO on 3/20/13 for review. The EQRO's review of the updated PIP proposal was received on 4/8/13, a subsequent proposal update was submitted to the EQRO on 5/2/13 and a call with the EQRO and DMS is scheduled for 6/5/13 to discuss. Please refer to the "BH PIP Emails with EQRP" document.</p> <p><b>IPRO Comments:</b> No change in review determination. At the time of the audit this was the status of the PIP. The revised PIP was due in February 2013. Reminders were sent 2/19 and 3/20.</p> |                         |  |   |
| 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 | NA- project was implemented in January 2013.  | Not Applicable          | Only baseline rates for the 2013 PIPs are available at this time.  |   |



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| timeframes for reporting:  |   |                      |  |   |
| 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 - PIP proposals were submitted to DMS (8/31/12) and were approved. | Full                 | 2013 and 2014 PIP proposals and reports were submitted timely in 2012 and 2013.  |   |
| B. Baseline Measurement – due at a maximum, one calendar year after the project proposal and no later than September 1 of the contract year.   | NA-not yet available.   | Full                 | The baseline reports for the 2013 PIPs were submitted timely.  |   |
| C. 1 <sup>st</sup> Remeasurement – no more than two calendar years after baseline measurement and no later than September 1 of the contract year.  | NA-not yet available.   | Not Applicable       | Only baseline measurements for the 2013 PIPs are available at this time.   |   |
| D. 2 <sup>nd</sup> Remeasurement – no more than one calendar year after the first remeasurement and no later than September 1 of the contract year.  | NA-not yet available.   | Not Applicable       | Only baseline measurements for the 2013 PIPs are available at this time.   |   |
| <b>20.5 Quality and Member Access Committee</b>  |   |                      |  |   |
| The Contractor shall establish and   | Full - The plan has established a Quality and Member                    | Full                 | The QI Program Description describes the   |   |



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| 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.   | Access Committee (QMAC), which is described in the QI Program Description as including members, individuals from consumer advocacy groups or the community. As per the QMAC description, the QMAC is responsible for representing the interests of members. The QMAC meets quarterly and meetings were held on 3/23/12, 6/1/12, 9/7/12, and 12/7/12. The QMAC meets in conjunction with the HealthConnections Council, although these are described as two separate committees. The 2012 QMAC membership provided by the plan includes members, advocacy and community representatives. |                         | 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 access. Meeting minutes were provided for 3/29/2013, 6/6/2013, 9/18/2013, and 12/13/2013. |   |
| 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. Responsibilities of the Committee shall include: | Full - QMAC meetings are held in two geographic regions, Bowling Green and Lexington, to facilitate participation. A call in number is also provided. Members represent a variety of regions and both men and women are represented. Racial and ethnic minority representation cannot be ascertained by from the membership list, but the committee is described as representing the plan's member population. Child and youth advocacy groups, Children with Special Needs and adult members are represented. Participation is active as per minutes.                                  | 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.  |   |
| A. Providing review and comment on quality and access standards;   | Full - Review and comment on quality and access standards are documented in the QI Program Description as primary responsibilities of the QMAC. The QI Work Plan, Evaluation and Program Description  | Full                    | QMAC minutes from 3/29/2013 (and subsequent meetings) indicate that the committee reviewed network adequacy and appointment availability.   |   |



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|  | were all discussed in committee, as were 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 - 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 are documented in the QI Program Description as primary responsibilities of the QMAC. QMAC minutes indicated that the committee reviewed grievances and appeals and members discussed timeframes for reviews on 3/23/12 | 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.   |   |
| C. Review and provide comment on Member Handbooks;   | Full - Review and comment on member handbooks are documented in the QI Program Description as primary responsibilities of the QMAC, and this review is reflected in committee minutes of 3/23/12.   | 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.   |   |
| D. Reviewing Member education materials prepared by the Contractor;  | Full - Review of member education materials is documented in the QI Program Description as a primary responsibility of the QMAC. The QMAC reviewed the Member Handbook, Mommy and Baby Matters Handbook, OTC program brochure and provider directory as per committee minutes. The QMAC committee minutes include review of member newsletters on 6/1/12, 9/7/12 and 12/7/12.                   | Full                    | Review of member education materials is listed in the QI Program Description as a primary responsibility of the QMAC.<br><br>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. |   |
| E. Recommending community outreach activities; and   | Full - Recommending community outreach activities is documented in the QI Program Description as a  | Full                    | Recommending community outreach activities is listed in the QI Program  |   |



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|--|--|-------------------------|---|---|
|  | primary responsibility of the QMAC. The QMAC was updated regarding community outreach activities on during each meeting and outreach was discussed as reflected in minutes.  |                         | Description as a primary responsibility of the QMAC.<br><br>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.   |   |
| F. Providing reviews of and comments on Contractor and Department policies that affect Members.    | Full - Providing review and comment on policies that affect members are documented in the QI Program Description as primary responsibilities of the QMAC. Committee minutes reflect reviews of the QI Program Description, Work Plan, appeals and overturns, and network updates including behavioral health. The QI Program Evaluation was also reviewed. | Full                    | Review of policies that affect members is listed in the QI Program Description as primary responsibilities of the QMAC.<br><br>Discussion of network adequacy, access and availability, appeals and grievances, community engagement activities and cultural preferences is documented in the 2013 meeting minutes. |   |
| The list of the Members participating with the QMAC shall be submitted to the Department annually. | NA-The QI Program Description notes that the list of QMAC members will be submitted to the Department annually. This requirement was waived by DMS.  | Full                    | The QI Program Description notes that the list of QMAC members will be submitted to the Department annually.<br><br>WellCare provided the committee roster as described previously.   |   |
| <b>20.8 Assessment of Member and Provider Satisfaction and Access</b>                              |  |                         |   |   |



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|--|---|-------------------------|--|---|
| 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 - As per the QI Work plan, planning is underway for behavioral health satisfaction surveys (MHSIP and YSS-F). The plan provided a statement that the CAHPS member survey is underway; the first submission is due to the Department in August 2013. The plan provided a statement that a provider survey would be conducted in April 2013 and would be submitted to the Department in August 2013. As per onsite staff and the QI Work Plan, a member and provider satisfaction workgroup has been formed. | 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.  |   |
| The Contractor shall provide a copy of the current CAHPS survey tool to the Department.  | Full - The plan indicated that the CAHPS survey is currently underway. The QI Work Plan indicates that questions were "revamped" in 4 <sup>th</sup> quarter.  | Full                    | WellCare provided documentation of DMS approval for the CAHPS survey tools.  |   |
| Annually, the Contractor shall assess the need for conducting special surveys to support quality/performance improvement initiatives that target subpopulations perspective and experience with access, treatment and services.  | Full - The QI Work Plan documents planning for behavioral health surveys and access and availability services for some vendor services. The QI Work Plan includes as a goal a survey to determine members' understanding of oral health, although this does not appear to have been implemented yet as per the Work Plan. As per onsite staff and the QI Work Plan, a member and provider satisfaction workgroup has been formed.   | Full                    | WellCare reported having conducted adult and child oral health survey. The MCO provided reports of the results during the onsite review.<br><br>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 |   |



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|--|--|-------------------------|--|---|
|  |  |                         | spreadsheet format.  |   |
| To meet the provider satisfaction survey requirement the Contractor shall submit to the Department for review and approval the Contractor's current provider satisfaction survey tool.   | NA -The QI Work Plan notes that Kentucky-specific survey requirements were defined for incorporation into the survey vendor contract in 2013. This requirement was waived by DMS for 2012. | Full                    | WellCare indicated that a Provider Satisfaction Survey was conducted in April 2013 and the results submitted to DMS in August 2013.              |   |
| 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. | NA-survey results not yet available.   | Full                    | WellCare provided documentation of DMS approval of its surveys and submitted reports of the results which included response rates.               |   |
| All survey results must be reported to the Department, and upon request, disclosed to Members.   | NA-survey results not yet available.   | Full                    | CAHPS member survey results were reported in the document: 2012 Health Outcomes and 2013 Member Satisfaction.                                    |   |



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|---|--|-------------------------|---|--|
| <b>37.5 QAPI Reporting Requirements</b><br>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 - The plan did not submit quarterly reports for review, although the QI Work Plan is labeled MCO report #17 and was updated quarterly. Reports were received timely by DMS. | Full                    | WellCare submitted quarterly reports to DMS as required, including quality-related reports and the QI Work Plan updates.                                  |  |
| <b>Reference the following documents for further information:</b><br><b>Appendix K</b><br><b>Appendix N</b><br><b>Appendix O</b>  |  |                         |   |  |



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**Scoring Grid:**

| <b>Compliance Level</b> | <b>Full</b> | <b>Substantial</b> | <b>Minimal</b> | <b>Non-Compliance</b> |
|-------------------------|-------------|--------------------|----------------|-----------------------|
| Points Value            | <b>3</b>    | <b>2</b>           | <b>1</b>       | <b>0</b>              |
| Number of Elements      | 89          | 0                  | 0              | 0                     |
| Total Points            | 267         | 0                  | 0              | 0                     |

**Overall Compliance Determination:**

| <b>Compliance Level</b> | <b>Full</b> | <b>Substantial</b> | <b>Minimal</b>    | <b>Non-Compliance</b> |
|-------------------------|-------------|--------------------|-------------------|-----------------------|
| Points Range            | <b>3.0</b>  | <b>2.0 – 2.99</b>  | <b>1.0 – 1.99</b> | <b>0 – 0.99</b>       |
| Points Average          | <b>3.0</b>  |                    |                   |                       |

**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.**

**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



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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

## 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



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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



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| <b>Grievance System</b><br><i>(See Final Page for Suggested Evidence)</i>  |                           |                         |  |  |
|--|---------------------------|-------------------------|--|--|
| State Contract Requirements<br>(Federal Regulations 438.402, 438.404, 438.406, 438.408,<br>438.410, 438.414, 438.416, 438.420, 438.424)  | Prior Results & Follow-Up | Review<br>Determination | Comments (Note: For any element that<br>deviates from the requirements, an<br>explanation of the deviation must be<br>documented in the Comments section | Health Plan's and DMS'<br>Responses and Plan of action |
| <b>24. General Requirements for Grievances and Appeals</b>   |                           |                         |  |  |
| The Contractor shall have a grievance system in place for Members that includes a grievance process related to "dissatisfaction" and an appeals process related to a Contractor "action," including the opportunity to request a State fair hearing pursuant to KRS Chapter 13B.   |                           |                         |  |  |
| The Contractor shall implement written policies and procedures describing how the Member may submit a request for a grievance or an appeal with the Contractor or submit a request for a state fair hearing with the State. The policy shall include a description of how the Contractor resolves the grievance or appeal. |                           |                         |  |  |
| 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.  |                           |                         |  |  |
| The Contractor shall make available reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.   |                           |                         |  |  |
| The Contractor shall name a specific individual(s) designated as the Contractor's Medicaid Member grievances or appeals with the authority to administer the policies and procedures for resolution of a grievance or appeal, to review patterns/trends in grievances or appeals, and to initiate corrective action.       |                           |                         |  |  |



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| <p>The Contractor shall ensure that the individuals who make decisions on grievances or appeals are not involved in any previous level of review or decision-making. The Contractor shall also ensure that health care professionals with appropriate clinical expertise shall make decisions for the following:</p> | <p>Substantial - P/P C7AP-035-PR001 and P/P C7GR-003-PR001 indicate that individuals making decisions will not have been involved in previous decisions, and addresses health care professional involvement in decisions where appropriate. P/P C7GR-003-PR001 notes that as per C7QI-053 (not provided for this review) all potential quality of care concerns are forwarded to the nurse reviewer for processing. Onsite staff indicated that senior coordinators review complaints each morning and clinical issues are highlighted for review by clinical nurse management.</p> <p><u>Member Grievance and Appeal File Review and Provider Appeal File Review</u><br/>           All appeal files included documentation of review initiated by a health care professional for the circumstances identified in contract. One member grievance file alleging lack of emergency department treatment for an allergic reaction that was referred to the hospital for follow-up since the physician was non- participating (although the hospital was) did not appear to have clinical review in the file.</p> <p><u>Recommendation for WellCare</u><br/>           WellCare should ensure that potential quality</p> | <p>Full</p>          | <p>This requirement is addressed in the Kentucky Members Appeal Process (C7AP-035) and the Medicaid Grievance Policy (C7GR-003). This documentation indicates that individuals making decisions have not been involved in previous decisions. These policies also address healthcare professionals' involvement in decisions.</p> <p>As per the Quality of Care Policy (C7QI-053), all potential quality of care concerns are forwarded to a nurse reviewer for processing.</p> <p><u>Grievance File Review</u><br/> <u>10 Quality Grievance Files were reviewed:</u><br/>           10 of 10 were resolved timely<br/>           10 of 10 were acknowledged timely<br/>           2 of 2 (clinical) cases had appropriate health care professional review<br/>           10 of 10 contained the nature of the grievance<br/>           10 of 10 contained the date of receipt<br/>           10 of 10 contained correspondence between the MCO and member<br/>           10 of 10 contained the date of resolution<br/>           10 of 10 contained the resolution<br/>           10 of 10 contained a notice of resolution<br/>           3 of 10 involved extensions:</p> |   |



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|---|---|-------------------------|---|--|
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|   | <p>issues undergo clinical review.</p> <p><b>MCO Response:</b> It is WellCare's policy that all potential quality of care cases undergo clinical review by the Medical Director. It is the responsibility of the QI Specialist to review the case with the Medical Director. Since this review there was a staffing change to the person in the QI Specialist position and as such, all cases are reviewed with the Medical Director. Please refer to policy C7QI-053 Quality of Care Issues.</p> |                         | <p>3 of 3 were resolved timely, within 14 days<br/>           0 of 3 extensions were requested by the member<br/>           3 of 3 contained written notice of the extension to the member</p> <p>10 of 10 contained documentation of the substance of the grievance, including aspects of clinical care, where applicable<br/> <b>Resolution Notice:</b><br/>           10 of 10 contained information considered in the investigation<br/>           10 of 10 contained the findings and conclusions<br/>           10 of 10 contained the disposition</p> <p>Few of the cases were quality of care issues. Most cases related to quality of service.</p> <p>Two cases were related to quality of dental care and were referred to Avesis and investigated.</p> <p><u>10 random grievance files were reviewed:</u><br/>           10 of 10 were resolved timely<br/>           10 of 10 were acknowledged timely<br/>           No cases were clinical, so an appropriate health care professional review was N/A</p> |  |



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|   |                           |                      | 10 of 10 contained the nature of the grievance<br>10 of 10 contained the date of receipt<br>10 of 10 contained correspondence between the MCO and member<br>10 of 10 contained the date of resolution<br>10 of 10 contained the resolution<br>10 of 10 contained a notice of resolution<br>No cases involved extensions<br>10 of 10 contained documentation of the substance of the grievance, including aspects of clinical care, where applicable<br>Resolution Notice:<br>10 of 10 contained information considered in the investigation<br>10 of 10 contained the findings and conclusions<br>10 of 10 contained the disposition<br><br><u>Appeal File Review:</u><br><u>EPSDT Appeals File Review:</u><br>5 files were reviewed; 1 was an expedited appeal<br>5 of 5 were resolved timely<br>4 of 4 were acknowledged timely<br>5 of 5 were reviewed by an appropriate health professional<br>5 of 5 contained the nature of the appeal<br>5 of 5 contained the date received |   |



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|   |                           |                      | 5 of 5 contained correspondence between the MCO and member<br>5 of 5 contained the date of resolution<br>5 of 5 contained the resolution<br>5 of 5 contained a resolution notice<br>Expedited appeal:<br>1 of 1 contained attempt to provide oral notice<br>1 of 1 informed the member of limited time to present evidence<br>5 of 5 provided opportunity to review the case file<br>Extensions:<br>No files involved extensions<br>5 of 5 included as parties to appeal, member, representative, and estate, if applicable<br>Resolution Notice:<br>5 of 5 contained the results and reason<br>State fair hearing, right to receive benefits, and potential financial responsibility were NA<br>Regarding expedited appeals, during the file review, WellCare provided documentation of informing the member of limited time to present evidence via |   |



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|   |                           |                      | <p>telephone. Because the appeal is expedited, it is not feasible to provide an acknowledgement letter within 5 days or provide this information in written format. All the expedited appeals were resolved within 3 days. In the case of missing documentation, the member/provider will be notified immediately.</p> <p><u>Appeal File Review</u><br/>           5 files were reviewed; 3 were expedited appeals<br/>           5 of 5 were resolved timely<br/>           2 of 2 were acknowledged timely<br/>           5 of 5 were reviewed by an appropriate health professional<br/>           5 of 5 contained the nature of the appeal<br/>           5 of 5 contained the date received<br/>           5 of 5 contained correspondence between the MCO and member<br/>           5 of 5 contained the date of resolution<br/>           5 of 5 contained the resolution<br/>           5 of 5 contained a resolution notice<br/>           Expedited appeal:<br/>               3 of 3 contained attempt to provide oral notice<br/>               3 of 3 informed the member of limited time to present evidence</p> |   |



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|   |  |                         | 5 of 5 provided opportunity to review the case file<br>Extensions:<br>No files involved extensions<br>5 of 5 included as parties to appeal, member, representative, and estate, if applicable<br>Resolution Notice: 5 of 5 contained the results and reason<br>State fair hearing, right to receive benefits, and potential financial responsibility were NA              |  |
| A. An appeal of a Contractor denial that is based on lack of medical necessity;   |  |                         |   |  |
| B. A Contractor denial that is upheld in an expedited resolution; and   |  |                         |   |  |
| C. A grievance or appeal that involves clinical issues.   | Substantial - This criterion is included in P/P C7AP-035-PR001 and P/P C7GR-003-PR001.<br><br><u>Member grievance file review</u><br>One case of 20 cases reviewed with potential clinical issues did not appear to include clinical review as noted above.<br><br><u>Recommendation for WellCare</u><br>WellCare should ensure that potential quality issues undergo clinical review. | Full                    | This requirement is addressed in the Kentucky Members Appeal Process (C7AP-035) and the Medicaid Grievance Policy (C7GR-003).<br><br><u>Grievance File Review</u><br>As noted above, few grievance cases related to quality of care issues. Most cases related to quality of service.<br>The two cases that contained potential dental QOC issues were referred to Avesis |  |



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|   | <p><b>MCO Response:</b> It is WellCare's policy that all potential quality of care cases undergo clinical review by the Medical Director. It is the responsibility of the QI Specialist to review the case with the Medical Director. Since this review there was a staffing change to the person in the QI Specialist position and as such, all cases are reviewed with the Medical Director. Please refer to policy C7QI-053 Quality of Care Issues.</p> |                         | and were reviewed by the Dental Director.  |  |
| <p>The Contractor shall provide Members, separately or as a part of the Member handbook, information on how they or their representative(s) can file a grievance or an appeal, and the resolution process. The Member information shall also advise Members of their right to file a request for a state fair hearing with the Cabinet, upon notification of a Contractor action, or concurrent with, subsequent to or in lieu of an appeal of the Contractor action.</p> |  |                         |  |  |
| <p>The Contractor shall ensure that punitive or retaliatory action is not taken against a Member or service provider that files a grievance or an appeal, or a provider that supports a Member's grievance or appeal.</p>   |  |                         |  |  |
| <p><b>24.1 Grievance Process</b></p>  |  |                         |  |  |
| <p>A grievance is an expression of dissatisfaction about any matter or aspect of the Contractor or its operation, other than a Contractor action as defined in this contract.</p>   |  |                         |  |  |



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| <p>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 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.</p> |  |                         |  |  |
| <p>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 resolution.</p>   |  |                         |  |  |
| <p>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.</p>   | <p>Minimal - P/P C7GR-003-PR001 indicates that resolution will be completed within 30 calendar days of receipt of a written or oral grievance. For many of the reviewed files as noted below, resolution could not be determined.</p> <p><u>Member Grievance File Review</u><br/>           Of 10 random grievances, 10/10 received written resolution letters within 30 days. For 2/10 of these grievances, both of which involved complaints about receiving a bill for services, the resolution letters were sent within 30 days, but the complaint was not yet resolved. For these 2 cases, claims were still being investigated when the resolution letters</p> | Full                    | <p>This requirement is addressed in the Kentucky Medicaid Grievance Procedure (C7GR-003-PR-001). This policy indicates that resolution will be completed within thirty (30) calendar days of receipt of a written or oral grievance.</p> <p>The investigation and resolution process for grievances is communicated to the Plan's members in the Member Handbook.</p> <p><u>Grievance File Review</u><br/>           As described above, all grievances were resolved timely and resolution notices were sent.</p> |  |



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|   | <p>were sent.</p> <p>19/20 member quality grievance files included resolution letters written within 30 days.</p> <p>There were also 9/20 quality member grievances for which a resolution letter was sent within 30 days, although the resolution did not appear finalized at the time the letter was sent. 8/9 of these files indicated that medical records had been requested.</p> <p>For the one file, records were not requested and resolution of nurse review is not clear in the file.</p> <p>For 1/20 of the member quality grievances, it was not completely clear from the file what information was considered and how it was resolved, although it appeared that only claims were reviewed. Onsite staff provided a Kentucky Nurse Review Form subsequent to the file review.</p> <p><b>MCO Response:</b> Grievance resolution contract requirement is 30 calendar days; the Claims Department has 30 days to process the claim. To meet our contractual</p> |                         |  |  |



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|   | <p>requirement; the grievance dept contacts the billing provider to investigate the reason for the billing; and provide any necessary information needed to (re)process the claim appropriately. In addition we forward the issue over to the Provider Relations Manager. This is to ensure the provider is educated on not billing members for covered services. The mentioned grievance sample file was billed for the incorrect co-insurance; this information was communicated to the member in the resolution letter. Since the mailing of the letter; the plan has reprocessed and reimbursed member's co-insurance. This particular issue the claim was reprocessed on Jan. 17, 2013. Please refer to additional document.</p> <p>Quality of Care issues are investigated separately; yet simultaneously to the grievance process. In the future, when preparing case packets for auditing purposes; the Grievance Department will include the investigational documentation/notes and findings of the quality of care allegation with the Plan's grievance requested samples for future auditing purposes. This process will outline the holistic of the complete process and resolution of these types of issues.</p> |                         |  |  |



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| <p>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.</p> | <p>Substantial - P/P C7GR003-PR001 includes this language relevant to an extension.</p> <p><u>Member Grievance File Review</u><br/>           The resolution letter for one case indicated that more research was needed to resolve the grievance. This resolution letter was dated more than 30 days from receipt. The fourteen-day extension was not specifically indicated. The 9/20 resolution letters with a quality issue being investigated, although resolution letters were sent, did not include the extension time frame.</p> <p><u>Recommendation for WellCare</u><br/>           The plan should ensure that grievance investigation among departments is coordinated and that members are informed of extension timeframes for resolution of grievances if needed.</p> <p><b>MCO Response:</b> There was no extension requested. The grievance was not routed to Grievance department timely; when the grievance was received in the grievance department the compliance timeframe for resolution was expired.</p> | Full                    | <p>This requirement is addressed in the Kentucky Medicaid Grievance Procedure (C7GR-003-PR-001). This policy indicates that the timeframe may be extended up to fourteen (14) calendar days if the member asks for an extension or the Plan documents that additional information is needed and the delay is in the member's best interest.</p> <p>The Kentucky Medicaid Grievance Procedure states that if the timeframe is extended for any reason other than at the member's request, the Plan must notify the member within two (2) business days of the decision, in writing, of the reason for the delay.</p> <p>The requirements pertaining to extensions are communicated to the member in the Member Handbook.</p> <p><u>Grievance File Review</u><br/>           As described above, all grievance files granted extensions were resolved timely within 14 days.</p> |  |
| Upon resolution of the grievance, the Contractor shall mail a  |  |                         |  |  |



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| resolution letter to the Member. This resolution letter may not take the place of the acknowledgment letter referred to in Section B above, unless the resolution of the grievance has been completed and can be communicated to the Member in the same correspondence acknowledging receipt of the grievance. The resolution letter shall include, but not be limited to, the following: |  |                         |  |  |
| A. All information considered in investigating the grievance;   | <p>Substantial - P/PGR003-PR001 notes that resolution letters will include the substance of the grievance and actions taken, and that documentation regarding the grievance will be provided to the member on request.</p> <p><u>Member Grievance File Review</u><br/>           For 2/10 random member grievances and 9/20 quality member grievances, investigations were not complete at the time of resolution letters; therefore, this information could not be included. The letters did indicate that investigation was continuing.</p> <p><u>Recommendation for WellCare</u><br/>           The plan should ensure that members are informed of all investigation of grievances undertaken.</p> <p><b>MCO Response:</b> Quality of Care issues are investigated separately; yet simultaneously to</p> | Full                    | <p>This requirement is addressed in the Kentucky Medicaid Grievance Procedure (C7GR-003-PR-001). This policy indicates that resolution letters include the substance of the grievance and any and all actions taken, and that documentation regarding the grievance will be provided to the member upon request.</p> <p>This requirement is communicated to the member in the Member Handbook.</p> <p><u>Grievance File Review</u><br/>           As described above, all files contained resolution letters and the letters contained the required information.</p> |  |



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|   | <p>the grievance process. In the future, the Grievance Department will include the investigational documentation/notes and findings of the quality of care allegation with the grievance samples provided for auditing. This process will outline the holistic of the complete process and resolution of these types of issues.</p> <p>We have enhanced our current language to inform the member(s): We forwarded your concerns to our medical review department to review and continue the investigation of your potential quality of care (PQOC). We keep track of all complaints and grievances we get about each provider. This is part of our quality assurance program. This way, we can see if providers have any grievances against them, or if there are any patient care or quality concerns. If there are, they will be addressed through this program with:</p> <ul style="list-style-type: none"> <li>• A review by their peers</li> <li>• Additional education</li> <li>• Internal audits</li> </ul> <p>The results of these actions are kept private. But please know that we look into and act on each of your concerns.<br/>Grievance files with possible quality of care</p> |                      |  |   |



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|   | grievance type; will be reviewed/audited during the grievance letter review approval process (conducted prior to the mailing of the resolution letter) to ensure the appropriate language has been captured in the grievance resolution letter.  |                         |   |  |
| B. Findings and conclusions based on the investigation; and   | <p>Minimal - P/PGR003-PR001 indicates that resolution letters will contain the decision, reason for decision and actions taken.</p> <p><u>Member Grievance File Review</u><br/>           For 2/10 random member grievances and 9/20 quality member grievances, investigations were not complete at the time of resolution letters; therefore, this information could not be included.</p> <p>Resolution of quality issues should be included in grievance files, and members informed of investigation findings and conclusions.</p> <p><b>MCO Response:</b> Quality of Care issues are investigated separately; yet simultaneously to the grievance process. In the future, the Grievance Department will include the investigational documentation/notes and findings of the quality of care allegation with the grievance samples provided for auditing.</p> | Full                    | <p>This requirement is addressed in the Kentucky Medicaid Grievance Procedure (C7GR-003-PR-001). This policy states that the resolution letters will contain the decision, the reason for the decision and any and all actions taken.</p> <p>This requirement is communicated to the member in the Member Handbook.</p> <p><u>Grievance File Review</u><br/>           As described above, all files contained resolution letters and the letters contained the required information.</p> |  |



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|   | This process will outline the holistic of the complete process and resolution of these types of issues.  |                      |   |   |
| C. The disposition of the grievance.  | <p>Minimal - P/P-GR003-PR001 notes that grievance resolution letters include actions taken, decision and reason for the decision. For 2/10 random member grievances and 9/20 quality member grievances, investigations were not complete at the time of resolution letters; therefore, this information could not be included.</p> <p><b>MCO Response:</b> In the future, the Grievance Department will include the investigational documentation/notes and findings of the quality of care allegation with the grievance samples provided for auditing. This process will outline the holistic of the complete process and resolution of these types of issues.</p> <p>We have enhanced our current language to inform the member(s): We forwarded your concerns to our medical review department to review and continue the investigation of your potential quality of care (PQOC). We keep track of all complaints and grievances we get about each provider. This is part of our quality assurance program. This way, we can</p> | Full                 | <p>This requirement is addressed in the Kentucky Medicaid Grievance Procedure (C7GR-003-PR-001). This policy states that grievance resolution letters include the decision, actions taken and the reason for the decision.</p> <p><u>Grievance File Review</u><br/>As described above, all files contained resolution letters and the letters contained the required information.</p> |   |



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|   | see if providers have any grievances against them, or if there are any patient care or quality concerns. If there are, they will be addressed through this program with: <ul style="list-style-type: none"> <li>• A review by their peers</li> <li>• Additional education</li> <li>• Internal audits</li> </ul> The results of these actions are kept private. But please know that we look into and act on each of your concerns. |                         |   |  |
| <b>24.2 Appeal Process</b>  |  |                         |   |  |
| An appeal is a request for review by the Contractor of a Contractor action.   |  |                         |   |  |
| A. An action for purpose of an appeal is:   |  |                         |   |  |
| (1) the denial or limited authorization of a requested services, including the type or level of service;                                |  |                         |   |  |
| (2) the reduction, suspension, or termination of a previously authorized service;   |  |                         |   |  |
| (3) the denial, in whole or in part, of payment for a service;  |  |                         |   |  |
| (4) the failure of the Contractor to provide services in a timely manner, as defined by the Department or its designee; or              |  |                         |   |  |
| (5) the failure of the Contractor to complete the authorization request in a timely manner as defined in 42 CFR 438.408.                |  |                         |   |  |



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| (6) for a resident of a rural area with only one Contractor, the denial of a Member's request to exercise his or her right under 42 CFR 438.52(b)(2)(ii) to obtain services outside the network.                                      | <p>Substantial - P/P C7AP-035 indicates that an action includes denial of a rural resident member's request to obtain services "outside of the Plan region" in rural areas with only one Contractor.</p> <p><b>Recommendation for WellCare</b><br/>The plan should include right of a member to obtain services outside the network for residents of rural areas with only one contractor.</p> <p><b>MCO Response:</b> Please refer to the updated draft policy C7AO-035 Kentucky Member Appeal Process that incorporates Region 3 Definition of an action.</p> | Full                    | <p>This requirement is addressed in The Kentucky Member Appeal Process (C7AP-0350. This policy states that an action includes the denial of a rural resident member's request to obtain services outside of the Plan region in rural areas with only one Plan. This language addresses the statutory requirements.</p> <p>The appeals process is communicated to the members in the Member Grievance and Appeal Procedure of the Member Handbook.</p> |  |
| B. The Contractor shall mail a notice of action to the Member or service provider. The notice shall comply with 42 CFR 438.10(c) regarding language and (d) regarding format and shall contain, but not be limited to, the following: |   |                         |   |  |
| (1) the action the Contractor has taken or intends to take;   |   |                         |   |  |
| (2) the reasons for the action;   |   |                         |   |  |
| (3) the Member's or the service provider's right, as applicable, to file an appeal of the Contractor action through the Contractor;   |   |                         |   |  |
| (4) the Member's right to request a state fair hearing and what the process would be;   |   |                         |   |  |



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| (5) the procedures for exercising the rights specified;   |  |                      |   |   |
| (6) the circumstances under which expedited resolution of an appeal is available and how to request it; and   |  |                      |   |   |
| (7) the Member's right to have benefits continue pending resolution of an appeal or state fair hearing, how to request the continuation of benefits, and the circumstances under which the Member may be required to pay the costs of continuing these benefits.  |  |                      |   |   |
| The notice shall be mailed within ten (10) days of the date of the action for previously authorized services as permitted under 42 CFR 431.213 and 431.214, and within fourteen (14) days of the date of the action for newly requested services. Denials of Claims that may result in Member financial liability require immediate notification. | Substantial - Procedures outlined in P/P C7 UM MD 2.2 include the mailing of notice of action within 10 days of the date of action for previously authorized services and 14 days for newly requested services. Immediate notifications of denials of claims that may result in member financial liability do not appear to be reflected in policies.<br><br><b>Recommendation for WellCare</b><br>The plan should insure inclusion of immediate notification of denials that could result in member financial liability in policies and procedures.<br><br><b>MCO Response:</b> Please refer to the example member denial letter stating notification of potential financial liability in addition to the denial letter business requirement document | Full                 | This requirement is addressed in the Adverse Determinations Proposed Action Policy (C7UM MD-2.2).<br><br>During the onsite interview, WellCare provided documentation that it is the MCO's procedure to notify members immediately if the denial of claims may result in member financial responsibility. |   |



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|  | that outlines the process and procedures.  |                         |  |  |
| C. 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. |  |                         |  |  |
| D. 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. The Contractor shall appoint at least one person to review the appeal who was not involved in the initial decision and who is not the subordinate of any person involved in the initial decision.  |  |                         |  |  |
| E. The Contractor shall have a process in place that ensures that an oral or written inquiry from a Member seeking to appeal an action is treated as an appeal (to establish the earliest possible filing date for the appeal). An oral appeal shall be followed by a written appeal that is signed by the Member within ten (10) calendar days. The Contractor shall use its best efforts to assist Members as needed with the written appeal and may continue to process the appeal.   | Substantial - P/P C7AP-035-PR001 notes that oral appeals are considered filed on the day that the oral appeal is received. The member receives an acknowledgement letter requesting written signed appeal statement within ten calendar days. P/P C7AP-035-PR001 notes that the plan will make available reasonable assistance to assist members with procedural steps, although not specifically in context of written appeals to follow oral | Full                    | This requirement is addressed in The Kentucky Member Appeals Process (C7AP-035) and The Kentucky Medicaid Grievance Procedure (C7GR-003-PR-001). The policies state that verbal appeals are considered filed on the day that the verbal appeal is received. The member receives an acknowledgment letter requesting a written signed appeal statement within ten (10) calendar days. It is also noted that the |  |



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|   | <p>appeals.</p> <p><b><u>Recommendation for WellCare</u></b><br/>           Since the appeal is considered invalid unless written appeal is received, the plan should consider including efforts to assist members as needed with written appeals in policy.</p> <p><b>MCO Response:</b> It is the practice of the Health Plan to assist members with completing forms and filing appeals. As outlined in the procedure document (page 3-4), upon receiving a verbal request for an appeal, the Customer Service Representative makes the member aware that the request for appeal must be followed up in writing. Upon receiving the request for appeal within the Appeals Department, an acknowledgment letter along with a request for a signed written statement is mailed to the member within 5-business days of receipt of the request. If the Plan does not receive a written request within 10- calendar days, a second (2nd) request for a signed written statement is sent to the member. In addition to the above process, the member is also made aware that their written request must be followed up in writing in the member written Notice of Action letter.</p> |                         | <p>plan will assist members with the procedural steps involved in an appeal.</p> <p>The appeals process is communicated to the members in the Member Grievance and Appeal Procedure of the Member Handbook. Additionally, the procedure states that upon receiving a verbal request for an appeal, a Customer Service Representative will make the member aware that the request must be followed up in writing. Upon receiving a request for an appeal, the Appeals Department issues an acknowledgment letter that advises the member of the requirement for a signed written statement. This is done within five (5) business days of the request.</p> <p>In addition to the above process, the member is also made aware that their written request must be followed up in writing in the Notice of Action letter.</p> |  |



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| <b>State Contract Requirements</b><br><b>(Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)</b>   | <b>Prior Results &amp; Follow-Up</b> | <b>Review Determination</b> | <b>Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)</b> | <b>Health Plan's and DMS' Responses and Plan of action</b> |
| F. Within five working days of receipt of the appeal, the Contractor shall provide the grievant 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 requests an expedited resolution.  |                                      |                             |   |  |
| G. 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. |                                      |                             |   |  |
| H. 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.   |                                      |                             |   |  |
| I. 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), 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.         |                                      |                             |   |  |
| J. For all appeals, the Contractor shall provide written notice within the thirty (30) calendar-day timeframe for resolutions to   |                                      |                             |   |  |



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| 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 and reasoning behind the appeal resolution; and  |                                      |                             |   |  |
| (2) the date it was completed.   |                                      |                             |   |  |
| K. 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.   |                                      |                             |   |  |
| L. 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;   |                                      |                             |   |  |



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| (4) the time period covered by the original authorization has not expired; and   |                           |                         |  |  |
| (5) the Member requests extension of the benefits.   |                           |                         |  |  |
| M. 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.  |                           |                         |  |  |
| N. 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). |                           |                         |  |  |
| O. 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  |                           |                         |  |  |



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| 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.  |                           |                         |  |  |
| <b>24.3 Expedited Resolution of Appeals</b>   |                           |                         |  |  |
| An expedited resolution of an appeal is an expedited review by the Contractor of a Contractor action.   |                           |                         |  |  |
| A. The Contractor shall establish and maintain an expedited review process for appeals when the Contractor determines that allowing the time for a standard resolution could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function. Such a determination is based on: |                           |                         |  |  |
| (1) a request from the Member;  |                           |                         |  |  |
| (2) a provider's support of the Member's request;   |                           |                         |  |  |
| (3) a provider's request on behalf of the Member; or  |                           |                         |  |  |
| (4) the Contractor's independent determination.   |                           |                         |  |  |
| The Contractor shall ensure that the expedited review process is convenient and efficient for the Member.   |                           |                         |  |  |
| B. 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.  |                           |                         |  |  |



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| C. 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. |   |                         |  |  |
| E. 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.   |   |                         |  |  |
| F. The Contractor shall provide an expedited resolution, if the request meets the definition of an expedited appeal, in response to an oral or written request from the Member or service provider on behalf of the Member.   |   |                         |  |  |
| G. The Contractor shall inform the Member of the limited time available to present evidence and allegations in fact or law.   | Substantial - As per P/P C7AP-035-PR001 Customer Service informs the member of the limited time available to present evidence and allegations in fact or law.<br><br><u>Member Appeal File Review</u><br>1/3 member expedited appeal files (EPSDT request) did not appear to include documentation that the member was informed of the limited time available to present evidence in an expedited review. | Full                    | This requirement is addressed in the Kentucky Member Appeals Process (C7AP-035-PR-001). The expedited appeals process is communicated to the members in the Member Handbook and in the Notice of Action letter. For expedited appeal requests received verbally, Customer Service informs members of the limited time available to present evidence and allegation of fact or law. This language is stated in the Kentucky Member Appeals Process (C7AP-035-PR-001) as well. |  |
|   | <b><u>Recommendation for WellCare</u></b>   |                         |  |  |



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|---|---|-------------------------|---|--|
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|   | <p>The plan should ensure that documentation regarding information to the member of the limited time to provide evidence is included in files.</p> <p><b>MCO Response:</b> For expedited appeal request received verbally, Customer Service informs members of the limited time available to present evidence and allegation of fact or law. For written expedited appeal request, the member is made aware of their ability to submit evidence and allegation of fact or law in the Member Handbook and in the member's written Notice of Action letter. Due to the short timeframe allowed to process an expedited appeal, written correspondence isn't issued by the Appeals Department.</p> |                         | <p><u>Appeal File Review</u></p> <p>The expedited appeal files reviewed included member notification of the limited time available to present evidence.</p> |  |
| H. 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.  |   |                         |   |  |
| I. The Contractor shall document in writing all oral requests for   |   |                         |   |  |



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| State Contract Requirements<br>(Federal Regulations 438.402, 438.404, 438.406, 438.408,<br>438.410, 438.414, 438.416, 438.420, 438.424)  | Prior Results & Follow-Up | Review<br>Determination | Comments (Note: For any element that<br>deviates from the requirements, an<br>explanation of the deviation must be<br>documented in the Comments section | Health Plan's and DMS'<br>Responses and Plan of action |
| expedited resolution and shall maintain the documentation in the case file.  |                           |                         |  |  |
| <b>24.4 State Hearings for Members</b>   |                           |                         |  |  |
| A Member may request a State Fair Hearing if he or she is dissatisfied with an Action that has been taken by the Contractor, within thirty (30) days of receiving notice of the Action or within thirty (30) days of the final decision by the Contractor.   |                           |                         |  |  |
| All documents supporting the Contractor's Action must be received by the Department no later than five (5) days from the date the Contractor receives notice from the Department that a State Fair Hearing has been filed. These records shall be made available to the Member upon request by either the Member or the Member's legal counsel. The Department will provide the Member with a hearing process that shall adhere to 907 KAR 1:563, 42 CFR 438 Subpart F and 42 CFR 431 Subpart E. |                           |                         |  |  |
| 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.   |                           |                         |  |  |
| <b>27.8 Provider Grievances and Appeals</b>  |                           |                         |  |  |
| The Contractor shall establish and maintain written policies and procedures for the filing of Provider grievances and appeals. A provider shall have the right to file a grievance or an appeal with the Contractor. Provider grievances or appeals shall be resolved  |                           |                         |  |  |



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|---|--|-------------------------|---|--|
| State Contract Requirements<br>(Federal Regulations 438.402, 438.404, 438.406, 438.408,<br>438.410, 438.414, 438.416, 438.420, 438.424)   | Prior Results & Follow-Up  | Review<br>Determination | Comments (Note: For any element that<br>deviates from the requirements, an<br>explanation of the deviation must be<br>documented in the Comments section  | Health Plan's and DMS'<br>Responses and Plan of action |
| 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. A Provider may not file a grievance or an appeal on behalf of a Member without written designation by the Member as the Member's representative. A Provider shall have the right to file an appeal with the Contractor regarding provider payment or contractual issues. |  |                         |   |  |
| <b>27.9 Other Related Processes</b>   |  |                         |   |  |
| 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.  |  |                         |   |  |
| 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, HSD, an administrative law judge, judicial appeal, or closure of a file, whichever occurs later.  | Substantial - Grievance and appeal policies and procedures include Record Keeping that indicates grievance and appeal files will be maintained in accordance with contractual requirements for recordkeeping and maintenance of confidentiality of member records for ten years. Description of a secure and designated area for grievance and appeal files and accessibility to the Department for review does not appear to be specified in policies and procedures. | Full                    | This requirement is addressed in the Kentucky Medicaid Grievance Procedure (C7GR-003-PR-001) and the Records and Information Management Policy (C13RIM.001). These policies state that documents and records shall be scanned, and maintained in the secured Grievance and Appeals electronic archive system. This system is accessible to the department on request, for a period of 10 years, following the year created. |  |
|   | <b>Recommendation for WellCare</b><br>The plan should ensure description of secure   |                         |   |  |



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|--|--|-------------------------|--|--|
| State Contract Requirements<br>(Federal Regulations 438.402, 438.404, 438.406, 438.408,<br>438.410, 438.414, 438.416, 438.420, 438.424)  | Prior Results & Follow-Up  | Review<br>Determination | Comments (Note: For any element that<br>deviates from the requirements, an<br>explanation of the deviation must be<br>documented in the Comments section)  | Health Plan's and DMS'<br>Responses and Plan of action   |
|  | <p>maintenance of grievance and appeal files and accessibility to the Department on request in policies and procedures.</p> <p><b>MCO Response:</b> Please refer to policy C7GR-003 Kentucky Medicaid Grievance Procedure Document PR-001 that has been updated with the following language: All documents and records shall be scanned, and maintained in the secured Grievance and Appeals electronic archive system; accessible to the department on request, for a period of 10 years, following the year created. Additionally, please refer to policies C12RIM.001 Records and Information Management and C13RIM.002 Review and Maintenance of Records Retention Schedule.</p> |                         |  |  |
| <p>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.</p> | <p>Substantial - Policies and procedures for grievances and appeals as noted above include record keeping sections that specify inclusion of the date and a copy of the appeal or grievance, notice of determination and any other notices related to the appeal; determination or resolution and date of determination or resolution of appeals and grievance in the files. Acknowledgement letters are listed in grievance record keeping in P/P C7 GR-003, but do not appear to be included in P/P C7AP-035-PR001, which does</p>   | <p>Substantial</p>      | <p>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.</p> <p>The Medicaid Grievance Policy (C7GR-003)</p> | <p>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.</p> |



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|---|--|----------------------|--|---|
| State Contract Requirements<br>(Federal Regulations 438.402, 438.404, 438.406, 438.408,<br>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 |
|   | <p>include member written confirmation, if any. P/P C7 GR-003 record keeping requirements include requests for documentation or records related to the grievance, but do not appear to include correspondence or resolution notices sent to the member. As noted above, member grievances did not include ultimate resolution in files for 2/10 random member grievances and 9/20 quality member grievances.</p> <p><b><u>Recommendation for WellCare</u></b><br/>           The plan should ensure all pertinent information is included in files, so that a complete record of receipt, investigation and resolution are maintained.</p> <p><b>MCO Response:</b> In the future, the Grievance Department will include the investigational documentation/notes and findings of the quality of care allegation with the grievance samples provided for auditing. This process will outline the holistic of the complete process and resolution of these types of issues.</p> |                      | <p>notes that acknowledgment letters are listed in grievance record keeping but do not appear in the Kentucky Member Appeals Process (C7AP-035-PR-001).</p> <p>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.</p> <p><b><u>Grievance and Appeal File Review</u></b><br/>           As described above, all files reviewed 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.</p> <p><b><u>Recommendation for WellCare</u></b><br/>           The updated policy addresses this requirement and its implementation will be reviewed during the next compliance review.</p> |   |



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| Documentation regarding the grievance shall be made available to the Member, if requested.  |                           |                         |  |  |



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**Scoring Grid:**

| <b>Compliance Level</b> | <b>Full</b> | <b>Substantial</b> | <b>Minimal</b> | <b>Non-Compliance</b> |
|-------------------------|-------------|--------------------|----------------|-----------------------|
| Points Value            | <b>3</b>    | <b>2</b>           | <b>1</b>       | <b>0</b>              |
| Number of Elements      | 12          | 1                  | 0              | 0                     |
| Total Points            | 36          | 2                  | 0              | 0                     |

**Overall Compliance Determination:**

| <b>Compliance Level</b> | <b>Full</b> | <b>Substantial</b> | <b>Minimal</b>    | <b>Non-Compliance</b> |
|-------------------------|-------------|--------------------|-------------------|-----------------------|
| Points Range            | <b>3.0</b>  | <b>2.0 – 2.99</b>  | <b>1.0 – 1.99</b> | <b>0 – 0.99</b>       |
| Points Average          |             | <b>2.92</b>        |                   |                       |

**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.**

**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



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## Grievance System

### Suggested Evidence

#### Documents

Policies/procedures for:

- Grievances including handling of quality-related cases
- Appeals
- State hearings

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

Process for quality oversight of grievance processing

Evidence of quality oversight and follow-up for grievance processing

#### 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



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| Health Risk Assessment<br>(See Final Page for Suggested Evidence)  |  |                      |   |  |
|--|--|----------------------|---|--|
| State Contract Requirements<br>(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  |
| <b>34.1 Health Risk Assessment</b>   |  |                      |   |  |
| The Contractor shall have programs and processes in place to address the preventive and chronic 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. |  |                      |   |  |
| The Contractor shall conduct initial health screening assessment 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. Members whose Contractor has a reasonable belief to be pregnant shall be screened within thirty (30) days of Enrollment, and if pregnant, referred for appropriate prenatal care.                          | Minimal - P/P C6CS-037 and Addendum F describe the initial health screening assessment, but not specific to any time frames.<br><br><u>HRA File Review</u><br>The plan submitted only 5/50 files for review. Record review of completed HRAs did not provide clear documentation of meeting these standards. Of the 5 completed HRAs, all had a completion date of 2/6/13, which was well beyond the 90 days. There was a separate list provided with these members that contained the category of "Date Closed" which was within the 90 days. When details were requested, the Plan stated they were looking into this. There were 26 files that were "not found" from the sample. No explanation was available, except that The Meyers Group, who handles these, had no copies to provide or record of any contact with these members. "Unable to Contact" members had only number of phone call | 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 | 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 system. Please refer to the document, CAP_3_Tool_HRA_2014.<br><br><u>DMS Recommendation:</u><br>WellCare should add the following to its CAP for HRA follow-up:<br><ul style="list-style-type: none"> <li>- 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.</li> </ul> |



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|---|--|-------------------------|--|---|
| State Contract Requirements<br>(Federal Regulation: Not Applicable) | Prior Results & Follow-Up  | Review<br>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   |
|   | <p>attempts with no details. Comments were vague such as "Not Available". The Member Handbook does provide the timeframes as per state contract requirements.</p> <p><b>MCO Response:</b> Please refer to the updated Addendum F in policy C6CS-37. A welcome call is attempted for each new enrollee within 30 days of the enrollee's effective date. Up to 3 attempts are made to each new enrollee.</p> |                         | <p>45.7% completion within 30 days for pregnant members.</p> <p>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.</p> <p>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.</p> <p><u>HRA File Review</u><br/>           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.</p> <p><b>Recommendation for WellCare</b><br/>           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</p> | <ul style="list-style-type: none"> <li>- 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.</li> </ul> |



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| State Contract Requirements<br>(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  |
|  |   |                      | all attempts to reach the member are documented.  |  |
| 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. | <p>Minimal - P/P C6CS-037 and Addendum F describe the process of contacting the member by phone or an attempt to leave a message for the member to return the call. HRAs are also mailed to members. There is no documentation of making reasonable efforts.</p> <p><u>HRA File Review</u><br/>Documentation provided by the vendor to the Contractor did not provide details of the member contact. Review of the members that were unable to be contacted was based on a spreadsheet that did not indicate all dates and results for each call. Upon further investigation, the Plan discovered that there was a loss of 26 files that the vendor had no record of, and the Plan did not have any other information regarding contact for these members.</p> <p><b>MCO Response:</b> WellCare utilizes a delegated entity to conduct the HRA. The delegated entity receives a secure file and begins outreach. Members will be outreached within 30 days of enrollment. Three attempts are made at altered times of the day and different days of the week. There are two messages used when calling members for the first and second attempts. There is a separate message should the call be answered by someone other than the member. When a message is left for the member a grace</p> | Minimal              | <p>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 submitted and includes 3 rounds of outbound calls with 6 attempts for busy/no answers.</p> <p>A new Member Welcome Kit is distributed containing an HRA with instructions for completion and a return envelope.</p> <p>A member with no telephone is flagged in CareConnects, a Member Services system that is used for inbound calls.</p> <p><u>HRA File Review</u><br/>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.</p> <p><b>Recommendation for WellCare</b><br/>For members with an invalid telephone number, the MCO should conduct additional</p> | 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 system. Please refer to the document, CAP_3_Tool_HRA_2014. |



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| State Contract Requirements<br>(Federal Regulation: Not Applicable)   | Prior Results & Follow-Up   | Review<br>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 |
|   | period of two days is followed before making another attempt. Quarterly reports are generated to monitor the outcomes and trends. Please refer to the HRA Corrective Action Plan that has been implemented.   |                         | mailings to encourage completion of an HRA. The MCO/vendor should ensure that all attempts to reach the member are documented.   |   |
| 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, behavioral health services and/ or any other health or community services. | <p>Substantial - P/P C6Cs-037 and Addendum F states that the Customer Service Associates who initiate the HRA "will obtain and verify as much information as possible." The script referred to in the policy does indicate the Customer Service Associate will verify demographic information.</p> <p><u>HRA File Review</u><br/>The completed HRAs did indicate health and behavioral information is asked in the health risk assessment. Demographic information is not documented as having been verified or asked.</p> <p><u>Recommendation for WellCare</u><br/>Completed HRA forms and P/P should include documentation that demographic information was verified.</p> <p><b>MCO Response:</b> Please refer to the updated Addendum F in policy C6CS-37 and HRA Corrective Action Plan.</p> | Full                    | This is addressed in P/P C06CS-037, and all listed elements are included in policy. Welcome call scripts were provided for children and adults, as well as new member questionnaire template, and each includes this information. Screen shots of Case Management HRAs include detailed assessment of the need for care management and other services as listed in contract. |   |
| The Contractor shall use appropriate healthcare professionals in the assessment process.  | Minimal - P/P C6CS-037 and Addendum F does not specify what healthcare professional is involved in the HRA process. An algorithm of the HRA Process was provided when the Contractor was asked about details of the process but again did not specify any health care professional that   | Full                    | <p>P/P 06CS-037 Addendum C indicates that WellCare utilizes healthcare professionals in the assessment process.</p> <p>Screen shots of Case Management HRAs includes names of staff, with some titles</p>  |   |



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|---|---|-------------------------|---|---|
|   | <p>determines a member is in need of additional assistance or special health care needs.</p> <p><b>MCO Response:</b> The process begins with a contracted vendor to outreach members. Upon completion of the HRA the data is run through an algorithm for initial stratification/acuity level. Upon member assignment to case management, case manager will analyze and review initial stratification/acuity level for accuracy and change stratification level if indicated. The HRA stratification/acuity will identify the most vulnerable members for case management. The member is assigned to a RN case manager or SW case management based on needs. Please refer to the updated Addendum F in policy C6CS-37 and HRA Corrective Action Plan.</p> |                         | <p>such as Field Outreach Coordinator, Care Coordinator. In some instances, these individuals have a credential such as BA or BSW MS.</p> <p>During the onsite review, the plan provided a flowchart of the HRA process and job descriptions for professionals conducting the HRAs (Care Coordinator and Field Outreach Coordinator).</p> |   |
| <p>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.</p> | <p>Substantial - P/P C6CS-037 and Addendum F state that any special health care needs identified for the new enrollee is forwarded to Case Management and identifies and resolves any potential issues such as incorrect PCP assigned. Assistance for arranging an initial visit to the PCP assigned, if correct, is not stated directly in the policy. This policy does state that a Customer Service Associate will contact the member with a script. The script states in Section 9 that the Customer Service Associate will direct the member to contact Customer Service if assistance is needed in making an appointment with the PCP.</p>  | Full                    | <p>This is addressed in P/P 06CS-037, which notes that members will be offered assistance with scheduling a PCP visit as part of the welcome call; this is included in the welcome call script.</p>   |   |



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|   | <p><b>Recommendation for WellCare</b><br/>           The Plan should include the script details in the policy, addressing these specific state contract requirements, as the script is not part of the policy.</p> <p><b>MCO Response:</b> Please refer to the updated Addendum F in policy C6CS-37. After verification of primary care physician members are asked if they would like assistance with scheduling appointment with their PCP. Upon request for assistance the member is directed notify customer service at the number located on the back of their ID card for assistance.</p> |                         |   |  |
| 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. |   |                         |   |  |



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**Scoring Grid:**

| Compliance Level   | Full     | Substantial | Minimal  | Non-Compliance |
|--------------------|----------|-------------|----------|----------------|
| Points Value       | <b>3</b> | <b>2</b>    | <b>1</b> | <b>0</b>       |
| Number of Elements | 3        | 0           | 2        | 0              |
| Total Points       | 9        | 0           | 2        | 0              |

**Overall Compliance Determination:**

| Compliance Level | Full       | Substantial       | Minimal           | Non-Compliance  |
|------------------|------------|-------------------|-------------------|-----------------|
| Points Range     | <b>3.0</b> | <b>2.0 – 2.99</b> | <b>1.0 – 1.99</b> | <b>0 – 0.99</b> |
| Points Average   |            | <b>2.2</b>        |                   |                 |

**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.**

**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



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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

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



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| <b>Quality Assessment and Performance Improvement: Structure and Operations – Credentialing</b><br><i>(See Final Page for Suggested Evidence)</i>  |   |                                 |   |  |
|--|---|---------------------------------|---|--|
| <b>State Contract Requirements<br/>(Federal Regulation 438.214)</b>  | <b>Prior Results &amp; Follow-Up</b>      | <b>Review<br/>Determination</b> | <b>Comments (Note: For any element that<br/>deviates from the requirements, an<br/>explanation of the deviation must be<br/>documented in the Comments section)</b> | <b>Health Plan's and DMS'<br/>Responses and Plan of Action</b> |
| <b>27.2 Provider Credentialing and Recredentialing</b>   |   |                                 |   |  |
| 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, |   |                                 |   |  |
| defining the scope of providers covered,   |   |                                 |   |  |
| the criteria and the primary source verification of information used to meet the criteria,   |   |                                 |   |  |
| the process used to make decisions and the extent of delegated credentialing and recredentialing arrangements.   |   |                                 |   |  |
| The contractor shall have a process for receiving input from participating providers regarding credentialing and recredentialing of providers.   |   |                                 |   |  |
| 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.  |   |                                 |   |  |
| Providers required to be recredentialed by the Contractor per Department policy are physicians, audiologists, certified registered nurse anesthetists,   | NA-Not applicable for this review period. | Full                            | C6CR-PR-001 Credentialing and Recredentialing procedure addresses this requirement.   |  |



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|--|--------------------------------------|---------------------------------|---|--|
| <b>State Contract Requirements<br/>(Federal Regulation 438.214)</b>  | <b>Prior Results &amp; Follow-Up</b> | <b>Review<br/>Determination</b> | <b>Comments (Note: For any element that<br/>deviates from the requirements, an<br/>explanation of the deviation must be<br/>documented in the Comments section)</b> | <b>Health Plan's and DMS'<br/>Responses and Plan of Action</b> |
| advanced registered nurse practitioners, podiatrists, 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. |                                      |                                 |   |  |
| 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.                                   |                                      |                                 |   |  |
| 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.  |                                      |                                 |   |  |
| 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)   |                                      |                                 |   |  |



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| <b>State Contract Requirements<br/>(Federal Regulation 438.214)</b>  | <b>Prior Results &amp; Follow-Up</b> | <b>Review<br/>Determination</b> | <b>Comments (Note: For any element that<br/>deviates from the requirements, an<br/>explanation of the deviation must be<br/>documented in the Comments section)</b> | <b>Health Plan's and DMS'<br/>Responses and Plan of Action</b> |
| related to credentialing. The Contractor's enrolled providers shall complete a credentialing application in 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; |                                      |                                 |   |  |
| B. A governing body, or the groups or individuals to whom the governing body has formally delegated the credentialing function;  |                                      |                                 |   |  |
| C. A review of the credentialing policies and procedures by the formal body;   |                                      |                                 |   |  |
| D. A credentialing committee which makes recommendations regarding credentialing;  |                                      |                                 |   |  |
| E. Written procedures, if the Contractor delegates the credentialing function, as well as evidence that the effectiveness is monitored;  |                                      |                                 |   |  |
| F. Written procedures for the termination or suspension of Providers; and  |                                      |                                 |   |  |
| G. Written procedures for, and the implementation of, reporting to the appropriate authorities serious quality deficiencies resulting in suspension or termination of a provider.                |                                      |                                 |   |  |



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|--|--------------------------------------|---------------------------------|---|--|
| <b>State Contract Requirements<br/>(Federal Regulation 438.214)</b>  | <b>Prior Results &amp; Follow-Up</b> | <b>Review<br/>Determination</b> | <b>Comments (Note: For any element that<br/>deviates from the requirements, an<br/>explanation of the deviation must be<br/>documented in the Comments section)</b> | <b>Health Plan's and DMS'<br/>Responses and Plan of Action</b> |
| The contractor shall meet requirements under KRS 205.560(12) related to credentialing. Verification of the Providers credentials shall include the following:  |                                      |                                 |   |  |
| A. A current valid license or certificate to practice in the Commonwealth of Kentucky.   |                                      |                                 |   |  |
| B. A Drug Enforcement Administration (DEA) certificate and number, if applicable;  |                                      |                                 |   |  |
| C. Primary source of graduation from medical school and completion of an appropriate residency, or accredited nursing, dental, physician assistant or vision 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;  |                                      |                                 |   |  |
| 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;                           |                                      |                                 |   |  |
| F. Previous five (5) years work history;   |                                      |                                 |   |  |
| G. Professional liability claims history;  |                                      |                                 |   |  |
| 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        |                                      |                                 |   |  |



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|---|--------------------------------------|---------------------------------|---|--|
| <b>State Contract Requirements<br/>(Federal Regulation 438.214)</b>   | <b>Prior Results &amp; Follow-Up</b> | <b>Review<br/>Determination</b> | <b>Comments (Note: For any element that<br/>deviates from the requirements, an<br/>explanation of the deviation must be<br/>documented in the Comments section)</b> | <b>Health Plan's and DMS'<br/>Responses and Plan of Action</b> |
| through attestation;  |                                      |                                 |   |  |
| I. Current, adequate malpractice insurance, as verified through attestation;  |                                      |                                 |   |  |
| J. Documentation of revocation, suspension or probation of a state license or DEA/BNDD number;  |                                      |                                 |   |  |
| K. Documentation of curtailment or suspension of medical staff privileges;  |                                      |                                 |   |  |
| L. Documentation of sanctions or penalties imposed by Medicare or Medicaid;   |                                      |                                 |   |  |
| M. Documentation of censure by the State or County professional association; and  |                                      |                                 |   |  |
| N. Most recent information available from the National Practitioner Data Bank.  |                                      |                                 |   |  |
| 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;  |                                      |                                 |   |  |
| B. Lack of present illegal drug use;  |                                      |                                 |   |  |
| C. History of loss of license and felony convictions;   |                                      |                                 |   |  |
| D. History of loss or limitation of privileges or disciplinary activity;  |                                      |                                 |   |  |
| E. Sanctions, suspensions or terminations imposed by  |                                      |                                 |   |  |



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|---|---|---------------------------------|---|--|
| <b>State Contract Requirements<br/>(Federal Regulation 438.214)</b>   | <b>Prior Results &amp; Follow-Up</b>  | <b>Review<br/>Determination</b> | <b>Comments (Note: For any element that<br/>deviates from the requirements, an<br/>explanation of the deviation must be<br/>documented in the Comments section)</b>   | <b>Health Plan's and DMS'<br/>Responses and Plan of Action</b>   |
| Medicare or Medicaid; and   |   |                                 |   |  |
| F. Applicant attests to correctness and completeness of the application   |   |                                 |   |  |
| 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;  |   |                                 |   |  |
| B. Information about sanctions or limitations on licensure from the appropriate state boards applicable to the practitioner type; and   |   |                                 |   |  |
| C. Other recognized monitoring organizations appropriate to the practitioner's discipline.  |   |                                 |   |  |
| At the time of credentialing, the Contractor shall perform an initial visit to potential providers, as it deems necessary and/or as required by law.                          | Substantial - WellCare's 2012 Credentialing Program Description provided for review. As part of the initial credentialing process site inspection evaluations (SIE's) are required for the office of primary care physicians (PCP's) and Obstetrician and Gynecology offices. Re-credentialing SIE's are required for PCP offices. P/P C6CR-027, Site Inspection Evaluation provides details of the process.<br><br>At the onsite review, the MCO | 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.<br><br>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. | 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. |



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| <b>State Contract Requirements<br/>(Federal Regulation 438.214)</b>   | <b>Prior Results &amp; Follow-Up</b>  | <b>Review<br/>Determination</b> | <b>Comments (Note: For any element that<br/>deviates from the requirements, an<br/>explanation of the deviation must be<br/>documented in the Comments section)</b>  | <b>Health Plan's and DMS'<br/>Responses and Plan of Action</b> |
|   | <p>stated that the initial visit to the providers, unless deemed necessary, is not a required function of the credentialing process.</p> <p><b><u>Recommendation for WellCare</u></b><br/>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.</p> <p><b>MCO Response:</b> Please refer to policy C6CR-027 Site Inspection Evaluation.</p> |                                 | <p>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.</p> <p>This modification was outside the review period.</p> <p><b><u>Recommendation for WellCare</u></b><br/>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.</p> |  |
| The Contractor shall document a structured review to evaluate the site against the Contractor's organizational standards and those specified by this contract.  |   |                                 |  |  |
| 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.          |   |                                 |  |  |
| 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 |   |                                 |  |  |



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| recrediting policies and procedures. There shall be evidence that before making a recrediting decision, the Contractor has verified information about sanctions or limitations on practitioner from: |                                      |                                 |   |  |
| A. A current license to practice;  |                                      |                                 |   |  |
| B. The status of clinical privileges at the hospital designated by the practitioner as the primary admitting facility;   |                                      |                                 |   |  |
| C. A valid DEA, if applicable;   |                                      |                                 |   |  |
| D. Board certification, if the practitioner was due to be recertified or become board certified since last credentialed or recredentialed;   |                                      |                                 |   |  |
| E. Five (5) year history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the practitioner; and  |                                      |                                 |   |  |
| F. A current signed attestation statement by the applicant regarding:  |                                      |                                 |   |  |
| 1. The ability to perform the essential functions of the position, with or without accommodation;  |                                      |                                 |   |  |
| 2. The lack of current illegal drug use;   |                                      |                                 |   |  |
| 3. A history of loss, limitation of privileges or any disciplinary action; and   |                                      |                                 |   |  |
| 4. Current malpractice insurance.  |                                      |                                 |   |  |



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| There shall be evidence that before making a recredentialing decision, the Contractor has verified information about sanctions or limitations on practitioner from :  |                           |                         |  |   |
| A. The national practitioner data bank;   |                           |                         |  |   |
| B. Medicare and Medicaid;   |                           |                         |  |   |
| C. State boards of practice, as applicable; and   |                           |                         |  |   |
| D. Other recognized monitoring organizations appropriate to the practitioner's specialty.   |                           |                         |  |   |
| <b>The</b> 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. |                           |                         |  |   |
| The Contractor shall establish ongoing monitoring of provider sanctions, complaints and quality issues between recredentialing cycles, and take appropriate action.   |                           |                         |  |   |
| 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   |                           |                         |  |   |



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| agencies, free-standing surgical centers, residential treatment centers and clinics.   |  |                                 |   |  |
| 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, 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. | NA-Not applicable for this review period.  | Not Applicable                  | C6CR-001 notes that recredentialing is required every three years (36 months) as per NCQA and URAC standards. This policy details the MCO's recredentialing standards and methodology.<br><br>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.  |  |                                 |   |  |
| 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.   | Non-Compliance - Policies/procedures provided do not address this requirement.<br><br><b>MCO Response:</b> Please refer to policies C6CR-046 Ongoing Monitoring of Providers, C6CR-007 Corrective Action, and C6CR-025 Reporting of Adverse Actions. | Full                            | C6CR-025 Reporting of Adverse Actions states: "The Plan is required to report to the National Practitioner Data Bank (NPDB) and to the appropriate State Licensing authority and other state agencies as appropriate, adverse actions taken by the Plan against practitioners that arises as a result of quality of care or conduct by the practitioner in relation to Plan-provided services. The Plan is also required to notify state agencies of other provider terminations".<br><br>C6CR-046 Ongoing Monitoring of Providers states: "In addition to providers being checked during initial and re-credentialing, all |  |



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|  |  |                                 | <p>current participating providers are monitored on a monthly basis". Also, "Appropriate interventions are implemented as indicated by finding of poor quality that may affect the health and safety of members".</p> <p>C6CR-007 Corrective Action states that a participating provider's activity or professional conduct is, or is reasonably probable of being detrimental to member/consumer safety or to the delivery of quality care, is or reasonably probable of being disruptive to one of the health plans, corrective action against such participating practitioner may be initiated up to and including termination.</p>                |  |
| <p>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.</p> | <p>Substantial - The MCO advised that during the review period there were no cases that required peer review by the Credentialing Committee, therefore no reports were sent to DMS.</p> <p><b><u>Recommendation for WellCare</u></b><br/>The following language should be included in a policy/procedure or the Credentialing Program<br/>Description: If a provider requires review by the Contractor's credentialing Committee, based on</p> | <p>Full</p>                     | <p>C6CR-025 Reporting of Adverse Actions states: "In the event an adverse determination is made concerning a practitioner which results in the restriction, suspension, or termination of the participation status of the practitioner for a period of thirty days or more, and such determination arises as a result of the provider's conduct or clinical practice, the Credentialing Department will report to the National Practitioner Data Bank and all appropriate outside agencies, the nature of such restriction, suspension or termination, in accordance with regulatory guidelines. The reports shall be forwarded within 15-days of</p> |  |



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|   | <p>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.</p> <p><b>MCO Response:</b> Please refer to policies C6CR-007 Corrective Action and C6CR-025 Reporting of Adverse Actions.</p> |                                 | <p>final actions".</p> <p>C6CR-007 Corrective Action states that a participating provider's activity or professional conduct is, or is reasonably probable of being detrimental to member/consumer safety or to the delivery of quality care, is or reasonably probably of being disruptive to one of the health plans, corrective action against such participation practitioner may be initiated up to and including terminations.</p> |  |
| <p>The Contractor shall use the provider types summaries listed at:<br/><a href="http://chfs.ky.gov/dms/provEnr/Provider+Types.htm">http://chfs.ky.gov/dms/provEnr/Provider+Types.htm</a></p>   |   |                                 |  |  |
| <p><b>28.1 Network Providers to be Enrolled</b></p>   |   |                                 |  |  |
| <p>The Contractor's Network shall include Providers from throughout the provider community. The Contractor 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</p> |   |                                 |  |  |



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| <b>State Contract Requirements<br/>(Federal Regulation 438.214)</b>   | <b>Prior Results &amp; Follow-Up</b> | <b>Review<br/>Determination</b> | <b>Comments (Note: For any element that<br/>deviates from the requirements, an<br/>explanation of the deviation must be<br/>documented in the Comments section)</b> | <b>Health Plan's and DMS'<br/>Responses and Plan of Action</b> |
| <p>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, advanced practice registered nurses, physician assistants, birthing centers, dentists, primary care centers including, home health agencies, rural health clinics, opticians, optometrists, audiologists, hearing aid vendors, 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, 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 may also enroll other providers, which meet the credentialing requirements, to the extent necessary to provide covered services to the Members.</p> <p>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</p> |                                      |                                 |   |  |



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| <b>State Contract Requirements<br/>(Federal Regulation 438.214)</b>  | <b>Prior Results &amp; Follow-Up</b>                           | <b>Review<br/>Determination</b> | <b>Comments (Note: For any element that<br/>deviates from the requirements, an<br/>explanation of the deviation must be<br/>documented in the Comments section)</b> | <b>Health Plan's and DMS'<br/>Responses and Plan of Action</b> |
| hospitals, nursing facilities, home health agencies, independent laboratories, preventive health care providers, 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 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.   |  |                                 |   |  |
| 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.   |  |                                 |   |  |
| The Contractor must offer participation agreements with currently enrolled Medicaid providers who have received electronic health record incentive funds who   | Non- Compliance - Not addressed in the documentation provided. | Full                            | Addressed in C7ND MD-001 Network Development Addendum H: "Participation agreements will be offered to currently   |  |



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| are willing to meet the terms and conditions for participation established by the Contractor.   | <b>MCO Response:</b> Please refer to policy C6NI-001 Geo Access Reporting.  |                         | 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 Company".  |   |
| <b>28.2 Out-of-Network Providers</b>  |   |                         |   |   |
| 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 by the Department report all out-of-network utilization by Members. | Non-Compliance - A report of out-of-network utilization was not provided for review.<br><br><b>MCO Response:</b> Please refer to the following five out of network utilization reports:<br><br>Out of Network State Report81 1stQtr2012<br><br>Out of Network State Report81 2ndQtr2012<br><br>Out of Network State Report81 3rdQtr2012<br><br>Out of Network November 2012 Report<br><br>Out of Network December 2012 Report | Full                    | Plan submitted Report #81 Par and Non-Par Participation. #81 reports the number of claims, billed amount and paid amount for both participating providers and non-participating providers.<br><br>Onsite Note: MCO provided email notification from DMS which indicated that report 81 fulfills this requirement. |   |
| <b>28.3 Contractor's Provider Network</b>   |   |                         |   |   |
| The Contractor may enroll providers in their network  | Non-Compliance - Not addressed in   | Full                    | C6CR-046 Ongoing Monitoring of Providers  |   |



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| <p>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 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 Emergency Medical Services.</p> | <p>the documents provided.</p> <p><b>MCO Response:</b> Please refer to policies C6CR-046 Ongoing Monitoring of Providers, C6CR-007 Corrective Action, and C6CR-025 Reporting of Adverse Actions.</p> |                                 | <p>states: "The Plan conducts ongoing monitoring of the provider network through the collection and review of:</p> <ul style="list-style-type: none"> <li>• Medicare and Medicaid sanctions</li> <li>• Sanctions or limitations on licensure</li> <li>• Grievances</li> <li>• Information from identified quality of care concerns and/or adverse events"</li> </ul> <p>C6CR-007 Corrective Action states that a participating provider's activity or professional conduct is, or is reasonably probable of being detrimental to member/consumer safety or to the delivery of quality care, is or reasonably probably of being disruptive to one of the health plans, corrective action against such participation practitioner may be initiated up to and including terminations.</p> <p>C6CR-025 Reporting of Adverse Actions states: "In the event an adverse determination is made concerning a practitioner which results in the restriction, suspension, or termination of the participation status of the practitioner for a period of thirty days or more, and such determination arises as a result of the provider's conduct or clinical practice, the Credentialing Department will report to the National Practitioner Data Bank and all</p> |  |



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|  |  |                                 | appropriate outside agencies, the nature of such restriction, suspension or termination, in accordance with regulatory guidelines. The reports shall be forwarded within 15-days of final actions".  |   |
| <b>28.4 Enrolling Current Medicaid Providers</b>   |  |                                 |  |   |
| <p>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.</p> | <p>Substantial - P/P C6CR-001 addresses this requirement.</p> <p><u>Credentialing File Review</u><br/>Twenty credentialing files were reviewed: 10 PCP credentialing files and 10 Specialist credentialing files.</p> <p>PCP Files:<br/>2 files – Unable to determine hospital privileges.<br/>2 files – Out of state License (no license in KY)<br/>1 file– Unable to determine if provider has a current license.<br/>2 files– KY Board of Medical Licensure missing.</p> <p>Specialist Files:<br/>2 files - Out of state License (no license in KY)</p> | <p>Substantial</p>              | <p>C6CR-001 Credentialing &amp; Re-Credentialing addresses this requirement.</p> <p><u>Credentialing File Review</u><br/>Twenty credentialing files were reviewed: 10 PCP credentialing files and 10 Specialist credentialing files.</p> <p>Specialist Files:<br/>1 file – license expired after license verification, but before credentialing decision.</p> <p>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.</p> <p><b>Recommendation for WellCare</b><br/>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</p> | <p>WellCare uses the Council for Affordable Quality 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.</p> <p>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.</p> |



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|  | <p><b><u>Recommendation for WellCare</u></b><br/>The files for the PCPs were consistent; copies of the physician's license are maintained with the PCP files. Several of the specialist files accepted the provider's license via the Internet documentation. Specialist licensure should also be maintained in their respective files.</p> <p><b>MCO Response:</b> The Credentialing department is currently auditing 100% of files to ensure requirements in the policy are being met.</p> |                                       | <p>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.</p>   |  |
| <b>28.5 Enrolling New Providers and Providers not Participating in Medicaid</b>  |  |                                       |   |  |
| <p>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.</p> | <p>Non- Compliance - Not addressed in documentation provided.</p> <p><b>MCO Response:</b> Please refer to policies C6CR-046 Ongoing Monitoring of Providers, C6CR-024 Medicaid/Medicare Eligibility Federal and State Sanctions and Opt Out, and the KY Medicaid Enrollment Process document.</p>  | <p>Full</p>                           | <p>C6CR-046 Ongoing Monitoring of Providers states the Plan accesses regulatory websites that identify sanction information and the information is cross-checked against the Plan's network of providers to ensure participating and non-participating providers are eligible to participate in Federal and State funded programs such as Medicaid and Medicare.</p> <p>C6CR-024 Medicaid/Medicare Eligibility Federal and State Sanctions and Opt Out refers to eligibility to participate in Medicare</p> |  |



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|---|---|---------------------------------|--|--|
| <b>State Contract Requirements<br/>(Federal Regulation 438.214)</b>   | <b>Prior Results &amp; Follow-Up</b>  | <b>Review<br/>Determination</b> | <b>Comments (Note: For any element that<br/>deviates from the requirements, an<br/>explanation of the deviation must be<br/>documented in the Comments section)</b>  | <b>Health Plan's and DMS'<br/>Responses and Plan of Action</b> |
|   |   |                                 | <p>or Medicaid programs by identifying providers who have been sanctioned.</p> <p>KY Medicaid Enrollment Process document was provided and addresses the process for obtaining a Medicaid number for potential providers.</p> <p>During the onsite review, WellCare provided an overview of the process for enrolling providers that do not have a Medicaid number. Upon receiving an application, WellCare will automatically complete the paperwork to request a Medicaid number for the provider.</p> |  |
| <b>28.6 Termination of Network Providers or Subcontractors</b>  |   |                                 |  |  |
| <p>Any Provider or Subcontractor who engages in activities that result in suspension, termination, or exclusion from the Medicare or Medicaid program shall be terminated from participation.</p> | <p>Non- Compliance - Not addressed in documentation provided.</p> <p><b>MCO Response:</b> Please refer to policies C7PR-015 Termination of Existing Providers, C6CR-046 Ongoing Monitoring of Providers and C6CR-024 Medicaid/Medicare Eligibility Federal and State Sanctions and Opt Out.</p> | <p>Full</p>                     | <p>C6CR-024 Medicaid/Medicare Eligibility Federal and State Sanctions and Opt Out addresses providers who are not eligible to participate in Medicare or Medicaid are also not eligible to be providers to WellCare members.</p>   |  |
| <p>The Department shall notify the Contractor of suspension, termination, and exclusion actions taken</p>   |   |                                 |  |  |



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|---|--|---------------------------------|---|--|
| <b>State Contract Requirements<br/>(Federal Regulation 438.214)</b>   | <b>Prior Results &amp; Follow-Up</b>   | <b>Review<br/>Determination</b> | <b>Comments (Note: For any element that<br/>deviates from the requirements, an<br/>explanation of the deviation must be<br/>documented in the Comments section)</b>   | <b>Health Plan's and DMS'<br/>Responses and Plan of Action</b> |
| against Medicaid providers by the Kentucky Medicaid program within three business days via e-mail. The Department will notify the Contractor of voluntary terminations within five business days via email.   |  |                                 |   |  |
| The Contractor shall notify the Department of suspension, termination, and exclusion from Contractor's network taken against a Provider within three business days via email. The Contractor shall notify the Department of voluntary terminations within five business days via email. The Contractor will provide all terminations monthly, via the Provider Termination Report as referenced in Appendix K. The Contractor shall terminate the Provider effective the same date as the Medicaid program termination. | Non- Compliance - Not addressed in documentation provided.<br><br><b>MCO Response:</b> Please refer to policies C7PR-015 Termination of Existing Providers, C6CR-046 Ongoing Monitoring of Providers, C6CR-041 Maintenance of Expiring Documentation, and C6CR-025 Reporting of Adverse Actions. | Full                            | C6CR-025 Reporting of Adverse Actions addresses the suspension, restriction or termination of the participation status of a practitioner and C7PR-015-001 Termination of Existing Providers addresses the notification within three business days via e-mail requirement. |  |



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**Scoring Grid:**

| <b>Compliance Level</b> | <b>Full</b> | <b>Substantial</b> | <b>Minimal</b> | <b>Non-Compliance</b> |
|-------------------------|-------------|--------------------|----------------|-----------------------|
| Points Value            | <b>3</b>    | <b>2</b>           | <b>1</b>       | <b>0</b>              |
| Number of Elements      | 9           | 2                  | 0              | 0                     |
| Total Points            | 27          | 4                  | 0              | 0                     |

**Overall Compliance Determination:**

| <b>Compliance Level</b> | <b>Full</b> | <b>Substantial</b> | <b>Minimal</b>    | <b>Non-Compliance</b> |
|-------------------------|-------------|--------------------|-------------------|-----------------------|
| Points Range            | <b>3.0</b>  | <b>2.0 – 2.99</b>  | <b>1.0 – 1.99</b> | <b>0 – 0.99</b>       |
| Points Average          |             | <b>2.82</b>        |                   |                       |

**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.**

**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



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## 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



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| State Contract Requirements<br>(Federal Regulations 438.206, 438.207,<br>438.208, 438.114)   | Prior Results &<br>Follow-Up  | Review<br>Determination | Comments (Note: For any element that<br>deviates from the requirements, an<br>explanation of the deviation must be<br>documented in the Comments section)   | Health Plan's and DMS'<br>Responses and Plan of Action |
|--|---|-------------------------|---|--|
| <b>27.3 Primary Care Provider Responsibilities</b>   |   |                         |   |  |
| 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. |   |                         |   |  |
| 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 - P/P C7UM-4.5 Care Coordination Continuity of Care and Transition of Care: Addendum E Kentucky states: The company's Utilization Management Department maintains continuity of care protocols that include: "A mechanism for direct access to specialists for enrollees identified as having special | 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". Policy C7AP-035 addresses member's right to appeal this decision. The date on the policy is revised 3/5/14 and was | WellCare has revised this policy.                      |



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| <p style="text-align: center;">State Contract Requirements<br/> (Federal Regulations 438.206, 438.207,<br/> 438.208, 438.114)</p> | <p style="text-align: center;">Prior Results &amp;<br/> Follow-Up</p>  | <p style="text-align: center;">Review<br/> Determination</p> | <p style="text-align: center;">Comments (Note: For any element that<br/> deviates from the requirements, an<br/> explanation of the deviation must be<br/> documented in the Comments section)</p>                                       | <p style="text-align: center;">Health Plan's and DMS'<br/> Responses and Plan of Action</p> |
|---|--|--|--|---|
|   | <p>health care needs, as appropriate for their conditions and identified needs.”</p> <p>P/P C7PC-003, Medicaid and Medicare Provider Manuals/Handbooks and Provider Training and Education: Addendum E: Kentucky only mentions appeals as it applies to the provider in the provider handbook.</p> <p>Member Handbook (page 9) states: “There are also times when a specialist can be your PCP, provided: You have a chronic condition and have a historical relationship with the Specialist and the specialist and our medical director agree in writing to assume the responsibilities of the PCP.”</p> <p><b><u>Recommendation for WellCare</u></b></p> <p>It is recommended that the policy address the issue of specialty providers may serve as PCPs under certain circumstances but the decision</p> |  | <p>not in effect during 2013.</p> <p><b><u>Recommendation for WellCare</u></b></p> <p>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.</p> |   |



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|--|--|-------------------------|---|--|
| State Contract Requirements<br>(Federal Regulations 438.206, 438.207,<br>438.208, 438.114)   | Prior Results &<br>Follow-Up   | Review<br>Determination | Comments (Note: For any element that<br>deviates from the requirements, an<br>explanation of the deviation must be<br>documented in the Comments section) | Health Plan's and DMS'<br>Responses and Plan of Action |
|  | is based on the agreement among the member as well and that the member has the right to appeal as written in the State Requirements.<br><br><b>MCO Response:</b> Please refer to policy C7ND MD-001 Network Development. |                         |   |  |
| 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;   |  |                         |   |  |
| 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; |  |                         |   |  |
| C. Maintaining a current medical record for the Member, including documentation of all PCP and specialty care services;  |  |                         |   |  |
| D. Discussing Advance Medical Directives with all Members as appropriate;  |  |                         |   |  |
| E. Providing primary and preventative care, recommending or arranging for all necessary preventive 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  |  |                         |   |  |



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|---|------------------------------|-------------------------|---|--|
| State Contract Requirements<br>(Federal Regulations 438.206, 438.207,<br>438.208, 438.114)  | Prior Results &<br>Follow-Up | Review<br>Determination | Comments (Note: For any element that<br>deviates from the requirements, an<br>explanation of the deviation must be<br>documented in the Comments section) | Health Plan's and DMS'<br>Responses and Plan of Action |
| G. Arranging and referring members when clinically appropriate, to behavioral health providers  |                              |                         |   |  |
| 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. |                              |                         |   |  |
| 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;                                   |                              |                         |   |  |
| (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                   |                              |                         |   |  |
| (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.   |                              |                         |   |  |
| B. Unacceptable   |                              |                         |   |  |



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| State Contract Requirements<br>(Federal Regulations 438.206, 438.207,<br>438.208, 438.114)  | Prior Results &<br>Follow-Up  | Review<br>Determination | Comments (Note: For any element that<br>deviates from the requirements, an<br>explanation of the deviation must be<br>documented in the Comments section)  | Health Plan's and DMS'<br>Responses and Plan of Action  |
|---|---|-------------------------|--|---|
| (1) Office phone is only answered during office hours;  | Non-Compliance - P/P C6NI-002 Addendum J: Kentucky-Medicaid has documentation regarding what is acceptable after hours but does not address what is unacceptable.<br><br><b>MCO Response:</b> Please refer to the updated draft policy C6NI-002 Provider Appointment Availability and After Hours Coverage. | Substantial             | Policy C6NI-002 Provider Appointment Accessibility and After-Hours Coverage Addendum J includes the following:<br>"The Contractor considers the following arrangements to be unacceptable:<br>1. Office phone is only answered during office hours<br><br><b>Recommendation for WellCare</b><br>Include acceptable and unacceptable office phone requirements in the Provider Manual.  | Page 23 of the Provider Manual lists coverage requirements. Recommended additions to Provider Manual have been submitted for next update. |
| (2) Office phone is answered after hours by a recording that tells Members to leave a message;  | Non-Compliance - P/P C6NI-002 Addendum J: Kentucky-Medicaid has documentation regarding what is acceptable after hours but does not address what is unacceptable.<br><br><b>MCO Response:</b> Please refer to the updated draft policy C6NI-002 Provider Appointment Availability and After Hours Coverage. | Substantial             | Policy C6NI-002 Provider Appointment Accessibility and After-Hours Coverage Addendum J includes the following:<br>"The Contractor considers the following arrangements to be unacceptable:<br>2. Office phone is answered after hours by a recording that tells Members to leave a message.<br><br><b>Recommendation for WellCare</b><br>Include acceptable and unacceptable office phone requirements in the Provider Manual. | 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 | P/P C6NI-002 Addendum J: Kentucky-Medicaid has documentation regarding what is acceptable after hours but does not address what is unacceptable.<br><br><b>MCO Response:</b> Please refer   | Substantial             | Policy C6NI-002 Provider Appointment Accessibility and After-Hours Coverage Addendum J includes the following:<br>"The Contractor considers the following arrangements to be unacceptable:<br>3. Office phone is answered after hours by a recording that directs Members to go to the emergency   | Page 23 of the Provider Manual lists coverage requirements. Recommended additions to Provider Manual have been submitted for next update. |



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|---|---|-------------------------|---|---|
| State Contract Requirements<br>(Federal Regulations 438.206, 438.207,<br>438.208, 438.114)  | Prior Results &<br>Follow-Up  | Review<br>Determination | Comments (Note: For any element that<br>deviates from the requirements, an<br>explanation of the deviation must be<br>documented in the Comments section)   | Health Plan's and DMS'<br>Responses and Plan of Action  |
|   | to the updated draft policy C6NI-002 Provider Appointment Availability and After Hours Coverage.  |                         | room for any services needed.<br><br><b>Recommendation for WellCare</b><br>Include acceptable and unacceptable office phone requirements in the Provider Manual.  |   |
| (4) Returning after-hours calls outside of thirty (30) minutes.   | Non-Compliance - P/P C6NI-002 Addendum J: Kentucky-Medicaid has documentation regarding what is acceptable after hours but does not address what is unacceptable.<br><br><b>MCO Response:</b> Please refer to the updated draft policy C6NI-002 Provider Appointment Availability and After Hours Coverage. | Substantial             | Policy C6NI-002 Provider Appointment Accessibility and After-Hours Coverage Addendum J includes the following:<br>"The Contractor considers the following arrangements to be unacceptable:<br>4. Returning after-hours calls outside of thirty (30) minutes.<br><br><b>Recommendation for WellCare</b><br>Include acceptable and unacceptable office phone requirements in the Provider Manual. | Page 23 of the Provider Manual lists coverage requirements. Recommended additions to Provider Manual have been submitted for next update. |
| <b>28.7 Provider Program Capacity Demonstration</b>   |   |                         |   |   |
| The Contractor shall assure that all Covered Services are as accessible to Members (in terms of timeliness, 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.  |   |                         |   |   |
| Emergency medical services shall be made available to   |   |                         |   |   |



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| <b>State Contract Requirements</b><br>(Federal Regulations 438.206, 438.207,<br>438.208, 438.114)   | <b>Prior Results &amp;<br/>           Follow-Up</b> | <b>Review<br/>           Determination</b> | <b>Comments (Note: For any element that<br/>           deviates from the requirements, an<br/>           explanation of the deviation must be<br/>           documented in the Comments section)</b> | <b>Health Plan's and DMS'<br/>           Responses and Plan of Action</b> |
|---|---|--|--|---|
| 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:   |   |  |  |   |
| 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.   |   |  |  |   |
| 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 (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. Specialists shall be commensurate with the subpopulations designated by the Department, and include sufficient pediatric specialists to meet the needs of Members younger than twenty-one (21) years of age. |   |  |  |   |
| C. 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   |   |  |  |   |



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| State Contract Requirements<br>(Federal Regulations 438.206, 438.207,<br>438.208, 438.114)  | Prior Results &<br>Follow-Up   | Review<br>Determination | Comments (Note: For any element that<br>deviates from the requirements, an<br>explanation of the deviation must be<br>documented in the Comments section)  | Health Plan's and DMS'<br>Responses and Plan of Action |
|---|--|-------------------------|--|--|
| Contractor's Network.   |  |                         |  |  |
| D. Hospital care for which transport time shall not exceed thirty (30) minutes, except in non-urban areas where access time may not exceed sixty (60) minutes, with the exception of Behavioral Health Services and physical rehabilitative services where access shall not exceed sixty (60) minutes.                |  |                         |  |  |
| E. General dental services for which transport time shall not exceed one (1) hour. Any exceptions shall be justified and documented by the Contractor. Appointment and waiting times shall not exceed three (3) weeks for regular appointments and forty eight (48) hours for urgent care.                            |  |                         |  |  |
| F. General vision, laboratory and radiology services for which transport time shall not exceed one (1) hour. Any exceptions shall be justified and documented by the Contractor. Appointment and waiting times shall not exceed thirty (30) days for regular appointments and forty eight (48) hours for Urgent Care. |  |                         |  |  |
| G. For Pharmacy services, travel time shall not exceed one (1) hour or the delivery site shall not be further than fifty (50) miles from the Member's residence. The Contractor is not required to provide transportation services to Pharmacy services.  | Substantial - P/P C6NI-001 addresses transport not to exceed one hour or > 50 miles. Contractor's responsibility to provide transportation to Pharmacy services not documented.<br><br><b><u>Recommendation for WellCare</u></b><br>Policy should be revised to include statement that | Full                    | Policy C6NI-001 Geo Access Reporting Addendum I states: "Pharmacy services, travel time shall not exceed one (1) hour or the delivery site shall not be further than fifty (50) miles from the Member's residence. The contractor is not required to provide transportation services to Pharmacy services.<br><br>Policy C6CS-039 Medicaid Non-Emergency Transportation Addendum E states: "The contractor is not required to provide transportation services to Pharmacy services". |  |



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|---|---|-------------------------|---|--|
| State Contract Requirements<br>(Federal Regulations 438.206, 438.207,<br>438.208, 438.114)        | Prior Results &<br>Follow-Up  | Review<br>Determination | Comments (Note: For any element that<br>deviates from the requirements, an<br>explanation of the deviation must be<br>documented in the Comments section) | Health Plan's and DMS'<br>Responses and Plan of Action |
|   | transportation to pharmacy services is not required.<br><br><b>MCO Response:</b> Please refer to policy C6CS-039 Medicaid Non-Emergent Transportation and C6NI-001 Geo Access Reporting.  |                         |   |  |
| The Contractor shall attempt to enroll the following Providers in its network as follows:         |   |                         |   |  |
| A. Teaching hospitals;  | Substantial - Teaching hospitals are not referenced in any policy documentation reviewed. Hospitals are designated on Geo Access maps.<br><br><b>Recommendation for WellCare</b><br>MCO policies should address teaching hospitals and attempts to enroll these providers should be documented.<br><br><b>MCO Response:</b> Please refer to policy C6NI-001 Geo Access Reporting. | Full                    | Addressed in C6NI-001 GeoAccess Reporting Addendum I.   |  |
| B. FQHCs and rural health clinics;  |   |                         |   |  |
| C. The Kentucky Commission for Children with Special  | Non-Compliance - No policies  | Full                    | C6NI-001 GeoAccess Reporting Addendum I   |  |



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|---|---|-------------------------|---|--|
| State Contract Requirements<br>(Federal Regulations 438.206, 438.207,<br>438.208, 438.114)  | Prior Results &<br>Follow-Up  | Review<br>Determination | Comments (Note: For any element that<br>deviates from the requirements, an<br>explanation of the deviation must be<br>documented in the Comments section)   | Health Plan's and DMS'<br>Responses and Plan of Action |
| Health Care Needs; and  | reviewed indicated that the Contractor was attempting to enroll The Kentucky Commission for Children with Special Health Care Needs in its network.<br><br><b>MCO Response:</b> Please refer to policy C6NI-001 Geo Access Reporting. |                         | states: "Provider Capacity Demonstration: The following geographic access standards for all regions shall be met:<br>l. Kentucky Commission for Children with Special Health Care Needs may be included in the Network."  |  |
| D. Community Mental Health Centers  |   |                         |   |  |
| 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. | Non-Compliance - Documentation provided does not address this requirement.<br><br><b>MCO Response:</b> Please refer to policy C6NI-001 Geo Access Reporting.  | Full                    | C6NI-001 Geo Access Reporting Addendum I states: "Provider Capacity Demonstration: The following geographic access standards for all regions shall be met:<br>n. Contractor shall meet coverage requirements for Behavior Health and Children with Special Health Care Needs according to the standards developed by the State of Kentucky".<br><br>C6NI-001 Geo Access Reporting Addendum I does not address the requirement to submit to the Department for approval documentation which supports that, if unable to reach agreement on terms and conditions with these specified providers, 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.<br>Policy C7ND MD-001, provided at the onsite |  |



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|   |  |                         | review, states that WellCare will notify the Department and will submit a corrective action plan.   |  |
| In consideration of the role that Department for Public Health, which contracts with the local health departments play in promoting population health of the provision of safety net services, the Contractor shall offer a participation agreement to public health departments. Such participation agreements shall include the following provisions: |  |                         |   |  |
| A. Coverage of the Preventive Health Package pursuant to 907 KAR 1:360.   | Non-Compliance - Documentation provided does not address participation agreements for coverage of the Preventive Health Package pursuant to 907 KAR1:360. Although this includes EPSDT, family planning and maternity services, it is not clear if the MCO has a participation agreement with local health departments.<br><br><b>MCO Response:</b> Please refer to policy C6NI-001 Geo Access Reporting and executed contract agreement with the Department of Public Health. | Full                    | WCKY DPH Contract ATTACHMENT A Provider Specific Requirements/Covered Services (Preventive Health Services Provider) states: "Subject to and in accordance with the terms and conditions of this Agreement, Contracted Provider shall provide or arrange for the provision of all Covered Services that are Preventive Health Package (as defined in the Kentucky Contract) services that are required pursuant to 907 KAR 1:360, available from the Providers that are within the scope of their medical or professional licenses or certifications. |  |
| B. Provide reimbursement at rates commensurate with those provided under Medicare.  | Non-Compliance - Not addressed in documents provided.  | Full                    | WCKY DPH Contract addresses that Health Plan shall reimburse the Department for Public Health at rates commensurate with those  |  |



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|   | <b>MCO Response:</b> Please refer to policy C6NI-001 Geo Access Reporting.  |                         | provided under Medicare.   |  |
| The Contractor may also include any charitable providers which serve Members in the Contractor Region, provided that such providers meet credentialing standards.   | Non-Compliance - Not addressed in documents provided.<br><br><b>MCO Response:</b> Please refer to policy C6NI-001 Geo Access Reporting. | Full                    | C6NI-001 Geo Access Reporting Addendum I states: "Provider Capacity Demonstration: The following geographic access standards for all regions shall be met:<br><br>m. Contractor may also include any charitable providers which serve Members provided such providers meet credentialing standards". |  |
| 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. |   |                         |  |  |
| <b>28.8 Program Mapping</b>   |   |                         |  |  |
| The Contractor shall initially submit a series of maps and charts in a format prescribed by the Department that describes the Contractor's Provider Network, as set forth below. The use of computer-generated maps is preferred. Maps shall include geographic detail including highways, major streets and the boundaries of the Contractor's   |   |                         |  |  |



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| network. In addition to the maps and charts, the Contractor shall provide an analysis of the capacity to serve all categories of Members. The analysis shall address the standards for access to care. |                              |                         |   |  |
| Maps shall include the location of all categories of Providers or provider sites as follows:   |                              |                         |   |  |
| A. Primary Care Providers (designated by a "P")  |                              |                         |   |  |
| B. Primary Care Centers, non FQHC and RHC (designated by a "C")  |                              |                         |   |  |
| C. Dentists (designated by a "D")  |                              |                         |   |  |
| D. Other Specialty Providers (designated by a "S")   |                              |                         |   |  |
| E. Non-Physician Providers - including nurse practitioners, (designated by a "N") nurse mid-wives (designated by a "M") and physician assistants (designated by a "A")                                 |                              |                         |   |  |
| F. Hospitals (designated by a "H")   |                              |                         |   |  |
| G. After hours Urgent Care Centers (designated by a "U")   |                              |                         |   |  |
| H. Local health departments (designated by a "L")  |                              |                         |   |  |
| I. Federally Qualified Health Centers/Rural Health Clinics (designated by a "F" or "R" respectively)   |                              |                         |   |  |
| J. Pharmacies (designated by a "X")  |                              |                         |   |  |
| K. Family Planning Clinics (designated by an "Z")  |                              |                         |   |  |
| L. Significant traditional Providers (designated by an "**")   |                              |                         |   |  |
| M. Maternity Care Physicians (designated by a "o")   |                              |                         |   |  |



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| N. Vision Providers (designated by a "V")  |   |                         |  |  |
| O. Community Mental Health Centers (designated by a "M")   |   |                         |  |  |
| The Contractor shall update these maps to reflect changes in the Contractor's Network on an annual basis, or upon request by the Department.   |   |                         |  |  |
| <b>28.9 Expansion and/or Changes in the Network</b>  |   |                         |  |  |
| If at any time, the Contractor determines that its Contractor Network is not adequate to comply with the access standards specified above, the Contractor shall notify the Department of this situation and 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. |   |                         |  |  |
| 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.   | Substantial - The Provider Manual states: "Providers are recruited to ensure a diverse selection of providers to care for the population served." This requirement is not addressed in the policies/procedures provided.<br><br><b><u>Recommendation for WellCare</u></b><br>The MCO should have policy/procedure including | Full                    | C6NI-002 Provider Appointment Accessibility and After-Hours Coverage Addendum J states: "The Contractor shall also make reasonable efforts to recruit additional providers based on Member requests provided the provider can meet the Contractor's terms and conditions". |  |



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|   | <p>efforts to recruit additional providers based on members' requests.</p> <p><b>MCO Response:</b> Please refer to the updated draft policy C6NI-002 Provider Appointment Availability and After Hours Coverage.</p> |                         |   |  |
| <b>30.1 Medicaid Covered Services</b>   |  |                         |   |  |
| 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.   |  |                         |   |  |
| 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 |  |                         |   |  |



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|--|--|-------------------------|--|--|
| incorporated by reference in the administrative regulations.   |  |                         |  |  |
| After the Execution Date, 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 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.   | Non-Compliance - Documentation provided does not address this requirement.<br><br><b>MCO Response:</b> Please refer to policy C9CC-006 Medicaid Written Member Materials and Marketing Materials and policy C9CC-002 Covered Services. In addition, please refer to the Additional | Full                    | C9CC-002 Covered Services addresses this requirement.<br><br>Additional Member Benefit example submitted. Shows 2 example of proposed additional services: a dental member incentive program and the Maternity Education and Reward Program. Documents show submission and approval from the Department. |  |



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|  | Member Benefit example document of two services that were implemented and received DMS approval.  |                         |  |  |
| If coverage of any Medicaid service provided by the Contractor requires the completion of a specific form (e.g., hospice, sterilization, hysterectomy, or abortion), the form shall be properly 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. | Non-Compliance - Documentation provided does not address this requirement.<br><br><b>MCO Response:</b> Please refer to policy C7QI-015 Medical Record Review and the Provider Manual section that speaks to this requirement. | Full                    | 30.1 Medicaid Covered Services Narrative addresses the completion of specific forms to be properly completed according to the appropriate KAR and requires providers/subcontractors to retain the form in the event of audit and a copy will be submitted to the Department upon request.<br><br>C7QI-015 Medical Record Review Addendum E addresses this requirement regarding document retention.<br><br>Provider Manual addresses the completion of specific forms (located on WellCare's website). |  |
| The Contractor shall not prohibit or restrict a Provider from advising a beneficiary 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.  |   |                         |  |  |
| 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    |   |                         |  |  |



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| greater than it would be if the services were provided within the Contractor's Network.   |   |                         |   |  |
| 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.   | Non-Compliance - Documentation provided does not address this requirement.<br><br><b>MCO Response:</b> Please refer to policy C7UM-4.5 Care Coordination Continuity of Care and Transition of Care. | Full                    | Policy C6CS-041 addresses this requirement.   |  |
| <b>32.3 Emergency Care, Urgent Care and Post Stabilization Care</b>   |   |                         |   |  |
| 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).   |   |                         |   |  |
| <b>32.4 Out-of-Network Emergency Care</b>   |   |                         |   |  |
| 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 accordance with 42 CFR 431.52 and 907 KAR 1:084. These regulations require that the Commonwealth, including Department and its Contractor, cover not only Medically Necessary services due to a medical emergency, but also out-of-state medical services if medical services are needed and the member's health would be endangered if he/she were required to travel to his/her state of residence. |   |                         |   |  |



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| 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.   | Non-Compliance - Documentation provided does not address this requirement.<br><br><b>MCO Response:</b> Please refer to the updated draft policy C6NI-002 Provider Appointment Availability and After Hours Coverage.   | Full                    | C6NI-002 Provider Appointment Availability and After Hours Coverage Addendum J states: "Payment for a non contracting provider shall not exceed the Medicaid fee for service rate".  |  |
| <b>30.2 Direct Access Services</b>  |  |                         |  |  |
| 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. | Substantial - There is no specific documentation addressing enrollment of Out-of-Network providers into the Contractor's Network.<br><br>Out-of-Network Analysis was reviewed. This analysis listed the top five out-of-network claims by provider specialty and included Emergency room, Radiology, Lab, Family Practice and Durable Medical Equipment (DME). The analysis did indicate that out of 7 DME providers, 4 are now in network. The analysis also reports that 3 of the top utilized out-of-network labs are now in network.<br><br><b><u>Recommendation for</u></b> | Full                    | C6NI-001 Geo Access Reporting Addendum I states: "If the network is unable to provide medically covered services to a particular member, the Company shall adequately and timely cover these services out-of-network for the member."<br><br>C7UM-4.5 Care Coordination Continuity of Care and Transition of Care Addendum G states: "The Company will ensure direct access and may not restrict the Member's access to services in accordance with 42 CFR 438 and applicable state statutes and regulations".<br><br>C6NI-002 Provider Appointment Accessibility and After-Hours Coverage Addendum J states: "The Contractor shall also make reasonable efforts to recruit additional providers based on Member requests provided the provider can meet the Contractor's terms and conditions". |  |



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|   | <p><b>WellCare</b><br/>           Although it appears that there are processes in place to evaluate and recruit out-of-network high volume services, there is no documentation that was available indicating the policy and procedures for this. It is recommended that this be included in the Access policy.</p> <p><b>MCO Response:</b> Please refer to the updated draft policy C6NI-001 Geo Access Reporting.</p> |                         |   |  |
| 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 and opticians;  |  |                         |   |  |
| B. Primary care dental and oral surgery services and evaluations by orthodontists and prosthodontists;  |  |                         |   |  |
| C. Voluntary family planning in accordance with federal and state laws and judicial opinion;  |  |                         |   |  |
| D. Maternity care for Members under 18 years of age;  |  |                         |   |  |
| E. Immunizations to Members under 21 years of age;  |  |                         |   |  |



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| F. Sexually transmitted disease screening, evaluation and treatment;  |  |                         |   |  |
| G. Tuberculosis screening, evaluation and treatment;  |  |                         |   |  |
| H. Testing for Human Immunodeficiency Virus (HIV), HIV-related conditions, and other communicable diseases as defined by 902 KAR 2:020;   |  |                         |   |  |
| I. Chiropractic services; and   |  |                         |   |  |
| J. Women's health specialists.  |  |                         |   |  |
| <b>32.6 Voluntary Family Planning</b>   |  |                         |   |  |
| 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. |  |                         |   |  |
| The Contractor shall maintain confidentiality for Family 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.  | Non-Compliance - Not addressed in P/P C7UM-4.9 Family Planning or in other policies reviewed.<br><br><b>MCO Response:</b> Please refer to policy C7UM-4.9 Family Planning. | Full                    | C7UM-4.9 Family Planning Addendum G states: "The Company ensures that it will maintain confidentiality for Family Planning Services in accordance with applicable federal and state laws and judicial opinions for Members under eighteen years of age pursuant to Title X, CFR 59.11 and KRS 214.185". |  |



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**Scoring Grid:**

| Compliance Level   | Full     | Substantial | Minimal  | Non-Compliance |
|--------------------|----------|-------------|----------|----------------|
| Points Value       | <b>3</b> | <b>2</b>    | <b>1</b> | <b>0</b>       |
| Number of Elements | 14       | 5           | 0        | 0              |
| Total Points       | 42       | 10          | 0        | 0              |

**Overall Compliance Determination:**

| Compliance Level | Full       | Substantial       | Minimal           | Non-Compliance  |
|------------------|------------|-------------------|-------------------|-----------------|
| Points Range     | <b>3.0</b> | <b>2.0 – 2.99</b> | <b>1.0 – 1.99</b> | <b>0 – 0.99</b> |
| Points Average   |            | <b>2.74</b>       |                   |                 |

**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.**

**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



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**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
- 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

Provider Access and Availability Reports

Provider program capacity/program mapping reports including geo access, in required format for:

- Primary care
- Specialty care
- Emergency care
- Hospital care



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- General dental services
- General vision, laboratory and radiology services
- Pharmacy services

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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| <b>36. Program Integrity</b>  |  |                         |  |   |
| 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 M, a Program Integrity plan of internal controls and policies and procedures for preventing, identifying and investigating enrollee and provider fraud, waste and abuse. This plan shall include, at a minimum:  | Substantial - WellCare Corporate Compliance Program and respective policies and procedures provided as described below.<br><br><b>MCO Response:</b> Please refer to documentation: #6_Tool_C12SIU FWA-001-PR_KY, page 3. Sub sections: State specific requirements and Ongoing Activity. | Full                    | Policy C12SIU-FWA-001-KY addresses the requirement of a Program Integrity Plan of internal controls.   |   |
| A. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state standards;  |  |                         |  |   |
| B. The designation of a compliance officer and a compliance committee that are accountable to senior management;  |  |                         |  |   |
| C. Effective training and education for the compliance officer, the organization's employees, subcontractors, providers and members regarding fraud, waste and abuse;   |  |                         |  |   |



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| D. Effective lines of communication between the compliance officer and the organization's employees;  |                           |                         |  |   |
| E. Enforcement of standards through disciplinary guidelines;  |                           |                         |  |   |
| F. Provision for internal monitoring and auditing of the member and provider;   |                           |                         |  |   |
| G. Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the Contractor's contract;  |                           |                         |  |   |
| 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;             |                           |                         |  |   |
| I. Contractor shall be subject to on-site review; and comply with requests from the department to supply documentation and records;   |                           |                         |  |   |
| 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 department; |                           |                         |  |   |
| K. Contractor shall provide procedures for appeal process;  |                           |                         |  |   |



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| 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; | <p>Substantial - P/P for verification of services not provided for review. Report #73, EOMB provided.</p> <p><b><u>Recommendation for WellCare</u></b><br/>Policy/procedure for service verification should be submitted for review.</p> <p><b>MCO Response:</b> Please refer to KY - Medicaid Recipient Verification Letters - Monthly - 6-13-2012 BRD and Fraud Waste and Abuse Procedure. Service verification letters are sent monthly and a report of these is provided to the SIU to ensure an appropriate sample was selected. Typically the sample is far greater than the 500 required.</p> <p>Documentation<br/> <ul style="list-style-type: none"> <li>•#6_Tool_KY Medicaid Recipient Verification Letters - Monthly - 6-13-2012</li> <li>•#6_Tool_C12SIU FWA-001-PR_KY, page 3, subsection Monthly Reporting</li> </ul>           Please refer to the revised Fraud Waste and Abuse Procedure, which has been updated to include a statement that member card sharing cases will be investigated and referred to DMS as appropriate.<br/>           #6_Tool_C12SIU FWA-001-PR_KY, page 2, subsection Ongoing Activity</p> | Full                    | Policy C12PD-010 addresses the requirement to verify member services. This policy shows that the sample is typically 600 members.                            |   |
| M. Contractor shall create a process for card sharing cases;  | <p>Minimal - Card-sharing is not specifically addressed in the documents provided.</p> <p><b>MCO Response:</b> Please refer to the revised Fraud Waste and Abuse Procedure, which has been updated to include a statement that member card sharing cases will be</p>  | Full                    | Member card sharing is addressed in Policy C12SIU_FWA-001 Fraud, Waste and Abuse.  |   |



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|   | investigated and referred to DMS as appropriate.<br>#6_Tool_C12SIU FWA-001-PR_KY, page 2, subsection<br>Ongoing Activity. |                         |  |   |
| 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; |   |                         |  |   |
| O. Contractor shall follow cases from the time they are opened until they are closed; and   |   |                         |  |   |
| 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.                     |   |                         |  |   |
| The plan shall be made available to the Department for review and approval.   |   |                         |  |   |
| <b>10.1 Administration/Staffing</b>   |   |                         |  |   |
| 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  |   |                         |  |   |



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| 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. |                           |                         |  |   |
| 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.  |                           |                         |  |   |
| <b>37.15 Ownership and Financial Disclosure</b>  |                           |                         |  |   |
| The Contractor agrees to comply with the provisions of 42 CFR 455.104. The Contractor shall provide true and complete disclosures of the following   |                           |                         |  |   |



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| 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: |                           |                         |  |   |
| 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, 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;   |                           |                         |  |   |
| 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 \$250,000   |                           |                         |  |   |



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| during the immediately preceding<br>twelve-month period;   |                           |                         |  |   |
| D. A description of any significant<br>business transactions between the<br>Contractor and any wholly-owned<br>supplier, or between the Contractor and<br>any Subcontractor, during the<br>immediately preceding five-year period;   |                           |                         |  |   |
| E. The identity of any person who has an<br>ownership or control interest in the<br>Contractor, any Subcontractor or<br>supplier, or is an agent or managing<br>employee of the Contractor, any<br>Subcontractor or supplier, who has been<br>convicted of a criminal offense related to<br>that person's involvement in any<br>program under Medicare, Medicaid, or<br>the services program under Title XX of<br>the Act, since the inception of those<br>programs; |                           |                         |  |   |
| F. The name of any officer, director,<br>employee or agent of, or any person with<br>an ownership or controlling interest in,<br>the Contractor, any Subcontractor or<br>supplier, who is also employed by the<br>Commonwealth or any of its agencies;<br>and  |                           |                         |  |   |
| G. The Contractor shall be required to<br>notify the Department immediately<br>when any change in ownership is   |                           |                         |  |   |



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| 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.   |                                      |                             |   |  |
| <b>State Contract, Appendix M</b>  |                                      |                             |   |  |
| <b>ORGANIZATION:</b><br>The Contractor's Program Integrity Unit (PIU) shall be organized so that:  |                                      |                             |   |  |
| A. Required Fraud, Waste and Abuse activities shall be conducted by staff that shall have sufficient authority to direct PIU activities; and shall include written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state regulations and standards; |                                      |                             |   |  |
| B. The unit shall be able to establish, control, evaluate and revise Fraud, Waste and Abuse detection, deterrent and prevention procedures to ensure their compliance with Federal and State requirements;   |                                      |                             |   |  |
| C. Adequate staff shall be assigned to the PIU to enable them to conduct the functions specified in this Appendix on a   |                                      |                             |   |  |



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| continuous and on-going basis; and staffing shall consist of a compliance officer, auditing and clinical staff;  |                           |                         |  |   |
| D. The unit shall be able to prioritize 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: |                           |                         |  |   |
| (1) Multi-State fraud or problems of national scope, or Fraud or Abuse crossing service area boundaries;   |                           |                         |  |   |
| (2) High dollar amount of potential overpayment; or  |                           |                         |  |   |
| (3) Likelihood for an increase in the amount of Fraud or Abuse or enlargement of a pattern.  |                           |                         |  |   |
| E. Contractor shall provide ongoing education to Contractor staff on Fraud, Waste and Abuse trends including CMS initiatives;  |                           |                         |  |   |
| F. 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.  |                           |                         |  |   |
| <b>FUNCTION:</b>   |                           |                         |  |   |



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| The Contractor shall establish a PIU to identify and refer to the Department any suspected Fraud or Abuse of Members and Providers. The Contractor's PIU shall be responsible for:  |                           |                         |  |   |
| A. Preventing 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. |                           |                         |  |   |
| B. Proactively detecting incidents of Fraud, Waste and Abuse that exist within the Contractor's program through the use of algorithm, investigations and record reviews;  |                           |                         |  |   |
| C. Determining the factual basis of allegations through investigation concerning fraud or abuse made by Members, Providers and other sources;   |                           |                         |  |   |
| D. Initiating appropriate administrative actions to collect overpayments, deny or to suspend payments that should not be made;  |                           |                         |  |   |
| E. Referring potential Fraud, Waste and Abuse cases to the OIG (and copying   |                           |                         |  |   |



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| DMS) for preliminary investigation and possible referral for civil and criminal prosecution and administrative sanctions;   |   |                         |   |   |
| F. Initiating and maintaining network and outreach activities to ensure effective interaction and exchange of information with all internal components of the Contractor as well as outside groups; |   |                         |   |   |
| G. Making and receiving recommendations to enhance the Contractor's ability to prevent, detect and deter Fraud, Waste or Abuse;   |   |                         |   |   |
| H. Providing prompt response to detected offenses and developing corrective action initiatives relating to the Contractor's contract;   |   |                         |   |   |
| I. Providing for internal monitoring and auditing of Contractor and its subcontractors; and supply the department with quarterly reports on the activity and ad hocs as necessary;                  | <p>Minimal - Internal monitoring and auditing are addressed in the CCP. Provision of quarterly reports to the Department related to subcontractors is noted. It is not evident that WellCare reports internal monitoring and auditing activities for the Contractor itself.</p> <p><b>MCO Response:</b> WellCare respectfully submits the following information in lieu of a CAP.</p> <p>Intent to comply with this provision is documented in the revised Fraud Waste and Abuse Policy and procedure. WellCare submits all required regulatory reports as requested per DMS.</p> | Full                    | Internal monitoring and auditing are addressed in the Corporate Compliance Program. Policy C12SIU FWA 001 Fraud, Waste and Abuse states that on a quarterly basis, WellCare's Compliance Department shall provide to the Department and the OIG, in a spreadsheet format, a report on all cases of suspected FWA by WellCare associates, subcontractors or vendors. |   |



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| <b>State Contract Requirements</b><br>(Federal Regulations: 438.602, 438.608, 438.610)  | <b>Prior Results &amp; Follow-Up</b>  | <b>Review Determination</b> | <b>Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)</b>  | <b>Health Plan's and DMS' Responses and Plan of Action</b> |
|   | Documentation:<br>•#6_Tool_C12SIU FWA-001<br>•#6_Tool_C12SIU FWA-001-PR_KY, page 2-3, Data Analysis<br>See Also:<br>•#6_Tool_Exhibit C Report 69 & 70 Provider Enrollment Activity.doc<br>•#6_Tool_MCO Reports Description Index 6.6.12.doc<br>•Tool 6_Report #69 Description.doc<br>•Tool 6_Report #69 Template.xlsx<br>•Tool 6_Report #70 Template.doc<br>•Tool 6_Report #70 Template.xlsx<br>•Tool 6_Report #70 Description.doc            |                             | Quarterly reports to the Department related to suspected fraud, waste and abuse address this requirement.  |  |
| J. Being subject to on-site review and fully complying with requests from the department to supply documentation and records; and   | Minimal - Provision of documentation is addressed in the FWA Policy. On-site reviews are not addressed in documents provided.<br><br><b>MCO Response:</b> WellCare respectfully submits the following information in lieu of a CAP.<br><br>Please refer to the revised FWA Policy C12SIU FWA-001, which has been updated to include this statement.<br><br>Documentation:<br>•#6_Tool_C12SIU FWA-001<br>•#6_Tool_C12SIU FWA-001-PR_KY, page 1 | Full                        | Policy C12SIU FWA-001 Fraud, Waste and Abuse addresses documentation requests. Also states that the SIU will be available for onsite reviews of case documentation and records as requested by the Commonwealth of Kentucky. |  |
| K. Creating an account receivables process to collect outstanding debt from members or providers and providing monthly reports of activity and collections to the department. |   |                             |  |  |



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| The Contractor's PIU shall:   |  |                      |  |   |
| A. 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;   | <p>Minimal - Review of data addressed in FWA Policy. Review of member and provider grievance and appeal data not specifically addressed.</p> <p><b>MCO Response:</b> WellCare respectfully submits the following information in lieu of a CAP.</p> <p>Please refer to the revised FWA Policy C12SIU FWA-001, which has been updated to include this statement.</p> <p>Documentation:<br/>           •#6_Tool_C12SIU FWA-001, page 4, External Referrals<br/>           •#6_Tool_C12SIU FWA-001-PR_KY</p> | Full                 | Addressed in C12SIU FWA-001.   |   |
| B. Conduct regularly scheduled post-payment audits of provider billings, investigate payment errors, produce printouts and queries of data and report the results of their work to the Contractor, the Department, and OIG; |  |                      |  |   |
| C. Conduct onsite and desk audits of providers and report the results to the Department, including any overpayments identified;   | <p>Non-Compliance - Documents provided do not address conduct of onsite and desk audits.</p> <p><b>MCO Response:</b> The 15 investigative files supplied for the review present documentation of desk audits. No onsite activities at provider facilities were conducted during the period. The updated Fraud Waste and Abuse Policy and Procedure is attached.</p> <p>Documentation:<br/>           •#6_Tool_C12SIU FWA-001</p>   | Full                 | Policy C12SIU FWA-001 addresses this requirement for desk audits of providers as needed.   |   |



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|  | •#6_Tool_C12SIU FWA-001-PR_KY, Reporting.   |                         |  |   |
| D. Maintain locally 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;   |   |                         |  |   |
| E. Designate a contact person to work with investigators and attorneys from the Department and OIG;  |   |                         |  |   |
| F. Ensure the integrity of PIU referrals to the Department. Referrals if appropriate by the unit shall not be subject to the approval of the Contractor's management or officials;   |   |                         |  |   |
| G. 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; | Substantial - P/P for verification of services not provided for review. Report #73, EOMB provided.<br><br><b><u>Recommendation for WellCare</u></b><br>Policy/procedure for service verification should be provided for review.<br><br><b>MCO Response:</b> Please refer to KY - Medicaid Recipient Verification Letters - Monthly - 6-13-2012 BRD. Service verification letters are sent monthly and a report of these is provided to the SIU to ensure an appropriate sample was selected. Typically the sample is far greater than the 500 required.<br><br>Documentation<br>•#6_Tool_KY Medicaid Recipient Verification Letters - | Full                    | Policy C12PD-010 Member Service Verification Process addresses this requirement. Monthly State report 73 shows that a minimum of 500 claims is sampled.      |   |



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|--|---|-------------------------|--|---|
| State Contract Requirements<br>(Federal Regulations: 438.602, 438.608,<br>438.610)   | Prior Results & Follow-Up   | Review<br>Determination | Comments (Note: For any element<br>that deviates from the<br>requirements, an explanation of<br>the deviation must be documented<br>in the Comments section) | Health Plan's and DMS' Responses and Plan of Action |
|  | Monthly - 6-13-2012<br>•#6_Tool_C12SIU FWA-001-PR_KY, page 3, subsection<br>Monthly Reporting<br>•#6_Tool_Report #73 Template<br>•#6_Tool_Report 73 Description   |                         |  |   |
| H. 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; |   |                         |  |   |
| I. Have a method for collecting administratively on member overpayments that were declined prosecution, known as Medicaid Program Violations (MPV) letters, and recover payments from the member;          |   |                         |  |   |
| J. Comply with the program integrity requirements set forth in 42 CFR 438.608 and provide policies and procedures to the Department for review;  |   |                         |  |   |
| K. Report any provider denied enrollment by Contractor for any reason, including those contained in 42 CFR 455.106, to the Department within 5 days of the enrollment denial;                              | Non-Compliance - Documentation of compliance not provided.<br><br><b>MCO Response:</b> WellCare respectfully submits the following information in lieu of a CAP.<br><br>The attached Fraud Waste and Abuse (FWA) policy is being edited, however, page 9 references reporting FWA to law enforcement etc. In addition to this the | Full                    | Policy C7PR-015 addresses this requirement.  |   |



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| <b>State Contract Requirements</b><br>(Federal Regulations: 438.602, 438.608, 438.610) | <b>Prior Results &amp; Follow-Up</b>  | <b>Review Determination</b> | <b>Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)</b> | <b>Health Plan's and DMS' Responses and Plan of Action</b> |
|  | <p>compliance program documentation includes a section about fraud reporting to government agencies, on page 7 – see the excerpt below:</p> <p>WellCare reports suspected or confirmed cases of fraud, waste and abuse, violations of the False Claims Act, or potential fraud or misconduct to appropriate law enforcement agencies, CMS or its designee, and/or other state or Federal government agencies as described in WellCare's policy on Fraud, Waste and Abuse.</p> <p>Providers that have submitted incomplete information in the application are not considered. They are not denied, but rather they are never considered since all necessary information is not included.</p> <p>All contractual and regulatory reporting requirements from the Kentucky Department of Medicaid Services are documented in the regulatory reporting package. Please see the Reporting Index referenced below. WellCare sends two provider reports regarding termination and denial of MCO participation. These terminated providers are also sent to the state via email upon receipt of termination from the credentialing department.</p> <p>WellCare has never received a regulatory reporting description or template for reporting provider enrollment and termination activity on a schedule beyond the attached reporting descriptions and templates.</p> <p>However, WellCare would provide information on a different schedule if asked by the Department.</p> |                             |   |  |



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| State Contract Requirements<br>(Federal Regulations: 438.602, 438.608,<br>438.610)  | Prior Results & Follow-Up  | Review<br>Determination | Comments (Note: For any element<br>that deviates from the<br>requirements, an explanation of<br>the deviation must be documented<br>in the Comments section) | Health Plan's and DMS' Responses and Plan of Action |
|   | Documentation:<br>•#6_Tool_C12SIU FWA-001, page 9<br>•#6_Tool_WC Corporate Compliance Program Revised 040413, page 7<br>•#6_Tool_Exhibit C Report 69 & 70 Provider Enrollment Activity.doc<br>•#6_Tool_MCO Reports Description Index 6.6.12.doc<br>•Tool 6_Report #69 Description.doc<br>•Tool 6_Report #69 Template.xlsx<br>•Tool 6_Report #70 Template.doc<br>•Tool 6_Report #70 Template.xlsx<br>•Tool 6_Report #70 Description.doc<br><br>See Also: #6_Tool_C12SIU FWA-001-PR_KY |                         |  |   |
| L. Have a method for recovering overpayments from providers;  |  |                         |  |   |
| M. Comply with the program integrity requirements of the Patient Protection and Affordable Care Act as directed by the Department;  |  |                         |  |   |
| N. Correct any weaknesses, deficiencies, or noncompliance items that are identified as a result of a review or audit conducted by DMS, CMS, or by any other State or Federal Agency 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; and | Non-Compliance - Not addressed in documents provided.<br><br><b>MCO Response:</b> WellCare respectfully submits the following information in lieu of a CAP.<br><br>Intent to comply with this provision is documented in the revised Fraud Waste and Abuse Procedure.<br><br>Documentation:<br>•#6_Tool_C12SIU FWA-001-PR_KY, page 1.  | Full                    | This is addressed in policy C12SIU FWA-001.  |   |



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|  | <p>Additionally, WellCare employees are bound to cooperate with all Government Audits, Inspections and Investigations.</p> <p>See also: #6_Tool_Code_of_Conduct_as_approved_by_the_Board_5.24.2012_with_summary_of_changes[1]</p>   |                         |  |   |
| O. Work cooperatively and collaboratively with the Department to enhance the contractors PIU and to address any deficiencies identified.   | <p>Non-Compliance - Not addressed in the documents provided.</p> <p><b>MCO Response:</b> WellCare respectfully submits the following information in lieu of a CAP.</p> <p>Intent to comply with this provision is documented in the revised Fraud Waste and Abuse Policy.</p> <p>Documentation:<br/> <ul style="list-style-type: none"> <li>•#6_Tool_C12SIU FWA-001-PR_KY, page 1.</li> </ul> </p>            | Full                    | This is addressed in C12SIU FWA-001.   |   |
| <b>PATIENT ABUSE:</b><br>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 carbon copy the Department for Medicaid Services and OIG. | <p>Non-Compliance - Documents provided do not address this requirement.</p> <p><b>MCO Response:</b> WellCare respectfully submits the following information in lieu of a CAP.</p> <p>Intent to comply with this provision is documented in the revised Fraud Waste and Abuse Policy.</p> <p>Documentation:<br/> <ul style="list-style-type: none"> <li>•#6_Tool_C12SIU FWA-001-PR_KY, page 3.</li> </ul> </p> | Full                    | This is addressed in C12SIU FWA-001.   |   |



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| <b>COMPLAINT SYSTEM:</b><br>The Contractor's PIU shall operate a process to receive, investigate and track the status of Fraud, Waste and Abuse complaints received from members, providers and all other sources which may be made against the Contractor, providers or members. The process 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;   |                           |                         |  |   |
| 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;   |                           |                         |  |   |
| C. Should the preliminary inquiry result 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 should take whatever actions may be necessary, up to and including, administrative recovery of identified overpayments;                  |                           |                         |  |   |
| D. Should the preliminary inquiry result in a reasonable belief that Fraud or Abuse has occurred, the PIU should refer   |                           |                         |  |   |



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| the case and all supporting documentation to the Department, with a copy to OIG;  |                           |                         |  |   |
| E. OIG will review the referral and attached documentation and make a determination as to whether OIG will investigate the case or return it to the PIU for them to conduct a preliminary investigation;  |                           |                         |  |   |
| F. OIG will notify the PIU in a timely manner as to whether the OIG will investigate or whether the PIU should conduct a preliminary investigation;   |                           |                         |  |   |
| G. If in the process of conducting a preliminary investigation, the PIU suspects a violation of either criminal Medicaid fraud statutes or the Federal False Claims Act, the PIU shall immediately notify the Department with a copy to the OIG of their findings and proceed only in accordance with instructions received from the OIG; |                           |                         |  |   |
| H. If OIG determines that it will keep a case referred by the PIU, the OIG will conduct an investigation, gather evidence, write a report and forward information to the Department and the PIU for appropriate actions;  |                           |                         |  |   |
| I. If OIG opens an investigation based on a complaint received from a source other  |                           |                         |  |   |



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| State Contract Requirements<br>(Federal Regulations: 438.602, 438.608,<br>438.610)   | Prior Results & Follow-Up   | Review<br>Determination | Comments (Note: For any element<br>that deviates from the<br>requirements, an explanation of<br>the deviation must be documented<br>in the Comments section)   | Health Plan's and DMS' Responses and Plan of Action |
| than the Contractor, OIG will, upon completion of the investigation, provide a copy of the investigative report to DMS and the PIU for appropriate actions;  |   |                         |  |   |
| J. If OIG investigation results in a referral to the Attorney General's Medicaid Fraud Control Unit and/or the U.S. Attorney, the OIG will notify DMS and the PIU of the referral. DMS and the PIU should only take actions concerning these cases in coordination with the law enforcement agencies that received the OIG referral; |   |                         |  |   |
| K. Upon approval of the Department, Contractor shall suspend provider payments in accordance with Section 6402 (h)(2) of the Affordable Care Act pending investigation of credible allegation of fraud; these efforts shall be coordinated through the Department;   |   |                         |  |   |
| L. Upon completion of the PIU's preliminary investigation, the PIU should provide the Department and OIG a copy of their investigative report, which should contain the following elements:  | <p>Substantial - Addressed in FWA Policy.</p> <p>A sample of 15 program integrity files were reviewed - 5 member files, 5 provider files and 5 ancillary providers. Sub-requirement results are provided below. Three files did not include any notes beyond October 2012. One file includes a note dated 10/26 stating that due diligence was initiated. No further notes are documented. Another file for this same member indicates that SIU case documents include claims, COB and eligibility, however none of these documents are in the file or discussed.</p> | Full                    | <p>This is addressed in policy C12SIU_FWA-001 and C12SIU-FWA-001. Reports 76 and 77 provided. Detail information is copied onto a CD and sent to DMS/OIG.</p> <p><u>Program Integrity File Review</u><br/>A sample of 10 program integrity files was reviewed. 5 member files and 5 provider files. Sub-requirement results are provided</p> |   |



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|  | <p><b><u>Recommendation for WellCare</u></b><br/>Complete files should be maintained, and include timely follow-up.</p> <p>MCO Response: Please refer to complete files which include all related documentation.</p>  |                         | below.   |   |
| (1) Name and address of subject,   |   |                         |  |   |
| (2) Medicaid identification number,  |   |                         |  |   |
| (3) Source of complaint,   |   |                         |  |   |
| (4) The complaint/allegation,  | <p>Substantial - 14 of 15 files were compliant. One file indicates that a detailed allegation was added on 3/16/12 however it is not documented in the file presented.</p> <p><b><u>Recommendation for WellCare</u></b><br/>The complaint/allegation should be clearly documented in program integrity files.</p> <p><b>MCO Response:</b> The status update notes in this case indicate the detailed allegation was updated on 3/16/12. Please refer to the case file which includes a copy of the audit trail as well as the case file including the detailed allegation as documentation that this activity was performed as indicated.</p> | Full                    | All 10 files contained the complaint/allegation.   |   |
| (5) Date assigned to the investigator,   |   |                         |  |   |
| (6) Name of investigator,  |   |                         |  |   |
| (7) Date of completion,  | Substantial - 12 of 15 files were compliant. Two files, for the same member and another file included notes dated   | Full                    | Of the 10 files, 4 files were noted as open and 6 had the completion   |   |



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| State Contract Requirements<br>(Federal Regulations: 438.602, 438.608,<br>438.610)                      | Prior Results & Follow-Up  | Review<br>Determination | Comments (Note: For any element<br>that deviates from the<br>requirements, an explanation of<br>the deviation must be documented<br>in the Comments section) | Health Plan's and DMS' Responses and Plan of Action |
|   | <p>in October 2012. No further notes documented; unable to determine the status of these cases.</p> <p><b><u>Recommendation for WellCare</u></b><br/>The status and resolution of cases should be clearly documented in the case files.</p> <p><b>MCO Response:</b> The files at issue were opened during the period and remained open and active at the time of the review. Between October 2012 and the date these files were provided, other work was being performed. Due diligence began and claims data was requested. Potential was eventually uncovered and referrals were made.</p> |                         | date.  |   |
| (8) Methodology used during investigation,  |  |                         |  |   |
| (9) Facts discovered by the investigation as well as the full case report and supporting documentation, | <p>Minimal - Files presented included a summary of documentation however the documentation gathered was not included in the file, such as query reports, claims reports, referral packets. In addition, one file was referred to WellCare from the OIG and after investigation was closed. There is no evidence in the file that a response was sent to the OIG.</p> <p><b>MCO Response:</b> Please refer to the complete files, including all documentation associated with each investigation.</p>   | Full                    | All 10 files contained facts discovered by the investigation as well as supporting documentation.  |   |
| (10) All exhibits or supporting documentation,  | <p>Minimal - As noted above, although documents were referenced, documents were not provided with the case files.</p>  | Full                    | All 10 files contained facts discovered by the investigation as well as supporting documentation.  |   |



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|  | <b>MCO Response:</b> As noted above, please refer to complete files. |                         |  |   |
| (11) Recommendations as considered necessary, for administrative action or policy revision,  |  |                         |  |   |
| (12) Overpayment identified, if any, and recommendation concerning collection.   |  |                         |  |   |
| M. The Contractor's PIU provide OIG and DMS a quarterly member and provider status report of all cases including actions taken to implement recommendations and collection of overpayments;  |  |                         |  |   |
| N. 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   |  |                         |  |   |
| O. The Contractor's PIU shall assure a Grievance and appeal process for Members and Providers in accordance with 907 KAR 1:671 and 907 KAR 1:563.  |  |                         |  |   |
| <b>REPORTING:</b><br>The Contractor's PIU shall provide a quarterly in narrative report format all activities and processes for each investigative case (from opening to closure) to the Department within 30 calendar days of investigation closure. If |  |                         |  |   |



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| any internal component 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 report all cases of suspected Fraud, Waste, Abuse or inappropriate practices by Subcontractors, Members or employees to the Department and OIG. |  |                         |  |   |
| The Contractor is required to report the following data elements to the Department and the OIG on a quarterly basis, in an excel format:   |  |                         |  |   |
| (1) PIU Case number;   |  |                         |  |   |
| (2) OIG Case number;   | <p>Non-Compliance - Reports 76 and 77 provided demonstrating reporting of member and provider FWA investigations. OIG case number not reported.</p> <p><b>MCO Response:</b> The OIG case number is not a field included on the template provided by Kentucky for these reports. See refer to the State approved templates and descriptions.</p> <p>Documentation:</p> <ul style="list-style-type: none"> <li>• #6_Tool_Report #76 Description</li> <li>• #6_Tool_Report #76 Template</li> <li>• #6_Tool_Report 77 Description</li> <li>• #6_Tool_Report # 77 Template</li> </ul> | Not Applicable          | <p>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.</p> <p><b>Recommendation for DMS</b><br/>DMS should consider revising the report templates for reports 76 and 77 to include the OIG case number.</p> |   |
| (3) Provider/Member name;  |  |                         |  |   |



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| State Contract Requirements<br>(Federal Regulations: 438.602, 438.608,<br>438.610)          | Prior Results & Follow-Up   | Review<br>Determination | Comments (Note: For any element<br>that deviates from the<br>requirements, an explanation of<br>the deviation must be documented<br>in the Comments section)   | Health Plan's and DMS' Responses and Plan of Action |
| (4) Provider/Member number;   |   |                         |  |   |
| (5) Date complaint received by Contractor;  |   |                         |  |   |
| (6) Source of complaint, unless the complainant prefers to remain anonymous;                |   |                         |  |   |
| (7) Date opened;  |   |                         |  |   |
| (8) Summary of complaint;   |   |                         |  |   |
| (9) Is complaint substantiated or not substantiated (Y or N answer only under this column); | <p>Minimal - Reports 76 and 77 provided demonstrating reporting of member and provider FWA investigations. The outcome of the investigation is not clearly documented in reports provided.</p> <p><b>MCO Response:</b> The OIG case number is not a field included on the template provided by Kentucky for these reports. See refer to the State approved templates and descriptions.</p> <p>Documentation:</p> <ul style="list-style-type: none"> <li>• #6_Tool_Report #76 Description</li> <li>• #6_Tool_Report #76 Template</li> <li>• #6_Tool_Report 77 Description</li> <li>• #6_Tool_Report # 77 Template</li> </ul> | Not Applicable          | <p>Reports 76 and 77 show reporting, however, this requirement is not included on the template provided by Kentucky for these reports.</p> <p><b>Recommendation for DMS</b><br/>DMS should consider revising the report templates for reports 76 and 77 to include this requirement.</p> |   |
| (10) PIU action taken (only provide the most current update);                               |   |                         |  |   |
| (11) Amount of overpayment (if any);  |   |                         |  |   |
| (12) Administrative actions taken to resolve findings of completed cases                    |   |                         |  |   |



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| including the following information:   |                           |                         |  |   |
| (a) The overpayment required to be repaid and overpayment collected to date;   |                           |                         |  |   |
| (b) Describe sanctions/withholds applied to Providers/Members, if any;   |                           |                         |  |   |
| (c) Provider/Members appeal regarding overpayment or requested sanctions. If so, list the date an appeal was requested, date the hearing was held, the date of the final decision, and to the extent they have occurred;   |                           |                         |  |   |
| (d) Revision of the Contractor's policies to reduce potential risk from similar situations with a description of the policy recommendation, implemented of aforementioned revision and date of implementation; and   |                           |                         |  |   |
| (e) Make MIS system edit and audit recommendations as applicable.  |                           |                         |  |   |
| <b>AVAILABILITY AND ACCESS TO DATA:</b><br>The Contractor shall:   |                           |                         |  |   |
| A. Gather, produce, keep 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 |                           |                         |  |   |



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| State Contract Requirements<br>(Federal Regulations: 438.602, 438.608,<br>438.610)   | Prior Results & Follow-Up  | Review<br>Determination | Comments (Note: For any element<br>that deviates from the<br>requirements, an explanation of<br>the deviation must be documented<br>in the Comments section) | Health Plan's and DMS' Responses and Plan of Action |
| reviews, investigations, investigative supporting documentation, finding 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;                             | <p>Non-Compliance - Not addressed in the documents provided.</p> <p><b>MCO Response:</b> WellCare respectfully submits the following information in lieu of a CAP.</p> <p>Intent to comply with this provision is documented in the revised Fraud Waste and Abuse Procedure and is also address in the regulatory reports #73, #72, #75 and #76.</p> <p>Documentation:</p> <ul style="list-style-type: none"> <li>• #6_Tool_C12SIU FWA-001-PR-KY, page 3</li> <li>• #6_Tool_Encounter Data information</li> <li>• #6_Tool_Report #73 Template</li> <li>• #6_Tool_Report 73 Description</li> <li>• #6_Tool_Report #72 Template</li> <li>• #6_Tool_Report 72 Description</li> <li>• #6_Tool_Report 75 Description</li> <li>• #6_Tool_Report #75 Template</li> <li>• #6_Tool_Report # 76 Template</li> <li>• #6_Tool_Report # 76 Description</li> </ul> | Full                    | This is addressed in policy C12SIU FWA-001.  |   |
| C. Backup, store or be able to recreate reported data upon demand for the Department and the OIG;  |  |                         |  |   |
| D. Permit reviews, investigations or audits of all books, records or other data, at the discretion of the Department or                            | Non-Compliance - Not addressed in the documents provided.  | Full                    | This is addressed in policy C12SIU FWA-001.  |   |



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| <b>Program Integrity</b><br><i>(See Final Page for Suggested Evidence)</i>  |  |                             |   |  |
|---|--|-----------------------------|---|--|
| <b>State Contract Requirements</b><br>(Federal Regulations: 438.602, 438.608, 438.610)  | <b>Prior Results &amp; Follow-Up</b>   | <b>Review Determination</b> | <b>Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)</b> | <b>Health Plan's and DMS' Responses and Plan of Action</b> |
| 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; | <p><b>MCO Response:</b> WellCare respectfully submits the following information in lieu of a CAP.</p> <p>Intent to comply with this provision is documented in the revised Fraud Waste and Abuse Procedure.</p> <p>Documentation:<br/>           •#6_Tool_C12SIU FWA-001-PR-KY, page 1</p> <p>Additionally, WellCare employees are bound to cooperate with all Government Audits, Inspections and Investigations.</p> <p>See also: #6_Tool_Code_of_Conduct_as_approved_by_the_Board_5.24.2012_with_summary_of_changes[1]</p>                 |                             |   |  |
| E. Produce records in electronic format for review and manipulation by the Department and the OIG;  | <p>Non-Compliance - Not addressed in the documents provided.</p> <p><b>MCO Response:</b> WellCare respectfully submits the following information in lieu of a CAP.</p> <p>Intent to comply with this provision is documented in the revised Fraud Waste and Abuse Procedure.</p> <p>Documentation:<br/>           •#6_Tool_C12SIU FWA-001-PR-KY, page 2</p> <p>Additionally, WellCare employees are bound to cooperate with all Government Audits, Inspections and Investigations.</p> <p>See also: #6_Tool_Code_of_Conduct_as_approved_</p> | Full                        | This is addressed in policy C12SIU FWA-001.   |  |



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|---|---|-----------------------------|---|--|
| <b>State Contract Requirements</b><br>(Federal Regulations: 438.602, 438.608, 438.610)            | <b>Prior Results &amp; Follow-Up</b>  | <b>Review Determination</b> | <b>Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)</b> | <b>Health Plan's and DMS' Responses and Plan of Action</b> |
|   | by_the_Board_5.24.2012_with_summary_of_changes[1]   |                             |   |  |
| F. Allow designated Department staff read access to ALL data in the Contractor's MIS systems; and | <p>Non-Compliance - Not addressed in the documents provided.</p> <p><b>MCO Response:</b> WellCare respectfully submits the following information in lieu of a CAP.</p> <p>Intent to comply with this provision is documented in the attached email between WellCare and DMS staff.</p> <p>At this time, we are currently seeking a candidate to fulfill the obligations this role requires.</p> <p>Documentation:</p> <ul style="list-style-type: none"> <li>#6_Tool_DMS System Access</li> <li>#6_Tool_C12SIU FWA-001-PR-KY</li> </ul> <p>Additionally, WellCare employees are bound to cooperate with all Government Audits, Inspections and Investigations.</p> <p>See also: #6_Tool_Code_of_Conduct_as_approved_by_the_Board_5.24.2012_with_summary_of_changes[1]</p> | Full                        | WellCare staff person runs data for DMS. This was approved by Bob Nowell at DMS. Director of Network Operations is fulfilling this requirement.         |  |
| G. Provide all contracted rates for providers upon request.                                       | <p>Non-Compliance - Not addressed in the documents provided.</p> <p><b>MCO Response:</b> WellCare respectfully submits the following information in lieu of a CAP.</p> <p>The Code of Conduct pages 23, 24 and 25 has information about proprietary information and the release of proprietary information.</p>   | Full                        | Addressed in FWA-001-PR-KY.   |  |



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|---|---|-------------------------|--|---|
| State Contract Requirements<br>(Federal Regulations: 438.602, 438.608,<br>438.610)  | Prior Results & Follow-Up   | Review<br>Determination | Comments (Note: For any element<br>that deviates from the<br>requirements, an explanation of<br>the deviation must be documented<br>in the Comments section) | Health Plan's and DMS' Responses and Plan of Action |
|   | <p>While DMS, its agents or other agencies have not requested provider rates, WellCare would release information requested as part of an investigation and/or audit pursuant the Fraud Waste and Abuse policy and procedure and Code of Conduct.</p> <p>Documentation:<br/>           •#6_Tool_Code_of_Conduct_as_approved_by_the_Board_5.24.2012_with_summary_of_changes[1], pages 23-25<br/>           •#6_Tool_C12SIU FWA-001<br/>           •#6_Tool_C12SIU FWA-001-PR-KY</p> |                         |  |   |
| The Contractor's PIU shall have 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.  |   |                         |  |   |
| The Contractor shall cooperate with the OIG, the United States Attorney's Office and other law enforcement agencies in the investigation or fraud or abuse cases.   |   |                         |  |   |
| In the event no action toward collection of overpayments is taken by the Contractor after one hundred and eighty (180) days the Commonwealth may begin collection activity and shall retain any overpayments collected. If the Contractor takes appropriate action to collect overpayments, the | <p>Non-Compliance - Not addressed in the documents provided.</p> <p><b>MCO Response:</b> WellCare respectfully submits the following information in lieu of a CAP.</p> <p>Intent to comply with this provision is documented in the revised Fraud Waste and Abuse Procedure.</p>  | Full                    | C12SIU-FWA-001-KY addresses the requirement toward collection of overpayment.  |   |



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|--|---|-----------------------------|---|---|
| <b>State Contract Requirements</b><br>(Federal Regulations: 438.602, 438.608, 438.610)                                   | <b>Prior Results &amp; Follow-Up</b>  | <b>Review Determination</b> | <b>Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)</b>   | <b>Health Plan's and DMS' Responses and Plan of Action</b>  |
| Commonwealth will not intervene.   | Documentation: <ul style="list-style-type: none"> <li>#6_Tool_C12SIU FWA-001-PR_KY, page 3.</li> </ul>  |                             |   |   |
| The Contractor shall provide identity and cover documents and information for law enforcement investigators under cover. | <p>Non-Compliance - Not addressed in the documents provided.</p> <p><b>MCO Response:</b> WellCare respectfully submits the following information in lieu of a CAP.</p> <p>The Code of Conduct on page 31 has the following:</p> <p>Government Reimbursement and the False Claims Act<br/>As a provider of services under contracts with government programs, WellCare is subject to federal and state false claims acts which prohibit submission of a false claim or making a false record or statement in order to gain reimbursement from and/or avoid an obligation to a government sponsored program such as Medicare or Medicaid. WellCare adheres to all applicable laws, rules, regulations and program requirements when filing or otherwise presenting any bid, bill or claim for payment, any cost or expenditure report, any encounter data or other medical record reports, or any other information to federal or state health programs.</p> <p>WellCare discussed concerns regarding this provision based on federal laws in March of 2012 with representatives of the Medicaid Fraud Waste Control Unit in Kentucky. Based on the complexity of the issues WellCare raised at that time, including data integrity in reporting and quality of care for legitimate members seeing targeted providers, the KY MFCU decided to</p> | Non-Compliance              | <p>Per WellCare, this needs to be discussed further with DMS.</p> <p>WellCare discussed concerns regarding this provision based on federal laws in March of 2012 with representatives of the Medicaid Fraud Waste Control Unit in Kentucky. Based on the complexity of the issues WellCare raised at that time, including data integrity in reporting and quality of care for legitimate members seeing targeted providers, the KY MFCU decided to postpone any request for undercover credentials. To date, WellCare has not been requested to pursue identity cover.</p> <p><b><u>Recommendation for WellCare</u></b><br/>WellCare should include this requirement in policy/procedure.</p> | <p>Please refer to the CAP document CAP_6_Tool_Program Integrity_2014. WellCare is committed to identifying, preventing, remedying and reporting fraud, waste and abuse ("FWA") utilizing all lawful means. WellCare also seeks to fully support the Kentucky Medicaid Fraud Waste Control Unit ("Kentucky MFCU") in its efforts to combat FWA. The pending issue regarding Kentucky MFCU's request to WellCare for assistance in creating a fictitious Medicaid account was previously discussed in March 2012 by a now former WellCare employee with a Kentucky MFCU representative whom WellCare has been informed is no longer employed in such capacity. At that time, WellCare expressed concerns regarding the subject request, based on WellCare's interpretation of federal laws that proscribe creating false identifications to facilitate the provision of receipt of any federally subsidized program benefits. WellCare was also concerned about the impact of this conduct on the integrity of data reported to the state and federal governments, and regarding quality of care for legitimate members seeing targeted providers. As such, the KY MFCU then agreed to postpone any request for fictitious credentials. Until now, the request had not been renewed. Under the circumstances, WellCare respectfully requests a dialogue with the appropriate Kentucky MFCU representatives to address WellCare's concerns.</p> |



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|--|--|-------------------------|--|---|
| State Contract Requirements<br>(Federal Regulations: 438.602, 438.608,<br>438.610) | Prior Results & Follow-Up  | Review<br>Determination | Comments (Note: For any element<br>that deviates from the<br>requirements, an explanation of<br>the deviation must be documented<br>in the Comments section) | Health Plan's and DMS' Responses and Plan of Action |
|  | <p>postpone any request for undercover credentials. To date, WellCare has not been requested to pursue identity cover at this time.</p> <p>Documentation:<br/>           #6_Tool_Code_of_Conduct_as_approved_<br/>           by_the_Board_5.24.2012_with_summary_of_changes[1],<br/>           page 31</p> |                         |  |   |



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**Program Integrity**

**Scoring Grid:**

| Compliance Level   | Full     | Substantial | Minimal  | Non-Compliance |
|--------------------|----------|-------------|----------|----------------|
| Points Value       | <b>3</b> | <b>2</b>    | <b>1</b> | <b>0</b>       |
| Number of Elements | 23       | 0           | 0        | 1              |
| Total Points       | 69       | 0           | 0        | 0              |

**Overall Compliance Determination:**

| Compliance Level | Full       | Substantial       | Minimal           | Non-Compliance  |
|------------------|------------|-------------------|-------------------|-----------------|
| Points Range     | <b>3.0</b> | <b>2.0 – 2.99</b> | <b>1.0 – 1.99</b> | <b>0 – 0.99</b> |
| Points Average   |            | <b>2.88</b>       |                   |                 |

**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.**

**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



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**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



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**Early and Periodic Screening, Diagnosis and Treatment (EPSDT)**  
*(See Final Page for Suggested Evidence)*

| State Contract Requirements<br>(Federal Regulation: Not Applicable)  | Prior Results & Follow-Up | Review<br>Determination | Comments (Note: For any element that<br>deviates from the requirements, an<br>explanation of the deviation must be<br>documented in the Comments section) | Health Plan's and<br>DMS' Responses and Plan of Action |
|--|---------------------------|-------------------------|---|--|
| <b>8.4 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</b>   |                           |                         |   |  |
| The Contractor shall provide all Members under the age of twenty-one (21) years EPSDT services in compliance with the terms of this Contract and policy statements issued during the term of this Contract by the Department or CMS. The Contractor shall file EPSDT reports in the format and within the timeframes required by the terms of this Contract as indicated in Appendix J. The Contractor shall comply with 907 KAR 11:034 that delineates the requirements of all EPSDT providers participating in the Medicaid program. |                           |                         |   |  |
| Health care professionals who meet the standards established in the above-referenced regulation shall provide EPSDT services. Additionally, the Contractor shall:  |                           |                         |   |  |
| A. Provide, through direct employment with the Contractor or by Subcontract, accessible and fully trained EPSDT Providers who meet the requirements set forth under 907 KAR 1:034*, and who are supported by adequately equipped offices to perform EPSDT services.  |                           |                         |   |  |
| B. Effectively communicate information (e.g. written notices, verbal explanations, face to face counseling or home visits when appropriate or necessary) with members and their families who are eligible for EPSDT services [i.e. Medicaid eligible persons who are under the age of twenty-one (21)] regarding the value of preventive health care, benefits provided as part of EPSDT services, how to access these services, and the Member's right to access these services.  |                           |                         |   |  |



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*(See Final Page for Suggested Evidence)*

| State Contract Requirements<br>(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 |
|---|--|----------------------|---|---|
| <p>Members and their families shall be informed about EPSDT and the right to Appeal any decision relating to Medicaid services, including EPSDT services, upon initial enrollment and annually thereafter where Members have not accessed services during the year.</p> | <p>Substantial - Information regarding the right to appeal any decision relating to Medicaid services (without specifically mentioning EPSDT) is included in the Member Handbook.</p> <p>P/P C7QI-034 EPSDT Policy Appendix E Kentucky addresses this requirement.</p> <p><u>UM File Review</u><br/>Five UM decisions related to EPSDT (child members) were reviewed. All 5 files were completed timely and were compliant with UM contract requirements.</p> <p><u>Appeal File Review</u><br/>Five member appeals related to EPSDT (child members) were reviewed. All 5 appeals were completed timely. Three appeals were expedited appeals. One of the 3 expedited appeals did not inform the member of the limited time available to present evidence.</p> <p><b><u>Recommendation for WellCare</u></b></p> | <p>Full</p>          | <p>All Medicaid Services are eligible to be appealed; there are no excluded services from the appeal process. The Member Handbook explains that EPSDT is a Medicaid service, and that all Medicaid services can be appealed.</p> <p><u>Appeal File Review</u><br/>Five member appeals related to EPSDT (child members) were reviewed. All 5 appeals were completed timely and were compliant.</p> |   |



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| State Contract Requirements<br>(Federal Regulation: Not Applicable)  | Prior Results & Follow-Up  | Review<br>Determination | Comments (Note: For any element that<br>deviates from the requirements, an<br>explanation of the deviation must be<br>documented in the Comments section) | Health Plan's and<br>DMS' Responses and Plan of Action |
|--|--|-------------------------|---|--|
|  | <p>The Member Handbook should include appeal rights for EPSDT services. Appeal letters should inform members of the limited time available to present evidence for expedited appeals.</p> <p><b>MCO Response:</b> The Member Handbook revision is currently underway and language regarding member appeal rights for EPSDT services will be included in the Handbook revision.</p> |                         |   |  |
| C. Provide EPSDT services to all eligible Members in accordance with EPSDT guidelines issued by the Commonwealth and federal government and in conformance with the Department's approved periodicity schedule, a sample of which is included in Appendix J.   |  |                         |   |  |
| D. Provide all needed initial, periodic and inter-periodic health assessments in accordance with 907 KAR 1:034*. The Primary Care Provider assigned to each eligible member shall be responsible for providing or arranging for complete assessments at the intervals specified by the Department's approved periodicity schedule and at other times when Medically Necessary. |  |                         |   |  |
| E. Provide all needed diagnosis and treatment for eligible Members in accordance with 907 KAR 1:034*. The Primary Care Provider and other Providers in the Contractor's Network shall provide diagnosis and  |  |                         |   |  |



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| State Contract Requirements<br>(Federal Regulation: Not Applicable)  | Prior Results & Follow-Up  | Review<br>Determination | Comments (Note: For any element that<br>deviates from the requirements, an<br>explanation of the deviation must be<br>documented in the Comments section)   | Health Plan's and<br>DMS' Responses and Plan of Action |
|--|--|-------------------------|---|--|
| treatment, and/or Out-of-Network Providers may provide treatment if the service is not available with the Contractor's Network.  |  |                         |   |  |
| F. Provide EPSDT Special Services for eligible members, including identifying providers who can deliver the Medically Necessary services described in federal Medicaid law and developing procedures for authorization and payment for these services. Current requirements for EPSDT Special Services are included in Appendix J. |  |                         |   |  |
| G. Establish and maintain a tracking system to monitor acceptance and refusal of EPSDT services, whether eligible Members are receiving the recommended health assessments and all necessary diagnosis and treatment, including EPSDT Special Services when needed.  | <p>Non-Compliance - Documents provided do not address tracking of acceptance and refusal of EPSDT services. P/P C7QI-034 addresses monitoring of receipt/non-receipt of services but does not include acceptance and refusal by members. Evidence of a tracking system not provided.</p> <p><b>MCO Response:</b> It is the responsibility of the Plan's participating providers to document and track member's refusal and acceptance of EPSDT services. To ensure providers are performing this function, WellCare conducts medical record audits. The baseline medical record audit will occur in the Fall 2013.</p> | Full                    | <p>P/P C7QI-034 addresses monitoring of receipt/non-receipt of services. The EPSDT Program Description addresses this area. Periodicity letter sent to providers for members requiring EPSDT services. WellCare uses an EPSDT tracking data base. The MCO sends notification to members if they have not received services. A list of member is also sent to providers. WellCare began conducting an annual MR review in the Fall of 2013. 62 of the 69 provider groups did not meet the goal of 80%.</p> |  |



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*(See Final Page for Suggested Evidence)*

| State Contract Requirements<br>(Federal Regulation: Not Applicable)  | Prior Results & Follow-Up  | Review<br>Determination | Comments (Note: For any element that<br>deviates from the requirements, an<br>explanation of the deviation must be<br>documented in the Comments section) | Health Plan's and<br>DMS' Responses and Plan of Action |
|--|--|-------------------------|---|--|
|  | Please refer to page 11,<br>section "Early and Periodic<br>Screening, Diagnostic and<br>Treatment (EPSDT) of the<br>Provider Manual and policy<br>C7QI 015 Medical Record<br>Review. |                         |   |  |
| H. Establish and maintain an effective and on-going Member Services case management function for eligible members and their families to provide education and counseling with regard to Member compliance with prescribed treatment programs and compliance with EPSDT appointments. This function shall assist eligible Members or their families in obtaining sufficient information so they can make medically informed decisions about their health care, provide support services including transportation and scheduling assistance to EPSDT services, and follow up with eligible Members and their families when recommended assessments and treatment are not received. |  |                         |   |  |
| I. Maintain a consolidated record for each eligible member, including reports of informing about EPSDT, information received from other providers and dates of contact regarding appointments and rescheduling when necessary for EPSDT screening, recommended diagnostic or treatment services and follow-up with referral compliance and reports from referral physicians or providers.  |  |                         |   |  |
| J. Establish and maintain a protocol for coordination of physical health services and Behavioral Health Services for eligible members with behavioral health or  |  |                         |   |  |



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*(See Final Page for Suggested Evidence)*

| State Contract Requirements<br>(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 |
|--|---|----------------------|--|---|
| developmentally disabling conditions.  |   |                      |  |   |
| Coordination procedures shall be established for other services needed by eligible members that are outside the usual scope of Contractor services. Examples include early intervention services for infants and toddlers with disabilities, services for students with disabilities included in the child's individual education plan at school, WIC, Head Start, Department for Community Based Services, etc.   |   |                      |  |   |
| K. Participate in any state or federally required chart audit or quality assurance study.  |   |                      |  |   |
| L. Maintain an effective education/ information program for health professionals on EPSDT compliance (including changes in state or federal requirements or guidelines). At a minimum, training shall be provided concerning the components of an EPSDT assessment, EPSDT Special Services, and emerging health status issues among Members which should be addressed as part of EPSDT services to all appropriate staff and Providers, including medical residents and specialists delivering EPSDT services. In addition, training shall be provided concerning physical assessment procedures for nurse practitioners, registered nurses and physician assistants who provide EPSDT screening services. |   |                      |  |   |
| M. Submit Encounter Record for each EPSDT service provided according to requirements provided by the Department, including use of specified EPSDT procedure codes and referral codes. Submit quarterly and annual reports on EPSDT services including the current Form CMS-416.  | Substantial - Addressed in P/P C7QI-034. Evidence of submission and acceptance of encounter data provided.<br><br>Quarterly reports on EPSDT services including Form CMS- | Full                 | Requirement is addressed in P/P C7QI-034. Evidence of submission and acceptance of encounter data provided. Quarterly reports were also submitted as evidence. |   |



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| State Contract Requirements<br>(Federal Regulation: Not Applicable) | Prior Results & Follow-Up  | Review<br>Determination | Comments (Note: For any element that<br>deviates from the requirements, an<br>explanation of the deviation must be<br>documented in the Comments section) | Health Plan's and<br>DMS' Responses and Plan of Action |
|---|--|-------------------------|---|--|
|   | <p>416 provided for review.</p> <p>Annual report was submitted to DMS in March 2013. WellCare reported an EPSDT screening rate of 68% for the Categorically Needy category. Across age groups, the screening rate ranged from 38% (6-9 years of age) to 90% (1-2 years of age). WellCare reported an EPSDT participation rate of 45% for the Categorically Needy category. Across age groups, the participation rate ranged from 34% (15-18 year of age) to 92% (age &lt; 1 year).</p> <p>WellCare did not provide EPSDT screening and participation rates for the Medically Needy category.</p> <p><b><u>Recommendation for WellCare</u></b><br/>           The MCO should report EPSDT screening and participation rates for the Categorically Needy and Medically Needy categories, and total screening and participation rates combining the categories.</p> |                         |   |  |



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**Early and Periodic Screening, Diagnosis and Treatment (EPSDT)  
(See Final Page for Suggested Evidence)**

| State Contract Requirements<br>(Federal Regulation: Not Applicable) | Prior Results & Follow-Up  | Review<br>Determination | Comments (Note: For any element that<br>deviates from the requirements, an<br>explanation of the deviation must be<br>documented in the Comments section) | Health Plan's and<br>DMS' Responses and Plan of Action |
|---|--|-------------------------|---|--|
|   | <p><b>MCO Response:</b> The CMS 416 measure specifications do not provide guidance on how to differentiate members who are medically needy versus categorically needy, therefore WellCare placed all members in the categorically needy category on the CMS 416 report. The rates reported were total rates for all members meeting the criteria for this report. Since receiving the EQRO's findings, WellCare requested guidance from DMS on how to differentiate between members who are medically needy versus categorically needy as the State makes this determination. A conference call between the Plan and DMS was held on 6/26/13 to discuss this issue. DMS provided the Plan with the program logic to differentiate medically needy and categorically needy members on 6/26/13. Please refer to the email correspondence documentation between the Plan and DMS.</p> |                         |   |  |
| N. Provide an EPSDT Coordinator staff function with                 | Minimal - P/P C7QI-034   | Full                    | Org chart provided shows an EPSDT   |  |



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|---|--|-------------------------|---|--|
| adequate staff or subcontract personnel to serve the Contractor's enrollment or projected enrollment.   | <p>Addendum E-Kentucky addresses EPSDT Coordinator position. This position has not been filled. The Plan states they are actively recruiting for this position.</p> <p><b>MCO Response:</b> This position has been filled; please see the updated organizational chart. One of the QI Specialist positions in the QI department serves as the EPSDT Coordinator.</p> |                         | coordinator position that addresses this requirement.   |  |
| <b>22.1 Required Functions</b>  |  |                         |   |  |
| L. Arranging for and assisting with scheduling EPSDT Services in conformance with federal law governing EPSDT for persons under the age of 21 years.  |  |                         |   |  |
| <b>37.9 EPSDT Reports</b>   |  |                         |   |  |
| The Contractor shall submit Encounter Records to the Department's Fiscal Agent for each Member who receives EPSDT Services. This Encounter Record shall be completed according to the requirements provided by the Department, including use of specified EPSDT procedure codes and referral codes. Annually the Contractor shall submit a report on EPSDT activities, utilization and services and the current Form CMS-416 to the Department. | <p>Substantial - Addressed in P/P C7Q1-034. MCO Report #24 is an overview of activities related to EPSDT and includes CMS-416.</p> <p>Annual report was submitted to DMS in March 2013. WellCare reported an EPSDT screening rate of 68% for the Categorically Needy category. Across age groups, the</p>  | Full                    | Addressed in P/P C7Q1-034. MCO Report #24 is an overview of activities related to EPSDT and includes CMS-416. WellCare provided the EPSDT screening and participation rates for the Medically Needy category. |  |



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|   | <p>screening rate ranged from 38% (6-9 years of age) to 90% (1-2 years of age). WellCare reported an EPSDT participation rate of 45% for the Categorically Needy category. Across age groups, the participation rate ranged from 34% (15-18 year of age) to 92% (age &lt; 1 year).</p> <p>WellCare did not provide EPSDT screening and participation rates for the Medically Needy category.</p> <p><b><u>Recommendation for WellCare</u></b><br/>The MCO should report EPSDT screening and participation rates for the Categorically Needy and Medically Needy categories, and total screening and participation rates combining the categories.</p> <p><b>MCO Response:</b> The CMS 416 measure specifications do not provide guidance on how to differentiate members who are medically needy versus categorically needy, therefore WellCare placed all members in the categorically needy</p> |                         |   |  |



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|---|---|-------------------------|--|---|
|   | <p>category on the CMS 416 report. The rates reported were total rates for all members meeting the criteria for this report. Since receiving the EQRO's findings, WellCare requested guidance from DMS on how to differentiate between members who are medically needy versus categorically needy as the State makes this determination. A conference call between the Plan and DMS was held on 6/26/13 to discuss this issue. DMS provided the Plan with the program logic to differentiate medically needy and categorically needy members on 6/26/13. Please refer to the email correspondence documentation between the Plan and DMS.</p> |                         |  |   |



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**Scoring Grid:**

| <b>Compliance Level</b> | <b>Full</b> | <b>Substantial</b> | <b>Minimal</b> | <b>Non-Compliance</b> |
|-------------------------|-------------|--------------------|----------------|-----------------------|
| Points Value            | <b>3</b>    | <b>2</b>           | <b>1</b>       | <b>0</b>              |
| Number of Elements      | 5           | 0                  | 0              | 0                     |
| Total Points            | 15          | 0                  | 0              | 0                     |

**Overall Compliance Determination:**

| <b>Compliance Level</b> | <b>Full</b> | <b>Substantial</b> | <b>Minimal</b>    | <b>Non-Compliance</b> |
|-------------------------|-------------|--------------------|-------------------|-----------------------|
| Points Range            | <b>3.0</b>  | <b>2.0 – 2.99</b>  | <b>1.0 – 1.99</b> | <b>0 – 0.99</b>       |
| Points Average          | <b>3.0</b>  |                    |                   |                       |

**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.**

**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



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### Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Suggested Evidence

#### Documents

Policies/procedures for:

- EPSDT services
- Identification of members requiring EPSDT special services
- Education/information program for health professionals
- EPSDT provider requirements
- Coordination of physical health services and behavioral health services
- Coordination of other services, e.g., early intervention services

EPSDT member/provider ratio and case management ratio for EPSDT children with special needs

Evidence of communication of required EPSDT information with eligible members and families

EPSDT Coordinator position description

Description of tracking system to monitor acceptance and refusal of EPSDT services

Process for monitoring compliance with EPSDT services requirements including periodicity schedule

Evidence of case management function providing education and counseling for patient compliance

Process for ensuring follow-up evaluation, referral and treatment in response to EPSDT screening results

Linkage agreements between MCO providers and behavioral health providers to assure provision of EPSDT services

Copies of practitioner training materials and other educational/informational materials and attendance records

Process for calculating EPSDT participation and screening rates including quality control measures

Evidence of submission of EPSDT Encounter Records, including special EPSDT procedure codes and referral codes

#### File Review

Sample of UM and member and provider appeals related to EPSDT services selected by the EQRO

#### Reports

EPSDT reports (quarterly and annual 416 reports)

Annual EPSDT report of EPSDT activities, utilization and services



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(See Final Page for Suggested Evidence)**

| State Contract Requirements<br>(Federal Regulation 438.230)  | Prior Results & Follow-Up   | Review<br>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>5.3 Delegations of Authority</b>  |   |                         |  |   |
| <p>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.</p> | <p>WellCare contracts with multiple entities including:<br/>           Alere – case management and disease management<br/>           Avesis – vision and dental services<br/>           Bluegrass – behavioral health crisis line<br/>           BHM Healthcare Solutions – behavioral health services<br/>           CareCore – utilization management for radiology, cardiology, sleep management, musculoskeletal management<br/>           CareNet – nurse advice line<br/>           DentaQuest – dental services (terminated 8/31/12)<br/>           Focus Health – behavioral health services<br/>           Max Specialty Benefits – audiology services<br/>           Walgreens – pharmacy services</p> <p>The following entities are delegated credentialing:<br/>           Association of PCPs<br/>           CenterCare<br/>           Cincinatti Children's Hospital<br/>           St. Jude's<br/>           Vanderbilt<br/>           Ashland Area Health Alliance<br/>           Jennie Stuart Medical Center<br/>           The Physicians Network</p> <p>In addition, Comprehensive Health Management provides customer services at various sites.</p> |                         |  |   |



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|--|--|----------------------|--|---|
| 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. |  |                      |  |   |
| B. Before any delegation, the Contractor shall evaluate the prospective subcontractor's ability to perform the activities to be delegated.   | <p>Substantial - WellCare provided pre-delegation audit results for all subcontractors with the exception of Vanderbilt. The audit was conducted 7/23/12 however the audit results were not included in the documents provided for review.</p> <p><b>Recommendation for WellCare</b><br/>WellCare should provide the pre-delegation audit results for Vanderbilt.</p> <p><b>MCO Response:</b> Please refer to the pre-delegation audit documents for Vanderbilt.</p> | Full                 | <p>WellCare contracts with multiple entities including:</p> <p>Alere – provides case management and disease management services to WellCare members of KY</p> <p>Avesis – provides vision and dental services for WellCare members of KY</p> <p>Bluegrass – provides a behavioral health crisis line for WellCare members of KY (contract terminated on 12/31/13)</p> <p>BHM Healthcare Solutions – provides behavioral health services for WellCare members of KY (contract terminated on 7/22/13)</p> <p>CareCore – provides utilization management for radiology, cardiology, sleep management and musculoskeletal management for WellCare members of KY</p> <p>CareNet – provides a nurse advice line for WellCare members of KY</p> |   |



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|---|---------------------------|-------------------------|---|---|
|   |                           |                         | <p>Catamaran – provides pharmaceutical services for WellCare members of KY (formerly known as CatalystRx)</p> <p>DentaQuest –provides dental services for WellCare members of KY (contract terminated 8/31/12)</p> <p>Focus Health – provides behavioral health services for WellCare member of KY</p> <p>Max Specialty Benefits – provides audiology services for WellCare members of KY</p> <p>The following entities are delegated credentialing:</p> <p>Ashland Area Health Alliance<br/>Association of PCPs<br/>CenterCare<br/>Cincinatti Children's Hospital<br/>Jennie Stuart Medical Center<br/>Linkia<br/>Partners in Pediatrics<br/>The Physicians Network<br/>St. Jude's<br/>University of Louisville<br/>Vanderbilt Medical Group</p> <p>This requirement is addressed in the</p> |   |



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|---|---|-------------------------|--|---|
|   |   |                         | <p>Delegation Oversight Policy as well as the Delegation Oversight Entity Monitoring Procedure.</p> <p>All pre-delegation documentation for subcontracted entities is accounted for.</p>   |   |
| <p>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.</p> | <p>Minimal - WellCare provided annual audit results for all subcontractors due for an annual review during the review period. WellCare maintains a Delegation Oversight Committee (DOC), located at its Corporate Headquarters in Tampa. Local MCO representatives attend meetings by telephone. Committee meeting agendas and minutes demonstrated oversight of pre-delegation and annual audit reports and corrective actions taken.</p> <p>P/P C7QI-023-PR-001, Delegation Oversight, describes WellCare's oversight processes for pre-delegation, annual audits and ongoing monitoring. This policy references preparation and review of quarterly reports for each delegated entity. Documents provided for review did not include evidence of quarterly reports and limited review of these reports.</p> <p>Medicaid Quality Improvement Committee (QIC) minutes were reviewed. QIC minutes demonstrate presentation of DOC minutes and discussion of pre-delegation, focused and annual audit results and corrective action plans. A separate agenda item, Delegation Oversight, was added in May 2012. A subset of subcontractors</p> | <p>Full</p>             | <p>This requirement is addressed in The Delegation Oversight Policy as well as The Delegation Oversight Entity Monitoring Procedure.</p> <p>The Plan monitors the Subcontractor's performance at least quarterly using the Delegation Entity Scorecard and audits each entity annually following the Annual Audit Oversight Process. Entity scorecards are submitted on a monthly basis for all functions, except Credentialing (semi annual).</p> <p>Committee meeting minutes and agendas demonstrate oversight of pre-delegation, corrective actions taken by subcontractors and annual audit reports.</p> <p>Quarterly reports of the Delegation Oversight Committee are included in the documentation and show that they are presented to the KY Quality Improvement Committee (QIC). This is evidenced by the QIC Delegation</p> |   |



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|---|--|-------------------------|---|---|
|   | <p>are discussed in the minutes, however, with the exception of Alere, all discussions are focused on the results of audits rather than review of subcontractor reporting.</p> <p>P/P C7QI-PR-076, Delegation Entity Scorecard, effective 5/15/12 describes the procedure used by WellCare to receive and review delegated entity scorecards monthly (customer service, claims, network development, UM, disease management and provider appeals), and semi-annually (credentialing).</p> <p>Documents provided for review included submitted Delegation Entity Scorecards for some subcontractors. Review of the scorecards by the Delegation Oversight Auditors and presentation of review results to the Delegation Oversight Committee was not evident in the documents provided.</p> <p><b>MCO Response:</b> Quarterly reports of the Delegation Oversight Committee are presented to the KY Quality Improvement Committee (QIC). In addition, the Delegation Oversight Committee meets each month to discuss performance of the delegated entities; this is a two tiered approach to the oversight process. Please refer to the documents below attached.</p> <ul style="list-style-type: none"> <li>•QIC Delegation Oversight report.</li> <li>•Entity scorecards are submitted on a monthly basis for all functions, except Credentialing (semi</li> </ul> |                         | <p>Oversight Report.</p> <p>In addition, the Delegation Oversight Committee meets each month (minutes and agendas provided) to discuss performance of the delegated entities.</p> |   |



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|--|--|-------------------------|--|--|
|  | annual). See attached template<br>•Delegation Oversight Committee meeting minutes on scorecard analysis<br>•Sample Action Register for KY vendors.   |                         |  |  |
| D. If the Contractor identifies deficiencies or areas for improvement, the Contractor and the Subcontractor shall take corrective action.  | Minimal - Delegation Oversight Committee meeting minutes demonstrate actions taken in response to pre-delegation and annual audit results.<br><br>Quarterly reports for delegates were not provided. Actions taken in response to quarterly reports and scorecards were not evident.<br><br><b>MCO Response:</b> Please refer to the quarterly reports and minutes of the DOC where the scorecards were discussed. | Full                    | This requirement is addressed in The Delegation Oversight Policy as well as The Delegation Oversight Entity Monitoring Procedure.<br><br>Delegation Oversight Committee meeting minutes demonstrate actions taken in response to pre-delegation and annual audit results. Quarterly reports for delegated were provided with Delegation Entity Scorecards. |  |
| 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. |  |                         |  |  |
| F. The Contractor shall assure that the Subcontractor is in compliance with the requirement in 42 CFR 438.   | Minimal - See components above.<br><br><b>MCO Response:</b> Please refer to the quarterly reports and minutes of the DOC where the scorecards were discussed.  | Full                    | This requirement is addressed in The Delegation Oversight Policy as well as The Delegation Oversight Entity Monitoring Procedure.<br><br>Delegation Oversight Committee meeting minutes demonstrate actions taken in response to pre-delegation and annual audit results. Quarterly reports for delegated were provided with Delegation Entity Scorecards. |  |



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| <b>7.1 Subcontractor Indemnity</b>   |                           |                         |  |   |
| Except as otherwise provided in this Contract, all Subcontracts between the Contractor and its Subcontractors, 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.  |                           |                         |  |   |
| 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. |                           |                         |  |   |
| <b>7.2 Requirements</b>  |                           |                         |  |   |
| All Subcontractors must be eligible for participation in the Medicaid program as applicable. 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, or otherwise interact  |                           |                         |  |   |



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| <p>with a Member. 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.</p> |                           |                         |  |   |
| <p>The Department's subcontract review shall assure that all Subcontracts:</p>  |                           |                         |  |   |
| <p>A. Identify the population covered by the Subcontract;</p>   |                           |                         |  |   |
| <p>B. Specify the amount, duration and scope of services to be provided by the Subcontractor;</p>   |                           |                         |  |   |



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|---|---------------------------|-------------------------|---|--|
| C. Specify procedures and criteria for extension, renegotiation, and termination;   |                           |                         |   |  |
| D. Specify that Subcontractors use only Medicaid providers in accordance with this Contract;  |                           |                         |   |  |
| E. Make full disclosure of the method of compensation or other consideration to be received from the Contractor;  |                           |                         |   |  |
| F. Provide for monitoring by the Contractor of the quality of services rendered to Members in accordance with the terms of this Contract;   |                           |                         |   |  |
| G. Contain no provision that provides incentives, monetary or otherwise, for the withholding from Members of Medically Necessary Covered Services;  |                           |                         |   |  |
| H. Contain a prohibition on assignment, or on any further subcontracting, without the prior written consent of the Department;  |                           |                         |   |  |
| 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; |                           |                         |   |  |
| 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 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,  |                           |                         |   |  |



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| State Contract Requirements<br>(Federal Regulation 438.230)   | Prior Results & Follow-Up                     | Review<br>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 |
|---|---|-------------------------|--|---|
| without limitation,   |   |                         |  |   |
| (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,  |   |                         |  |   |
| (2) all QAPI requirements,  |   |                         |  |   |
| (3) all record keeping and reporting requirements,  |   |                         |  |   |
| (4) all obligations to maintain the confidentiality of information,   |   |                         |  |   |
| (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,  |   |                         |  |   |
| (6) all indemnification and insurance requirements, and   |   |                         |  |   |
| (7) all obligations upon termination;   |   |                         |  |   |
| 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; |   |                         |  |   |
| M. A Subcontractor with NCQA/URAC or other national   | Substantial - Addressed in WellCare P/P C7QI- | Substantial             | This requirement is addressed in the   | Subcontractors are required to submit               |



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(See Final Page for Suggested Evidence)**

| State Contract Requirements<br>(Federal Regulation 438.230)   | Prior Results & Follow-Up   | Review<br>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  |
|---|---|-------------------------|---|--|
| <p>accreditation shall provide the Contractor with a copy of its' current certificate of accreditation together with a copy of the survey report.</p> | <p>023, Delegation Oversight.</p> <p>It is not clear how this requirement is communicated to subcontractors. Contract language does not specify this requirement. WellCare did provide certificates and survey reports for its subcontractors.</p> <p><b>Recommendation for WellCare</b><br/>WellCare should provide its methodology for notifying subcontractors of the requirement to submit accreditation certificates and survey reports to the MCO.</p> <p><b>MCO Response:</b> Accreditation is part of the Delegation addenda, refer to submitted documents. In addition, Accreditation certificates are pulled by the Auditor as part of the audit process.</p> <ul style="list-style-type: none"> <li>•Delegation Addendum</li> <li>•Delegation Oversight Audit Tool (Credentialing)</li> </ul> <p><b>IPRO Comments:</b> Delegation addendum addresses health plan accreditation, not subcontractor accreditation.</p> |                         | <p>Delegation Oversight Policy as well as the Delegation Oversight Entity Monitoring Procedure.</p> <p>Documentation was provided that shows certification and survey reports for the subcontracted entities.</p> <p>WellCare noted that during the audit, subcontractors are required to submit accreditation certificates and survey reports.</p> <p><b>Recommendation for WellCare</b><br/>Wellcare should include in the Delegation addendum the requirement for the subcontractor to provide accreditation certificates and survey reports to the MCO.</p> | <p>accreditation certificates and reports. This element is included in the delegation audit tool. The contract requires the subcontractor to provide copy of its current accreditation and copy of survey report but does not prescribe methodology.</p> <p>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.</p> |
| <p>N. Provide a process for the Subcontractor to identify deficiencies or areas of improvement, and any necessary corrective action.</p>              |   |                         |   |  |
| <p>O. The remedies up to, and including, revocation of the subcontract available to the Contractor if the</p>   |   |                         |   |  |



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| State Contract Requirements<br>(Federal Regulation 438.230)   | Prior Results & Follow-Up | Review<br>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 does not fulfill its obligations.   |                           |                         |  |   |
| P. Contain provisions that suspected fraud and abuse be reported to the contractor.   |                           |                         |  |   |
| Section 7.2 requirements would be applicable to Subcontractors characterized as Providers/Risk Arrangements including, but not limited to, physicians, hospitals, ancillary providers, IPAs/PHOs, Provider Networks, and Vision Care, Dental and Behavior Health Services; and to those who interact and assist Members including, but not limited to, Radiology Benefit Manager, Disease Management/Case Management, Health Risk Assessments, Pre-Certification Services, PBM, Recoveries, Translation Services and 24-hour Section 7.2 requirements shall not apply to Subcontracts for administrative services or other vendor contracts that do not impact Members. |                           |                         |  |   |
| <b>7.3 Disclosure of Subcontractors</b>   |                           |                         |  |   |
| The Contractor shall inform the Department of any Subcontractor providing Covered Services which 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 \$250,000 or five percent (5%) of the Subcontractor's operating expense.   |                           |                         |  |   |
| <b>7.4 Remedies</b>   |                           |                         |  |   |
| 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   |                           |                         |  |   |



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*(See Final Page for Suggested Evidence)*

| State Contract Requirements<br>(Federal Regulation 438.230)                              | Prior Results & Follow-Up | Review<br>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 |
|--|---------------------------|-------------------------|--|---|
| invoke such a remedy against the Contractor or require the termination of this Contract. |                           |                         |  |   |



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**Scoring Grid:**

| Compliance Level   | Full | Substantial | Minimal | Non-Compliance |
|--------------------|------|-------------|---------|----------------|
| Points Value       | 3    | 2           | 1       | 0              |
| Number of Elements | 4    | 1           | 0       | 0              |
| Total Points       | 12   | 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   |      | 2.80        |            |                |

**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.**

**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



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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



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**Quality Assessment and Performance Improvement: Health Information Systems (HIS)**  
*(See Final Page for Suggested Evidence)*

| State Contract Requirements<br>(Federal Regulations 438.242)  | Prior Results &<br>Follow-Up | Review<br>Determination | Comments (Note: For any element that<br>deviates from the requirements, an<br>explanation of the deviation must be<br>documented in the Comments section) | Health Plan's and DMS'<br>Responses and Plan of Action |
|---|------------------------------|-------------------------|---|--|
| <b>17.1 Encounter Data Submission</b>   |                              |                         |   |  |
| The Contractor shall have a computer and data processing system sufficient to accurately produce the data, reports and Encounter Record set in formats and timelines prescribed by the Department as defined in the Contract. |                              | Full                    | Policy C12ENC-001-PR-001 Kentucky Submission Procedure and C12ENC-001 End to End process, along with the work flow diagram address this requirement.      |  |
| The system shall be capable of following or tracing an Encounter within its system using a unique Encounter Record identification number for each Encounter.  |                              | Full                    | WellCare Control Number (WCN) Assignment Tech Spec addresses the tracking of encounters through a unique WCN.   |  |
| At a minimum, the Contractor shall be required to electronically provide Encounter Record to the Department, on a weekly schedule.  |                              | Full                    | Procedure IT.1401.PR.006 addresses this requirement. Report #64 shown as evidence of submissions.   |  |
| Encounter Record must follow the format, data elements and method of transmission specified by the Department.  |                              | Full                    | Procedure IT.1401.PR.006 addresses this requirement.  |  |
| All changes to edits and processing requirements due to Federal or State law changes shall be provided to the Contractor in writing no less than sixty (60) working days prior to implementation, whenever possible.          |                              |                         |   |  |
| The Contractor shall submit electronic test data files as required by the Department in the format referenced in this Contract and as specified by the Department.  |                              | Not Applicable          | No evidence provided that the Department has requested test data files.   |  |
| The electronic test files are subject to Department review and approval before production of data.  |                              |                         |   |  |
| The Contractor shall have the capacity to track and report on all Erred Encounter Records.  |                              | Full                    | Procedure IT.1401.PR.006 addresses this requirement.  |  |
| The Contractor shall be required to use procedure codes, diagnosis codes and other codes used for reporting   |                              | Full                    | Procedure IT.1401.PR.006 addresses this requirement.  |  |



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**Quality Assessment and Performance Improvement: Health Information Systems (HIS)**  
*(See Final Page for Suggested Evidence)*

| State Contract Requirements<br>(Federal Regulations 438.242)   | Prior Results &<br>Follow-Up | Review<br>Determination | Comments (Note: For any element that<br>deviates from the requirements, an<br>explanation of the deviation must be<br>documented in the Comments section)   | Health Plan's and DMS'<br>Responses and Plan of Action |
|--|------------------------------|-------------------------|---|--|
| Encounter Record in accordance with guidelines defined by the Department in writing. The Contractor must also use appropriate NPI/Provider numbers for Encounter Records as directed by the Department.  |                              |                         |   |  |
| All subcontracts with Providers or other vendors of service must have provisions requiring that Encounter Record is reported/submitted in an accurate and timely fashion.  |                              | Full                    | Addressed in provider and subcontractor agreements.   |  |
| The Contractor shall specify to the Department the name of the primary contract person assigned responsibility for submitting and correcting Encounter Record, and a secondary contact person in the event the primary contract person is not available.   |                              | Full                    | The names of the primary and secondary MCO contact persons were provided.   |  |
| <b>17.2 Technical Workgroup</b>  |                              |                         |   |  |
| The Contractor shall assign staff to participate in the Encounter Technical Workgroup periodically scheduled by the Department. The workgroup's purpose is to enhance the data submission requirements and improve the accuracy, quality and completeness of the Encounter Record.                             |                              | Full                    | Encounter Contacts Narrative document was submitted as evidence of the MCO contacts.<br><br>Email from DMS to WellCare: Confirmation of participation with technical workgroup shows proof of attendance. |  |
| <b>18 Kentucky Health Information Exchange (KHIE)</b>  |                              |                         |   |  |
| The Contractor shall provide all adjudicated Claims data within twenty-four (24) hours of final claim adjudication in support of KHIE. The Contractor shall provide the KHIE with all clinical data as soon as it is available. The Contractor will also share with the KHIE any Member patient clinical data. |                              | Not Applicable          | The requirement to submit to KHIE was suspended by KDMS in March 2013.  |  |
| The PCPs in the Contractor's network shall be required to connect to KHIE within one (1) year of the effective date  |                              | Not Applicable          | The requirement to submit to KHIE was suspended by KDMS in March 2013.  |  |



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**Quality Assessment and Performance Improvement: Health Information Systems (HIS)**  
*(See Final Page for Suggested Evidence)*

| State Contract Requirements<br>(Federal Regulations 438.242)  | Prior Results &<br>Follow-Up | Review<br>Determination | Comments (Note: For any element that<br>deviates from the requirements, an<br>explanation of the deviation must be<br>documented in the Comments section) | Health Plan's and DMS'<br>Responses and Plan of Action |
|---|------------------------------|-------------------------|---|--|
| of the contract with the Contractor or other schedule as determined by the Department. Furthermore, the Contractor shall encourage all providers in their Network to establish connectivity with the KHIE.  |                              |                         |   |  |
| <b>29.1 Claims Payments</b>   |                              |                         |   |  |
| In accordance with the Balanced Budget Act (BBA) Section 4708, the Contractor shall implement Claims payment procedures that ensure 90% of all Provider Claims for which no further written information or substantiation is required in order to make payment are paid or denied within thirty (30) days of the date of receipt of such Claims and that 99% of all Claims are processed within ninety (90) days of the date of receipt of such Claims. |                              | Full                    | Policy C6CL MD-006 - Prompt Pay addresses this contractual requirement. Report #46 presented as evidence.   |  |
| In addition, the Contractor shall comply with the Prompt-Pay statute, codified within KRS 304.17A-700-730, as may be amended, and KRS 205.593, and KRS 304.14-135 and 99-123, as may be amended.  |                              | Full                    | Policy C6CL MD-006 - Prompt Pay addresses this contractual requirement.   |  |



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**Quality Assessment and Performance Improvement: Health Information Systems**

**Scoring Grid:**

| Compliance Level   | Full     | Substantial | Minimal  | Non-Compliance |
|--------------------|----------|-------------|----------|----------------|
| Points Value       | <b>3</b> | <b>2</b>    | <b>1</b> | <b>0</b>       |
| Number of Elements | 11       | 0           | 0        | 0              |
| Total Points       | 33       | 0           | 0        | 0              |

**Overall Compliance Determination:**

| Compliance Level | Full       | Substantial       | Minimal           | Non-Compliance  |
|------------------|------------|-------------------|-------------------|-----------------|
| Points Range     | <b>3.0</b> | <b>2.0 – 2.99</b> | <b>1.0 – 1.99</b> | <b>0 – 0.99</b> |
| Points Average   | <b>3.0</b> |                   |                   |                 |

**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.**

**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

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



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**Suggested Evidence**

**Documents**

Policies/procedures for:

- Claims processing
- Claims payment
- Encounter data reporting

Process for verifying the accuracy and completeness of provider and vendor reported data

Process for screening data for completeness, logic and consistency

Evidence of timely and accurate reporting of encounter data to DMS

Process for monitoring compliance with claims payment timeliness requirements

Process for tracking and reporting erred encounter records

Evidence of participation in Encounter Technical workgroup

Method for meeting KHIE requirements

Status of efforts to have PCPs establish connectivity to KHIE

**Reports**

Timeliness of Claims Payment

Results of compliance monitoring for timeliness of claims payment and compliance with prompt pay statute

Internal quality measurement results related to accuracy and completeness of encounter data, including analysis and follow-up



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**Case Management/Care Coordination**  
*(See Final Page for Suggested Evidence)*

| State Contract Requirements<br>(Federal Regulation: 438.208)   | Prior Results & Follow-Up | Review<br>Determination | Comments (Note: For any element that<br>deviates from the requirements, an<br>explanation of the deviation must be<br>documented in the Comments section) | Health Plan's and DMS'<br>Responses and Plan of Action |
|--|---------------------------|-------------------------|---|--|
| <b>2. Definitions</b>  |                           |                         |   |  |
| <u>Care Coordination</u> 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.   |                           |                         |   |  |
| <u>Care Management System</u> 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.  |                           |                         |   |  |
| <u>Care Plan</u> 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. |                           |                         |   |  |
| <u>Case Management</u> 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.  |                           |                         |   |  |
| <u>Children with Special Health Care Needs</u> means Members who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and  |                           |                         |   |  |



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*(See Final Page for Suggested Evidence)*

| State Contract Requirements<br>(Federal Regulation: 438.208)  | Prior Results & Follow-Up | Review<br>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 |
|---|---------------------------|-------------------------|--|---|
| who also require health and related services of a type or amount that is 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.  |                           |                         |  |   |
| <u>CHIPRA</u> 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 their existing program and expands insurance coverage to additional low-income, uninsured children.                     |                           |                         |  |   |
| <u>Comprehensive Assessment</u> 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. |                           |                         |  |   |
| <b>34.2 Care Management System</b>  |                           |                         |  |   |
| 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.   |                           |                         |  |   |
| Members needing Care Management Services shall be identified through the health risk assessment, evaluation of Claims data, Physician referral or other mechanisms that may be utilized by the Contractor.  |                           |                         |  |   |



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| State Contract Requirements<br>(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 |
|--|---|----------------------|--|---|
| 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. |   |                      |  |   |
| Care coordination shall be linked to other Contractor systems, such as QI, Member Services and Grievances.   | <p>Non-Compliance - Linkage of care coordination with other contractor systems not addressed in the policies provided.</p> <p><b>MCO Response:</b> WellCare of Kentucky has measures in place to ensure communication and coordination of member needs is addressed between the multidisciplinary team. Please refer to policies C7GR-003, C7Q1-053, and the 2012 UM Program Description and 2012 CM Program Description.</p> <p>Quality: The team members with quality issues complete an RQU note describing the issue or issues that have been determined require further investigation. Included in the note is the member medical record. This member is then placed in the quality queue for the quality department to investigate.</p> | Full                 | Addressed in the 2013 UM Program Description and P/P C7QI-053 (Quality of Care Issues).  |   |



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| State Contract Requirements<br>(Federal Regulation: 438.208)   | Prior Results & Follow-Up  | Review<br>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 |
|--|--|-------------------------|--|---|
|  | <p>Member Services: The Member number is provided in the member Handbook along with the communication letters sent from case management. Case management is notified with all member inquires in to the call center. Outreach is attempted from a health services team member to follow up with the member.</p> <p>Grievances: Health Services staff provides member the number of Customer Services or assist with a warm transfer to the customer services department. Customer Services complies the information and routes with the appropriate personal. Upon receipt the grievance department initiates an investigation. Communication between the health services department and grievance department takes places to expedite a resolution.</p> |                         |  |   |
| <b>34.3 Care Coordination</b>  |  |                         |  |   |
| The care coordinators and case managers will work together with the primary care providers as teams to provide appropriate services for Members. | Minimal - Addressed in P/P C7CM 1.2, CM Program Description Process and engagement of providers is addressed in C7CM   | Full                    | Addressed in the 2013 CM Program Description and P/P C7CM-MD-1.2 -PR-004.<br><br><a href="#">Care Coordination File Review</a>                   |   |



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| State Contract Requirements<br>(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 |
|--|--|----------------------|---|---|
|  | <p>1.2-PR-004, CM Medical Comprehensive Assessment.</p> <p><u>Care Coordination File Review</u><br/>           16 of 20 files reviewed were compliant. Four files demonstrated gaps in documentation and/or f/u on needs identified.</p> <p><b>MCO Response:</b> WellCare of Kentucky has a standard operating procedure in place for inclusion of the Primary Care Providers on the Care Management team to provide appropriate services to our members. WellCare requires members to have a PCP as a strategy to increase quality-of-care and achieve optimal outcomes. At the time of enrollment the Case Manager is expected to notify the PCP of the member's enrollment in the CM program, conduct a discussion of the member's service needs and barriers to care, obtain additional clinical information from the PCP, discuss utilization patterns (ex: ED utilization and inpatient hospitalizations), identify and discuss any HEDIS care gaps, and provide reports and updates on the member's progress.</p> |                      | <p>12 cases were reviewed for care coordination. 8 of 12 contained a comprehensive assessment and care plan and demonstrated identification of physical and behavioral health needs and facilitation and coordination of services. The remaining 4 cases – 3 refused CM and 1 could not be reached despite multiple attempts to reach the member.</p> <p><u>Complex Case Management File Review</u><br/>           10 files were reviewed. 9/10 files contained a comprehensive assessment and demonstrated identification of physical and behavioral health needs and facilitation and coordination of services. The remaining case declined CM but a brief assessment and assistance were provided.</p> <p>7 of 10 contained a care plan. The remaining 3 – 1 was a DCBS client with an IP BH stay and placement issues. The member was followed but not enrolled in CM, 1 member declined CM but was assisted (per above), 1 member had frequent IP/ED events, multiple outreach attempts, assistance with needs, but was not enrolled in CM due to inconsistent ability to contact.</p> |   |



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| State Contract Requirements<br>(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 |
|---|--|----------------------|--|---|
|   | (Please refer to the documents, "Case Management Program and Engagement of Provider Corrective Action Plan" and "Documentation Gaps Corrective Action Plan".<br><br><b>FILE REVIEWS</b><br><br>Please refer to the document "Case Management File Review Responses". |                      |  |   |
| Care coordination is a process to assure that the physical and behavioral health needs of the 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.  |  |                      |  |   |
| 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 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 |  |                      |  |   |



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| 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.  |  |                      |   |  |
| The Care Plan shall be developed in accordance with 42 CFR 438.208.   |  |                      |   |  |
| <p>The Contractor shall develop and implement policies and procedures to ensure access to care coordination for all DCBS clients.</p> <p>The Contractor shall track, analyze, report, and when indicated, develop corrective action plans on indicators that measure utilization, access, complaints and grievances, and satisfaction with care and services specific to the DCBS population.</p> | <p>Minimal - Complaint report provided by WellCare states that no appeals or grievances have been filed for this population. Analysis report on Admits/Readmits for the period of 1/12-10/12 provided.</p> <p>Documentation provided does not address measurement of access and satisfaction for this population.</p> <p><b>MCO Response:</b> Please refer to policy C7CM MD 48PR 001 Individuals with Special Health Care Needs Case Management, identifies methodology to ensure access to care coordination and the 2012 CM Program Description.</p> <p>WellCare measures utilization and</p> | Minimal              | <p>Addressed in the 2013 CM Program Description and P/P C7CM MD-4.8.</p> <p>Quantitative performance measures include:</p> <ol style="list-style-type: none"> <li>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)</li> <li>2. Case Management Satisfaction Survey</li> <li>3. Readmission Reduction</li> <li>4. Gap in care closure</li> <li>5. ED utilization reduction</li> </ol> <p>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.</p> | <p>A CAP has been submitted to correct identified deficiencies. Please refer to the document CAP_10_Tool_CM_CC_2014.</p> |



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|   | <p>access specific to the DCBS population on monthly and quarterly basis, please refer to reports #65 and 66.</p> <p>WellCare also monitors complaints and grievances for all eligible members. Refer to policy C7GR-003 Kentucky Medicaid Grievance Procedure, which applies to all members including the DCBS population.</p> |                         | <p>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“.</p> <p>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.</p> <p><b><u>Recommendation for WellCare</u></b><br/>WellCare should track, analyze, report, and when indicated, develop corrective action plans on indicators that measure utilization, access, and satisfaction with care and services specific to the DCBS population.</p> |  |
| 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. |   |                         |  |  |
| <b>35.1 Individuals with Special Health Care Needs (ISHCN)</b>  |   |                         |  |  |
| 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,   |   |                         |  |  |



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| 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.  |                           |                         |  |   |
| 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.   |                           |                         |  |   |
| 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.   |                           |                         |  |   |
| The Contractor shall employ reasonable efforts to identify ISHCN's based on the following populations: Children in/or receiving Foster Care or adoption 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; and individuals with chronic behavioral health illnesses. |                           |                         |  |   |



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| 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. |  |                         |  |   |
| The Contractor shall have in place policies governing the mechanisms utilized to identify, screen, and assess individuals with special health care needs.  |  |                         |  |   |
| 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.  |  |                         |  |   |
| 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.  |  |                         |  |   |
| <b>35.2 DCBS Protection and Department for Aging and Independent Living DAIL Protection and Permanency Clients</b>   |  |                         |  |   |
| Members who are adult guardianship clients or foster 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.                        | Minimal - Addressed in policies and procedures for ISHCN and case management/care coordination.<br><br><u>DCBS Service Plan File Review</u><br>WellCare reports difficulty obtaining service plans from DCBS | Full                    | The plan submitted Foster Care Report #65 and their Guardianship Report #66 from July 2013 through December 2013.<br><br>Onsite, WellCare provided P/P C7CM – 1.2 – PR-017 which includes Kentucky State-specific requirements that specify DAIL and | WellCare will continue efforts to obtain service plans and will continue to meet with our state partners on a consistent basis to address concerns. |



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| <p>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.</p> <p>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.</p> <p>A monthly report of Foster Care Cases shall be sent to Department thirty (30) days after the end of each month.</p> | <p>and service plans provided often do not include detailed information. WellCare is working with DCBS to develop alternative options in order to obtain more detailed information about members. At the request of DCBS, the MCO does not complete HRAs for this population. WellCare reported that 6 cases are currently actively coordinated with DCBS.</p> <p>Of the 20 files reviewed, a service plan was provided for one file. Regardless of provision of a service plan, files reviewed demonstrated ongoing care coordination, when appropriate.</p> <p><u>DCBS Claims File Review</u><br/> IPRO also conducted a claims review of DCBS members; all professional/outpatient claims, documentation of outreach efforts including outreach to EPSDT services, and any case management or care coordination files for selected members were requested.</p> <p>Twenty files were reviewed with the following results:</p> |                      | <p>DCBS will develop and share a Service Plan with WellCare upon member enrollment.</p> <p>WellCare indicated that obtaining Service Plans continues to be a challenge; however, the MCO has been working continuously with DCBS/DAIL to obtain the Service Plans. WellCare documented repeated efforts to obtain Service Plans, despite varied levels of success. As noted in the file review, DCBS sometimes provided other documents in lieu of Service Plans. WellCare provided meeting logs for the monthly meetings with DCBS. The meeting logs contained requests for Service Plans not received by WellCare.</p> <p><u>DCBS Service Plan File Review</u><br/> 20 files were reviewed. 3/20 contained a Service Plan. Other documents were provided for 13 cases such as an RTC treatment plan, psych assessment, DCBS family assessment, MCO notes. No documentation was provided for 4. For the 3 files for which there were Service Plans:<br/> 1 of 3 contained both DCBS and WellCare signatures<br/> 3 of 3 demonstrated use of the Service Plan by WellCare/DCBS to determine medical needs and need for CM<br/> 13 of 20 files demonstrated ongoing care coordination. For the remaining 7, this was</p> |   |



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|  | <p>11 of 20 files included evidence of at least one well visit during the review period. Of the remaining 9 files, 5 files lacked evidence of a well visit and 4 files were not applicable (members were not due for a well visit).</p> <p>Of the 11 files including a well visit, provision of EPSDT services was evident in 8 files (3 files – claims did not show evidence of an EPSDT service code).</p> <p>Outreach efforts were not evident in the 8 files lacking a well visit and/or EPSDT service claim.</p> <p>Care coordination was evident in 2 files reviewed. The remaining files did not require care coordination services.</p> <p><b>MCO Response:</b> Please refer to policy C7CM-1.2 Behavioral Health Comprehensive Assessment and Planning and 2012 CM Program Description.</p> <p>The internal process was changed to be compliant with the written policy and procedures. Only cases</p> |                      | <p>not applicable.</p> <p>2 of 20 were enrolled in CM. For the 2 files where the member was enrolled in CM:</p> <p>2 of 2 demonstrated coordination with the foster parent/DCBS</p> <p>2 of 2 demonstrated consultation with DCBS before developing a new care plan</p> <p>17 of 20 files demonstrated monthly meetings with DCBS via meeting logs provided by WellCare.</p> <p><u>DCBS Claims File Review</u></p> <p>10 files were reviewed for DCBS EPSDT service and care coordination. The sample was comprised of members with serious acute needs, inpatient members in BH facilities, members with BH conditions and issues related to finding appropriate long term placement, as well as an infant in hospice care that expired.</p> <p>For many cases, most or all of the review elements were not applicable, but any information available was reviewed. Claims review for EPSDT services was often not applicable for these members. The case management, coordination, and preventive health services were member-appropriate in all cases.</p> <p>For the 10 files reviewed:<br/>1 of 10 contained documentation of a PCP</p> |   |



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|   | <p>with active case management have been opened to case management services. Prior to receiving case management plans Once a case is identified that could be appropriate for case management, the HRA is completed, the case is assigned in pending status to the case manager and a request for the service plan is made.</p> <p>Additionally file reviews and reports have been used to monitor that only active case management cases are being enrolled.</p> <p>Please refer to the Service Plan Corrective Action Plan.</p> |                      | <p>visit, for 9 this was NA<br/>           3 of 10 contained documentation of EPSDT services, for 7 this was NA. In the CM/CC file review overall, identification of gaps in preventive care (HEDIS) and follow-up was noted.</p> <p>Outreach for EPSDT services was not applicable to any of the 10<br/>           3 of 10 demonstrated care coordination between PH and BH, for 7, this was NA<br/>           7 of 10 demonstrated facilitation of care coordination between PH and BH by the CM, for 3 this was NA</p> <p><b>Recommendation for WellCare</b><br/>           WellCare should continue its efforts to obtain Service Plans and to meet with DMS and DCBS staff to establish effective information-sharing protocols.</p> |   |
| <b>35.3 Adult Guardianship Clients</b>  |   |                      |   |   |
| <p>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.</p> |   |                      |   |   |
| <b>35.4 Children in Foster Care</b>   |   |                      |   |   |



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| <p>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.</p> <p>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.</p> | <p>Minimal - WellCare provided MCO Report #20, Outreach/Education to Special Populations that demonstrates contact with DCBS. In addition, the MCO provided Report 65, Foster Care Report for 2012.</p> <p><u>DCBS Service Plan File Review</u><br/>WellCare reports difficulty obtaining service plans from DCBS and service plans provided often do not include detailed information. WellCare is working with DCBS to develop alternative options in order to obtain more detailed information about members. At the request of DCBS, the MCO does not complete HRAs for this population.</p> <p>Of the 20 files reviewed, a service plan was provided for one file. Regardless of provision of a service plan, files reviewed demonstrated ongoing care coordination, when appropriate.</p> <p><b>MCO Response:</b> Please refer to policy C7CM-1.2 Behavioral Health Comprehensive Assessment and</p> | <p>Full</p>          | <p>Addressed in P/P C7CM-1.2 -PR-017 (Case Management - Behavioral Health Comprehensive Assessment and Planning) and P/P C7CM-MD-1.2 -PR-004 (Case Management Medical Comprehensive Assessment and Planning).</p> <p>The plan provided MCO Report #20 (Outreach/Education to Special Populations (population examples) that demonstrates outreach conducted to the Foster Care and other Special Populations. In addition, the MCO provided Report 65, Foster Care Report for 2012.</p> <p>As described above, WellCare indicated that obtaining Service Plans has sometimes been a challenge; however, the MCO has been working continuously with DCBS/DAIL to obtain the Service Plans. The Service Plan file review reflected that in many cases, though the Service Plan was not available, other documentation with summary member information was provided.</p> <p><u>DCBS Service Plan File Review</u><br/>See element 35.2</p> |   |



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|  | <p>Planning.</p> <p>The internal process was changed to be compliant with the written policy and procedures. Only cases with active case management have been opened to case management services. Prior to receiving case management plans Once a case is identified that could be appropriate for case management, the HRA is completed, the case is assigned in pending status to the case manager and a request for the service plan is made.</p> <p>Additionally file reviews and reports have been used to monitor that only active case management cases are being enrolled.</p> <p>Please refer to the service plan corrective action plan to address the ongoing care coordination and signatures from DCBS staff.</p> <p>Monthly care coordination meetings with DCBS administrators have occurred and are scheduled through the remainder of the year, please see document "DCBS Meeting Schedule". These meetings address any concerns related to</p> |                         |  |   |



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|   | the resolution of disagreements on services plans.  |                         |  |   |
| 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.   | NA - Addressed in P/P C7CM 1.2-PR-004.<br><br><u>DCBS Service Plan Review</u><br>None of the files reviewed required case management services.  | Full                    | <u>DCBS Service Plan Review</u><br>See element 35.2  |   |
| 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.   | NA - Addressed in P/P C7CM 1.2-PR-004.<br><br><u>DCBS Service Plan Review</u><br>None of the files reviewed required case management services.  | Full                    | <u>DCBS Service Plan Review</u><br>See element 35.2  |   |
| 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 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 | Minimal - Addressed in P/P C7CM 1.2-PR-004.<br><br><u>DCBS Service Plan Review</u><br>WellCare reports difficulty obtaining service plans from DCBS and service plans provided often do not include detailed information. WellCare is working with DCBS to develop alternative options in order to obtain more detailed information about members. At the request of DCBS, the MCO does not complete HRAS | Full                    | Addressed in P/P C7CM-1.2 -PR-017 and P/P C7CM-MD-1.2 -PR-004.<br><br><u>DCBS Service Plan Review</u><br>See element 35.2                        |   |



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| process.  | <p>for this population.</p> <p>Of the 20 files reviewed, a service plan was provided for one file. Regardless of provision of a service plan, files reviewed demonstrated ongoing care coordination, when appropriate.</p> <p><b>MCO Response:</b> Please refer to the Service Plan Corrective Action Plan.</p>   |                         |   |  |
| <b>35.5 Children Receiving Adoption Assistance</b>  |   |                         |   |  |
| 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. | <p>Minimal - Addressed in P/P C7CM 1.2-PR-004.</p> <p><u>DCBS Service Plan Review</u><br/>WellCare reports difficulty obtaining service plans from DCBS and service plans provided often do not include detailed information. WellCare is working with DCBS to develop alternative options in order to obtain more detailed information about members. At the request of DCBS, the MCO does not complete HRAs for this population.</p> <p>Of the 20 files reviewed, a service plan was provided for one file.</p> | Full                    | <p>Addressed in P/P C7CM-1.2 -PR-017 and P/P C7CM-MD-1.2 -PR-004.</p> <p><u>DCBS Service Plan Review</u><br/>See element 35.2</p>                         |  |



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|  | <p>Regardless of provision of a service plan, files reviewed demonstrated ongoing care coordination, when appropriate.</p> <p><b>MCO Response:</b> The internal process was changed in Feb. 2012. Since this time, only cases with active case management have been opened to case management services. Additionally file reviews and reports have been used to monitor that only active case management cases are being enrolled. Please refer to the Service Plan Corrective Action Plan.</p> |                      |  |   |
| <b>32. 9 Pediatric Sexual Abuse Examination</b>  |   |                      |  |   |
| 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. | <p>Non-Compliance - Availability of providers to perform forensic pediatric sexual abuse examinations was not addressed in the documents provided.</p> <p><b>MCO Response:</b> WellCare of KY partners with the Kentucky Association of Children's Advocacy Centers to perform this service when requested by DCBS. We currently have contracts with 11 Child Advocacy Centers listed</p>   | Full                 | Addressed. P/P C7ND MD-001 (Network Development).  |   |



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|  | below:<br>Lincoln Trail Advocacy Support<br>Center<br>Hopes Place Inc/Children's<br>Advocacy Center<br>Gateway Children's Advocacy<br>Center<br>Pennyrile Children's Advocacy<br>Center<br>Northern Kentucky Children's<br>Advocacy Center<br>The Children's Advocacy Center of<br>Green River<br>Lake Cumberland Children's<br>Advocacy Center<br>Barren River Area Child Advocacy<br>Center<br>Children's Advocacy Center of the<br>Bluegrass<br>Judi's Place for Kids<br>Kentucky River Children's<br>Advocacy Center |                         |   |  |
| <b>32.8 Pediatric Interface</b>  |  |                         |   |  |
| The Contractor shall establish procedures to coordinate care for children receiving school-based services and early intervention services, in a manner that prevents duplication of Contractor provided services. The Contractor shall monitor the continuity and coordination of care for these children as part of its QAPI program. Services provided under these programs are authorized |  |                         |   |  |



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|--|---------------------------|----------------------|--|---|
| under the Federal Individuals with Disabilities Education Act, but typically excluded from Contractor coverage except 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. IEP services should not be duplicated.  |                           |                      |  |   |
| School-Based Services provided by schools are excluded from Contractor coverage and are paid by the Department through fee-for-service Medicaid when provided by a Medicaid enrolled provider. School-Based Services provided by public health departments are included in Contractor coverage. 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. Coordination between the schools and the Contractor shall ensure that Members receive medically necessary services that complement the individual education plan (IEP) services and promote the highest level of function for the child. |                           |                      |  |   |
| The Contractor shall coordinate services between the First Steps program and Contractor coverage. The First Steps program is an entitlement program established by the Federal Individuals with Disabilities Education Act (IDEA) and is funded by federal, state and local funds. The goal of the program is to provide early intervention services to children from birth up to age three who have developmental disabilities or delays. The intended outcome of the program is to ensure maximum amelioration of the impact of developmental disabilities   |                           |                      |  |   |



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**Case Management/Care Coordination**  
*(See Final Page for Suggested Evidence)*

| State Contract Requirements<br>(Federal Regulation: 438.208)   | Prior Results & Follow-Up | Review<br>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 |
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| or delays on infants and toddlers by early and ongoing provision of rehabilitation services.   |                           |                         |  |   |
| In order for Contractor and its Providers to effectively manage care for Members who qualify for these services, it will be necessary to coordinate the care provided through both programs as children who are receiving these services are identified, to share information with early intervention/school-based service providers with appropriate permission from parents. |                           |                         |  |   |
| Services provided under HANDS shall be excluded from Contractor coverage. HANDS is a home visitation program for first-time parents. It services children under three (3) years of age and it promotes good parenting skills.  |                           |                         |  |   |
| <b>37.11 DCBS and DAIL Service Plans Reporting</b>   |                           |                         |  |   |
| 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.  |                           |                         |  |   |



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**Case Management/Care Coordination/Department for Community Based Services (DCBS) Clients**

**Scoring Grid:**

| Compliance Level   | Full     | Substantial | Minimal  | Non-Compliance |
|--------------------|----------|-------------|----------|----------------|
| Points Value       | <b>3</b> | <b>2</b>    | <b>1</b> | <b>0</b>       |
| Number of Elements | 9        | 0           | 1        | 0              |
| Total Points       | 27       | 0           | 1        | 0              |

**Overall Compliance Determination:**

| Compliance Level | Full       | Substantial       | Minimal           | Non-Compliance  |
|------------------|------------|-------------------|-------------------|-----------------|
| Points Range     | <b>3.0</b> | <b>2.0 – 2.99</b> | <b>1.0 – 1.99</b> | <b>0 – 0.99</b> |
| Points Average   |            | <b>2.80</b>       |                   |                 |

**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.**

**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



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### **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 and early intervention services
- Pediatric sexual abuse examination
- Measurement of utilization, access, complaint and grievance, and satisfaction data 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 satisfaction with care 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

Number of DCBS and DAIL clients enrolled in the MCO as of the last day of the review period (December 31, 2013)

Number of DCBS and DAIL clients enrolled in the MCO who are enrolled in case management/care coordination as of the last day of the review period (December 31, 2013)

Monthly reports of Foster Care cases



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**File Review**

Care Coordination files for a random sample of cases selected by EQRO  
Logs of DCBS/MCO and DAIL/MCO meetings to review members  
DCBS and DAIL Service Plans for a sample of cases selected by EQRO  
DCBS Case Management files/claims records



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| <b>22.6 Member Rights and Responsibilities</b>   |   |                         |  |  |
| 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. |   |                         |  |  |
| 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.  | Substantial - WellCare advised that the out-of-network providers can access member rights and responsibilities on the Website.<br><br>Member's Rights and Responsibilities are included in the Member Handbook and Provider Manual.<br><br><b><u>Recommendation for WellCare</u></b><br>The MCO should include in its policies/procedures the method for providing this policy to out-of network providers.<br><br><b>MCO Response:</b> Please refer to the updated draft policy, C6CS-116 Disclosure of Rights and Responsibilities. | Full                    | Addressed in P/P C6CS-116 Medicaid Customer Service Disclosure of Rights and Responsibilities. Out-of-Network providers are directed to the MCO website to locate this information in the Provider Manual. |  |
| The Contractor's written policies and procedures that are designed to protect the rights of Members shall include, without limitation, the right to:   |   |                         |  |  |



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| A. Respect, dignity, privacy, confidentiality and nondiscrimination;   |                           |                         |   |  |
| B. A reasonable opportunity to choose a PCP and to change to another Provider in a reasonable manner;  |                           |                         |   |  |
| C. Consent for or refusal of treatment and active participation in decision choices;   |                           |                         |   |  |
| D. Ask questions and receive complete information relating to the Member's medical condition and treatment options, including specialty care;  |                           |                         |   |  |
| 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 the Department; |                           |                         |   |  |
| F. Timely access to care that does not have any communication or physical access barriers;   |                           |                         |   |  |
| G. Prepare Advance Medical Directives pursuant to KRS 311.621 to KRS 311.643;  |                           |                         |   |  |
| H. Assistance with Medical Records in accordance with applicable federal and state laws;   |                           |                         |   |  |
| I. Timely referral and access to medically indicated specialty care; and   |                           |                         |   |  |
| J. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.   |                           |                         |   |  |
| The Contractor shall also have policies addressing the responsibility of each Member to:   |                           |                         |   |  |
| A. Become informed about Member rights:  |                           |                         |   |  |



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| B. Abide by the Contractor's and Department's policies and procedures;  |                           |                         |   |  |
| C. Become informed about service and treatment options;   |                           |                         |   |  |
| D. Actively participate in personal health and care decisions, practice healthy life styles;  |                           |                         |   |  |
| E. Report suspected Fraud and Abuse; and  |                           |                         |   |  |
| F. Keep appointments or call to cancel.   |                           |                         |   |  |
| <b>22.2 Member Handbook</b>   |                           |                         |   |  |
| 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. |                           |                         |   |  |
| 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.  |                           |                         |   |  |
| The Member Handbook shall be available in a hardcopy format as well as an electronic format online.   |                           |                         |   |  |
| 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  |                           |                         |   |  |



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| the authority to review the Contractor's Member Handbook at any time.  |                           |                         |   |  |
| The handbook shall be written at the sixth grade reading comprehension level and shall include at a minimum the following information:   |                           |                         |   |  |
| 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 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;  |                           |                         |   |  |
| 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;   |                           |                         |   |  |
| 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;   |                           |                         |   |  |
| E. Member rights and responsibilities including reporting suspected fraud and abuse;   |                           |                         |   |  |
| 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;   |                           |                         |   |  |



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| G. Procedures for obtaining transportation for both emergency and non-emergency situations;  |                           |                         |   |  |
| H. Information on the availability of maternity, family planning and sexually transmitted disease services and methods of accessing those services;                                    |                           |                         |   |  |
| I. Procedures for arranging EPSDT for persons under the age of 21 years;   |                           |                         |   |  |
| J. Procedures for obtaining access to Long Term Care Services;   |                           |                         |   |  |
| K. Procedures for notifying the Department for Community Based Services (DCBS) of family size changes, births, address changes, death notifications;                                   |                           |                         |   |  |
| L. A list of direct access services that may be accessed without the authorization of a PCP;   |                           |                         |   |  |
| 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; |                           |                         |   |  |
| N. Information about how to access care before a PCP is assigned or chosen;  |                           |                         |   |  |
| O. A Member's right to obtain second opinion and information on obtaining second opinions related to surgical procedures, complex and/or chronic conditions;                           |                           |                         |   |  |
| P. Procedures for obtaining Covered Services from non-network providers;   |                           |                         |   |  |
| 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                     |                           |                         |   |  |



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| Grievances and Appeals;   |                           |                         |   |  |
| R. Information about the Cabinet for Health and Family Services' independent ombudsman program for Members;   |                           |                         |   |  |
| S. Information on the availability of, and procedures for obtaining behavioral health/substance abuse health services;  |                           |                         |   |  |
| T. Information on the availability of health education services;  |                           |                         |   |  |
| U. Information deemed mandatory by the Department; and  |                           |                         |   |  |
| V. The availability of care coordination, case management and disease management provided by the Contractor.  |                           |                         |   |  |
| <b>30.3 Second Opinions</b>   |                           |                         |   |  |
| 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 for a second opinion. |                           |                         |   |  |
| <b>22.1 Required Functions</b>  |                           |                         |   |  |
| 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 Standard Time (EST). The call center shall meet the current American Accreditation Health Care  |                           |                         |   |  |



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| 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 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). | Substantial - P/P C6CS-006, Twenty-Four Hour Coverage addresses this requirement. Addressed in Member Handbook.<br><br><b><u>Recommendation for WellCare</u></b><br>The policy should be updated to include the following: The twenty-four/seven (24/7) call-in system is 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).<br><br><b>MCO Response:</b> Please refer to CareNet's, our 24/7 nurse line vendor, policies and procedures on triage call processing and staff qualifications. | Full                    | Addressed in the MCO agreement with CareNet, the MCO's vendor for providing the 24-hour nurse advice line. The advice line is addressed in the Member Handbook. |  |
| 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   |   |                         |   |  |



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| answer, for their member services and twenty-four/seven (24/7) hour toll-free medical call-in system to the Department.  |   |                      |   |  |
| 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. | <p>Substantial - Foreign language interpreters are addressed in the Member Handbook.</p> <p>P/P C6EN MD-004, New Member Materials addresses this requirement.</p> <p>The MCO advised that at this time the Member Handbook is only available in English as their Spanish population is less than 5%.</p> <p>No evidence of ongoing staff training provided.</p> <p><b><u>Recommendation for WellCare</u></b><br/>Evidence of ongoing staff training should be provided.</p> <p><b>MCO Response:</b> Please refer to the staff Cultural Competency Training report supporting this requirement and policy C6CS-002 Medicaid Customer Service Requirements.</p> | Substantial          | <p>Foreign language interpreters are addressed in the Member Handbook.</p> <p>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.</p> <p>Evidence of ongoing training of staff and providers was not evident in the documents provided.</p> <p><b><u>Recommendation for WellCare</u></b><br/>The MCO should provide evidence of ongoing training for staff and providers.</p> | <p>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.</p> <p><b><u>DMS Recommendation:</u></b><br/>To be reviewed in 2015. WellCare should provide documentation of the training content and attendance for staff and providers.</p> |
| 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   |   |                      |   |  |



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| 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.  |   |                         |   |  |
| The Contractor's Member Services function shall also be responsible for:  |   |                         |   |  |
| A. Ensuring that Members are informed of their rights and responsibilities;   |   |                         |   |  |
| B. Monitoring the selection and assignment process of PCPs;   |   |                         |   |  |
| C. Identifying, investigating, and resolving Member Grievances about health care services;  |   |                         |   |  |
| D. Assisting Members with filing formal Appeals regarding plan determinations;  |   |                         |   |  |
| E. Providing each Member with an identification card that identifies the Member as a participant with the Contractor, unless otherwise approved by the Department;  |   |                         |   |  |
| 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;   |   |                         |   |  |
| 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; | Non-Compliance - Not addressed in documentation provided.<br><br><b>MCO Response:</b> Please refer to the Kentucky addendum in the updated draft policy, C6CS-002 Medicaid Customer Service Requirements. | Full                    | Addressed in P/P C6CS-002 Medicaid Customer Service Requirements, Kentucky addendum.  |  |



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| 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);   |  |                         |   |  |
| I. Explaining or answering any questions regarding the 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; |  |                         |   |  |
| K. Facilitating direct access to specialty physicians in the circumstances of:<br>(1) Members with long-term, complex health conditions;<br>(2) Aged, blind, deaf, or disabled persons; and  | Non-Compliance - Documents provided do not address this requirement. | Full                    | Addressed in P/P C6CS-002 Medicaid Customer Service Requirements, Kentucky addendum.  |  |



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| (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.  | <b>MCO Response:</b> Please refer to the Kentucky addendum in the updated draft policy, C6CS-002 Medicaid Customer Service Requirements.   |                         |   |  |
| 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) years;  | Non-Compliance - Documents provided do not address this requirement.<br><br><b>MCO Response:</b> Please refer to the Kentucky addendum in the updated draft policy, C6CS-002 Medicaid Customer Service Requirements. | Full                    | Addressed in P/P C6CS-002 Medicaid Customer Service Requirements, Kentucky addendum.  |  |
| 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;  | Non-Compliance - Documents provided do not address this requirement.<br><br><b>MCO Response:</b> Please refer to the Kentucky addendum in the updated draft policy, C6CS-002 Medicaid Customer Service Requirements. | Full                    | Addressed in P/P C6CS-002 Medicaid Customer Service Requirements, Kentucky addendum.  |  |
| 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; | Non-Compliance - Documents provided do not address this requirement.<br><br><b>MCO Response:</b> Please refer to the Kentucky addendum in the updated draft policy, C6CS-002 Medicaid Customer Service Requirements. | Full                    | Addressed in P/P C6CS-002 Medicaid Customer Service Requirements, Kentucky addendum.  |  |



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| O. Facilitating access to behavioral health services and pharmaceutical services;   | Non-Compliance - Documents provided do not address this requirement.<br><br><b>MCO Response:</b> Please refer to the Kentucky addendum in the updated draft policy, C6CS-002 Medicaid Customer Service Requirements.   | Full                    | Addressed in P/P C6CS-002 Medicaid Customer Service Requirements, Kentucky addendum.  |  |
| 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;  | Non-Compliance - Documents provided do not address this requirement.<br><br><b>MCO Response:</b> Please refer to policy C6CS-039 Medicaid Non-Emergent Transportation Assistance and the Kentucky addendum in the updated draft policy, C6CS-002 Medicaid Customer Service Requirements. | Full                    | Addressed in P/P C6CS-002 Medicaid Customer Service Requirements, Kentucky addendum and C6CS-039 Medicaid Non-Emergent Transportation Assistance.         |  |
| 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 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;   | Non-Compliance - Documents provided do not address this requirement.<br><br><b>MCO Response:</b> Please refer to policy C6CS-039 Medicaid Non-   | Full                    | Addressed in P/P C6CS-002 Medicaid Customer Service Requirements, Kentucky addendum and C6CS-039 Medicaid Non-Emergent Transportation Assistance.         |  |



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|   | Emergent Transportation Assistance and the Kentucky addendum in the updated draft policy, C6CS-002 Medicaid Customer Service Requirements.   |                         |   |  |
| 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;   |  |                         |   |  |
| T. Facilitating access to Member Health Education Programs;   | Non-Compliance - Documents provided do not address this requirement.<br><br><b>MCO Response:</b> Please refer to policy C6EN MD-004 New member Material, page 10 and the Kentucky addendum in the updated draft policy, C6CS-002 Medicaid Customer Service Requirements. | Full                    | Addressed in P/P C6CS-002 Medicaid Customer Service Requirements, Kentucky addendum and C6EN MD-004 New Member Materials. Information on health education services included in the Member Handbook. |  |
| U. Assisting members in completing the Health Risk Assessment (HRA) as outlined in <b>Covered Services</b> 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 |  |                         |   |  |
| 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   | Non-Compliance - Documents provided do not address this requirement.<br><br><b>MCO Response:</b> The Customer  | Full                    | Per P/P C6CS-051 Customer Service QI Workgroup and the QI Program Description, the Customer Service QI Work Group (CSQIW) is charged with identifying opportunities for improvement in              |  |



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| provided to the Department.  | Service Quality Improvement Work Group (CSQIW) functions as a multidisciplinary work group to identify opportunities for improvement in the customer service provided to our members and providers. This multidisciplinary workgroup meets to discuss topics that affect our customers. The issues are gathered in Customer Service using the feedback of external customers. It is the responsibility of the workgroup to analyze the issue(s), determine root cause and brainstorm about the possible solutions and the opportunities for improvement. In addition, Member Services functions are annually evaluated and included in the QI Program Evaluation. Please refer to policy C6CS_51 Customer Service Quality Improvement Workgroup, the CSQIW 2013 Charter document, section XIX of the 2012 QI Program Evaluation, and the Kentucky addendum in the updated draft policy, C6CS-002 Medicaid Customer Service Requirements. |                         | customer service. The workgroup provides a quarterly presentation to the QIC and Medical Advisory Council including trended results and actionable recommendations.<br><br>The Medicaid QI Program Evaluation, Operational Service Initiatives and Indicators, includes performance results, barriers and recommendations. The annual QI Program Evaluation is submitted to the Department.<br><br>Also addressed in P/P C6CS-002 Medicaid Customer Service Requirements. |  |
| <b>30.4 Billing Members for Covered Services</b>   |  |                         |   |  |
| 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 |  |                         |   |  |



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| cost sharing requirements provided under this contract. Any Provider who knowingly and willfully bills a Member 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. | Non-Compliance - This requirement was not included in Policy C9CC-015.<br><br><b>MCO Response:</b> Please refer to the member handbook (Page 12) and policy C9CL MD-001 Balance Billing Members, which addresses compliance with this requirement. | Full                 | Addressed in P/P C6CL MD-001 Balance Billing Members and in the Member Handbook under Information About Services section.                        |   |
| <b>22.9 Choice of Providers</b>  |  |                      |  |   |
| 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.  |  |                      |  |   |
| 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.  |  |                      |  |   |
| <b>23.4 PCP Changes</b>  |  |                      |  |   |



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| The Contractor shall have written policies and procedures 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.   |                           |                         |   |  |
| 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. |                           |                         |   |  |
| 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.                              |                           |                         |   |  |
| 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   |                           |                         |   |  |



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| of the PCP/patient relationship or inability to meet the 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. |                           |                         |   |  |
| The initial Provider must serve until the new Provider begins serving the Member, barring ethical or legal issues. The Member has the right to Appeal such a transfer in the formal Appeals process. The Provider shall make the change for request in writing. Member may request PCP change in writing, face to face or via telephone.  |                           |                         |   |  |
| The Contractor shall provide written notice within fifteen (15) days to a member whose PCP has been voluntarily or involuntarily disenrolled or been terminated from participation in the Contractor's network.   |                           |                         |   |  |
| <b>30.5 Referral for Non-covered Contractor Services</b>  |                           |                         |   |  |
| When it is necessary for a Member to receive a Medicaid service that is outside the scope of the contract, 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   |                           |                         |   |  |



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| 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. |                           |                         |   |  |



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**Scoring Grid:**

| Compliance Level   | Full     | Substantial | Minimal  | Non-Compliance |
|--------------------|----------|-------------|----------|----------------|
| Points Value       | <b>3</b> | <b>2</b>    | <b>1</b> | <b>0</b>       |
| Number of Elements | 13       | 1           | 0        | 0              |
| Total Points       | 39       | 2           | 0        | 0              |

**Overall Compliance Determination:**

| Compliance Level | Full       | Substantial       | Minimal           | Non-Compliance  |
|------------------|------------|-------------------|-------------------|-----------------|
| Points Range     | <b>3.0</b> | <b>2.0 – 2.99</b> | <b>1.0 – 1.99</b> | <b>0 – 0.99</b> |
| Points Average   |            | <b>2.93</b>       |                   |                 |

**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.**

**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



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**Documents**

Policies/Procedures for:

- Member rights and responsibilities
- 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

Sample of member notifications of voluntary and involuntary PCP termination

Evidence of provision of Member Handbook within five business days of notification of enrollment

**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



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*(See Final Page for Suggested Evidence)*

| State Contract Requirements<br>(Federal Regulation 438.206, 438.10)  | Prior Results & Follow-Up | Review<br>Determination | Comments (Note: For any element that<br>deviates from the requirements, an<br>explanation of the deviation must be<br>documented in the Comments section) | Health Plan's and DMS'<br>Responses and Plan of Action |
|--|---------------------------|-------------------------|---|--|
| <b>22.3 Member Education and Outreach</b>  |                           |                         |   |  |
| 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 all Members. The Outreach Program shall encourage Members and community partners to use the information provided to best utilize services and benefits.  |                           |                         |   |  |
| Educational and outreach efforts shall be carried on throughout the Contractor's Region. Creative methods will be used to reach 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. |                           |                         |   |  |
| 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.  |                           |                         |   |  |
| <b>22.4 Outreach to Homeless Persons</b>   |                           |                         |   |  |
| The Contractor shall assess the homeless population within the Contractor's Region and by implementing and   |                           |                         |   |  |



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| State Contract Requirements<br>(Federal Regulation 438.206, 438.10)   | Prior Results & Follow-Up   | Review<br>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 |
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| maintaining a customized outreach plan for Homeless Persons population, including victims of domestic violence.   |   |                         |  |   |
| The plan shall include: (A) utilizing existing community resources such as shelters and clinics; and (B) Face-to-Face encounters.   |   |                         |  |   |
| 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. | Substantial - WellCare provided the Homeless Outreach Plan for 2012 as evidence for this requirement.<br><br>WellCare did not provide evidence of assistance with transportation to access health care providers for homeless members.<br><br><b>MCO Response:</b> Please refer to two submitted documents Homeless Outreach Plan and Homeless Transportation Assistance. | Full                    | The Homeless Outreach Plan includes a description of WellCare's "My Family Navigator" that helps members connect with local safety net programs and services including transportation. The Navigator includes 133 organizations providing transportation support, both general and medical transportation, and addresses needs in all 120 counties.<br><br>The MCO provided a report, Health Connection Member Referrals 2013, providing evidence of handling transportation requests. |   |
| <b>22.5 Member Information Materials</b>  |   |                         |  |   |
| 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,  | Non-Compliance - WellCare did not provide evidence of a policy and procedure for member information materials.<br><br><b>MCO Response:</b> Please refer to policies C9CC-001 - Medicaid Post-Enrollment Member  | Full                    | P/P C9CC-001 Medicaid Post-Enrollment Member Materials addresses written materials at the 6 <sup>th</sup> grade level. Also addressed in P/P C9CC-006 Medicaid Written Member Materials and Marketing Materials Review and Approval Process, Kentucky addendum, and C6EN MD-004 New Member Materials, Kentucky   |   |



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| State Contract Requirements<br>(Federal Regulation 438.206, 438.10)                     | Prior Results & Follow-Up  | Review<br>Determination | Comments (Note: For any element that<br>deviates from the requirements, an<br>explanation of the deviation must be<br>documented in the Comments section) | Health Plan's and DMS'<br>Responses and Plan of Action |
|---|--|-------------------------|---|--|
|   | Materials, C9CC--006 - Medicaid Written Member Materials and Marketing Materials Review and Approval Process, and C6EN MD-004 New Member Materials.  |                         | addendum.   |  |
| be published in at least a 14-point font size, and                                      | Non-Compliance - WellCare did not provide evidence of a policy and procedure for member information materials.<br><br><b>MCO Response:</b> Please refer to policies C9CC-001 - Medicaid Post-Enrollment Member Materials and C6EN MD-004 New Member Materials. | Full                    | Addressed in P/P C9CC-001 and C6EN MD-004.  |  |
| shall comply with the Americans with Disabilities Act of 1990 (Public Law USC 101-336). | Non-Compliance - WellCare did not provide evidence of a policy and procedure for member information materials.<br><br><b>MCO Response:</b> Please refer to policies C9CC-001 - Medicaid Post-Enrollment Member Materials and C6EN MD-004 New Member Materials. | Full                    | Addressed in P/P C9CC-001 and C6EN MD-004.  |  |
| Font size requirements shall not apply to Member Identification Cards.                  | Non-Compliance - WellCare did not provide evidence of a policy and procedure for member information materials.<br><br><b>MCO Response:</b> Please refer to   | Full                    | Addressed in P/P C6EN MD-004.   |  |



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|   | policies C9CC-001 - Medicaid Post-Enrollment Member Materials and C6EN MD-004 New Member Materials.   |                         |   |  |
| Braille and audiotapes shall be available for the partially blind and blind.  | <p>Non-Compliance - WellCare did not provide evidence of a policy and procedure for member information materials.</p> <p><b>MCO Response:</b> Please refer to policies C9CC-001 - Medicaid Post-Enrollment Member Materials, C9CC-006 - Medicaid Written Member Materials and Marketing Materials Review and Approval Process and C6EN MD-004 New Member Materials.</p> | Full                    | Addressed in P/P C9CC-001 and C6EN MD-004. P/P C9CC-006 includes availability of materials in alternative formats.  |  |
| Provisions to review written materials for the illiterate shall be available. | <p>Non-Compliance - WellCare did not provide evidence of a policy and procedure for member information materials.</p> <p><b>MCO Response:</b> Please refer to policies C9CC-001 - Medicaid Post-Enrollment Member Materials, C9CC-006 - Medicaid Written Member Materials and Marketing Materials Review and Approval Process and C6EN MD-004 New Member Materials.</p> | Full                    | Addressed in P/P C9CC-001 and C6EN MD-004.  |  |
| Telecommunication devices for the deaf shall be                               | Non-Compliance - WellCare did   | Full                    | Addressed in P/P C9CC-001 and C6EN MD-  |  |



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*(See Final Page for Suggested Evidence)*

| State Contract Requirements<br>(Federal Regulation 438.206, 438.10)   | Prior Results & Follow-Up  | Review<br>Determination | Comments (Note: For any element that<br>deviates from the requirements, an<br>explanation of the deviation must be<br>documented in the Comments section)                          | Health Plan's and DMS'<br>Responses and Plan of Action |
|---|--|-------------------------|--|--|
| available.  | not provide evidence of a policy and procedure for member information materials.<br><br><b>MCO Response:</b> Please refer to policies C9CC-001 - Medicaid Post-Enrollment Member Materials and C6EN MD-004 New Member Materials.   |                         | 004.   |  |
| Language translation shall be available if five (5) percent of the population in any county has a native language other than English. | Non-Compliance - WellCare did not provide evidence of a policy and procedure for member information materials.<br><br><b>MCO Response:</b> Please refer to policies C9CC-001 - Medicaid Post-Enrollment Member Materials, C9CC-006 - Medicaid Written Member Materials and Marketing Materials Review and Approval Process and C6EN MD-004 New Member Materials. | Full                    | Addressed in P/P C9CC-001, C9CC-006 and C6EN MD-004.   |  |
| Materials shall be updated as necessary to maintain accuracy, particularly with regard to the list of participating providers.        | Non-Compliance - WellCare did not provide evidence of a policy and procedure for member information materials.<br><br><b>MCO Response:</b> Please refer to policies C9CC-001 - Medicaid Post-Enrollment Member Materials (Appendix D pg 11) and C6EN MD-004 New Member   | Full                    | P/P C9CC-001 addresses updates to the Provider Directory once a year. Per the onsite interview, a provider lookup is available on the plan's website. The site is updated nightly. |  |



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| State Contract Requirements<br>(Federal Regulation 438.206, 438.10)   | Prior Results & Follow-Up   | Review<br>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 |
|---|---|-------------------------|---|---|
|   | Materials.  |                         |   |   |
| 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.   | <p>Non-Compliance - WellCare did not provide evidence of a policy and procedure for member information materials.</p> <p><b>MCO Response:</b> Please refer to policies C9CC-001 - Medicaid Post-Enrollment Member Materials; and C9CC--006 - Medicaid Written Member Materials and Marketing Materials Review and Approval Process.</p>   | Full                    | Addressed in P/P C9CC-001 and C9CC-006.   |   |
| <b>28.12 Cultural Consideration and Competency</b>  |   |                         |   |   |
| 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 styles which respect Member's cultural background. | <p>Minimal - P/P C9CC-007, Cultural Competency provided as evidence for this requirement.</p> <p>As stated in the above policy - WellCare shall have a comprehensive written Cultural Competency Plan (CCP) describing how WellCare will ensure that services and materials are provided in a culturally competent manner to all members ("members" and "enrollees" are used interchangeably in this policy), including those with limited English proficiency.</p> | Full                    | <p>P/P C9CC-007 Cultural Competency states that the MCO shall have a comprehensive written Cultural Competency Plan (CCP). The CCP was provided at the onsite review.</p> <p>The 2012 QI Program Evaluation includes as assessment of member cultural needs and preferences. Efforts used by the MCO to educate providers and staff include: cultural competency training and availability of cultural competency toolkit on the MCO website for providers. The MCO monitored languages requested for translation by members calling customer services. The majority of requests were for translations in Spanish and Arabic.</p> |   |



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| State Contract Requirements<br>(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 |
|--|---|----------------------|---|---|
|  | <p>During the onsite visit, WellCare did not provide a CCP addressing the above.</p> <p><b>MCO Response:</b> Please refer to the Cultural Competency Plan which describes how WellCare ensures that services and member s are provided in a culturally competent manner.</p>  |                      |   |   |
| <p>The Contractor shall communicate such policies to Subcontractors.</p> | <p>Substantial - P/P C9CC-007 provided as evidence for this requirement; however the policy does not explain how this information will be communicated to subcontractors.</p> <p>During the onsite, the MCO advised that subcontractors could access the Cultural Competency policy on the WellCare Website.</p> <p><b>Recommendation for WellCare</b><br/>Policy/procedure should address how this information is communicated to subcontractors.</p> <p><b>MCO Response:</b> Please refer to the Cultural Competency Plan</p> | <p>Full</p>          | <p>P/P C9CC-007 states that the MCO educates subcontractors on the CCP and distributes a summary via provider manuals. The full CCP can be accessed on the WellCare website.</p> <p>The Provider Manual includes a detailed section on Cultural Competency and refers the provider to the website for full access. Web link to the CCP is included on page 30 of the Provider Manual.</p> <p>During the onsite it was determined that subcontractors are made aware of the CCP through the Provider Manual.</p> |   |



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| State Contract Requirements<br>(Federal Regulation 438.206, 438.10) | Prior Results & Follow-Up  | Review<br>Determination | Comments (Note: For any element that<br>deviates from the requirements, an<br>explanation of the deviation must be<br>documented in the Comments section) | Health Plan's and DMS'<br>Responses and Plan of Action |
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|   | and updated policy C9CC-007<br>addresses how subcontractors<br>are informed on policies related<br>to cultural competency. |                         |   |  |



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**Scoring Grid:**

| <b>Compliance Level</b> | <b>Full</b> | <b>Substantial</b> | <b>Minimal</b> | <b>Non-Compliance</b> |
|-------------------------|-------------|--------------------|----------------|-----------------------|
| Points Value            | <b>3</b>    | <b>2</b>           | <b>1</b>       | <b>0</b>              |
| Number of Elements      | 13          | 0                  | 0              | 0                     |
| Total Points            | 39          | 0                  | 0              | 0                     |

**Overall Compliance Determination:**

| <b>Compliance Level</b> | <b>Full</b> | <b>Substantial</b> | <b>Minimal</b>    | <b>Non-Compliance</b> |
|-------------------------|-------------|--------------------|-------------------|-----------------------|
| Points Range            | <b>3.0</b>  | <b>2.0 – 2.99</b>  | <b>1.0 – 1.99</b> | <b>0 – 0.99</b>       |
| Points Average          | <b>3.0</b>  |                    |                   |                       |

**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.**

**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



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**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



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|---|--|----------------------|---|---|
| State Contract Requirements (Federal Regulation 417.436[d])   | 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>38.1 Medical Records</b>   |  |                      |   |   |
| Member Medical Records if maintained by the Contractor shall be maintained timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review. Complete Medical Records include, but are not limited to, medical charts, prescription files, hospital records, provider specialist reports, consultant and other health care professionals' findings, appointment records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided under the Contract. The medical record shall be signed by the provider of service. |  |                      |   |   |
| The Contractor shall have medical record confidentiality policies and procedures in compliance with state and federal guidelines and HIPAA. The Contractor shall protect Member information from unauthorized disclosure as set forth in Confidentiality of Records of this Agreement.  | <p>Minimal - P/P C13HIP.02.038 HIPAA Business Associate Agreement provided.</p> <p>Policies/procedures addressing confidentiality and HIPAA not provided.</p> <p>MCO did not provide P/Ps C13HIP.01.002, HIPAA Records and Safeguards Policy and C13HIP.01.00, HIPAA, Use and Disclosure of PHI Policy for review. P/P C7QI-015, Medical Record Review includes review of provider office compliance with confidentiality standards. Medical record reviews were not conducted in 2012; scheduled to begin in Fall 2013.</p> | Full                 | This requirement was addressed with the following received policies: P/Ps C13HIP.01.002, P/P C7QI-015 and C13HIP.01.001-ST HIPAA Privacy Office Charter Standard. MCO also provided C13HIP.01.002 HIPAA Records and Safeguards, C13HIP 01.006 HIPAA Use and Disclosure of PHI and BAA between WellCare and DMS. |   |



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|--|--|----------------------|---|---|
| State Contract Requirements (Federal Regulation 417.436[d])  | 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 |
|  | <p><b>MCO Response:</b> Please refer to policies C13HIP.01.002 HIPAA Records and Safeguards, and C13HIP 01.006 HIPAA Use and Disclosure of PHI. Also refer to the BAA between WellCare and DMS.</p>  |                      |   |   |
| <p>The Contractor shall conduct HIPAA privacy and security audits of providers as prescribed by the Department.</p>  | <p>Minimal - P/P C13HIP.02.038 HIPAA Business Associate Agreement provided.</p> <p>Policies/procedures addressing confidentiality and HIPAA not provided.</p> <p>P/P C7QI-015, Medical Record Review includes review of provider office compliance with confidentiality standards. Medical record reviews were not conducted in 2012; scheduled to begin in Fall 2013.</p> <p><b>MCO Response:</b> Please refer to policies C13HIP.01.002 HIPAA Records and Safeguards, and C13HIP 01.006 HIPAA Use and Disclosure of PHI. Also refer to the BAA between WellCare and DMS.</p> | Full                 | <p>This requirement was addressed with the following documents: C13HIP.01.002 HIPAA Records and Safeguards, C13HIP 01.006 HIPAA Use and Disclosure of PHI and the BAA between WellCare and DMS.</p> |   |
| <p>The Contractor shall include provisions in its Subcontracts for access to the Medical Records of its Members by the Contractor, the Department, the Office of the Inspector General and other authorized Commonwealth and federal agents thereof, for purposes of auditing. Additionally, Provider contracts shall provide that when a Member changes PCP, the Medical Records or copies of Medical Records shall be forwarded to the new PCP or Partnership within ten</p> |  |                      |   |   |



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|--|---------------------------|----------------------|--|---|
| State Contract Requirements (Federal Regulation 417.436[d])  | 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 |
| (10) Days from receipt of request. The Contractor's PCPs shall have Members sign a release of Medical Records before a Medical Record transfer occurs.   |                           |                      |  |   |
| The Contractor shall have a process to systematically review provider medical records to ensure compliance with the medical records standards. The Contractor shall institute improvement and actions when standards are not met. The Contractor shall have a mechanism to assess the effectiveness of practice-site follow-up plans to increase compliance with the Contractor's established medical records standards and goals. |                           |                      |  |   |
| The Contractor shall develop methodologies for assessing performance/compliance to medical record standards of PCP's/PCP sites, high risk/high volume specialist, dental providers, providers of ancillaries services not less than every three (3) years. Audit activity shall, at a minimum:   |                           |                      |  |   |
| A. Demonstrate the degree to which providers are complying with clinical and preventative care guidelines adopted by the Contractor;   |                           |                      |  |   |
| B. Allow for the tracking and trending of individual and plan wide provider performance over time;   |                           |                      |  |   |



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|--|---------------------------|----------------------|--|---|
| State Contract Requirements (Federal Regulation 417.436[d])  | 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. Include mechanism and processes that allow for the identification, investigation and resolution of quality of care concerns; and  |                           |                      |  |   |
| D. Include mechanism for detecting instances of over-utilization, under-utilization, and miss utilization.   |                           |                      |  |   |
| <b>27.6 Medical Records</b>  |                           |                      |  |   |
| The Contractor shall require their Providers to maintain Member medical records on paper or in an electronic format. Member Medical Records shall be maintained timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review. Complete Medical Records include, but are not limited to, medical charts, prescription files, hospital records, provider specialist reports, consultant and other health care professionals' findings, appointment records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided under the Contract. The medical record shall be signed by the provider of service. |                           |                      |  |   |
| The Member's Medical Record is the property of the Provider who generates the record. However, each Member or  |                           |                      |  |   |



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|--|---------------------------|----------------------|--|---|
| State Contract Requirements (Federal Regulation 417.436[d])  | 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 |
| their representative is entitled to one free copy of his/her medical record. Additional copies shall be made available to Members at cost. Medical records shall generally be preserved and maintained for a minimum of five (5) years unless federal requirements mandate a longer retention period (i.e. immunization and tuberculosis records are required to be kept for a person's lifetime). |                           |                      |  |   |
| The Contractor shall ensure that the PCP maintains a primary medical record for each member, which contains sufficient medical information from all providers involved in the Member's care, to ensure continuity of care. The medical chart organization and documentation shall, at a minimum, require the following:  |                           |                      |  |   |
| A. Member/patient identification information, on each page;  |                           |                      |  |   |
| B. Personal/biographical data, including date of birth, age, gender, marital status, race or ethnicity, mailing address, home and work addresses and telephone numbers, employer, school, name and telephone numbers (if no phone contact name and number) of emergency contacts, consent forms, identify language spoken and guardianship information;  |                           |                      |  |   |



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|---|--------------------------------------|-----------------------------|---|--|
| <b>State Contract Requirements (Federal Regulation 417.436[d])</b>  | <b>Prior Results &amp; Follow-Up</b> | <b>Review Determination</b> | <b>Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)</b> | <b>Health Plan's and DMS' Responses and Plan of Action</b> |
| C. Date of data entry and date of encounter;  |                                      |                             |   |  |
| D. Provider identification by name;   |                                      |                             |   |  |
| E. Allergies, adverse reactions and any known allergies shall be noted in a prominent location;   |                                      |                             |   |  |
| F. Past medical history, including serious accidents, operations, and illnesses. For children, past medical history includes prenatal care and birth information, operations, and childhood illnesses (i.e. documentation of chickenpox); |                                      |                             |   |  |
| G. Identification of current problems;  |                                      |                             |   |  |
| H. The consultation, laboratory, and radiology reports filed in the medical record shall contain the ordering provider's initials or other documentation indicating review;   |                                      |                             |   |  |
| I. Documentation of immunizations pursuant to 902 KAR 2:060;  |                                      |                             |   |  |
| J. Identification and history of nicotine, alcohol use or substance abuse;  |                                      |                             |   |  |
| K. Documentation of reportable diseases and conditions to the local health department serving the jurisdiction in which the patient resides or Department for Public Health pursuant to 902 KAR 2:020;                                    |                                      |                             |   |  |



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|---|---------------------------|----------------------|--|---|
| State Contract Requirements (Federal Regulation 417.436[d])   | 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. Follow-up visits provided secondary to reports of emergency room care;   |                           |                      |  |   |
| M. Hospital discharge summaries;  |                           |                      |  |   |
| N. Advanced Medical Directives, for adults;   |                           |                      |  |   |
| O. All written denials of service and the reason for the denial; and  |                           |                      |  |   |
| P. Record legibility to at least a peer of the writer. Any record judged illegible by one reviewer shall be evaluated by another reviewer.  |                           |                      |  |   |
| A Member's medical record shall include the following minimal detail for individual clinical encounters:  |                           |                      |  |   |
| A. History and physical examination for presenting complaints containing relevant psychological and social conditions affecting the patient's medical/behavioral health, including mental health, and substance abuse status; |                           |                      |  |   |
| B. Unresolved problems, referrals and results from diagnostic tests including results and/or status of preventive screening services (EPSDT) are addressed from previous visits; and  |                           |                      |  |   |
| C. Plan of treatment including:<br>1. Medication history, medications   |                           |                      |  |   |



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|--|---|----------------------|--|---|
| State Contract Requirements (Federal Regulation 417.436[d])  | 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 |
| prescribed, including the strength, amount, directions for use and refills; and<br>2. Therapies and other prescribed regimen; and<br>3. Follow-up plans including consultation and referrals and directions, including time to return.   |   |                      |  |   |
| <b>27.7 Advance Medical Directives</b>   |   |                      |  |   |
| The Contractor shall comply with laws relating to Advance Medical Directives pursuant to KRS 311.621 – 311.643 and 42 CFR Part 489, Subpart I and 42 CFR 422.128, 438.6 and 438.10 Advance Medical Directives, including living wills or durable powers of attorney for health care, allow adult Members to initiate directions about their future medical care in those circumstances where Members are unable to make their own health care decisions. | <p>Substantial - Advance Medical Directives is addressed in the Member Handbook and the Provider Manual</p> <p>A policy/procedure addressing Advance Directives was not provided.</p> <p><b><u>Recommendation for WellCare</u></b><br/>A policy/procedure for addressing Advance Medical Directives should be developed and made available for review.</p> <p><b>MCO Response:</b> Please refer to policy C7QI 015 Medical Record Review.</p> <p><b>I PRO Comments:</b> No change in review determination. This policy includes monitoring for an advance directive. It does not address the requirements for advance directives.</p> | Full                 | This requirement was addressed with the following polices: Policy C6CS-007 Advance Directives and Policy C7QI 015.                               |   |
| The Contractor shall, at a minimum, provide written information on Advance Medical Directives to all Members and shall notify all Members of any changes in  | Substantial - Advance Medical Directives is addressed in the Member Handbook and the Provider Manual  | Full                 | This requirement was addressed with the following polices: Policy C6CS-007 Advance Directives and Policy C7QI 015.                               |   |



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|--|--|----------------------|---|---|
| State Contract Requirements (Federal Regulation 417.436[d])  | 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   |
| <p>the rules and regulations governing Advance Medical Directives within ninety (90) Days of the change and provide information to its PCPs via the Provider Manual and Member Services staff on informing Members about Advance Medical Directives.</p> | <p>A policy/procedure addressing Advance Directives was not provided.</p> <p>A policy/procedure addressing Advance Directives was not provided.</p> <p><b>Recommendation for WellCare</b><br/>           A policy/procedure for addressing Advance Medical Directives should be developed and made available for review.</p> <p><b>MCO Response:</b> Please refer to policy C7QI 015 Medical Record Review.</p> <p><b>IPRO Comments:</b> No change in review determination. This policy includes monitoring for an advance directive. It does not address the requirements for advance directives.</p> |                      |   |   |
| <p>PCPs have the responsibility to discuss Advance Medical Directives with adult Members at the first medical appointment and chart that discussion in the medical record of the Member.</p>   | <p>Substantial - The Provider Manual addresses this requirement.</p> <p>A policy/procedure addressing Advance Directives was not provided.</p> <p><b>Recommendation for WellCare</b><br/>           A policy/procedure for addressing Advance Medical Directives should be developed and made available for review.</p> <p><b>MCO Response:</b> Please refer to policy C7QI 015 Medical Record Review.</p>   | Full                 | <p>This requirement is partially addressed with the following polices received from the MCO: Policy C6CS-007 Advance Directives and Policy C7QI 015.</p> <p>These documents do not address the PCPs responsibility to discuss the Advance Medical Directives with adult members at the first medical appointment.</p> <p>During the onsite review, the MCO advised that the Provider Manual references this specific requirement. Plan provided Provider Manual page specifically</p> | <p>Please refer to Policy C6CS-007 Advance Directives, Addendum B. which specifically states, "PCPs have the responsibility to discuss Advance Medical Directives with adult Members at the first medical appointment and chart that discussion in the medical record of the member," on Page 5 at the bottom of the first paragraph. The Plan believes we are in full compliance with this requirement as this policy was provided prior to the onsite review and the policy contained this information.</p> |



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| <b>Medical Records</b><br><i>(See Final Page for Suggested Evidence)</i>   |   |                      |   |   |
|--|---|----------------------|---|---|
| State Contract Requirements (Federal Regulation 417.436[d])  | 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 |
|  | <p><b>IPRO Comments:</b> No change in review determination. This policy includes monitoring for an advance directive. It does not address the requirements for advance directives.</p>  |                      | <p>referencing the requirement.</p> <p>Final Compliance Finding:<br/>           Policy C6CS-007 Advance Directives, Addendum B states on Page 5 at the bottom of the first paragraph:<br/>           "PCPs have the responsibility to discuss Advance Medical Directives with adult Members at the first medical appointment and chart that discussion in the medical record of the member;"</p> <p>The compliance level was changed from "Substantial" to "Full" and the recommendation removed.</p> |   |
| <b>38.2 Confidentiality of Records</b>   |   |                      |   |   |
| <p>The parties agree that all information, records, and data collected in connection with this Contract, including Medical Records, shall be protected from unauthorized disclosure as provided in 42 CFR Section 431, subpart F, KRS 194.060A, KRS 214.185, KRS 434.840 to 434.860, and any applicable state and federal laws, including the laws specified in Section 40.12.</p> | <p>Minimal - The MCO provided the On Boarding Process for new hires. This document does not address this requirement.</p> <p>P/P C13HIP.02.038 HIPAA Business Associate Agreement provided.</p> <p>Policies/procedures addressing confidentiality and HIPAA not provided.</p> <p>MCO did not provide P/Ps C13HIP.01.002, HIPAA Records and Safeguards Policy and C13HIP.01.00, HIPAA, Use and Disclosure of PHI Policy for review.</p> <p><b>MCO Response:</b> Please refer to policies C13HIP.01.002 HIPAA Records and Safeguards, and</p> | Full                 | <p>This requirement was addressed with the following polices: C13HIP.01.002 HIPAA Records and Safeguards, C13HIP 01.006 HIPAA Use and Disclosure of PHI and the BAA between WellCare and DMS. Guidance and permitted uses and disclosure of PHI addressed.</p>  |   |



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|   | C13HIP 01.006 HIPAA Use and Disclosure of PHI. Also refer to the BAA between WellCare and DMS.   |                      |   |   |
| The Contractor shall have written policies and procedures for maintaining the confidentiality of Member information consistent with applicable laws. Policies and procedures shall include, but not be limited to, adequate provisions for assuring confidentiality of services for minors who consent to diagnosis and treatment for sexually transmitted disease, alcohol and other drug abuse or addiction, contraception, or pregnancy or childbirth without parental notification or consent as specified in KRS 214.185. The policies and procedures shall also address such issues as how to contact the minor Member for any needed follow-up and limitations on telephone or mail contact to the home. | <p>Minimal - The MCO provided the On Boarding Process for new hires. This document does not address this requirement.</p> <p>P/P C13HIP.02.038 HIPAA Business Associate Agreement provided.</p> <p>Policies/procedures addressing confidentiality and HIPAA not provided.</p> <p>MCO did not provide P/Ps C13HIP.01.002, HIPAA Records and Safeguards Policy and C13HIP.01.00, HIPAA, Use and Disclosure of PHI Policy for review.</p> <p><b>MCO Response:</b> Please refer to policies C13HIP.01.002 HIPAA Records and Safeguards, and C13HIP 01.006 HIPAA Use and Disclosure of PHI.</p> | Full                 | This requirement was addressed with Policy C13HIP 01.006 HIPAA Use and Disclosure of PHI. The policy addresses procedure for maintaining the confidentiality of Member information.                     |   |
| The Contractor on behalf of its employees, agents and assigns, shall sign a confidentiality agreement.  | <p>Non-Compliance - Evidence of a signed confidentiality statement was not provided.</p> <p><b>MCO Response:</b> Please refer to Employee Confidentiality Examples 1-3. Also refer to the BAA between WellCare and DMS.</p>  | Full                 | This requirement was addressed by the Signed Employee Confidentiality Agreements received from the MCO with electronic signatures.  |   |
| Except as otherwise required by law, regulations or this contract, access to such information shall be limited by the Contractor and the Department to persons who or agencies which require  | <p>Non-Compliance - The MCO provided the On Boarding Process for new hires. This document does not address this requirement.</p> <p>A policy/procedure for confidentiality of records</p>  | Full                 | This requirement was addressed with the following polices: Policies C13HIP.01.002 HIPAA Records and Safeguards, and C13HIP 01.006 HIPAA Use and Disclosure of PHI and the BAA between WellCare and DMS. |   |



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| the information in order to perform their duties related to the administration of the Department, including, but not limited to, the US Department of Health and Human Services, U.S. Attorney's Office, the Office of the Inspector General, the Office of the Attorney General, and such others as may be required by the Department.   | was not provided.<br><br><b>MCO Response:</b> Please refer to policies C13HIP.01.002 HIPAA Records and Safeguards, and C13HIP 01.006 HIPAA Use and Disclosure of PHI. Also refer to the BAA between WellCare and DMS. |                      |  |   |
| <b>40.12 Health Insurance Portability and Accountability Act</b>  |   |                      |  |   |
| The Contractor agrees to abide by the rules and regulations regarding the confidentiality of protected health information as defined and mandated by the Health Insurance Portability and Accountability Act (42 USC 1320d) and set forth in federal regulations at 45 CFR Parts 160 and 164. Any Subcontract entered by the Contractor as a result of this agreement shall mandate that the subcontractor be required to abide by the same statutes and a regulation regarding confidentiality of protected health information as is the Contractor. |   |                      |  |   |



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**Scoring Grid:**

| <b>Compliance Level</b> | <b>Full</b> | <b>Substantial</b> | <b>Minimal</b> | <b>Non-Compliance</b> |
|-------------------------|-------------|--------------------|----------------|-----------------------|
| Points Value            | <b>3</b>    | <b>2</b>           | <b>1</b>       | <b>0</b>              |
| Number of Elements      | <b>9</b>    | <b>0</b>           | <b>0</b>       | <b>0</b>              |
| Total Points            | <b>27</b>   | <b>0</b>           | <b>0</b>       | <b>0</b>              |

**Overall Compliance Determination:**

| <b>Compliance Level</b> | <b>Full</b> | <b>Substantial</b> | <b>Minimal</b>    | <b>Non-Compliance</b> |
|-------------------------|-------------|--------------------|-------------------|-----------------------|
| Points Range            | <b>3.0</b>  | <b>2.0 – 2.99</b>  | <b>1.0 – 1.99</b> | <b>0 – 0.99</b>       |
| Points Average          | <b>3.0</b>  |                    |                   |                       |

**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.**

**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



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#### Medical Records

#### Suggested Evidence

##### Documents

Policies/procedures for:

- Confidentiality/HIPAA
- Access to medical records
- Transfer of records
- Medical records and documentation standards
- Process and tools for assessing/monitoring provider compliance with medical record standards including performance goals
- Advance Medical Directives

Sample contracts between MCO and network providers and subcontractors demonstrating provisions for medical records and documentation standards; and confidentiality/HIPAA requirements

Member materials related to Advance Directives

Provider materials related to Advance Directives

Evidence of signed confidentiality agreement on behalf of employees, agents and assigns

##### Reports

Provider compliance assessment/monitoring results and follow-up



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|---|---------------------------|-------------------------|---|--|
| State Contract Requirements<br>(Federal Regulation: Not Applicable)   | Prior Results & Follow-Up | Review<br>Determination | Comments (Note: For any element that<br>deviates from the requirements, an<br>explanation of the deviation must be<br>documented in the Comments section) | Health Plan's and DMS'<br>Responses and Plan of Action |
| <b>33.3 General Behavioral Health Requirements</b>  |                           |                         |   |  |
| The Department requires the Contractor's provision of mental 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.        |                           |                         |   |  |
| <b>33.4 Covered Behavioral Health Services</b>  |                           |                         |   |  |
| The Contractor shall assure the provision of all Medically Necessary Behavioral Health Services for Members. These services are described in Appendix I.  |                           |                         |   |  |
| 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-IV multi-axial classification. The Contractor may require use of other diagnostic and assessment instrument/outcome measures in addition to the DSM-IV. |                           |                         |   |  |
| Providers shall document DSM-IV diagnosis and assessment/outcome information in the Member's medical record.  |                           |                         |   |  |
| <b>33.5 Behavioral Health Provider Network</b>  |                           |                         |   |  |
| The Contractor must emphasize utilization management, assuring the services authorized are provided, are medically necessary and produce positive health outcomes. The Department and DBHDID will coordinate on the requirement of data collection and reporting to   |                           |                         |   |  |



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| 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 DSM-IV classification for Behavioral Health billings.  |  |                         |   |   |
| The Contractor shall provide access to psychiatrists, psychologists, and other behavioral health service providers.   |  |                         |   |   |
| In order to meet the provider network requirement for BH services, Community Mental Health Centers (CMHCs) located within the Contractor service region shall be offered participation in the Contractor provider network.  |  |                         |   |   |
| Network providers shall have experience serving children and adolescents, persons with disabilities, the elderly, and cultural or linguistic minorities.  | <p>Non-Compliance - This requirement is not addressed in the documents provided.</p> <p><b>MCO Response:</b> Please refer to the provider manual, which addresses our policy on the responsibilities of our provider network (pg 28-30) and the provider manual notification letter that was distributed to providers.</p> | Full                    | <p>Addressed in Provider Manual (pages 28-30), noted required experience regarding cultural competence and linguistic accessibility.</p> <p>Onsite, WellCare provided P/P C6NI-001GeoAccess Reporting, which describes the requirements for the BH network and the specific clinical experience required.</p> |   |
| The Contractor shall ensure accessibility and availability of qualified providers to all Members in the service area pursuant to Provider Program Capacity Demonstration as contained in the RFP. When necessary to meet the access standards for Behavioral Health Services for its Members, the Contractor may include in its provider network other specialty care clinic providers with comparable core | <p>Substantial - Provider capacity demonstrated in Geo Access reports.</p> <p>WellCare provided reports demonstrating monitoring of compliance with appointment standards for Q2, Q3, and Q4 2012 with the following results:</p>  | Full                    | <p>Addressed in provided documents Final KY 2013 CAID Timely Access Report Q1-Q4.</p> <p>BH Urgent compliance ranged from 60.5% in Q4 to 85.1% in Q2.</p>   |   |



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| services of the CMHC's.   | <p>BH Urgent compliance ranged from 59% in Q4 to 80.6% in Q2.</p> <p>BH Psych Emergency compliance ranged from 83.3% in Q3 to 97.4% in Q4.</p> <p>BH Post Inpatient compliance ranged from 69.2% in Q4 to 93.5% in Q2.</p> <p>BH Routine compliance ranged from 90% in Q3 to 97.4% in Q4.</p> <p>BH Screening &amp; Triage compliance ranged from 76.7% in Q3 to 79.5% in Q4.</p> <p>These results were reviewed onsite as the folders submitted to IPRO in the pre-onsite documents were empty.</p> <p><b>Recommendation for WellCare</b><br/>Evidence of corrective actions taken in response to the results should be provided.</p> <p><b>MCO Response:</b> Please refer to the two sample corrective action responses received from providers following appointment audit fails.</p> |                      | <p>BH Psych Emergency compliance ranged from 82.1% in Q3 to 92.1% in Q4.</p> <p>BH Post Inpatient compliance ranged from 71.1% in Q4 to 91.7% in Q1.</p> <p>BH Routine compliance ranged from 81.6% in Q4 to 100% in Q1-Q2.</p> <p>BH Screening &amp; Triage compliance was 69.4% in Q1, but not included in reports for Q2-Q4.</p> <p>Corrective action responses are addressed in 2013 Provider Responses BH Appointment Audits document.</p> |   |
| 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 |  |                      |   |   |



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| provide under their licenses.   |   |                         |   |  |
| Since the Contractors shall offer participation agreements to the Community Mental Health Centers to participate in their Behavioral Health network, should a Community Mental Health Center decline participation in the Contractor in that service area, or if the Contractor fails to meet access or any other terms and conditions of the contract the Contractor may meet its BH network requirements by offering participation to other qualified specialty care clinic providers with comparable core CMHC services. |   |                         |   |  |
| The Contractor shall maintain a Member education process to help Members know where and how to obtain Behavioral Health Services.   |   |                         |   |  |
| The Contractor shall permit Members to participate in the selection of the appropriate behavioral health individual practitioner(s) who will serve them and shall provide the Member with information on accessible in-network Providers with relevant experience.  |   |                         |   |  |
| <b>33.6 Behavioral Health Services Hotline</b>  |   |                         |   |  |
| 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.  | <p>Substantial - Addressed in Behavioral Health Crisis Hotline procedure, Crisis Line Backup Support, and Member Handbook.</p> <p>P/P CBCS 062 Customer Service Crisis Policy also provided however file could not be opened.</p> <p><b><u>Recommendation for WellCare</u></b><br/>The MCO should ensure that requested</p> | Full                    | <p>Addressed in P/P CBCS 062 and Member Handbook.</p> <p>Onsite, WellCare provided additional documentation:</p> <ul style="list-style-type: none"> <li>- Hotline staff credentials for business hours and after hours</li> <li>- The process flow chart for Emergency Services/Crisis</li> </ul> |  |



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|  | <p>policies/procedures are accessible.</p> <p><b>MCO Response:</b> Please refer to policy CBCS 062 Customer Service Crisis, Member Handbook, page 3, and copy of Member Medicaid Card.</p> <p><b>MCO Response:</b> Please refer to policy CBCS 062 Customer Service Crisis, Member Handbook, page 3, and copy of Member Medicaid Card.</p> |                      | <p>Hotline/Customer Service Center<br/>Clinical Specialists</p> <ul style="list-style-type: none"> <li>- P/P C6CS-121 Behavioral Health Customer Service Requirements</li> </ul>   |   |
| Crisis hotline staff must include or have access to qualified Behavioral Health Services professionals to assess, triage and address specific behavioral health emergencies.                         |  |                      |  |   |
| 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. |  |                      |  |   |
| It is not acceptable for an intake line to be answered by an answering machine.  | <p>Non-Compliance - P/P CBCS 062 Customer Service Crisis Policy provided however file could not be opened.</p> <p><b>MCO Response:</b> Please refer to policy CBCS 062 Customer Service Crisis, BH Staffing Plan, Blue Grass Contract, Crisis Training and BH Workflows.</p>   | Substantial          | <p>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.</p> <p>Onsite, WellCare provided:</p> <ul style="list-style-type: none"> <li>- Bluegrass Training Checklist</li> <li>- P/P C6CS-121 Behavioral Health Customer Service Requirements</li> </ul> | 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. |



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|   |   |                         | - P/P C6CS-062 Customer Service Handling of Crisis Calls<br><br>WellCare noted that the call statistics for the Crisis Hotline in the quarterly reports reflect "0" hold time.<br><br><b><u>Recommendation for WellCare</u></b><br>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. |  |
| 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:       |   |                         |  |  |
| A. Ninety-nine percent (99%) of calls are answered by the fourth ring or an automated call pick-up system;  |   |                         |  |  |
| B. No incoming calls receive a busy signal;   |   |                         |  |  |
| 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; |   |                         |  |  |
| D. The call abandonment rate is seven percent (7%) or less;   |   |                         |  |  |
| E. The average hold time is two (2) minutes or less; and  | Minimal - Call Center metrics demonstrate | Substantial             | Hotline MCO Reports in the 2013  | WellCare has entered a contract with a                 |



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|   | <p>compliance for Q1, Q2 and Q3 2012. Metrics for Q4 show non-compliance for each month, reaching 13 minutes in December 2012. As a result, a corrective action plan was requested of Bluegrass.</p> <p><b>MCO Response:</b> On February 11 2013 The Plan and Bluegrass, the Plan's after hours delegated vendor, discussed the reported Hold Times for Oct 3:10, Nov 8:23 and Dec 13:04. These were not calls that were placed 'on Hold'. These were outlier calls that took the longest to answer, the Highest Maximum Delay' calls. No corrective action plan was needed for Bluegrass. Please refer to the BH Staffing Plan, Blue Grass Contract, Crisis Training and BH Workflows.</p> <p><b>IPRO Comments:</b> No change in review determination. Reports provided onsite indicated average hold times as exceeding the standard.</p> |                      | <p>Medicaid QI Work Plan (page 55) indicate that Average Hold Time is Not Applicable as Behavioral Health callers are not placed on hold.</p> <p>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.</p> <p>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).</p> <p>Onsite, WellCare noted that the call statistics for the Crisis Hotline in the quarterly reports reflect "0" hold time.</p> <p>The Step Action Procedure: Concurrent – Behavioral Health Crisis Hotline lists all types of calls: Emergent: In Danger, High Risk, and Mod-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...).</p> <p><b>Recommendation for WellCare</b></p> | <p>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.</p> |



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|  |  |                      | 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.  |   |
| 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. | <p>Non-Compliance - P/P CBCS 062 Customer Service Crisis Policy provided however file could not be opened.</p> <p><b>MCO Response:</b> Please refer to policy CBCS 062 Customer Service Crisis, BH Staffing Plan, Blue Grass Contract, Crisis Training and BH Workflows.</p> | Substantial          | <p>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.</p> <p>Additionally, WellCare provided the Step Action Procedure: Concurrent-Behavioral Health Crisis Hotline. This process directs the rep to contact 911, the CMHC Mobile Unit.</p> <p>Policies do not address immediate connection to local Suicide Hotline or other Crisis Response Systems.</p> <p><b>Recommendation for WellCare</b><br/>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.</p> | 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.  | Non-Compliance - P/P CBCS 062 Customer Service Crisis Policy provided however file could not be opened.  | Full                 | Addressed by P/P CBCS 062 Customer Service Crisis Policy and Crisis Call Process documents.   |   |



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| State Contract Requirements<br>(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  |
|   | <p><b>MCO Response:</b> Please refer to policy CBCS 062 Customer Service Crisis, BH Staffing Plan, Blue Grass Contract, Crisis Training and BH Workflows.</p>  |                      |  |  |
| <p>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.</p>                 | <p>Non-Compliance - P/P CBCS 062 Customer Service Crisis Policy provided however file could not be opened.</p> <p><b>MCO Response:</b> Please refer to policy CBCS 062 Customer Service Crisis, BH Staffing Plan, Blue Grass Contract, Crisis Training and BH Workflows.</p> | Minimal              | <p>Call duration limits not addressed by documents provided.</p> <p>Onsite, WellCare referred the reviewer to the P/P C6CS-062, however, the policy addresses Customer Service Handling of Crisis Calls.</p> <p>WellCare also referenced the monthly call metrics by employee. Call duration ranged from 1 minute to 3:48 minutes.</p> <p><b>Recommendation for WellCare</b><br/>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.</p> | <p>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.</p> |
| <p>Hotline services shall meet Cultural Competency requirements and provide linguistic access to all Members, including the interpretive services required for effective communication.</p> | <p>Substantial - Call center metrics show use of translation services as needed.</p> <p>Policy/procedure addressing hotline access to linguistic services not provided.</p> <p><b>Recommendation for WellCare</b></p>  | Full                 | <p>Linguistic access requirements addressed by Phone Translation Services Step Action document and C6CS 121 Behavioral Health Customer Service Requirements (page 1).</p>  |  |



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|   | <p>Policy/procedure addressing hotline access to linguistic services should be provided.</p> <p><b>MCO Response:</b> Please refer to the Phone Translation Services Step Action, TTY TDD Phone Services Step Action documents, BH Staffing Plan, Blue Grass Contract, Crisis Training and BH Workflows.</p>  |                      |   |  |
| <p>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.</p> | <p>Non-Compliance - Documents provided do not address this requirement.</p> <p><b>MCO Response:</b> Training for the Behavioral Health Services Hotline staff includes serving multiple contractor programs as training includes information on the different product lines and look up tools as explained in the uploaded policy C6CS-121 Behavioral Health Customer Service Requirements, BH Staffing Plan, Blue Grass Contract, Crisis Training and BH Workflows.</p> | Substantial          | <p>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.</p> <p>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.</p> <p><b>Recommendation for WellCare</b><br/>Policy should address staff knowledge of multiple contractor programs and multiple service areas.</p> | <p>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</p> |



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| The Contractor shall conduct on-going quality assurance to ensure these standards are met.   |  |                         |  |  |
| The Contractor shall monitor its performance against the Behavioral Health Services Hotline standards and submit performance reports summarizing call center performance as indicated.   |  |                         |  |  |
| 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.   |  |                         |  |  |
| <b>33.7 Coordination between the Behavioral Health Provider and the PCP</b>  |  |                         |  |  |
| 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 disorders. PCPs may provide any clinically appropriate Behavioral Health Services within the scope of their practice.   |  |                         |  |  |
| 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. | <p>Substantial - The provider training materials do not explicitly address screening and identification of behavioral health disorders.</p> <p><b>Recommendation for WellCare</b><br/>           Provider training should address screening and identification of behavioral health disorders.</p> <p><b>MCO Response:</b> Please refer to the KY Medicaid</p> | Full                    | Onsite, WellCare directed the reviewer to the provider website, where guidelines for behavioral health disorders include screening and diagnosis. Provider Manual page 101 states that WellCare will work with PCPs to ensure appropriate screening and evaluation procedures for the detection and treatment of behavioral health |  |



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|   | <p>Provider Training materials, which specifically address BH screening (page 13). The training material; as well as, links to clinical best practices are all found on the provider portal. Please also refer to the BH Staffing Plan, Blue Grass Contract, Crisis Training and BH Workflows.</p> |                      | <p>disorders. Additionally, WellCare provided the ADHD Tool Kit for PCPs.</p> <p><u>BH/PH Coordination File Review</u><br/>10 files were reviewed. 9/10 contained a comprehensive assessment, care plan and identification of physical and behavioral health and facilitation and coordination of services. One file was not applicable.</p> <p>3 of 10 contained follow up for missed appointments. The remaining 7 members had no missed appointments documented. For those with missed appointments, CM did a thorough job following up to reschedule.</p> <p>3 of 10 contained documentation of the case manager and behavioral health service providers participating in discharge planning. The remaining 7 members did not have an inpatient BH stay.</p> <p>9 of 10 demonstrated Information sharing and monitoring of diagnosis, treatment, and follow-up and medication usage. One file was not applicable.</p> |   |
| The Contractor shall develop policies and procedures and provide to the Department for approval regarding clinical coordination between Behavioral Health Service Providers and PCPs. |  |                      |   |   |



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| 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. | <p>Non-Compliance - Provider Manual does not address referral for known or suspected and untreated physical health problems or disorders.</p> <p><b>MCO Response:</b> Please refer to the KY Medicaid Provider Training materials, which demonstrate this requirement (page 13).</p> <p>Please refer to the Provider Manual (pg 115), which outlines responsibility of behavioral health providers for referring members with physical health problems.</p> <p>Additionally, please refer to BH Staffing Plan, Blue Grass Contract, Crisis Training and BH Workflows.</p> <p><b>I PRO Comments:</b> No change in review determination. This information was not included in the 2012 Provider Manual.</p> | Full                 | Addressed in KY Medicaid Provider Manual (page 102).   |   |
| 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.  |   |                      |  |   |
| <b>33.8 Follow-up after Hospitalization for Behavioral Health Services</b>   |   |                      |  |   |
| The Contractor shall require, through Provider contract provision, that all Members receiving inpatient psychiatric services are scheduled for outpatient follow-  |   |                      |  |   |



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| up and/or continuing treatment prior to discharge.  |   |                      |  |   |
| The outpatient treatment must occur within fourteen (14) days from the date of discharge.   |   |                      |  |   |
| The Contractor shall ensure that Behavioral Health Service Providers contact Members who have missed appointment within twenty-four (24) hours to reschedule appointments.  |   |                      |  |   |
| <b>33.9 Court-Ordered Services</b>  |   |                      |  |   |
| "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 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. | Non-Compliance - Court-ordered services are not addressed in the documents provided; it is not evident how this information is shared with providers.<br><br><b>MCO Response:</b> Please refer to policy C6CL MD-007 Behavioral Health Services, which addresses Court Ordered Services in KY (page 21) and the Outpatient Clinical Record Review Tool. | Full                 | Addressed in C6CL MD-007 Behavioral Health Services (page 21).   |   |
| 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.                                 | Non-Compliance - Court-ordered services are not addressed in the documents provided; it is not evident how this information is shared with providers.<br><br><b>MCO Response:</b> Please refer to policy C6CL MD-007 Behavioral Health Services, which addresses Court Ordered Services in KY (page 21), the  | Full                 | Addressed in C6CL MD-007 Behavioral Health Services (page 21).   |   |



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|  | Outpatient Clinical Record Review Tool, and BH Workflows   |                      |  |   |
| <b>33.10 Community Mental Health Center (CMHC)</b>   |  |                      |  |   |
| The Contractor shall coordinate with the Community Mental Health Center (CMHC) or other qualified special health care providers, other 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 committed by a court of law to the state psychiatric hospital. |  |                      |  |   |
| 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.             | Minimal - Agreement with Central State Hospital provided. Responsibility to assure continuity of care for successful transition into community-based supports is not addressed.<br><br><b>MCO Response:</b> WellCare has established agreements with each of the state hospitals. In addition, WellCare staff attends quarterly planning meetings to plan for successful transition back to community based supports. Please refer to the Continuity of Care minutes from 4/9/13, minutes from 4/9/13, 1/10/13, and 10/11/12, 4th quarter 2012 report, and the Outpatient Clinical Record Review Tool. | Full                 | Addressed in 10-10-13 Continuity of Care Minutes ARH.  |   |
| In addition, the Contractor Behavioral Health Service Providers shall participate in quarterly Continuity of Care meetings hosted by the state operated or state contracted psychiatric hospital.  | Non-Compliance - Documents provided do not address this requirement.<br><br><b>MCO Response:</b> WellCare has established agreements with each of the state hospitals. In  | Full                 | Addressed in 10-10-13 Continuity of Care Minutes ARH.  |   |



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|   | addition, WellCare staff attends quarterly planning meetings to plan for successful transition back to community based supports. Please refer to the Continuity of Care minutes from 4/9/13, minutes from 4/9/13, 1/10/13, and 10/11/12, 4th quarter 2012 report, and the Outpatient Clinical Record Review Tool.   |                         |   |  |
| The Contractor shall ensure the Behavioral Health Service Providers assign a case manager prior to or on the date of discharge and provide case management services 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.  |   |                         |   |  |
| 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. | Non-Compliance - Documents provided do not address this requirement.<br><br><b>MCO Response:</b> WellCare has established agreements with each of the state hospitals. In addition, WellCare staff attends quarterly planning meetings to plan for successful transition back to community based supports. Please refer to the Continuity of Care minutes from 4/9/13, minutes from 4/9/13, 1/10/13, and 10/11/12, 4th quarter 2012 report, and the Outpatient Clinical Record Review Tool.<br><br>Please also refer to policy C7UM-5.3 Discharge Planning. | Full                    | Addressed in C7UM-5.3 discharge planning BH included (page 9, Addendum F) and C7UM-5.3 Discharge Planning.  |  |
| Appropriate follow up by the Behavioral Health Service  | Non-Compliance - Documents provided do not  | Full                    | Addressed in KY Medicaid Provider   |  |



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| State Contract Requirements<br>(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 |
| 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.  | address this requirement.<br><br><b>MCO Response:</b> Please refer to policy C7UM-5.3 Discharge Planning. |                      | Manual (page 19).<br><br>Onsite, WellCare described a medical record assessment of hospital discharge practices related to BH and a cross-state inpatient/outpatient BH work group focusing on the HEDIS Follow-up After Hospitalization (FUH) measure.<br><br>WellCare indicated that reports are sent to each facility with the facility-specific FUH rate and a list of members discharged with a BH diagnosis.<br><br>WellCare directed the reviewer to the Addendum (F) Kentucky to P/P C7UM MD 5.3 which includes the specific language as stated in the Contract:<br><i>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.</i> |   |
| 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. |   |                      |  |   |
| <b>33.11 Program and Standards</b>  |   |                      |  |   |
| Appropriate information sharing and careful monitoring of diagnosis, treatment, and follow-up and medication  |   |                      |  |   |



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| State Contract Requirements<br>(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 |
| 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); |   |                      |   |   |
| B. Facilitate the exchange of information among providers to reduce inappropriate or excessive use of psychopharmacological medications and adverse drug reactions;   |   |                      |   |   |
| 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;   | <p>Non-Compliance - Documents provided do not address evaluation of member-approved communications between behavioral health providers and PCPs.</p> <p><b>MCO Response:</b> Please refer to the KY Medicaid Provider Manual, pg 115, which discusses coordination of care. Additionally, please refer to policy C7QI-015 Medical Record Review, which addresses monitoring and evaluation of performance, the Outpatient Clinical Record Review Tool, BH Case Management Program Description, and 2012 BH Program.</p> | Full                 | <p>Addressed in KY Medical Provider Manual and C7QI-015 Medical Record Review.</p> <p>Member-approved coordination of care communication between BH providers and PCPs is strongly recommended by MCO on p102 of KY Medicaid Provider Manual.</p> <p>C7QI-015 Medical Record Review identifies a method to evaluate coordination of care (page 16).</p> |   |
| D. Protect the confidentiality of Member information and records; and   |   |                      |   |   |
| E. Monitor and evaluate the above, which shall be a part of the Quality Improvement Plan.   |   |                      |   |   |



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| 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 medications shall be closely monitored. The findings of these evaluations will be provided to the Contractor. |                           |                         |   |  |



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**Scoring Grid:**

| <b>Compliance Level</b> | <b>Full</b> | <b>Substantial</b> | <b>Minimal</b> | <b>Non-Compliance</b> |
|-------------------------|-------------|--------------------|----------------|-----------------------|
| Points Value            | <b>3</b>    | <b>2</b>           | <b>1</b>       | <b>0</b>              |
| Number of Elements      | 14          | 4                  | 1              | 0                     |
| Total Points            | 42          | 8                  | 1              | 0                     |

**Overall Compliance Determination:**

| <b>Compliance Level</b> | <b>Full</b> | <b>Substantial</b> | <b>Minimal</b>    | <b>Non-Compliance</b> |
|-------------------------|-------------|--------------------|-------------------|-----------------------|
| Points Range            | <b>3.0</b>  | <b>2.0 – 2.99</b>  | <b>1.0 – 1.99</b> | <b>0 – 0.99</b>       |
| Points Average          |             | <b>2.68</b>        |                   |                       |

**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.**

**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



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### 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



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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



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| Pharmacy Benefits<br>(See Final Page for Suggested Evidence)   |  |                         |   |   |
|--|--|-------------------------|---|---|
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| <b>31.1 Pharmacy Requirements</b>  |  |                         |   |   |
| 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;                          |  |                         |   |   |
| B. Retrospective utilization review services;  |  |                         |   |   |
| C. Formulary and non-formulary services, including prior authorization services;   |  |                         |   |   |
| D. Pharmacy provider relations and call center services, in addition to Provider Services specified elsewhere; and   | <p>Substantial - Document provided, KY Medicaid Quick Reference Guide for All Services 09 2012, is not supported by an underlying policy for annual review/revision.</p> <p><b>Recommendation for WellCare</b><br/>All documents should be supported within context of policy.</p> <p><b>MCO Response:</b> Please refer to policy and procedure C20RX_012 Pharmacy Call Center and C20RX_012 PR001 Pharmacy Call Center Procedure (2).</p> | Full                    | Policy and procedure C20RX_012 Pharmacy Call Center last revised 8/16/12 and C20RX_012 PR001 Pharmacy Call Center Procedure (2) last revised 7/9/12 provides underlying policy for pharmacy provider relations and call center. |   |



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|--|---|-------------------------|--|---|
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| E. Seamless interfaces with the information systems of the Commonwealth and as needed, any related vendors.  |   |                         |  |   |
| <b>31.2 Formulary and Non-Formulary Services</b>   |   |                         |  |   |
| 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. | <p>Minimal - P/P C20RX-150-PR-002 Drug Evaluation Review (DER) Process states: "WellCare formularies contain a list of formulary drugs and indicate if those drugs have utilization management requirements [prior authorization (PA), quantity limit, step therapy]. A provider or member may become aware of the need to submit a DER for a prescribed medication based on the information provided in WellCare's formulary." However, the formulary lists provided do not indicate any levels of utilization management requirements.</p> <p>"Preferred Drug List PA statement" is an undated document that is not associated with a policy, and does not refer to a policy. The statement clarifies that "preferred products that require prior authorization...are noted on the PDL" and "any product NOT on the PDL will require prior authorization". Step therapy and other utilization management tools are not indicated on the formulary but should be per P/P C20RX-150-PR-002. Utilization management notices appear only on the Preferred Drug List (PDL) updates. Providers receive PDL updates and can review the</p> | Full                    | The provided document ky_medicaid_pdl_10_2013 satisfies the communication of preferred drug listing and utilization requirements (e.g. prior authorization, quantity limits, step therapy) to pharmacy providers and members. The policy supporting the preferred drug list, C20RX-136-PR001 (last revised 10/29/13) is also provided. MCO reports provided. |   |



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| Pharmacy Benefits<br>(See Final Page for Suggested Evidence)        |   |                         |  |   |
|---|---|-------------------------|--|---|
| State Contract Requirements<br>(Federal Regulation: Not Applicable) | Prior Results & Follow-Up   | Review<br>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 |
|   | <p>comprehensive PDL and updates on the WellCare KY website (<a href="https://kentucky.wellcare.com/provider/pharmacy">https://kentucky.wellcare.com/provider/pharmacy</a>) however drugs that require utilization management are not clear for pharmacies (until point of service (POS) adjudication) or the public. The document, "Preferred Drug List PA statement" needs to be placed within the context of a policy, and not be a stand-alone undated document.</p> <p><u>MCO Report #39</u><br/>           For the time period of November 2011- November 2012, WellCare reported 3,245,939 prescriptions including 2,017,971 new prescriptions and 1,229,968 refills. There were 329,109 non-PDL prescriptions and 38,075 prior authorizations (PA) requested of which 52.4% of PAs were denied. From the data provided it is unclear as to how many PAs were for step therapy, clinical issues or straight non-formulary items. It is unclear as to the outcome of the non-PDL requests for which PA was not obtained.</p> <p><b>MCO Response:</b> The WellCare PDL identifies drugs that require Prior Authorization (PA), drugs that require Step Therapy (ST), drugs with Age Limits (AL), drugs with Quantity Limits (QL) and products that are available Over-the-Counter (OTC) when ordered by prescription. These are noted in the "Coverage Detail"</p> |                         |  |   |



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| State Contract Requirements<br>(Federal Regulation: Not Applicable)  | Prior Results & Follow-Up  | Review<br>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 |
|  | <p>column. Please refer to documents KY Medicaid PDL_Q2 2013 and KY Medicaid PDL Updates 6_2013.</p> <p>In reference to MCO Report #39, the State reporting template does not request nor require break-down of prior authorization data.</p> <p>Please refer to the highlighted lines on Report #39 Formulary Management Template and the Report #39 Description from DMS.</p> <p><b>IPRO Comments:</b> No change in review determination. Documents provided are outside the review period. No evidence in the form of a policy/procedure was provided to support the free standing document "Preferred Drug List PA Statement".</p> <p>No response was provided regarding the outcomes of the large number of non-PDL requests for which PA was not obtained (291,034).</p> |                         |  |   |
| <p>The Contractor shall utilize a Pharmacy and Therapeutics Committee (P&amp;T Committee). The committee shall meet periodically throughout the calendar year as necessary and make recommendations to the Contractor for changes to the drug formulary.</p> | <p>Substantial - P/P C20RX-134-PR-001, Corporate Pharmacy Committees notes that the Pharmacy and Therapeutics Committee is required to convene public meetings related to development and administration of the PDL per KY state code.</p> <p>Evidence of public meeting agendas was found on WellCare KY website<br/> <a href="https://kentucky.wellcare.com/provider/phar">https://kentucky.wellcare.com/provider/phar</a></p>   | Full                    | <p>P/P C20RX-134-PR-001, Corporate Pharmacy Committees notes that the Pharmacy and Therapeutics (P&amp;T) Committee is required to convene public meetings related to development and administration of the PDL per KY state code. P&amp;T Open Forum Signed Minutes 11.6.2013 and P&amp;T Open Forum Signed Minutes 8.7.2013 reveal speakers wholly constituted of pharmaceutical industry representatives.</p> |   |



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|---|--|-------------------------|---|--|
| State Contract Requirements<br>(Federal Regulation: Not Applicable)   | Prior Results & Follow-Up  | Review<br>Determination | Comments (Note: For any element that deviates<br>from the requirements, an explanation of the<br>deviation must be documented in the Comments<br>section) | Health Plan's and<br>DMS'<br>Responses and Plan of<br>Action |
|   | <p><a href="#">macy</a>), however meeting minutes indicating public inclusion that support KY state code were not provided.</p> <p><b>Recommendation for WellCare</b><br/>Committee minutes demonstrating public input should be provided for review.</p> <p><b>MCO Response:</b> Please refer to the P&amp;T Forum presentation from the 5/9/2012 quarterly meeting. Speaker slides include those individuals that requested the opportunity to speak before the Committee. All were present and provided testimony at this meeting.</p> <p><b>IPRO Comments:</b> No change in review determination. Documentation of public participation should be included within P&amp;T meeting minutes.</p> |                         |   |  |
| <p>The Contractor shall provide information to its pharmacy providers regarding the Preferred Drug List (PDL) for Medicaid Members. 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.</p> | <p>Substantial - Providers receive PDL updates and can review the comprehensive PDL and updates on the WellCare KY website (<a href="https://kentucky.wellcare.com/provider/pharmacy">https://kentucky.wellcare.com/provider/pharmacy</a>) however drugs that require utilization management are not clear for pharmacies (until POS adjudication) or the public.</p> <p><b>Recommendation for WellCare</b><br/>Pharmacies and members should have access to the PDL including utilization management requirements.</p>  | Full                    | <p>C20RX-136-Preferred Drug List, C20RX-136-PR001, and ky_medicaid_pdl_10_2013 satisfy this requirement.</p>  |  |



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|---|---|-------------------------|---|--|
| State Contract Requirements<br>(Federal Regulation: Not Applicable)   | Prior Results & Follow-Up   | Review<br>Determination | Comments (Note: For any element that deviates<br>from the requirements, an explanation of the<br>deviation must be documented in the Comments<br>section) | Health Plan's and<br>DMS'<br>Responses and Plan of<br>Action |
|   | <b>MCO Response:</b> Utilization Management edits is noted on both the Comprehensive PDL and PDL Updates. Please refer to Please refer to documents KY Medicaid PDL_Q22013 and KY Medicaid PDL Updates 6_2013.  |                         |   |  |
| <b>31.3 Pharmacy Claims Administration</b>  |   |                         |   |  |
| The Contractor shall process, adjudicate, and pay 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. | Substantial - KY Medicaid Quick Reference Guide includes instructions for submitting paper claims but policy addressing these requirements was not found.<br><br><b>Recommendation for WellCare</b><br>All documents should be supported within context of policy.<br><br><b>MCO Response:</b> See refer to page #6 part "d" of policy C20RX-152-PR-004 for paper claims processing attached. | Full                    | C20RX-152-PR-004 for paper claims processing satisfies this requirement.  |  |
| 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.  |   |                         |   |  |
| 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.   |   |                         |   |  |
| <b>31.4 Pharmacy Rebate Administration</b>  |   |                         |   |  |



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|---|--|-------------------------|--|---|
| State Contract Requirements<br>(Federal Regulation: Not Applicable)   | Prior Results & Follow-Up  | Review<br>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 |
| <p>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, 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.</p> | <p>Substantial - Stand-alone document titled "Rebate Administration" provides guidance for dispute resolution but is not a stated policy of WellCare and is not dated. This should be placed within context of a policy.</p> <p><b>Recommendation for WellCare</b><br/>All documents should be supported within context of policy.</p> <p><b>MCO Response:</b> The process exists based on contract requirements and the proposal submitted by WellCare in response to the original RFP requirement. Please refer to policy C12ENC-001 Encounter End to End Process and Kentucky Draft Addendum.</p> | Full                    | <p>Policy C12ENC-001 Encounter End to End Process and Kentucky Draft Addendum satisfy this requirement.</p>                                      |   |
| <b>37.12 Prospective Drug Utilization Review Report</b>   |  |                         |  |   |
| <p>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.</p>   |  |                         |  |   |



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**Scoring Grid:**

| <b>Compliance Level</b> | <b>Full</b> | <b>Substantial</b> | <b>Minimal</b> | <b>Non-Compliance</b> |
|-------------------------|-------------|--------------------|----------------|-----------------------|
| Points Value            | <b>3</b>    | <b>2</b>           | <b>1</b>       | <b>0</b>              |
| Number of Elements      | 6           | 0                  | 0              | 0                     |
| Total Points            | 18          | 0                  | 0              | 0                     |

**Overall Compliance Determination:**

| <b>Compliance Level</b> | <b>Full</b> | <b>Substantial</b> | <b>Minimal</b>    | <b>Non-Compliance</b> |
|-------------------------|-------------|--------------------|-------------------|-----------------------|
| Points Range            | <b>3.0</b>  | <b>2.0 – 2.99</b>  | <b>1.0 – 1.99</b> | <b>0 – 0.99</b>       |
| Points Average          | <b>3.0</b>  |                    |                   |                       |

**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.**

**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



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**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**

Retrospective Drug UR reports