KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: WellCare of Kentucky

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation 438.236, 438.240)	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**
19.1 QAPI Program			Includes review of MCO Report #84 QAPI Program Description (see Quarterly Desk Audit results).	
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 requirement for a QAPI is met per the MCO's 2016 Quality Improvement program Description and is supported by QIC meeting minutes for 2016.			
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 requirement is met per the MCO's 2016 Quality Improvement Program Description. It is also met per the MCO's 2016 HEDIS and CAHPs submissions, which include measures of access, quality and outcomes of care. It is also met per the PIPs that the MCO has conducted in 2016, which also assess quality and access to care.			
The Contractor's QI structures and processes shall be planned, systematic and clearly defined.	Full - The requirement is met per documentation in the QI Program Description, with evidence of implementation in the 2016 Medicaid QI Work Plan, which describes the PIPs that the MCO has undertaken in 2016.			
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	Full - The 2016 Medicaid QI Work Plan and committee minutes for 2016 demonstrate that quality initiatives are developed and implemented based on data analysis of a variety of quality indicators, including surveys, HEDIS data and internal monitoring activities.			

Final Findings

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

State Contract Requirements (Federal Regulation 438.236, 438.240)	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
identified by an accreditation body.				
The QAPI program shall be developed in collaboration with input from Members.	Full - The QMAC minutes document participation by one MCO member and several community member participants. During one meeting, the MCO member was not present. The MCO has continued efforts to attract members to participate in the QAPI program, including asking providers and community partners to recommend participants. Recommendation for WellCare WellCare should continue efforts to increase recruitment of plan members for the QMAC to avoid the possibility that a meeting be convened absent of any MCO members.			
The Contractor shall maintain documentation of all member input; response; conduct of performance improvement activities; and feedback to Members.	Full - The 2016 QMAC minutes document member input and feedback regarding performance improvement activities.			
The Contractor shall have or obtain within 2-4 years and maintain National Committee for Quality Assurance (NCQA) accreditation for its Medicaid product line.	Full - This requirement is met per the NCQA certification of "Commendable" accreditation, granted August 31, 2015 with expiration date of September 2, 2017.			
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	Full - The MCO provided the certificate of accreditation and the Accreditation Summary Report dated 8/28/15 based on HEDIS 2015.			

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation 438.236, 438.240)	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 category, Standard, and element levels, as well as NCQA recommendations, as presented via the NCQA Interactive Survey System (ISS) Interactive Review Tool (IRT): Status, Summarized & Detailed Results, Performance, Performance Measures, Must Pass Results Recommendations and History.				
Annually, the Contractor shall submit the QAPI program description document to the Department in accordance with a format and timeline specified by the Department, after consultation with the Contractor.	Full - An email to DMS documented submission.			
The Contractor shall integrate Behavioral Health indicators into its QAPI program and include a systematic, ongoing process for monitoring, evaluating, and improving the quality and appropriateness of Behavioral Health Services provided to Members.	Full - The 2016 Medicaid QI Work Plan describes an initiative entitled "Physical Health Risks in the Seriously Mentally Ill Population", whose objective is to improve the preventive physical health care, including access to preventive/ambulatory health services and screenings for metabolic and cardiovascular risks, in the seriously mentally ill population. As reported in the 2016 QI Work Plan, third quarter 2016 monitoring and evaluation of behavioral health provider appointment availability indicated that of the 14 behavioral health providers audited, 42.9% were compliant with urgent care appointment availability standards, 92.9% were compliant with psychiatric emergency care appointment availability standards,			

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation 438.236, 438.240)	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**
	57.1% were compliant with post inpatient discharge appointment availability standards, and 100% were compliant with routine care appointment availability standards. WellCare onsite staff reported that the MCO is also working on the FUH HEDIS measure, with initiatives including working with hospitals to facilitate visits with outpatient providers prior to discharge, engaging nurse practitioners for home care, and working on transportation to facilitate. Thus far only one nurse practitioner, who sees only adults, has been engaged who meets criteria. Recommendation for WellCare WellCare should continue to monitor barriers to care as compliance with access standards in the behavioral health area continues to be suboptimal. WellCare should continue with its efforts to improve access.			
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 - In 2016, WellCare continued to collect data, analyze, and evaluate for improvements in the care provided by its network of providers and facilities relative to behavioral health. This includes the integrated case management program, monitoring admissions and readmissions, developing and reviewing clinical practice guidelines, and monitoring BH providers' compliance with medical record standards and access and availability standards. WellCare also reported the HEDIS BH-related measures in 2016 and conducted the 2016 Mental Health Statistic Improvement Program (MHSIP) survey.			

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation 438.236, 438.240)	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 also have mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.	New requirement	Full	This requirement is addressed in 2017 Kentucky Medicaid Quality Improvement Evaluation beginning on page 162.	
19.2 Annual QAPI Review				
The Contractor shall annually review and evaluate the overall effectiveness of the QAPI program to determine whether the program has demonstrated improvement in the quality of care and service provided to Members. The Contractor shall modify, as necessary, the QAPI Program, including Quality Improvement policies and procedures; clinical care standards; practice guidelines and patient protocols; utilization and access to Covered Services; and treatment outcomes to meet the needs of Members. The Contractor shall prepare a written report to the Department, detailing the annual review and shall include a review of completed and 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	Full – Includes review of MCO Report #85 QI Plan & Evaluation (see Quarterly Desk Audit results) The 2015 Medicaid QI Program Evaluation was reviewed and approved by the Utilization Management Medical Advisory Committee on March 30, 2016, by the Quality Improvement Committee on March 31, 2016 and by the Quality Member Access Committee on March 29, 2016. MCO Report #85 QI Plan & Evaluation was provided and reviewed.		Includes review of MCO Report #85 QI Plan & Evaluation (see Quarterly Desk Audit results).	

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
corrective actions implemented; corrective actions which are recommended or in progress; and any modifications to the program. There shall be evidence that QI activities have contributed to meaningful improvement in the quality of clinical care and quality of service, including preventive and behavioral health care, provided to Members. The Contractor shall submit this report as specified by the Department.				
22.3 External Quality Review				
The Contractor shall provide information to the EQRO as requested to fulfill the requirements of the mandatory and optional activities required in 42 CFR Parts 433 and 438.	Full - The 2015 Medicaid QI Program Evaluation indicated that the MCO submitted the required documents for the 2015 annual contract compliance assessment, and responded to items noted as less than fully compliant. PIPs conducted in collaboration with the EQRO are discussed beginning on page 263 of the QI Program Evaluation.			
The Contractor shall cooperate and participate in EQR activities in accordance with protocols identified under 42 CFR 438, Subpart E. These protocols guide the independent external review of quality outcomes and timeliness of, and access to, services provided by a Contractor providing	Full - The 2015 Medicaid QI Program Evaluation indicated that the MCO submitted the required documents for the 2015 annual contract compliance assessment, and responded to items noted as less than fully compliant. PIPs conducted in collaboration with the EQRO are discussed beginning on page 263 of the QI Program Evaluation			

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation 438.236, 438.240)	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**
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.				
22.4 EQR Administrative Reviews				
The Contractor shall assist the EQRO in competing all Contractor reviews and evaluations in accordance with established protocols previously described.	Full - WellCare continues to actively participate in all mandatory and optional EQR activities with the EQRO and conducted on behalf of DMS.			
The Contractor shall assist the Department and the EQRO in identification of Provider and Member information required to carry out annual, external independent reviews of the quality outcomes and timeliness 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.	Full - WellCare provided all documentation necessary for the annual compliance review in 2016; the 2016 technical report production; and records, data and documentation for focused/ validation studies, PIPs, and performance measure validation			
22.5 EQR Performance				
If during the conduct of an EQR by an EQRO acting on behalf of the	Full - Addressed by the MCO's response to last year's review.			

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Department, 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:				
A. Assign a staff person(s) to conduct follow-up concerning review findings;	Full - Addressed by the MCO's response to last year's review.			
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;	Full - Addressed by the MCO's response to last year's review.			
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; An extension to submit may be extended in accordance with Section 40.4.D;	Full - Addressed by the MCO's response to last year's review.			

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation 438.236, 438.240)	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**
D. The Contractor shall demonstrate how the results of the External Quality Review (EQR) are incorporated into the Contractor's overall Quality Improvement Plan and demonstrate progressive and measurable improvement during the term of this contract; and	Full - Addressed by the MCO's response to last year's review.			
E. If Contractor disagrees with the EQRO's findings, it shall submit its position to the Commissioner of the Department whose decision is final.	Full - WellCare developed and implemented corrective action plans where necessary. Any disagreement was reviewed by the EQRO and resolved prior to the issuance of the final report.			
19.3 QAPI Plan			Includes review of MCO report #17 QAPI Work Plan, MCO Report #84 QAPI Program Description, MCO Report #21 MCO Committee Activity, and MCO Report #85 QI Plan and Evaluation (see Quarterly Desk Audit results).	
The Contractor shall have a written QAPI work plan that	Full - This requirement was met per the 2016 Medicaid QI Work Plan with quarterly updates.			
outlines the scope of activities and	Full - The 2016 Medicaid QI Work Plan documents activities conducted/ continued during the calendar year, including detailed information and updates for each task.			
the goals,	Full - The 2016 Medicaid QI Work Plan documents goals for each activity.			

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation 438.236, 438.240)	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**
objectives, and	Full - The 2016 Medicaid QI Work Plan documents objectives for each activity.			
timelines for the QAPI program.	Full - The 2016 Medicaid QI Work Plan is reported via quarterly reports, with timeframes indicated.			
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.	Full - The 2016 Medicaid QI Work Plan is based on data from QI studies, CAHPS and other survey results, HEDIS rates and other internal data and studies.			
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 2016 Medicaid Quality Improvement Program Description addresses the requirements stated in the regulation. It was reviewed and approved by the Utilization Management Medical Advisory Committee, the Quality Improvement Committee and by the Quality Member Access Committee.			
designation of an accountable entity within the organization to provide direct oversight of QAPI;	Full - The 2016 Medicaid QI Program Description documents that it is the Board of Directors' ultimate responsibility for oversight of the QI program, which delegates responsibility for day-to- day operations to the QI Senior Director.			
review of written reports from the designated entity on a periodic basis, which shall include a description of QAPI activities, progress on objectives, and improvements made;	Full - The 2016 QAPI Work Plan and Quality Improvement Committee (QIC) minutes address QI initiatives, activity status and assessment of results.			

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation 438.236, 438.240)	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**
review on an annual basis of the QAPI program; and	Full - The 2016 Medicaid QI Program Description addresses this requirement.			
modifications to the QAPI program on an ongoing basis to accommodate review findings and issues of concern within the organization.	Full - The 2016 QI Work Plan includes quarterly updates to the QI activities, and modifications are based on study results and 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 2016 Medicaid QI Program Description specifies the primary responsibilities of the QIC related to oversight of the QI program. Quarterly minutes and agendas were provided.			
The committee structure shall be interdisciplinary and be made up of both providers and administrative staff. It should include a variety of medical disciplines, health professions and individual(s) with specialized knowledge and experience with Individuals with Special Health Care Needs.	Full - The 2016 Medicaid QI Program Description indicates that the Chairperson is the Kentucky Medical Director and includes both MCO Representation, including the President, Medical Director, several other directors and high-level personnel and includes MCO Corporate Representation.			
The committee shall meet on a regular basis and activities of the committee must be documented; all committee minutes and reports shall be available to the Department upon request.	Full - The 2016 QIC minutes document that regular meetings are held quarterly.			
QAPI activities of Providers and Subcontractors, if separate from the	Full - The Provider Newsletters were provided that document communication regarding QI activities and areas of focus to			

Quality Assessment and Performance Improvement: Measurement and Improvement (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Contractor'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.	providers. This requirement is also addressed in the Kentucky Medicaid Provider manual.			
The Contractor shall integrate other management activities such as Utilization Management, Risk Management, Member Services, Grievances and Appeals, Provider Credentialing, and Provider Services in its QAPI program.	Full - The 2016 QI Program Description and committee meeting minutes document that representatives from operational units across the MCO and at the corporate level are involved in QAPI initiatives.			
Qualifications, staffing levels and available resources must be sufficient to meet the goals and objectives of the QAPI program and related QAPI activities, including, but not limited to, monitoring and evaluation of Member's care and services, including the care and services of Members with special health	Full - The 2016 QI Program Description describes the role of the Medical Director, Role of the BH Medical Director, and the Role of the Quality Improvement Department and describes the number and disciplines of staff dedicated to the QI Program.			

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
care 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.				
The Contractor shall submit the QAPI work plan to the Department annually in accordance with a format and timeline specified by the Department.	Full - This requirement was met in submission of 2016 Quarterly Reports #17.			
19.4 QAPI Monitoring and Evaluation				
The Contractor, through the QAPI program, shall monitor and evaluate the quality of health care on an ongoing basis. Health care needs such as acute or chronic physical or behavioral conditions, high volume, and high risk, special needs populations, preventive care, and behavioral health shall be studied and prioritized for performance measurement, performance improvement and/or development of practice guidelines. Standardized quality	Full - The 2016 Medicaid QI Work Plan quarterly reports track progress regarding initiatives related to HEDIS performance measures and PIPs conducted by the MCO. The 2015 Medicaid QI Program Evaluation demonstrates evaluation of performance and action plans for improvement based on performance measures, surveys, PIPs and other MCO initiatives. The MCO maintains a set of clinical guidelines in both physical and behavioral health areas, which were submitted for review.			

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation 438.236, 438.240)	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**
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.				
Providers shall be measured against practice guidelines and standards adopted by the Quality Improvement Committee.	Full - The 2015 Medicaid QI Program Evaluation states that the MCO uses the annual HEDIS® measurement as its annual assessment of practitioner compliance against aspects of clinical practice guidelines.			
Areas identified for improvement shall be tracked and corrective actions taken as indicated.	Full - The 2016 QI Work Plan, 2015 QI Program Evaluation, and QIC committee minutes demonstrate tracking of performance and recommended areas for improvement. Quarterly tracking results are presented in the 2016 Quality Assessment and Performance Improvement Work Plan.			
The effectiveness of corrective actions must be monitored until problem resolution occurs. The Contractor shall perform reevaluations to assure that improvement is sustained.	Full - 2016 Quality Assessment and Performance Improvement Work Plan tracks performance and updates interventions, as needed, based on prior results.			
The Contractor shall use appropriate	Full - The 2016 Medicaid QI Program Description states that the			

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation 438.236, 438.240)	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**
multidisciplinary teams to analyze and address data or systems issues.	MCO has an integrated model of resources supporting the MCO's QI activities, including behavioral health. These resources include MCO associates that cross all functional areas of the organization that include, but are not limited to: the executive team, provider relations staff, case and disease management staff, and data analytics support. Resources supporting QI activities are assessed on an annual basis.			
The Contractor shall collaborate with existing provider quality improvement activities and to the extent possible, align with those activities to reduce duplication and to maximize outcomes.	Full - As stated in the 2015 Kentucky Medicaid Quality Improvement Evaluation report, the BH UM Care Managers were all trained prior to 12/31/15 and the new tools were implemented allowing for increased collaboration with providers to obtain appropriate clinical information to make medical necessity decisions. The MCO provided evidence of collaboration with providers in the conduct of its PIPs: Management of Physical Health Risks in the Seriously Mentally Ill Population and Improving Pediatric Oral Health; with the American Cancer Society for a colorectal screening initiative; with CMS for the pediatric dental initiative. The MCO collaborates with the Kentucky community college system to offer scholarships health care fields such as advanced practice nurses in underserved areas. WellCare also collaborates with the local chapter of the American Diabetes Association, and is represented on the board, and also collaborates with school based resource workers on health promotion.			

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Recommendation for WellCare It is recommended that the MCO increase collaboration between CMHCs and FQHCs.			
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 - MCO Report # 19 describes the Performance Improvement Projects the MCO is conducting which include, but are not limited to: Management of Physical Health Risks in the Seriously Mentally Ill Population, Improving Pediatric Oral Health, Follow-up after Hospitalization for Mental Illness (FUH) and Post-Partum Care.			
The Contractor shall develop or adopt practice guidelines that are disseminated to Providers and to Members and Potential Enrollees upon request.	Full - The MCO provided evidence of adoption and development of clinical practice guidelines in 2016 Quarterly Reports #17, Chronic Condition Clinical Practice Guidelines. Reference to locating them can be found in Provider newsletters and on the provider portal. Interqual is referenced in the Member Handbook.			
Mental Health and Substance Use practice guidelines shall also be submitted to the Department and DBHDID.	Full - The MCO provided a set of Clinical Guidelines that relate specifically to mental health and substance abuse. Quarterly report #17 provides evidence that the guidelines were submitted.			
The guidelines shall be based on valid and reliable medical/behavioral health evidence or consensus of health professionals;	Full - Each of the MCO's guidelines contains a section indicating the source of the guideline, which is a nationally-recognized organization.			
consider the needs of Members;	Full - Both physical and behavioral health guidelines are directly			

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation 438.236, 438.240)	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**
	related to the needs of the members.			
developed or adopted in consultation with contracting health professionals, and	Full - The 2016 Medicaid QI Program Description includes CPG development, review and annual approval as a primary responsibility of the UMAC.			
reviewed and updated periodically.	Full - The 2016 Medicaid QI Program Description states that CPGs are approved on an annual basis.			
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 - A section of the 2016 Medicaid QI Program Description is devoted to the use of CPGs in developing UM criteria.			
20.1 Kentucky Outcomes Measures and HEDIS Measures				
The Contractor shall implement steps targeted at health improvement for selected performance measures, 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	Full - The 2016 Medicaid QI Work Plan quarterly reports address QI activities related to HEDIS outcomes and preventive health measures, with objectives, goals, monitoring and interventions indicated.			

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation 438.236, 438.240)	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**
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.				
Additionally, the Department, Contractor, and the EQRO will review and evaluate the feasibility and strategy for rotation of measures requiring hybrid or medical record data collection to reduce the burden of measure production. The group may consider the annual HEDIS measure rotation schedule as part of this process.	Full - Kentucky MCOs follow the HEDIS measure rotation schedule.			
The Contractor in collaboration with the Department and the EQRO shall develop and initiate a performance measure specific to Individual Members with Special Health Care Needs (ISHCN).	Full - The 2016 Medicaid QI Work Plan quarterly reports include an indicator to assess Child and Adolescent Individuals with Special Health Care Needs. Its objective is to improve the percentage of child and adolescent members, in the SSI and Foster categories of aid, and those who received services from Commission for Children with Special Health Care Needs, who received specified services related to access to care and preventive care.			
The Department shall assess the Contractor's achievement of performance improvement related to the health outcome measures. The Contractor shall be expected to achieve	Full - The 2015 QI Evaluation shows trending and analysis of measures, including those not meeting MCO goals with recommendations for 2015.			

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation 438.236, 438.240)	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**
demonstrable and sustained improvement for each measure.				
Specific quantitative performance targets and goals are to be set by the workgroup. The Contractor shall report activities on the performance measures in the QAPI work plan quarterly and shall submit an annual report after collection of performance data. The Contractor shall stratify the data to each measure by the Medicaid eligibility category, race, ethnicity, 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.	Full - For each indicator being measured and reported in the 2015 QI Evaluation, goals are specified. Barriers to achieving the goals are reported as well as recommendations to overcoming the barriers.			
20.3 Reporting HEDIS Performance Measures			Includes review of MCO Report #96 Audited HEDIS Reports (see Quarterly Desk Audit results).	
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	Full - The HEDIS Final Audit Report prepared by HealthData Company was provided as well as the Medicaid IDSS that was locked and submitted to NCQA. Submission is evident in Annual Report #96.			

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation 438.236, 438.240)	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**
(preferred) or printed copy of the interactive data submission system tool (formerly the Data Submission tool) by no later than each August 31st.				
In addition, for each measure being reported, the Contractor shall provide trending of the results from all previous years in chart and table format. Where applicable, benchmark data and performance goals established for the reporting year shall be indicated. The Contractor shall include the values for the denominator and numerator used to calculate the measures.	Full - HEDIS performance measures were trended and benchmarked in the Medicaid 2015 QI Program Evaluation. CAHPS rates were benchmarked in the same report.			
For all reportable Effectiveness of Care and Access/Availability of Care measures, the Contractor shall stratify each measure by Medicaid eligibility category, race, ethnicity, gender and age.	Full - As in past years, MCO Report #96 presents effectiveness of Care and Access/Availability of Care performance measures stratified by race/ethnicity, gender, age, and category of aid.			
Annually, the Contractor and the Department will select a subset of targeted performance from the HEDIS reported measures on which the Department will evaluate the Contractor's performance. The Department shall inform the Contractor of its performance on each measure, whether the Contractor satisfied the goal	Not Applicable - DMS has not chosen a subset of measures for evaluation. Annually in collaboration with the EQRO, DMS evaluates the measures required for reporting.	Not Applicable	DMS has not chosen a subset of measures for evaluation.	

Quality Assessment and Performance Improvement: Measurement and Improvement (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation 438.236, 438.240)	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**
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.				
The Department reserves the right to evaluate the Contractor's performance on targeted measures based on the Contractor's submitted encounter data. The Contractor shall have 60 days to review and respond to findings reported as a result of these activities.	Not Applicable - DMS has not chosen a subset of measures for evaluation. Annually in collaboration with the EQRO, DMS evaluates the measures required for reporting.	Not Applicable	DMS has not chosen a subset of measures for evaluation.	
The Department further reserves the right to implement and require different quality measures. The Contractor shall be given no less than ninety (90) days to comply with any new quality measurement requirement.	New requirement	Not Applicable	DMS has not chosen a subset of measures for evaluation.	
20.4 Accreditation of Contractor by National Accrediting Body				
If the Contractor holds a current NCQA accreditation status it shall submit a copy of its current certificate of accreditation with a copy of the complete accreditation survey report, including	Full - Accreditation Report documents "Commendable" Accredited status effective 8/31/15 with expiration date 9/21/17.			

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation 438.236, 438.240)	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**
scoring of each category, standard, and element levels, and recommendations, as presented via the NCQA Interactive Review Tool (IRT) Status. Summarized & Detailed Results, Performance, Performance Measures, Must Pass Results Recommendations and History to the Department in accordance with timelines established by the Department.				
If a Contractor has not earned accreditation of its Medicaid product through the National Committee for Quality Assurance (NCQA) Health Plan, the Contractor shall be required to obtain such accreditation within two (2) to four (4) years from the effective date of its initial MCO contract with the Commonwealth.	Full - Accreditation Report documents "Commendable" Accredited status effective 8/31/15 with expiration date 9/21/17			
20.5 Performance Improvement Projects (PIPs)			Includes review of MCO Reports: #19 PIPs, #90 PIP Proposal, and #92 PIP Measurement (see Quarterly Desk Audit results).	
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	Full - The MCO provided documentation of conduct of the following PIPs in 2016: Antipsychotic Use in Children; Follow-Up for Hospitalization for Mental Illness; COPD; Childhood and Adolescent Immunization Postpartum care; Management of Physical Health Risks in the Seriously Mentally Ill Population; and Improving Pediatric Oral Health.			

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation 438.236, 438.240)	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**
condition in the enrolled population; the need(s) for a specific service(s); member demographic characteristics and health risks; and the interest of Members in the aspect of care/services to be addressed.				
The Contractor shall continuously monitor its own performance on a variety of dimensions of care and services for Members, identify areas for potential improvement, carry out individual PIPs, undertake system interventions to improve care and services, and monitor the effectiveness of those interventions. The Contractor shall develop and implement PIPs to 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	Full - The MCO provided reports describing status and progress of the PIPs that are currently being conducted during the reporting period.			

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation 438.236, 438.240)	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**
category, type of disability or special health care need, race, ethnicity, gender and age. PIPs shall also address the specific clinical needs of Members with conditions and illnesses that have a higher prevalence in the enrolled population. Non-clinical PIPs should address improving the quality, availability and accessibility of services provided by the Contractor to Members and Providers. Such aspects of service should include, but not be limited to, availability, accessibility, cultural competency of services, and complaints, grievances, and appeals.				
The Contractor shall develop collaborative relationships with local health departments, behavioral health agencies and other community based health/social agencies to achieve improvements in priority areas. Linkage between the Contractor and public health agencies is an essential element for the achievement of public health objectives.	Full - According to the 2016 Work Plan, the MCO partnered with Public Health Departments and Non-profit Hospitals around the commonwealth as they conduct community health needs assessments (CHNAs). The HCC was combined with the CHNA in over 15 counties, In addition, the MCO participated in forty-eight (48) homeless outreach events, for a total of 967 touches. These events included a Homeless Resource Fair with the Homeless Council of the Ohio Valley in Daviess County.			
The Contractor shall be committed to on-going collaboration in the area of service and clinical care improvements	Full - The MCO has fully cooperated with DMS and IPRO on all EQRO tasks and projects, reported all required performance measures, and cooperated with the 2016 compliance review.			

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
by the development of best practices and use of encounter data–driven performance measures and establishment of relationship with existing organizations engaged in provider performance improvement through education and training in best practices and data collection.	As described in the 2016 Work Plan, the MCO has also established relationships with community organizations and worked with providers to enhance access and availability and improve outcomes			
The Contractor shall monitor and evaluate the quality of care and services by initiating at least one PIP each year and participating in one collaborative PIP each year. The Department recognizes that the following conditions are prevalent in the Medicaid population in the Commonwealth and recommends that the Contractor considers the following topics for PIPs: diabetes, coronary artery disease screenings, colon cancer screenings, cervical cancer screenings, behavioral health, reduction in ED usage and management of ED Services. 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.	Full - The MCO is conducting 7 PIPs, including three specific to behavioral health.			

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation 438.236, 438.240)	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**
Additionally, the Department shall 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;. The Contractor shall submit reports on PIPs as specified by the Department.				
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 MCO utilized the required template for PIP reporting			
A. Topic and its importance to enrolled members;	Full - The MCO included a topic and relevance to the population in its PIPs.			
B. Methodology for topic selection;	Full - Methodology is included in the PIPs.			
C. Goals;	Full - The MCO included goals for indicators			
D. Data sources/collection;	Full -The MCO reported on data sources/ collection.			
E. Intervention(s) – not required for projects to establish baseline; and	Full -The MCO develops interventions designed to address identified barriers.			
F. Results and interpretations – clearly state whether performance goals were met, and if not met, analysis of the intervention and a	Full -The MCO reported PIP results using tables and referenced tables in corresponding narrative.			

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation 438.236, 438.240)	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**
plan for future action.				
The final report shall also answer the following questions and provide information on:				
A. Was Member confidentiality protected;	Full -Member confidentiality was protected in accordance with HIPAA procedures.			
B. Did Members participate in the performance improvement project;	Full -For the COPD, educational materials were mailed to members. For the Postpartum Care PIP, a "Baby Line" was offered to help support members. Targeted educational materials were sent to members in connection with the Follow-Up After Hospitalization PIP. WellCare presents PIPs to the QMAC and has conducted focus groups in the past. Recommendation for WellCare WellCare may consider conducting focus groups, surveys or presenting PIPs at the proposal stage to the QMAC for insight into member barriers to care relevant to the PIP.	Full	IPRO Reviewer will check on member focus groups or other surveys per the recommendation. As follow up to last year's recommendation, this requirement is addressed in Signed QMAC Minutes December 5 2017 on page 4.	
C. Did the performance improvement project include cost/benefit analysis or other consideration of financial impact;	Full -Financial impact is reported in the final PIP reports for Management of Chronic Obstructive Pulmonary Disease and Follow UP after Hospitalization for Mental Illness.			
D. How financial impact might determine sustainability of improvement achieved;	New requirement	Full	This requirement is addressed in the Improving Pediatric Oral Health on page 61 and in Management of Physical Health Risks in the Seriously Mentally Ill Population on page 82.	

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation 438.236, 438.240)	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**
E. Were the results and conclusions made available to members, providers and any other interested bodies;	Full Final PIP reports indicated that PIP results are shared with members via newsletters. PIPs results are reported to QMAC.			
F. Is there an executive summary;	Full - The PIPs include a section for the MCO to complete an abstract, which was completed for the 2016 submitted final PIP reports.			
G. How could findings be reported to a broad audience of relevant stakeholders or the general public; and	New requirement	Full	This requirement is addressed in Improving Pediatric Oral Health on page 62 and in Management of Physical Health Risks in the Seriously Mentally Ill Population on page 83.	
H. Do illustrations – graphs, figures, tables – convey information clearly?	Full - Baseline, interim and final rates are clearly reported.			
Performance reporting shall utilize standardized indicators appropriate to the performance improvement area. Minimum performance levels shall be specified for each performance improvement area, using standards derived from regional or national norms or from norms established by an appropriate practice organization. The norms and/or goals shall be pre-determined at the commencement of each performance improvement goal and the Contractor shall be monitored	Full - PIP Proposals include HEDIS performance indicators.			

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
for achievement of demonstrable and/or sustained improvement				
The Contractor shall validate if improvements were sustained through periodic audits of the relevant data and maintenance of the interventions that resulted in improvement. The timeframes for reporting:	Full - PIP reports compared baseline, interim and final rates to evaluate whether improvements were sustained.			
A. Project Proposal including baseline measurement – due September 1 of Contract year. Proposal with baseline measurement is required upon submission of completed PIP. If PIP identified as a result of Department/EQRO review, the project proposal shall be due sixty (60) days after notification of requirement.	Full - The MCO met submission requirements for proposal. The MCO met submission requirements for baseline data.			
B. 1st Remeasurement – no more than one calendar year after baseline measurement and no later than September 1 of the Contract year following baseline measurement.	Full - The MCO met submission requirements for remeasurement data.			
C. Conclusion – no more than one calendar year after the first remeasurement and no later than September 1 of the contract year	Full - The MCO met submission requirements for the Conclusion section.			

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation 438.236, 438.240)	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**
when the PIP concludes.				
20.6 Quality and Member Access Committee			Includes review of MCO Report #21 MCO Committee Activity and MCO Report #84 QAPI Program Description (see Quarterly Desk Audit results).	
The Contractor shall establish and maintain an ongoing Quality and Member Access Committee (QMAC) composed of Members, individuals from consumer advocacy groups or the community who represent the interests of the Member population.	Full - Meeting minutes for December 2015 indicate that the QMAC included members, individuals from advocacy groups and the community. Recommendation for WellCare WellCare should continue its efforts to recruit members for the QMAC.			
Members of the Committee shall be consistent with the composition of the Member population, including such factors as aid category, gender, geographic distribution, parents, as well as adult members and representation of racial and ethnic minority groups. Member participation may be excused by the Department upon a showing by Contractor of good faith efforts to obtain Member participation. Responsibilities of the Committee shall include:	Full - Per the QMAC 2016 rosters, External MCO members include a varied representation, geographically, and by gender. WellCare continues efforts to recruit additional membership as described above.			
A. Providing review and comment on quality and access standards;	Full - QMAC minutes for 2016 indicate that the committee reviewed network adequacy and appointment availability.			

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation 438.236, 438.240)	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. Providing review and comment on the Grievance and Appeals process as well as policy modifications needed based on review of aggregate Grievance and Appeals data;	Full - QMAC minutes for 2016 indicate that the committee reviewed grievances and appeals.			
C. Providing review and comment on Member Handbooks;	Full - The Member Handbook was reviewed at the March 2015 QMAC meeting per minutes.			
D. Reviewing Member education materials prepared by the Contractor;	Full - Member newsletters were reviewed at March and June 2015 QMAC meetings per minutes.			
E. Recommending community outreach activities; and	Full - Community outreach activity updates were provided at March and June 2015 QMAC meetings per minutes.			
F. Providing reviews of and comments on Contractor and Department policies that affect Members.	Full - Discussion of network adequacy, access and availability, appeals and grievances, community engagement activities and cultural preferences and innovation programs is documented as being discussed during the meetings.			
The list of the Members participating with the QMAC shall be submitted to the Department annually.	Full - The 2016 QI Program Description notes that the list of QMAC members will be submitted to the Department annually			
21.5 Assessment of Member and Provider Satisfaction and Access			Includes review of MCO Report #94 Member Surveys and Report #95 Provider Surveys (see Quarterly Desk Audit results).	
The Contractor shall conduct an annual survey of Members' and Providers' satisfaction with the quality of services	Full -The MCO provided the 2016 CAHPS Survey and 2016 Provider Satisfaction Survey Reports.			

Final Findings

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

State Contract Requirements (Federal Regulation 438.236, 438.240)	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
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.				
The Contractor shall provide a copy of the current CAHPS survey tool to the Department.	Full - The MCO provided documentation of DMS approval of the submitted 2016 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 MCO conducts satisfaction surveys regarding care management and uses CAHPS to identify access issues.			
To meet the provider satisfaction survey requirement the Contractor shall submit to the Department for review and approval the Contractor's provider satisfaction survey tool.	Full - The MCO provided documentation of DMS approval of the submitted 2015 CAHPS survey tools.			
The Department shall review and approve any Member and Provider				

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation 438.236, 438.240)	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**
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 conducting the Provider or other special surveys, the number and percentage of the Providers or Members to be surveyed, response rates and a sample survey instrument, shall be submitted to the Department along with the findings and interventions conducted or planned.	Full - The MCO submitted documentation that the survey tools and results were submitted to DMS.			
All survey results must be reported to the Department, and upon request, disclosed to Members.	Full - The 2015 Health Outcomes and 2016 Member Satisfaction document report survey results. Survey results are presented to the QMAC.			
38.5 QAPI Reporting Requirements The Contractor shall provide status reports of the QAPI program and work plan to the Department on a quarterly basis thirty (30) working days after the end of the quarter and as required under this section and upon request. All reports shall be submitted in electronic and paper format.			Includes review of MCO Report #16 Summary of QI Activities and MCO Report #17 QAPI Work Plan (see Quarterly Desk Audit results).	

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement

Scoring Grid:

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

Overall Compliance Determination:

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

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

Reviewer Decision:

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

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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement

Suggested Evidence

Documents

QI Program Description (MCO Report #84)
QI Work Plan (MCO Report #17)
Evidence of member involvement in development of QI program
Annual PIP proposals and summary reports (MCO Reports #19, 90 and 92)
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

Reports

Annual QI Evaluation Report (MCO Report #85)
HEDIS Final Audit Report and IDSS rates (MCO Report #96)
Healthy Kentuckians Outcomes Measures Report
CAHPS Report (MCO Report #94)
Provider Satisfaction Survey Report (MCO Report #95)
NCQA Accreditation Certificate and ISS Survey Report or status of accreditation
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 services
MCO Committee Activity (MCO Report #21)

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: WellCare of Kentucky

Final Findings

Grievance System (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
25.0 Member Grievances and Appeals				
25.1 General Requirements The Contractor shall have an organized grievance system that shall include- a grievance process, an appeals process, and access for Members to a State fair hearing pursuant to KRS Chapter 13B and 42 CFR 438 Subpart F. The Department shall provide a standardized form for Contractors to utilize for a Member to begin the Contractor's grievance and appeal process.	Deemed for 2017			
25.2 Member Grievance and Appeal Policies and Procedures				
The Contractor shall have a timely and organized Grievance and Appeal Process with written policies and procedures for resolving Grievances filed by Members. The Grievance and Appeal Process shall address Members' oral and written grievances. The Grievance and Appeal Process shall be approved in writing by the Department prior to implementation and shall be conducted in compliance with the notice, timeliness, rights and procedures in 42 CFR 438 subpart F, 907 KAR 17:010 and other applicable CMS and Department requirements. Grievance and Appeal policies and procedures shall include, but not be limited to:	Deemed for 2017			
A. Provide the Member the opportunity to present evidence and allegations of fact or law, in person as well as in writing; The Contractor must inform the Member of the limited time available for this sufficiently in advance of the resolution timeframe for appeals and expedited appeals as specified in 42 CFR 438.408(b) and (c);	Deemed for 2017 New Requirement	Full	This requirement is addressed in the C7-AP-035 - Kentucky Enrollee Appeals Process Policy.	

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: WellCare of Kentucky

Final Findings

Grievance System (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
B. Provide the Member and the Member's representative the Member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the Contractor, or at the direction of the Contractor, in connection with the appeal of the adverse benefit determination. This information shall be provided, upon request, free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in 42 CFRC.F.R. 438.408(b) and (c);	Deemed for 2017 New Requirements	Full	This requirement is addressed in the C7-AP-035 - Kentucky Enrollee Appeals Process Policy.	
C .Take into account all comments, documents, records, and other information submitted by the Member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination;	Deemed for 2017			
D. Consider the Member, the Member's representative, or the legal representative of the Member's estate as parties to the appeal;	Deemed for 2017			
E. A process for evaluating patterns of grievances for impact on the formulation of policy and procedures, access and utilization;	Deemed for 2017			
F. Procedures for maintenance of records of grievances separate from medical case records and in a manner which protects the confidentiality of Members who file a grievance or appeal;	Deemed for 2017			

Final Findings

Grievance System ***(See Final Page for Suggested Evidence)***				
State Contract Requirements **(Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)**	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
G. Ensure that a grievance or an appeal is disposed of and notice given as expeditiously as the Member's health condition requires but not to exceed 30 days from its initiation; If the Contractor extends the timeline for an appeal not at the request of the Member, the Contractor shall make reasonable efforts to give the Member prompt oral notice of the delay and shall give the Member written notice, within two (2) calendar days, of the reason for the decision to extend the timeframe and inform the enrollee of the right to file another grievance if he or she disagrees with that decision. Additionally, if the Contractor fails to resolve an appeal within this 30-day timeframe, the Member is deemed to have exhausted the Contractor's internal appeal process and may initiate a State Fair Hearing;	Deemed for 2017 New Requirement	Full	Includes member grievance – random, member grievance – quality, and member appeal file review results. This requirement is addressed in the C6-GR-003-PR-001 - Kentucky Medicaid Grievance Procedure Policy. **Member Grievance – Random File Review Results** Ten (10) files were reviewed; no files contained a request for extension. Ten (10) of 10 files met the 30-day resolution standard. **Member Grievance – Quality file Review Results** Ten (10) files were reviewed; no files contained a request for extension. Ten (10) of 10 files met the 30-day resolution standard. **Member Appeal File Review Results** These files were not required to be reviewed in 2018.	
H. Ensure individuals who make decisions on grievances and appeals were not involved in any prior level of review;	Deemed for 2017		Includes member grievance – random, member grievance – quality, and member appeal file review results.	
I. If the grievance involves a Medical Necessity	Deemed for 2017		Includes member grievance – random,	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
determination, ensure that the grievance and appeal is heard by health care professionals who have the appropriate clinical expertise;			member grievance – quality, and member appeal file review results.	
J. Process for informing Members, orally and/or in writing, about the Contractor's Grievance and Appeal Process by making information readily available at the Contractor's office, by distributing copies to Members upon enrollment; and by providing it to all subcontractors at the time of contract or whenever changes are made to the Grievance and Appeal Process;	Deemed for 2017			
K. Provide assistance to Members in filing a grievance if requested or needed including, but not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY-TTD and interpreter capability;	Deemed for 2017 New Requirement	Full	This requirement is addressed in the C6-GR-003-PR-001 - Kentucky Medicaid Grievance Procedure Policy.	
L. Include assurance that there will be no discrimination against a Member solely on the basis of the Member filing a grievance or appeal;	Deemed for 2017			
M. Include notification to Members in the Member Handbook regarding how to access the Cabinet's ombudsmen's office regarding grievances, appeals and hearings;	Deemed for 2017			
N. Provide oral or written notice of the resolution of the grievance in a manner to ensure ease of understanding;	Deemed for 2017		Includes member grievance – random and member grievance – quality file review results.	

Final Findings

Grievance System (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
O. Provide for an appeal of a grievance decision if the Member is not satisfied with that decision;	Deemed for 2017			
P. Provide for continuation of services, if appropriate, while the appeal is pending;	Deemed for 2017			
Q. Provide expedited appeals relating to matters which could seriously jeopardize the Member's life, physical or mental health, or ability to attain, maintain or regain maximum function;	Deemed for 2017			
R. Provide that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals to establish the earliest possible filing date for the appeal and must be confirmed in writing;	New requirement	Full	This requirement is addressed in the C7-AP-035 -Kentucky Enrollee Appeals Process Policy.	
S. Not require a Member or a Member's representative to follow an oral request for an expedited appeal with a written request;	Deemed for 2017			
T. Inform the Member of the limited time to present evidence and allegations of fact or law in the case of an expedited appeal;	Deemed for 2017			
U. Acknowledge receipt of each grievance and appeal;	Deemed for 2017			
V. Provide written notice of the appeal decision in a format and language that, at a minimum, meet the standards described in 42 90 CFR 438.10 and for notice of an expedited resolution, the Contractor shall also make reasonable efforts to provide oral notice;;	Deemed for 2017 New Requirement	Full	This requirement is addressed in the C6-GR-003-PR-001 - Kentucky Medicaid Grievance Procedure Policy.	

Final Findings

Grievance System (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
W. Provide for the right to request a hearing under KRS Chapter 13B;	Deemed for 2017			
X. Allows a Provider to file a grievance or appeal on the Member's behalf as provided in 907 KAR 17.010; and	Deemed for 2017			
Y. Notifies the Member that if a Service Authorization Request is denied and the Member proceeds to receive the service and appeal the denial, if the appeal is in the Contractor's favor, that the Member may be liable for the cost.	Deemed for 2017			
If the Contractor continues or reinstates the Member's benefits while the appeal is pending, the benefits must be continued until one of the following occurs: A. The Member withdraws the appeal or request for a State Fair Hearing;, B. The Member does not request a State Fair Hearing with continuation of benefits within 10 days from the date the Contractor mails an adverse appeal decision, C. A State Fair Hearing decision adverse to the Member is made, or D.	Deemed for 2017			
All grievance or appeal files shall be maintained in a secure and designated area and be accessible to the Department or its designee, or CMS 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.	Deemed for 2017			

Final Findings

Grievance System (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall 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. Documentation regarding the grievance shall be made available to the Member, if requested.				
Grievance File Review				
Within five (5) working days of receipt of the grievance, the Contractor shall provide the grievant with written notice that the grievance has been received and the expected date of its resolution. KAR S 17:010 Section 4 (2) (a)	Substantial - Includes grievance file review results. Requirement is addressed on page 3, bullet d under "Processing" of C7AP-034-PR-001 Kentucky Provider Appeals Process Procedure, and on page 4, bullet d under "Procedures" of C7AP-035-PR-001- Kentucky Member Appeals Process. <u>Member Grievance Random File Review</u> 7/10 were compliant. 3/10 did not meet the 5 working day requirement as confirmed by plan. <u>Member Grievance Quality File Review</u>	Substantial	Includes member grievance – random and member grievance – quality file review results. This requirement is addressed in the C6-GR-003-PR-001 - Kentucky Medicaid Grievance Procedure Policy. **<u>Member Grievance – Random File Review Results</u>** Nine (9) of 10 files met the 5-day notification standard; 1 file did not meet the requirement and contained no evidence of an acknowledgement letter being sent. **<u>Member Grievance – Quality File Review Results</u>**	WellCare appreciates IPROs recommendation. The Appeals and Grievance Department has several mechanisms in place to ensure appeals and grievance are processed within the applicable state contracted timeframes. The Department has a dashboard that runs daily to capture the department's daily inventory and lists all files that require closure. The dashboard captures all expedited, pre-service and retrospective appeals, in addition any dissatisfaction regarding the filing of grievances, the date of receipt, line of business, compliance timeframe, and other pertinent information needed to

Final Findings

Grievance System (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	8/10 were compliant. 2/10 did not meet the 5 working day requirement as confirmed by plan. **<u>Recommendation for WellCare</u>** WellCare should assure that Acknowledgement Letters are sent to the member within 5 working days of receipt of the grievance. <u>WellCare Response</u> WellCare is committed to improving our monitoring of compliance for all acknowledgment letters to ensure they meet the 5 business day requirement. To further insurance compliance with this contractual requirement, the Grievance Department will review and monitor all grievances three days from the receive date to ensure acknowledgment letters are in progress for mailing. This enhanced monitoring will further ensure the 5 business day notification requirement is met. We will implement this aggressive monitoring process effective 4/1/2017; and will continue this process until a sustained improvement of a full quarter is demonstrated.		Nine (9) of 10 files met the 5-day notification standard; 1 file that did not meet the requirement, because it was sent at 10 days. **<u>Recommendation for MCO</u>** The MCO should utilize a tracking and monitoring system/process to ensure that timeliness requirements are met.	manage the day-to-day operations of the department. The Department's Sr. Director, Managers, and Supervisors use the dashboard to prioritize work and manage the inventory throughout the day to ensure cases are addressed and resolved according to established timeframes. This dashboard is used to identify any department performance concerns and actions of coaching and re-training are conducted to ensure any untimeliness with resolution is corrected. Although we have these processes in place to ensure we meet compliance timeframes, there are instances where the plan may not be able to resolve cases timely. For instance, timeliness may be affected when a request for review does not reach the appeals/grievance departments timely but instead is sent to other departments such as Claims, Customer Service or Utilization Management. Another instance is when a request for review is not identified accurately by internal staff. For those files that missed timely

Final Findings

Grievance System (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
				review because they were sent to departments other than the Appeals/Grievance teams, our Department's Management team meet with our centralized Intake department/team to discuss the issues and any opportunities for improvement. The Appeals Management team also has on-going dialogue and meetings with our mailroom and Intake Departments. During the meetings, we provide examples of misdirected cases and we require the Intake Department to provide their staff with coaching and training on how to properly identify appeals and accurately route appeals to the correct department in a timely manner. The Appeals and Grievance management team will continue to monitor receipt of appeals/grievance, provide coaching and training as necessary, to ensure the appeal/grievance files meet the compliance timeframe.

Final Findings

Grievance System (*See Final Page for Suggested Evidence)*				
State Contract Requirements **(Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)**	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
The investigation and final Contractor resolution process for grievances shall be completed within thirty (30) calendar days of the date the grievance is received by the Contractor and shall include a resolution letter to the grievant that shall include: all information considered in investigating the grievance; findings and conclusions based on the investigation; and the disposition of the grievance. KAR 17:010 Section 4 (2) (b)	Substantial - Includes grievance file review results. This requirement is addressed on page 2 and 4, under "Decision Time Frame" of C7AP-034-PR-001 Kentucky Provider Appeals Process Procedure, on page 4, bullet d under "Processing" and on page 12, bullet b3 under "Post Service Appeals" of C7AP-035-PR-001-Kentucky Member Appeals Process. Investigations related to Quality of Care related grievances are addressed in Quality of Care Issues Policy on page 9 and flowchart on page 31. Member Grievance Random File Review 10/10 were compliant. Member Grievance Quality File Review 10/10 member quality grievance files included resolution letters written within 30 days, even though: -6/10 were compliant and completed investigations. -For 3 cases, allegations were still being investigated when the resolution letters were sent and medical records	Full	Includes member grievance – random and member grievance – quality file review results. This requirement is addressed in the C6-GR-003-PR-001 - Kentucky Medicaid Grievance Procedure Policy. **Member Grievance – Random File Review Results** Ten (10) of 10 files met the 30-day resolution standard and all notification requirements. **Member Grievance – Quality File Review Results** Ten (10) of 10 files met the 30-day resolution standard and all notification requirements.	

Final Findings

Grievance System (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	had not been received even though they had been requested 3 times per policy and the cases had been opened in April. -For 1 case, this third medical record request had just been sent and records had yet to be received. -MCO confirmed that 1 was never sent even though investigation completed and MCO terminated employee who didn't send notice. **Recommendation for WellCare** WellCare should update the Quality of Care Issues Policy to reflect referral of providers, who don't submit medical records within a defined time period after third request related to Quality of Care Grievances, to credentialing committee so they can't remain open indefinitely. WellCare Response Per IPRO's recommendation, the policy for Quality of Care Issues, C7-QI-053, has been revised to include referral of providers to the credentialing committee who do not respond to three medical record requests within a defined period of time. The policy is			

Final Findings

Grievance System (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	currently undergoing final approval through WellCare's internal policy approval process			
The Contractor may extend by of up to fourteen (14) calendar days if the Member requests the extension, or the Contractor determines that there is need for additional information and the extension is in the Member's interest. For any extension not requested by the Member, the Contractor shall give the Member written notice of the reason for the extension within two working days of the decision to extend the timeframe. 42 CFR 438.408 (c)	Deemed in 2017		Includes member grievance – random and member grievance – quality file review results.	
Appeal File Review				
Within five working days of receipt of the appeal, the Contractor shall provide the Member with written notice that the appeal has been received and the expected date of its resolution. The Contractor shall confirm in writing receipt of oral appeals, unless the Member or the service provider requests an expedited resolution. KAR 17:010 Section 4 (10) (a) and (b)	Deemed in 2017		Includes member appeal file review results.	
The Contractor has thirty (30) calendar days from the date the initial oral or written appeal is received by the Contractor to resolve the appeal. KAR 17:010 Section 4 (7)	Deemed in 2017		Includes member appeal file review results.	

Final Findings

Grievance System (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor may extend the thirty (30) day timeframe by fourteen (14) calendar days if the Member requests the extension, or the Contractor determines that there is need for additional information, and the extension is in the Member's interest. For any extension not requested by the Member, the Contractor shall give the Member written notice of the extension and the reason for the extension within two working days of the decision to extend the timeframe. KAR 17:010 Section 4 (11) and (12)	Deemed in 2017		Includes member appeal file review results.	
The Contractor shall provide the Member or the Member's representative a reasonable opportunity to present evidence of the facts or law, in person as well as in writing. 42 CFR 438.406 (b) (2)	Deemed in 2017		Includes member appeal file review results.	
The Contractor shall provide the Member or the representative the opportunity, before and during the appeals process, to examine the Member's case file, including medical or clinical records (subject to HIPAA requirements), and any other documents and records considered during the appeals process. The Contractor shall include as parties to the appeal the Member and his or her representative, or the legal representative of a deceased Member's estate. 42 CFR 438.406 (a) (3) (4)	Deemed in 2017		Includes member appeal file review results.	
For all appeals, the Contractor shall provide written notice	Deemed in 2017		Includes member appeal file review results.	

Final Findings

Grievance System (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
within the thirty (30) calendar-day timeframe for resolutions to the Member or the provider, if the provider filed the appeal. The written notice of the appeal resolution shall include, but not be limited to, the following information: 1) the results of the resolution process; (2) the date it was completed. KAR 17:010 Section 4 (13) (a) 42 CFR 438.408 (d) (2) and (e)				
The written notice of the appeal resolution for appeals not resolved wholly in favor of the Member shall include, but not be limited to, the following information: (1) the right to request a state fair hearing and how to do so; (2) the right to request receipt of benefits while the state fair hearing is pending, and how to make the request; and (3) that the Member may be held liable for the cost of continuing benefits if the state fair hearing decision upholds the Contractor's action. 42 CFR 438.408 (e) (2)	Deemed in 2017		Includes member appeal file review results.	
Expedited Appeals File Review				
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.	Deemed in 2017		Includes file review results for member appeals, if expedited.	

Final Findings

Grievance System (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
KAR 17:010 Section 4 (14) (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. KAR 17:010 Section 4 (14) (d) and (15)	Deemed in 2017		Includes file review results for member appeals, if expedited.	
The Contractor shall inform the Member of the limited time available to present evidence and allegations in fact or law. 42 CFR 438.406 (b) (2)	Deemed in 2017		Includes file review results for member appeals, if expedited.	
25.3 State Hearings for Members				
A Member may not file a grievance with the state. A Member shall exhaust the internal Appeal process with the Contractor prior to requesting a State Fair Hearing. The Contractor, the Member, or the Member's representative or legal representative of the Member's estate shall be parties to the hearing as provided in 907 KAR 17:010(5). 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 forty-five (45) days of the final appeal decision by the Contractor as provided for in 907 KAR 17:010. A Member may request a State Fair Hearing for an	Deemed in 2017 New Requirement	Full	This requirement is addressed in the C7-AP-035 - Kentucky Enrollee Appeals Process Policy.	

Final Findings

Grievance System (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
Action taken by the Contractor that denies or limits an authorization of a requested service or reduces, suspends, or terminates a previously authorized service. The standard timeframe for reaching a decision in a State Fair Hearing is found in KRS Chapter 13B. 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. The contractor shall authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires but not later than 72 hours from the date the Contractor receives notice reversing the determination, if the services were not furnished while the appeal was pending and the State Fair Hearing results in a decision to reverse the Contractor's decision to deny, limit, or delay services. The Contractor shall pay for disputed services received by the Member while the appeal was pending and the State Fair Hearing reverses a decision to deny authorization of the services. The Department shall provide for an expedited State Fair hearing within three (3) days of a request for an appeal that meets the requirements of an expedited appeal after a denial by the Contractor.				
28.9 Provider Grievances and Appeals				
The Contractor shall implement a process to ensure that a Provider shall have the right to file an internal appeal with the Contractor regarding denial of a health care service or	Substantial - Includes file review summary results for Provider Grievances and Provider Appeals.	Substantial	Includes file review results for provider grievances and provider appeals.	WellCare appreciates IPROs recommendation. The Appeals and Grievance Department has several

Final Findings

Grievance System (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
claim for reimbursement, provider payment or contractual issues. The Contractor shall provide written notification to the Provider regarding a denial. The Department shall provide a standard Provider Grievance Form to be used by the Contractor to initiate its provider grievance process. Appeals received from Providers that are on the Member's behalf for denied services with requisite consent of the Member are deemed Member appeals and not subject to this Section. Contractor shall log Provider appeals. Appeals shall be recorded in a written record and logged with the following details: date, nature of Appeal, identification of the individual filing the Appeal, identification of the individual recording the Appeal, disposition of the Appeal, corrective action required and date resolved. Provider grievances or appeals shall be resolved and the Provider shall receive in writing the resolution within thirty (30) calendar days. If the grievance or appeal is not resolved within thirty (30) days, the Contractor shall request a fourteen (14) day extension from the Provider. If the Provider requests the extension, the extension shall be approved by the Contractor. The Contractor shall ensure that there is no discrimination against a Provider solely on the grounds that the Provider filed an Appeal or is making an informal Grievance. The Contractor shall monitor and evaluate Provider Grievances and Appeals. The Contractor shall submit monthly reports to the Department regarding the number, type and outcomes including final denials of Provider Grievances and Appeals.	This requirement is addressed on page 5 under "State Reporting Requirement for Provider Appeals" of C7AP-034-PR-001 Kentucky Provider Appeals Process Procedure. Includes review of MCO Reports: #27 Grievance Activity #28 Appeal Activity #29 Grievances and Appeals Narrative (see Quarterly Desk Audit results) Provider Grievance File Review Deem for 2017 Provider Appeals File Review 9/10 were compliant for timeliness. 1/10 was sent outside timeliness standard which MCO confirmed. **Recommendation for WellCare** WellCare should assure that Resolution Letters are sent to the member within 30 calendar days of receipt of the grievance. Well Care Response The Appeals Department has several mechanisms in place to ensure appeals		Includes review of MCO Reports: #27 Grievance Activity #28 Appeal Activity #29 Grievances and Appeals Narrative (see Quarterly Desk Audit results) This requirement is addressed in the C7-AP-034-PR-001 - Kentucky Provider Appeals Process Procedure Policy. **Provider Appeal File Review Results** Nine (9) of 10 files met the 30-day resolution requirement. Ten (10) of 10 files met the documentation and notification requirements. No files contained an extension, and as such, this requirement was not applicable. **Provider Grievance File Review Results** Nine (9) of 10 files met the 30-day resolution requirement. Ten (10) of 10 files met the documentation and notification requirements. No files contained an extension, and as such, this requirement was not applicable. **Recommendation for MCO** The MCO should utilize a tracking and monitoring system/process to ensure timeliness requirements are met.	mechanisms in place to ensure appeals and grievance are processed within the applicable state contracted timeframes. The Department has a dashboard that runs daily to capture the department's daily inventory and lists all files that require closure. The dashboard captures all expedited, pre-service and retrospective appeals, in addition any dissatisfaction regarding the filing of grievances, the date of receipt, line of business, compliance timeframe, and other pertinent information needed to manage the day-to-day operations of the department. The Department's Sr. Director, Managers, and Supervisors use the dashboard to prioritize work and manage the inventory throughout the day to ensure cases are addressed and resolved according to established timeframes. This dashboard is used to identify any department performance concerns and actions of coaching and re-training are conducted to ensure any untimeliness with resolution is corrected.

Final Findings

Grievance System (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	are processed within the applicable state contracted timeframes. Internally, the Appeals Department utilizes a dashboard that runs daily to capture the department's inventory that are at risk for untimely completion. The dashboard is monitored several times throughout the day by the Department's management team. In addition to daily monitoring tools, WellCare's Appeals Department also employs a robust internal quality audit program which randomly selects appeal case files. These cases are selected monthly and are employee specific. Through the quality review process, files are reviewed to ensure that they were worked appropriately and consistent with plan guidelines. Through the review process, if an error is identified, the file may be reopened and reprocessed for accuracy. The one (1) non-compliant provider appeal file reviewed by IPRO during the onsite review was a result of the quality audit			Although we have these processes in place to ensure we meet compliance timeframes, there are instances where the plan may not be able to resolve cases timely. For instance, timeliness may be affected when a request for review does not reach the appeals/grievance departments timely but instead is sent to other departments such as Claims, Customer Service or Utilization Management. Another instance is when a request for review is not identified accurately by internal staff. For those files that missed timely review because they were sent to departments other than the Appeals/Grievance teams, our Department's Management team meet with our centralized Intake department/team to discuss the issues and any opportunities for improvement. The Appeals Management team also has on-going dialogue and meetings with our mailroom and Intake Departments. During the meetings, we provide examples of misdirected cases and we require the Intake

Final Findings

Grievance System (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	appeal process. With regards to this file, the initial appeal was processed timely; however, during a quality audit review, it was determined that the file was not completed appropriately. The appeal coordinator was instructed to re-open the appeal file and reprocess the case considering the additional information submitted. As a result, our completion timeline was negatively impacted as a second determination letter was issued based on the original receipt date. Final Review Determination No change in determination. WellCare should ensure that cases reviewed as part of the quality audit are processed timely.			Department to provide their staff with coaching and training on how to properly identify appeals and accurately route appeals to the correct department in a timely manner. The Appeals and Grievance management team will continue to monitor receipt of appeals/grievance, provide coaching and training as necessary, to ensure the appeal/grievance files meet the compliance timeframe.
A Provider who has exhausted the Contractor's internal appeal process shall have a right to appeal a final denial, in whole or in part, by the Contractor to an external independent third party in accordance with applicable state laws and regulations. The Contractor shall provide written notification to the Provider of its right to file an appeal. A Provider shall have a right to appeal a final decision by an external independent third party to the Cabinet for Health and Family Services Division of Administrative Hearings for	Full - MCO provided draft copies of the updated "Kentucky Provider Appeals Process Procedure" which addresses this new requirement on page 5 as well as the draft of the new Final Denial Notice letters which will be used to communicate this requirement. These were provided in draft form since the MCO reports that this regulation	Full	This requirement is addressed in the C7-AP-034-PR-001 - Kentucky Provider Appeals Process Procedure Policy.	

Final Findings

Grievance System (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
a hearing in accordance with applicable state laws and regulation. If the Provider prevails, in whole or in part, the Contractor shall comply with any Final Order within sixty (60) days unless the Final Order designates a different timeframe.	wasn't sent by the Department until December 1, 2016. WellCare Response In July 2016 Senate Bill 20 became effective and established a new external review process for providers. The Department subsequently filed 907 KAR 17:035 and 907 KAR 17:040 to implement the legislation on December 1, 2016. During the implementation phase, WellCare worked closely with the Department to update all of our provider and member correspondence as well as internal policy and procedure documents. At the time of IPRO's visit in early January, WellCare's "Kentucky Provider Appeals Process Procedure" was still in draft form, as sufficient time had not elapsed to allow our internal review/approval process to complete. Since IPRO's visit, the procedure has been approved. **Final Review Determination** The final review determination was changed to Full. Per DMS, the final			

Final Findings

Grievance System (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	policy was not due to DMS until 3/6/17. WellCare met this deadline. New Requirement			
28.10 Other Related Processes				
The Contractor shall provide information specified in 42 CFR 438.10(g)(1) about the grievance system to all service providers and subcontractors at the time they enter into a contract.	Deemed in 2017			
38.8 Grievance and Appeal Reporting Requirements				
The Contractor shall submit to the Department on a quarterly basis the total number of Member Grievances and Appeals and their disposition. The report shall be in a format approved by the Department and shall include at least the following information: A. Number of Grievances and Appeals, including expedited appeal requests; B. Nature of Grievances and Appeals; C. Resolution; D. Timeframe for resolution; and E. QAPI initiatives or administrative changes as a result of analysis of Grievances and Appeals.	Deemed in 2017	Full	Includes review of MCO Reports: #27 Grievance Activity #28 Appeal Activity #29 Grievances and Appeals Narrative (see Quarterly Desk Audit results) The MCO provided the required reports, all of which met all requirements.	
The Department or its contracted agent may conduct reviews or onsite visits to follow up on patterns of repeated Grievances or Appeals. Any patterns of suspected Fraud or Abuse identified through the data shall be immediately referred to the Contractor's Program Integrity Unit.	Deemed in 2017	Full	This requirement is addressed in the Fraud, Waste, and Abuse Policy and in the Medicaid Grievance Policy. There were no referrals from DMS during	.

Final Findings

Grievance System (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			the review period.	

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: WellCare of Kentucky

Final Findings

Grievance System
Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	11	2	0	0
Total Points	33	4	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.85**		

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

Reviewer Decision:

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

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

Final Findings

Grievance System
Suggested Evidence

Documents

Policies/procedures for:

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

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

Reports

Quarterly reports of grievances and appeals (MCO Reports #27, 28 and 29)

File Review

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

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: WellCare of Kentucky

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.214)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
28.2 Provider Credentialing and Recredentialing				
The Contractor shall conduct Credentialing and Recredentialing in compliance with National Committee for Quality Assurance standards (NCQA), 907 KAR 1:672 or other applicable state regulations 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. Detailed documentation and scope of the Credentialing and Recredentialing process is contained in **Appendix J. "Credentialing Process."** The Contractor shall complete the Credentialing or Recredentialing of a Provider within ninety (90) calendar days of receipt of all relative information from the Provider or within forty-five (45) days if the Provider is providing substance use disorder services. The status of pending requests for credentialing or recredentialing shall be submitted as required in **Appendix J.** "**Credentialing Process.**" Unless prohibited by NCQA standards, if the Contractor allows the Provider to provide covered services to its Members before the credentialing or recredentialing process is completed and the Provider is credentialed, the Contractor shall allow the Provider to be paid for the period from the date of its application for credentials to completion of the credentialing or recredentialing process. If the Contractor accepts the Medicaid enrollment application on behalf of the provider, the Contractor will use the format provided in **Appendix J. "Credentialing Process"** to transmit the listed provider	Deemed in 2017 New Requirement	Full	This requirement is addressed in the Credentialing & Recredentialing Procedure on pages 1, 13, 24, and 34.	

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
enrollment data elements to the Department. A Provider Enrollment Coversheet will be generated per provider. The Provider Enrollment Coversheet will be submitted electronically to the Department. The Contractor shall establish ongoing monitoring of provider sanctions, complaints and quality issues between recredentialing cycles, and take appropriate action.				
Appendix J- Credentialing Process				
This documentation shall include, but not be limited to:				
defining the scope of providers covered,	Deemed in 2017			
the criteria and the primary source verification of information used to meet the criteria,	Deemed in 2017			
the process used to make decisions and the extent of delegated credentialing and recredentialing arrangements.	Deemed in 2017			
The Contractor shall have a process for receiving input from participating providers regarding credentialing and recredentialing of providers.	Deemed in 2017			
Those providers accountable to a formal governing body for review of credentials shall include physicians,	Deemed in 2017			

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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, 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.	Deemed in 2017			
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.	Deemed in 2017			
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.	Deemed in 2017			
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	Deemed in 2017			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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 205.560 (12) related to credentialing. The Contractor's enrolled providers shall complete a credentialing application in accordance with the Department's policies and procedures.	Deemed in 2017			
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;	Deemed in 2017			
B. A governing body, or the groups or individuals to whom the governing body has formally delegated the credentialing function;	Deemed in 2017			
C. A review of the credentialing policies and procedures by the formal body;	Deemed in 2017			
D. A credentialing committee which makes recommendations regarding credentialing;	Deemed in 2017			
E. Written procedures, if the Contractor delegates the credentialing function, as well as evidence that the effectiveness is monitored;	Deemed in 2017			
F. Written procedures for the termination or	Deemed in 2017			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
suspension of Providers; and				
G. Written procedures for, and implementation of, reporting to the appropriate authorities serious quality deficiencies resulting in suspension or termination of a provider.	Deemed in 2017			
The contractor shall meet requirements under KRS 205.560(12) related to credentialing. Verification of the Providers credentials shall include the following:	Deemed in 2017		Includes credentialing file review summary results.	
A. A current valid license or certificate to practice in the Commonwealth of Kentucky.	Deemed in 2017			
B. A Drug Enforcement Administration (DEA) certificate and number, if applicable;	Deemed in 2017			
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.	Deemed in 2017			
D. Board certification if the practitioner states on the application that the practitioner is board certified in a specialty;	Deemed in 2017			
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;	Deemed in 2017			
F. Previous five (5) years work history;	Deemed in 2017			
G. Professional liability claims history;	Deemed in 2017			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
H. Clinical privileges and performance in good standing at the hospital designated by the Provider as the primary admitting facility, for all providers whose practice requires access to a hospital, as verified through attestation;	Deemed in 2017			
I. Current, adequate malpractice insurance, as verified through attestation;	Deemed in 2017			
J. Documentation of revocation, suspension or probation of a state license or DEA/BNDD number;	Deemed in 2017			
K. Documentation of curtailment or suspension of medical staff privileges;	Deemed in 2017			
L. Documentation of sanctions or penalties imposed by Medicare or Medicaid;	Deemed in 2017			
M. Documentation of censure by the State or County professional association;	Deemed in 2017			
N. Most recent information available from the National Practitioner Data Bank;	Deemed in 2017			
O. Health and Human Services Office of Inspector General (HHS OIG); and	Deemed in 2017			
P. System for Award Management (SAM).	Deemed in 2017			
The provider shall complete a credentialing application that includes a statement by the applicant regarding:	Deemed in 2017			
A. The ability to perform essential functions of the positions, with or without accommodation;	Deemed in 2017			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
B. Lack of present illegal drug use;	Deemed in 2017			
C. History of loss of license and felony convictions;	Deemed in 2017			
D. History of loss or limitation of privileges or disciplinary activity;	Deemed in 2017			
E. Sanctions, suspensions or terminations imposed by Medicare or Medicaid; and	Deemed in 2017			
F. Applicants attest to correctness and completeness of the application	Deemed in 2017			
Before a practitioner is credentialed, the Contractor shall verify information from the following organizations and shall include the information in the credentialing files:	Deemed in 2017			
A. National practitioner data bank, if applicable;	Deemed in 2017			
B. Information about sanctions or limitations on licensure from the appropriate state boards applicable to the practitioner type; and	Deemed in 2017			
C. Other recognized monitoring organizations appropriate to the practitioner's discipline.	Deemed in 2017			
At the time of credentialing, the Contractor shall perform an initial visit to potential providers, as it deems necessary and as required by law.	Deemed in 2017			
The Contractor shall document a structured review to evaluate the site against the Contractor's organizational standards and those specified by this contract.	Deemed in 2017			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The 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.	Deemed in 2017			
The Contractor shall have formalized recredentialing procedures. The Contractor shall formally recredential its providers at least every three (3) years. The Contractor shall comply with the Department's recredentialing policies and procedures. There shall be evidence that before making a recredentialing decision, the Contractor has verified information about sanctions or limitations on practitioner from:	Full - Includes Recredentialing file review summary results The 3 year re-credentialing requirement is addressed in C7CR-001 Credentialing and Re-Credentialing policy on page 3. It is also addressed on page 3 of the C7CR-009-PR-001 Assessment of Organizational Providers Procedure document. The verification process is addressed in C7CR-009-PR-001 on pages 23 to 25. The Credentialing Committee-Peer Review policy and procedure documents showcase a standardized structure and procedure of reviewing providers undergoing credentialing/re-credentialing. Other policies and procedural documents provided strengthen the MCO's ongoing oversight of providers and their practices. Recredentialing File Review Results 10/10 files were recredentialed timely.		Includes recredentialing file review summary results.	

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	10/10 files were compliant for verifying information.			
A. A current license to practice;	Deemed in 2017			
B. The status of clinical privileges at the hospital designated by the practitioner as the primary admitting facility;	Deemed in 2017			
C. A valid DEA number, if applicable;	Deemed in 2017			
D. Board certification, if the practitioner was due to be recertified or become board certified since last credentialed or recredentialed;	Deemed in 2017			
E. Five (5) year history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the practitioner; and	Deemed in 2017			
F. A current signed attestation statement by the applicant regarding:	Deemed in 2017			
1. The ability to perform the essential functions of the position, with or without accommodation;	Deemed in 2017			
2. The lack of current illegal drug use;	Deemed in 2017			
3. A history of loss, limitation of privileges or any disciplinary action;	Deemed in 2017			
4. Current malpractice insurance;	Deemed in 2017			
5. Health and Human Services Office of Inspector General (HHS OIG);	Deemed in 2017			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
6. System for Award Management (SAM).	Deemed in 2017			
There shall be evidence that before making a recredentialing decision, the Contractor has verified information about sanctions or limitations on practitioner from :	Deemed in 2017			
A. The national practitioner data bank;	Deemed in 2017			
B. Medicare and Medicaid;	Deemed in 2017			
C. State boards of practice, as applicable; and	Deemed in 2017			
D. Other recognized monitoring organizations appropriate to the practitioner's specialty.	Deemed in 2017			
The Contractor shall have written policies and procedures for the initial and on-going assessment of organizational providers with whom it intends to contract or which it is contracted. Providers include, but are not limited to, hospitals, home health agencies, free-standing surgical centers, residential treatment centers and clinics.	Deemed in 2017			
At least every three (3) years, the Contractor shall confirm the provider is in good standing with state and federal regulatory 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.	Deemed in 2017			
The Contractor shall have policies and procedures for	Deemed in 2017			

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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.	Deemed in 2017			
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.	Deemed in 2017			
The Contractor shall use the provider types summaries listed at: http://chfs.ky.gov/dms/provEnr/Provider+Type+Summaries.htm	Deemed in 2017			
29.1 Network Providers to be Enrolled				
The Contractor shall maintain, by written agreements, a network of Providers that consider the geographic location of Providers and its Members, the distance, travel time, the means of transportation ordinarily used by its Members, whether the location provides physical access for its Members with disabilities, and considers the numbers of network Providers who are not accepting new Medicaid patients. The Contractor's Network shall include Providers from throughout the provider community. The Contractor	Substantial - The Network Development policy, on page 45, states that it will enroll at least 'one (1) [FQHC] into our network (if there is a FQHC appropriately licensed to provide services in the region or service area) and at least one (1) teaching hospital'. Missing is wording that addresses the 'one (1) Rural Health Clinic'. Pages 45 to 47 of the Network Development Policy address all other	Full	This requirement is addressed in the Network Development – Medicaid Regulatory Requirements Policy on page 78.	

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
shall comply with the any willing provider statute as described in 907 KAR 1:672 or as amended 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) and one (1) Rural Health Clinic into its network for each region where available and at least one teaching hospital. In addition the Contractor shall enroll the following types of providers who are willing to meet the terms and conditions for participation established by the Contractor: physicians, psychiatrists advanced practice registered nurses, physician assistants, free-standing birthing centers, dentists, primary care centers including, home health agencies, rural health clinics, opticians, optometrists, audiologists, hearing aid vendors, speech language pathologists, physical therapists, occupational therapists, private duty nursing agencies, 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,	elements of this listed regulatory requirement. <u>Recommendation for WellCare</u> Please update bullet 4 on pg 45 of the Network Development Policy to include wording on having at least one Rural Health Center in all regions served where applicable. <u>WellCare Response</u> The Network Development policy, C6ND MD-001, submitted to IPRO for review does contain reference to contracting with rural health clinics on page 46 within bullet "x". However to be more clear, WellCare has implemented IPRO's recommendation to include the specific contract language. Please see attached revised policy with corrected language on page 46. <u>Final Review Determination</u> No change in determination. The revised policy will be acceptable for the next compliance review.			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
hospitals (including acute care, critical access, rehabilitation, and psychiatric hospitals), local health departments, and providers of EPSDT Special Services. The Contractor shall also enroll Psychologists, Licensed Professional Clinical Counselors, Licensed Marriage and Family Therapists, Licensed Psychological Practitioners, Behavioral Health Multi-Specialty Groups, Behavioral Health Services Organizations, Certified Family, Youth and Peer Support Providers, Licensed Clinical Social Workers, Targeted Case Managers, Chemical Dependency Treatment Centers, Residential Crisis Stabilization Units, Licensed Clinical Alcohol and Drug Counselors, Multi-Therapy Agencies(agencies providing physical, Speech and occupational therapies which include comprehensive Outpatient Rehabilitation Facilities, Special Health Clinics, Mobile Health Services, Rehabilitation Agencies and Adult Day Health Centers) and other independently licensed behavioral health professionals. The Contractor may also enroll other providers, which meet the credentialing requirements, to the extent necessary to provide covered services to the Members. Enrollment forms shall include those used by the Kentucky Medicaid Program as pertains to the provider type. The Contractor shall use such enrollment forms as required by the Department. The Department will continue to enroll hospitals, nursing facilities, home health agencies, independent laboratories, preventive health care providers, FQHC,				

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
RHC and hospices. The Medicaid provider file will be available for review by the Contractor so that the Contractor can ascertain the status of a Provider with the Medicaid Program and the provider number assigned by the Kentucky Medicaid Program.				
Providers performing laboratory tests are required to be certified under the CLIA. The Department will continue to update the provider file with CLIA information from the CASPER/QIES file formally known as OSCAR 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.	Deemed for 2017			
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.	Deemed for 2017			
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.	Deemed for 2017			
The Contractor must offer participation agreements with currently enrolled Medicaid providers who have received electronic health record incentive funds who are willing to meet the terms and conditions for participation established by the Contractor.	Deemed for 2017			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
29.2 Out-of-Network Providers	Deemed for 2017			
The Department will provide the Contractor with an expedited enrollment process to assign provider numbers for providers not already enrolled in Medicaid for emergency situations only.	Full This is addressed in C7ND MD-001 Network Development Addendum H that states "Participation agreements will be offered to currently enrolled Medicaid providers who have received electronic health record incentive funds who are willing to meet the terms and conditions for participation established by the Company".			
29.3 Contractor's Provider Network				
All providers in the Contractor's network shall be enrolled in the Kentucky Medicaid Program. The Contractor may enroll providers in their network who do not provide services to the fee-for-service population. Providers shall meet the credentialing standards described in the Provider Credentialing and Re-Credentialing section of this Contract and be eligible to enroll with the Kentucky Medicaid Program. A provider joining the Contractor's Network shall meet the Medicaid provider enrollment requirements set forth in the Kentucky Administrative Regulations and in the Medicaid policy and procedures manual for fee-for-service providers of the appropriate provider type. The Contractor shall provide written notice to Providers not accepted into the network along with the reasons for the non-acceptance. A provider cannot enroll or continue participation in the Contractor's Network if the provider has active sanctions imposed	Full - The first paragraph of this regulation is addressed in the C6ND MD-001 Network Development policy document on page 48. The company's written notices to providers rejected from joining their network are addressed on page 48 on the C6ND MD-001 Network Development Policy on bullets six to seven. The requirement addressing utilization of the National Practitioner Database as part of the credentialing process is addressed in the policy C7CR-001 Credentialing and Re-Credentialing on page 2.			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
by 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.	The final sentence of the requirement is addressed in full in C7CR-024 Medicare Medicaid Eligibility Federal and State Sanctions and Opt Out Policy on page 2. During the onsite, the MCO provided a sample of the written letter sent out to providers who are rejected from joining WellCare's network during the audit time period.			
29.4 Enrolling Current Medicaid Providers				
The Contractor will have access to the Department Medicaid provider file either by direct on-line inquiry access, by electronic file transfer, or by means of an extract provided by the Department. The Medicaid provider master file is to be used by the Contractor to obtain the ten-digit provider number assigned to a medical provider by the Department, the Provider's status with the Medicaid program, CLIA certification, and other information. The Contractor shall use the Medicaid Provider number as the provider identifier when transmitting information or communicating about any provider to the Department or its Fiscal Agent. The Contractor shall transmit a file of Provider data specified in this Contract for all credentialed Providers in the Contractor's network on a monthly basis and when any information changes.	Full - The language in C6ND MD-001 Network Development policy on page 47 addresses the listed requirement.			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
29.5 Enrolling New Providers and Providers not Participating in Medicaid				
A provider is not required to participate in the Kentucky Medicaid Fee-for-Service Program as a condition of participation with the Contractor's Network but must be enrolled in the Kentucky Medicaid Program. If a potential Provider has not had a Medicaid number assigned, the provider shall apply for enrollment with the Department and 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. When the Contractor has submitted the required data in the transmission of the provider file indicating inclusion in the Contractor's Network, the Department will enter the provider number on the master provider file and the transmitted data will be loaded to the provider file. The Contractor will receive a report within two weeks of transactions being accepted, suspended or denied. All documentation regarding a provider's qualifications and services provided shall be available for review by the Department or its agents at the Contractor's offices during business hours upon reasonable advance notice.	Full - The language addressing the provider's participation in the Kentucky Medicaid Program and WellCare's provision of DMS approved enrolled forms is listed on page 47 of the C6ND MD-001 Network Development Policy document.			
29.6 Termination of Network Providers				
A. The Contractor shall terminate from participation any Provider who (i) engages in an activity that violates any law or regulation and results in	Full - The language in C6ND MD-001 Network Development Policy on page 48 under bullet eight and page 2 on			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
suspension, termination, or exclusion from the Medicare or Medicaid program; (ii) has a license, certification, or accreditation terminated, revoked or suspended; (iii) has medical staff privileges at any hospital terminated, revoked or suspended; or (iv) engages in behavior that is a danger to the health, safety or welfare of Members.	the C7CR-007-PR-001 Corrective Action Procedure addresses this requirement.			
The Department shall notify the Contractor of suspension, termination, and exclusion actions taken against Medicaid providers by the Kentucky Medicaid program within three (3) business days via e-mail. The Contractor shall terminate the Provider effective upon receipt of notice by the Department.	Full- The language in C6ND MD-001 Network Development Policy on page 48 under bullet eight addresses this requirement.			
The Contractor shall notify the Department of termination from Contractor's network taken against a Provider under this subsection within three (3) business days via email. The Contractor shall indicate in its notice to the Department the reason or reasons for the termination.	Full- The language in C6ND MD-001 Network Development Policy on page 48 under bullet eight addresses this requirement.			
The Contractor shall notify any Member of the Provider's termination provided such Member has received a service from the terminated Provider within the previous six months. Such notice shall be mailed within fifteen (15) days of the action taken if it is a PCP and within thirty (30) days for any other Provider.	Full- The language in this requirement is addressed on page 2 of the C7CR0025 Reporting of Adverse Actions-NPDB and State Agencies policy. During the onsite, the MCO provided a sample letter sent to members notifying them of their provider's termination for the audit time period.			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
B. In the event a Provider terminates participation with the Contractor, the Contractor shall notify the Department of such termination by Provider within five business days via email. In addition, the Contractor will provide all terminations monthly, via the Provider Termination Report. The Contractor shall indicate in its notice to the Department the reason or reasons for which the PCP ceases participation.	Full- The language in this requirement is addressed on the C6ND-MD-001 Network Development policy on page 48. During the onsite, the MCO provided a sample of the Provider termination report that WellCare submits to DMS on a monthly basis, as well as a sample email that notifies DMS of the provider termination.			
The Contractor shall notify any Member of the Provider's termination provided such Member has received a service from the terminating Provider within the previous six months. Such notice shall be mailed the later of the following: (i) thirty (30) days prior to the effective date of the termination or (ii) within fifteen (15) days of receiving notice.	Full- The language in this requirement is addressed on page 2 and 3 of the C7CR0025 Reporting of Adverse Actions-NPDB and State Agencies policy. During the onsite, the MCO provided a sample letter that satisfies this requirement.			
C. The Contractor may terminate from participation any Provider who materially breaches the Provider Agreement with Contractor and fails to timely and adequately cure such breach in accordance with the terms of the Provider Agreement.	Full- The C7CR-007 Corrective Action Policy and Procedure addresses corrective action procedures taken against providers who are sanctioned and face state imposed disciplinary action.			
The Contractor shall notify any Member of the Provider's termination provided such Member has received a service from the terminating Provider within the previous six months. Such notice shall be	Full- The language in this requirement is addressed on page 2 and 3 of the C7CR0025 Reporting of Adverse Actions-NPDB and State Agencies			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
mailed the later of the following: (i) within fifteen (15) days of providing notice or (ii) thirty (30) days prior to the effective date of the termination.	policy. During the onsite, the MCO provided a sample letter that satisfies this requirement.			

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing

Scoring Grid:

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

Overall Compliance Determination:

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

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

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable	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

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing

Suggested Evidence

Documents

Policies and Procedures for:

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

Credentialing Committee description, membership, meeting agendas and minutes

Reports

Reports of oversight of delegated credentialing

Reports to DMS and/or other authorities of serious quality issues that could result in provider suspension or termination

Sample provider file report of provider credentialing for DMS Fiscal Agent

Sample reports to DMS of cases where a provider requires review by the Credentialing Committee

File Review

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

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

State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
28.3 Primary Care Provider Responsibilities				
A primary care provider (PCP) is a licensed or certified health care practitioner, including a doctor of medicine, doctor of osteopathy, advanced practice registered nurse (including a nurse practitioner, nurse midwife and clinical specialist), physician assistant, or clinic (including a FQHC, , FQHC look-alike 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.	Deemed for 2017			
Specialty providers may serve as PCPs under certain circumstances, depending on the Member's needs including for a Member who has a gynecological or obstetrical health care need, a disability, or chronic illness. 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.	Deemed for 2017			
The Contractor shall monitor PCP's actions to ensure he/she complies with the Contractor's and Department's				

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
policies including but not limited to the following:				
A. Maintaining continuity of the Member's health care;	Deemed for 2017			
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;	Deemed for 2017			
C. Maintaining a current medical record for the Member, including documentation of all PCP and specialty care services;	Deemed for 2017			
D. Discussing Advance Medical Directives with all Members as appropriate;	Deemed for 2017			
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;	Deemed for 2017			
F. Documenting all care rendered in a complete and accurate medical record that meets or exceeds the Department's specifications; and	Deemed for 2017			
G. Arranging and referring members when clinically appropriate, to behavioral health providers.	Deemed for 2017			
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 the hours of service of their practice. The PCP remains solely responsible for the PCP functions (A) through (G) above.	Deemed for 2017			
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:				

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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;	Deemed for 2017			
(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	Deemed for 2017			
(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.	Deemed for 2017			
B. Unacceptable				
(1) Office phone is only answered during office hours;	Deemed for 2017			
(2) Office phone is answered after hours by a recording that tells Members to leave a message;	Deemed for 2017			
(3) Office phone is answered after hours by a recording that directs Members to go to the emergency room for any services needed; and	Deemed for 2017			
(4) Returning after-hours calls outside of thirty (30) minutes.	Deemed for 2017			
29.7 Provider Program Capacity Demonstration				
The Contractor shall assure that all covered services are	Deemed for 2017			

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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 Medicaid Region; and that no incentive is provided, monetary or otherwise, to providers for the withholding from Members of medically necessary services.				
The Contractor shall make available and accessible facilities, service locations, and personnel sufficient to provide covered services consistent with the requirements specified in this section.	Full - This requirement is addressed by requirements A through J below.			
Emergency medical and behavioral health services shall be made available and accessible to Members twenty-four (24) hours a day, seven (7) days a week. Urgent care services by any provider in the Contractor's Program shall be made available and accessible within 48 hours of request. The Contractor shall provide the following:	Deemed for 2017 New Requirement	Full	This requirement is addressed in the Decrease in Emergency Room Overuse Policy.	
A. Primary Care Provider (PCP) delivery sites that are: no more than thirty (30) miles or thirty (30) minutes from Member residence in urban areas, and for Members in non-urban areas, no more than forty-five (45) minutes or forty-five (45) miles from Member residence; with a member to PCP (FTE) ratio not to exceed 1500:1; and with appointment and waiting times, not to exceed thirty (30) days from date of a Member's request for routine and preventive services and forty-eight (48) hours for Urgent Care.	Full - Includes review of MCO Report #12A GeoAccess Network Reports & Maps (see Quarterly Desk Audit results) Policy wording regarding delivery sites for PCP's is addressed in policies and procedure document C6ND MD-001 Network Development on page 49. Accessibility to PCP's was also addressed in the GEO Access reports which were reviewed. Reports that showed member to PCP ratios complied with		Includes review of MCO Report #12A GeoAccess Network Reports & Maps (see Quarterly Desk Audit results)	

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	language that the ratio of members to PCP's shall not exceed 1500:1. The procedure and policy document titled Provider Appointment and Accessibility also shows evidence of the MCO's oversight to meet this requirement. WellCare does audits in two rounds. The first is the initial audit and the second is the follow up for those non compliant with the standard. Findings for WellCare's PCP compliance audit in 2016 were as follows: Q1, round 1: 92.4% is in compliance with the urgent standard and 99.5% were in compliance with the routine standard. Q1, round 2: 88.5% is in compliance with the urgent standard and 94.9% with the routine standard. Q2, round 1: 89.4% is in compliance with the urgent standard and 95% with the routine standard. Q2, round 2: 100% is in compliance with the urgent			

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	standard and the routine standard. Q3, round 1: 88.5% is in compliance with the urgent standard and 92.9% with the routine standard. Q3, round 2: 90.5% is in compliance with the routine standard and 96.8% with the routine standard. A discussion onsite of current reporting processes, including the 2016 Q1 Access Availability export, show that Wellcare has ongoing process improvements in place to monitor, track and report on deficiencies in their provider network accessibility. As per IPRO's suggestions, Wellcare is working with The Myers Group, to institute a secret shopper type methodology for assessing the accessibility of its provider network. Wellcare provided corrective action plans and sample letters sent to providers who fail quarterly audits assessing provider accessibility. Provider deficiencies are listed on the letter, and providers are asked			

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	to address the listed issues in time for a second audit. The Network Integrity staff explained onsite how improvements in internal processes, the use of software like Salesforce and a central database has added to increased oversight, better monitoring and improved reporting of deficiencies within the provider network. Wellcare has continuous process improvements in place.			
B. If either the Contractor or a Provider (including Behavioral Health) requires a referral before making an appointment for specialty care, any such appointment shall be made within thirty (30) days for routine care or forty-eight (48) hours for Urgent Care.	Deemed for 2017			
C. In addition to the above, the Contractor shall include in its network Specialists designated by the Department; and include sufficient pediatric specialists to meet the needs of Members younger than 21 years of age. Access to Specialists shall not exceed sixty (60) miles or sixty (60) minutes. Appointment and waiting times shall not exceed thirty (30) days for regular appointments and forty eight (48) hours for urgent care.	Deemed for 2017 New Requirement	Full	Includes review of MCO Report #12A GeoAccess Network Reports & Maps (see Quarterly Desk Audit results). This requirement is addressed in the Provider Appointment Accessibility and After-Hours Policy. Access requirements for pediatrics specialties are addressed in the provider manual.	
D. Immediate treatment for any Emergency Medical or Behavioral Health Services by a health provider that is	Deemed for 2017			

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
most suitable for the type of injury, illness or condition, regardless of whether the facility is in Contractor's Network.				
E. Access to Hospital care shall not exceed thirty (30) miles or thirty (30) minutes, except in non-urban areas where access may not exceed sixty (60) miles or (60) minutes, with the exception of Behavioral Health Services and physical rehabilitative services where access shall not exceed sixty (60) miles or sixty (60) minutes.	Deemed for 2017		Includes review of MCO Report #12A GeoAccess Network Reports & Maps (see Quarterly Desk Audit results).	
F. Access for general dental services shall not exceed 60 miles or 60 minutes. Any exceptions shall be justified and documented by the Contractor. Appointment and waiting times shall not exceed thirty (30) days for regular appointments and 48 hours for urgent care.	Deemed for 2017 New Requirement	Full	Includes review of MCO Report #12A GeoAccess Network Reports & Maps (see Quarterly Desk Audit results). This requirement is addressed in the Provider Appointment Accessibility and After-Hours Policy. The MCO submitted its GeoAccess reports as evidence of compliance with this requirement.	
G. Access for general vision, laboratory and radiology services shall not exceed (60) miles or sixty (60) minutes. 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.	Full - Includes review of MCO Report #12A GeoAccess Network Reports & Maps(see Quarterly Desk Audit results) This requirement is addressed. GeoAccess Reports #12A showed access to vision, laboratory, and radiology services for all regions at 100% for minutes. Q1, Q2 and Q3 Myers Group		Includes review of MCO Report #12A GeoAccess Network Reports & Maps (see Quarterly Desk Audit results).	

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	survey results include laboratory and radiology services. For each quarter, all audited laboratory and radiology facilities were 100% compliant with the routine and urgent care appointment standards.			
H. Access for Pharmacy services shall not exceed Thirty (30) miles or thirty (30) minutes.	Deemed for 2017 New Requirement	Full	Includes review of MCO Report #12A GeoAccess Network Reports & Maps (see Quarterly Desk Audit results). This requirement is addressed in the Pharmacy-Related Terminations and Notifications: OIG – Sanctioned Exclusions and Pharmacy Audit Policy. The MCO submitted its GeoAccess reports as evidence of compliance with this requirement.	
I. In addition to any Community Mental Health Center or Local Health Department which the Contractor has in its network, the Contractor shall include in its network Mental Health and Substance Abuse providers for both adults and children in no fewer number than fifty (50%) percent of the Mental Health and Substance Abuse providers enrolled in the Medicaid program to provide out-patient, intensive out-patient, substance abuse residential, case management, mobile crisis, residential crisis stabilization, assertive community treatment and peer support services.	Deemed for 2017			
J. The Department shall notify the Contractor and all other MCOs on contract with the Department when more than five (5%) percent of Emergency Room visits in a	Deemed for 2017			

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

State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
Medicaid Region, in a rolling three (3) month period, are determined to be a non-emergent visit. The Contractor shall provide sufficient alternate sites for twenty-four (24) hour care and appropriate incentives to Members to reduce unnecessary Emergency Room visits so that the determination of non-emergent visits are reduced to no more than two (2%) percent in a rolling three (3) month period for that Medicaid Region. The Contractor and all other MCOs shall provide such alternate sites or incentives based upon the number of their respective members in the Medicaid Region.				
29.8 Additional Network Provider Requirements				
A. The Contractor shall attempt to enroll the following Providers in its network as follows:				
1. Teaching hospitals;	Deemed for 2017			
2. FQHCs and rural health clinics;	Deemed for 2017			
3. The Kentucky Commission for Children with Special Health Care Needs; and	Deemed for 2017			
4. Community Mental Health Centers	Deemed for 2017			
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.	Deemed for 2017			
B. In consideration of the role that Department for Public Health, which contracts with the local health departments plays in promoting population health of the				

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
provision of safety net services, the Contractor shall offer a participation agreement to the Department of Public Health for local health department services. Such participation agreements shall include, but not be limited to, the following provisions:				
1. Coverage of the Preventive Health Package pursuant to 907 KAR 1:360.	Deemed for 2017			
2. Provide reimbursement at rates commensurate with those provided under Medicare.	Deemed for 2017			
The Contractor may also include any charitable providers which serve Members in the Contractor Region, provided that such providers meet credentialing standards.	Deemed for 2017			
C. 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 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 the providers listed in this subsection, 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.	Deemed for 2017			
29.9 Provider Network Adequacy				
The Contractor shall submit information in accordance with Appendix L that demonstrates that the Contractor has an adequate network that meets the Department's standards in the Provider Program Capacity Demonstration section of this contract. The Contractor	Deemed for 2017		Includes review of MCO Report #12A GeoAccess Network Reports & Maps (see Quarterly Desk Audit results).	

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
shall notify the Department, in writing, of any anticipated network changes that may impact network standards herein.				
The Contractor shall update this information to reflect changes in the Contractor's Network monthly.	Deemed for 2017			
29.10 Expansion and/or Changes in the Network				
If at any time, the Contractor or the Department determines that its Contractor Network is not adequate to comply with the access standards specified above for 95% of its Members, the Contractor or Department shall notify the other of this situation and within fifteen (15) business days the Contractor shall submit a corrective action plan to remedy the deficiency. Providers in the Contractor's Network who will not accept Medicaid Members shall not be included in the assessment as to whether the Contractor's Network is adequate to comply with access standards. The corrective action plan shall describe the deficiency in detail, including the geographic location where the problem exists, and identify specific action steps to be taken by the Contractor and time-frames to correct the deficiency.	Deemed for 2017		Includes review of MCO Report #13 Access & Delivery Network Narrative (see Quarterly Desk Audit results).	
In addition to expanding the service delivery network to remedy access problems, the Contractor shall also make reasonable efforts to recruit additional providers based on Member requests. When Members ask to receive services from a provider not currently enrolled in the network, the Contractor shall contact that provider to determine an interest in enrolling and willingness to meet the Contractor's terms and conditions.	Deemed for 2017			
31.1 Medicaid Covered Services				
The Contractor shall provide Covered Services in an the	Deemed for 2017	Full	This requirement is addressed in the Medicaid	

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
amount, duration, and scope that is no less than the amount, duration, and scope furnished Medicaid recipients under fee-for-service program; that are reasonably be expected to achieve the purpose for which the services are furnished; enables the Member to achieve age-appropriate growth and development; and enables the Member to attain, maintain, or regain functional capacity. The Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. The contractor may establish measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Members; may place appropriate limits on a service on the basis of criteria applied under the Medicaid State Plan, and applicable regulations, such as medical necessity; and place appropriate limits on a service for utilization control, provided the services furnished can reasonably be expected to achieve their purpose. Services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the Member's ongoing need for such services and supports, and family planning services are provided in a manner that protects and enables the Member's freedom to choose the method of family planning.	New Requirement		Referral and Authorization Guidelines and in the Care Coordination Continuity of Care and Transition of Care Procedure.	
The Contractor shall provide, or arrange for the provision of Covered Services to Members in accordance with the state Medicaid plan, state regulations, and policies and procedures applicable to each category of Covered Services. 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	Deemed for 2017			

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

State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
receiving health care under fee for service prior to enrollment in the Plan. Appendix H 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 the State Medicaid Plan, applicable administrative regulations governing Kentucky Medicaid services and individual Medicaid program services manuals incorporated by reference in the administrative regulations.				
The Contractor may provide, or arrange to provide, services in addition to the services described above, provided quality and access are not diminished, the services are Medically Necessary health services and cost-effective. The cost for these additional services shall not be included in the Capitation Rate. The Contractor shall notify and obtain approval from Department for any new services prior to implementation. The Contractor shall notify the Department by submitting a proposed plan for additional services and specify the level of services in the proposal.	Full - This requirement is met in full through the policy Kentucky Covered Services. The onsite discussion regarding costs for additional services stated that clinical staff will determine medical necessity for such services, and UM team or case managers would get necessary approvals for additional services if they are listed outside the available listed services. The MCO has negotiated agreements on costs and payments for services.			
For any Medicaid service provided by the Contractor that requires the completion of a specific form (e.g., hospice, sterilization, hysterectomy, or abortion), the form shall be completed according to the appropriate Kentucky	Full - Policies regarding sterilization services and women's health were provided at the onsite audit to			

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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.	show requirement language for additional Medicaid services. Additionally, the requirement C7QI-015 Medical Record Review describes medical record retention and making patient information available to the Department upon request.			
The Contractor shall not prohibit or restrict a Provider from advising a Member about his or her health status, medical care, or treatment, regardless of whether benefits for such care are provided under the Contract, if the Provider is acting within the lawful scope of practice.	Deemed for 2017			
If the Contractor is unable to provide within its network necessary Covered Services, it shall timely and adequately cover these services out of network for the Member for as long as Contractor is unable to provide the services in accordance with 42 CFR 438.206. The Contractor shall coordinate with out-of-network providers with respect to payment. The Contractor will ensure that cost to the Member is no greater than it would be if the services were provided within the Contractor's Network.	Deemed for 2017			
A Member who has received Prior Authorization from the Contractor for referral to a specialist physician or for inpatient care shall be allowed to choose from among all the available specialists and hospitals within the Contractor's Network, to the extent reasonable and appropriate.	Full - This requirement is addressed in the Medicaid Referral and Authorization Guidelines Policy C6C5-041.			
33.3 Emergency Care, Urgent Care and Post Stabilization Care				

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Emergency Care shall be available to Members 24 hours a day, seven days a week. Urgent Care services shall be made available within forty-eight (48) hours of request. Urgent Care means care for a condition that is not likely to cause death or lasting harm but for which treatment should not wait for a normally scheduled appointment. Post Stabilization Care services are covered and reimbursed in accordance with 42 CFR 422.113(c) and 438.114(c). The Contractor shall not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. An Emergency Medical Services Provider shall have a minimum of ten (10) calendar days to notify the Contractor of the Member's screening and treatment before refusing to cover the emergency services based on a failure to notify. A Member who has an emergency medical condition shall not be liable for payment of subsequent screening and treatment needed to diagnose or stabilize the specific condition. The Contractor is responsible for coverage and payment of services until the attending Provider determines that the Member is sufficiently stabilized for transfer or discharge.	New Requirement	Full	This requirement is addressed in the Emergency Room and Urgent Care Services Policy.	
33.4 Out-of-Network Emergency Care				
The Contractor shall provide, or arrange for the provision of Emergency Care, even though the services may be received outside the Contractor's Network, in compliance with 42 CFR 438.114.	Deemed in 2017			
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.	Deemed in 2017			
31.2 Direct Access Services				

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall make Covered Services available and accessible to Members as specified in this contract. The Contractor shall routinely evaluate Out-of-Network utilization and shall contact high volume providers to determine if they are qualified and interested in enrolling in the Contractor's network. If so, the Contractor shall enroll the provider as soon as the necessary procedures have been completed. When a Member wishes to receive a direct access service or receives a direct access service from an Out-of-Network Provider, the Contractor shall contact the provider to determine if it is qualified and interested in enrolling in the network. If so, the Contractor shall enroll the provider as soon as the necessary enrollment procedures have been completed.	Full - This requirement is addressed in the Network Development policy and procedure document C6ND MD-001.			
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:	Deemed for 2017			
A. Primary care vision services, including the fitting of eye-glasses, provided by ophthalmologists, optometrists and opticians;	Deemed for 2017			
B. Primary care dental and oral surgery services and evaluations by orthodontists and prosthodontists;	Deemed for 2017			
C. Voluntary family planning in accordance with federal and state laws and judicial opinion;	Deemed for 2017			
D. Maternity care for Members under 18 years of age;	Deemed for 2017			
E. Immunizations to Members under 21 years of age;	Deemed for 2017			
F. Sexually transmitted disease screening, evaluation and treatment;	Deemed for 2017			

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
G. Tuberculosis screening, evaluation and treatment;	Deemed for 2017			
H. Testing for Human Immunodeficiency Virus (HIV), HIV-related conditions, and other communicable diseases as defined by 902 KAR 2:020;	Deemed for 2017			
I. Chiropractic services;	Deemed for 2017			
J. For members with special health care needs determined through an assessment to need a course of treatment or regular care monitoring, allow members to directly access a specialist as appropriate for the Member's condition and identified needs; and	New Requirement	Full	This requirement is addressed in the Medicaid Referral and Authorization Guidelines.	
K. Women's health specialists.	Deemed for 2017			
33.6 Voluntary Family Planning				
The Contractor shall ensure direct access for any Member to a Provider, qualified by experience and training, to provide Family Planning Services, as such services are described in Appendix H 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.	Deemed for 2017			
The Contractor shall maintain confidentiality for Family Planning Services in accordance with applicable federal and state laws and judicial opinions for Members less than 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.	Deemed for 2017			
All information shall be provided to the Member in a	Deemed for 2017			

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
confidential manner. Appointments for counseling and medical services shall be available as soon as possible with in a maximum of 30 days. If it is not possible to provide complete medical services to Members less than 18 years of age on short notice, counseling and a medical appointment shall be provided right away preferably within 10 days. Adolescents in particular shall be assured that Family Planning Services are confidential and that any necessary follow-up will assure the Member's privacy.				

Quality Assessment and Performance Improvement: Access

Scoring Grid:

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

Overall Compliance Determination:

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

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

Reviewer Decision:

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

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

Final Findings

Quality Assessment and Performance Improvement: Access

Suggested Evidence

Documents

Policies/procedures for:

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

Process for monitoring of provider compliance with hours of operation and availability, including after-hours availability
Process for monitoring of provider compliance with PCP responsibilities
Process for addressing non-emergent ER visits
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
GeoAccess network reports and maps (MCO Report #12A) for:

- Primary care
- Specialty care
- Behavioral health services including mental health and substance abuse providers

Final Findings

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

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

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: WellCare of Kentucky

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
21.0 Utilization Management				
21.1 Medical Necessity				
The Contractor shall have a comprehensive UM program that reviews services for Medical Necessity and clinical appropriateness, and that monitors and evaluates on an ongoing basis the appropriateness of care and services for physical and behavioral health.	Deemed for 2017			
A written description of the UM program shall outline the program structure and include a clear definition of authority and accountability for all activities between the Contractor and entities to which the Contractor delegates UM activities.	Deemed for 2017			
The description shall include the scope of the program;	Deemed for 2017			
the processes and information sources used to determine service coverage;	Deemed for 2017			
clinical necessity, appropriateness and effectiveness;	Deemed for 2017			
policies and procedures to evaluate care coordination, discharge criteria, site of services, levels of care, triage decisions and cultural competence of care delivery;	Deemed for 2017			
processes to review, approve, and deny services as needed, particularly but not limited to the EPSDT program.	Deemed for 2017			
The UM program shall be evaluated annually,	Deemed for 2017			

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
including an evaluation of clinical and service outcomes.				
The UM program evaluation along with any changes to the UM program as a result of the evaluation findings, will be reviewed and approved annually by the Medical Director, the Behavioral Health Director, or the Medicaid Commissioner.	Deemed for 2017			
21.2 National Standards for Medical Necessity Review				
The Contractor shall adopt Interqual for Medical Necessity, except that the Contractor shall utilize the American Society of Addiction Medicine (ASAM) for substance use. If Interqual does not cover a behavioral health service, the Contractor shall adopt the following standardized tools for medical necessity determinations - for adults: Level of Care Utilization System (LOCUS); for children: Child and Adolescent Service Intensity Instrument (CASII) or the Child and Adolescent Needs and Strengths Scale (CANS); for young children: Early Childhood Service Intensity Instrument (ECSII). If it is determined that one of the medical necessity criteria named in this section is not available or not specifically addressed for a service or for a particular population, the Contractor shall submit its proposed medical necessity criteria to the Department for approval, except that submissions involving medical necessity criteria will not be deemed approved after thirty (30) days. The Department may also, at its discretion, require the use of other criteria it creates or identifies for services or populations not	Full The requirement is addressed in Policy C7UM-3.4 Application of Criteria Policy, Addendum E – Kentucky (Medicaid), Kentucky Contract Section 21.2: National Standards for Medical Necessity Review on page 9. New Requirement	Full	This requirement is addressed in the C7-UM-3.4 - Application of Criteria Policy. The MCO states that no additional requests were made for DMS approval of medical necessity criteria during the review period.	

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
otherwise covered by the named criteria in the above paragraph. The Contractor will be given ninety (90) days to implement criteria the Department may otherwise require.				
The Contractor shall have in place mechanisms to check the consistency of application of review criteria.	Deemed for 2017			
The written clinical criteria and protocols shall provide for mechanisms to obtain all necessary information, including pertinent clinical information, and consultation with the attending physician or other health care provider as appropriate.	Deemed for 2017		Includes UM file review results.	
The Medical Director and Behavioral Health Director shall supervise the UM program and shall be accessible and available for consultation as needed. Decisions to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a physician who has appropriate clinical expertise in treating the Member's condition or disease.	Deemed for 2017		Includes UM file review results.	
The clinical reason for the denial, in whole or in part, specific to the Member shall be cited.	Full - Includes UM file review results The requirement is addressed by Policy C7UM MD-2.1, Addendum D – Kentucky Medicaid and Kentucky Exchange, Policy Statement on page 36. The Kentucky Notice of Action		Includes UM file review results.	

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Medical Necessity Denial Letter template contains a field to insert the "Most Recent Review History for Letter/Note to Member Narrative." UM File Review Results: 10 out of 10 files selected for review passed validation; all required elements were found in the selected files. Clinical reasons were stated on UM denials, and none of the samples selected indicated an extension.			
Physician consultants from appropriate medical, surgical and psychiatric specialties shall be accessible and available for consultation as needed.	Deemed for 2017			
The Medical Necessity review process shall be completed within two (2) business days of receiving the request and shall include a provision for expedited reviews in urgent decisions. Post-service review requests shall be completed within fourteen (14) days or, if the Member or the Provider requests an extension or the Contractor justifies a need for additional information and how the extension is in the Member's interest, may extend up to an additional fourteen (14) days.	New Requirement	Full	Includes UM file review results. This requirement is addressed in the C7-UM-3.4 - Application of Criteria Policy. **File Review Results** Ten (10) of 10 files met this requirement. None of the files contained an extension request.	
A. The Contractor shall submit its request to change any prior authorization requirement to the Department for review.	Deemed for 2017			
B. For the processing of requests for initial and continuing authorization of services, the Contractor	Deemed for 2017			

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
shall require that its subcontractors have in place written policies and procedures and have in effect a mechanism to ensure consistent application of review criteria for authorization decisions.				
C. In the event that a Member or Provider requests written confirmation of an approval, the Contractor shall provide written confirmation of its decision within three (3) working days of providing notification of a decision if the initial decision was not in writing. The written confirmation shall be written in accordance with Member Rights and Responsibilities.	Deemed for 2017			
D. The Contractor shall have written policies and procedures that show how the Contractor will monitor to ensure clinical appropriate overall continuity of care.	Deemed for 2017			
E. The Contractor shall have written policies to ensure the coordination of services: 1. Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays; 2. With the services the Member receives from any other MCO; 3. With the services the member receives in FFS; and 4. With the services the Member receives from community and social support providers.	New Requirement	Full	This requirement is addressed in the C7-UM-4.5 - Care Coordination Continuity of Care and Transition of Care Policy.	
F. The Contractor shall have written policies and procedures that explain how prior authorization data will be incorporated into the Contractor's overall Quality Improvement Plan.	Deemed for 2017			

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Each subcontract must provide that consistent with 42 CFR Sections 438.6(h) and 422.208, compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to a Member.	Deemed for 2017			
The program shall identify and describe the mechanisms to detect under-utilization as well as over-utilization of services.	Deemed for 2017			
The written program description shall address the procedures used to evaluate Medical Necessity, the criteria used, information sources, timeframes and the process used to review and approve the provision of medical services.	Deemed for 2017			
The Contractor shall evaluate Member satisfaction (using the CAHPS survey) and provider satisfaction with the UM program as part of its satisfaction surveys.	Deemed for 2017			
The UM program will be evaluated by the Department on an annual basis.	Deemed for 2017		Includes review of MCO Report #59 Prior Authorizations (see Quarterly Desk Audit results).	
21.3 Adverse Benefit Determination Related to Requests for Services and Coverage Denials				
The Contractor shall provide the Member written notice that meets the language and formatting requirements for Member materials, of any adverse benefit determination (not just service authorization actions) within the timeframes for	Deemed for 2017			

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
each type of adverse benefit determination pursuant to 42 CFR 438.210(c). The notice must explain:				
A. The adverse benefit determination the Contractor has taken or intends to take;	Deemed for 2017		Includes UM file review results.	
B. The reasons for the adverse benefit determination in clear, non-technical language that is understandable by a layperson;	Deemed for 2017		Includes UM file review results.	
C. The right to be provided upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Member's adverse benefit determination, including medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits;	New Requirement	Full	Includes UM file review results. This requirement is addressed in the C7-UM-MD-2.2 - Adverse Benefit Determinations Policy. **File Review Results** Ten (10) of 10 files met this requirement.	
D. Specific and detailed information as to why the service did not meet medical necessity, if the action related to a denial, in whole or in part, of a service is due to a lack of medical necessity;	New Requirement	Full	Includes UM file review results. This requirement is addressed in the C7-UM-MD-2.2 - Adverse Benefit Determinations Policy. **File Review Results** Ten (10) of 10 files met this requirement.	
E. The federal or state regulation supporting the action, if applicable;	Deemed for 2017		Includes UM file review results.	
F. The Member's right to appeal including information on exhausting the Contractor's one level of appeal as required by 42 CFR 438.402(b);	Deemed for 2017 New Requirement	Full	Includes UM file review results. This requirement is addressed in the C7-UM-	

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			MD-2.2 - Adverse Benefit Determinations Policy. **File Review Results** Ten (10) of 10 files met this requirement.	
G. The Member's right to request a State hearing after receiving notice that the adverse benefit determination is upheld;	Deemed for 2017 New Requirement	Full	Includes UM file review results. This requirement is addressed in the C7-UM-MD-2.2 - Adverse Benefit Determinations Policy. **File Review Results** Ten (10) of 10 files met this requirement.	
H. Procedures for exercising Member's rights to Appeal or file a Grievance;	Deemed for 2017		Includes UM file review results.	
I. Circumstances under which expedited resolution is available and how to request it;	Deemed for 2017		Includes UM file review results.	
J. The Member's rights to have benefits continue pending the resolution of the Appeal, how to request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of these services.	Deemed for 2017		Includes UM file review results.	
K. Be available in English, Spanish, and each non-English language;	Deemed for 2017 New Requirement	Non-Compliance	Includes UM file review results. This requirement is addressed in the C7-UM-MD-2.2 - Adverse Benefit Determinations Policy. **File Review Results** One (1) of 10 files met this requirement.	WellCare appreciates IPRO's recommendation but would like to respectfully request reconsideration of the non-compliant finding. As noted in IPROs comments, WellCare disclosed that an issue was uncovered in late 2017 regarding eviCore's Adverse Benefit Determination (ABD) letters. Corrective action steps were put in place

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			This result was discussed with the MCO during onsite interviews. It was identified that the issue lay with UM delegate EviCore. WellCare provided the following summary: "In Q4 2017, WellCare became aware of an issue with our subcontractor, EviCore, regarding the notice of adverse benefit determination (ABD) letters. The letters generated by EviCore did not contain the appropriate language block (1557 disclaimer) that was approved by Kentucky Department for Medicaid Services and required by CMS. WellCare's Delegation Oversight Department performed a focus audit of EviCore's denial letters in Q1 2018. Through the focus audit, WellCare identified that some letters were non-compliant with the 1557 disclaimer. These results were shared with the contract manager which issued a directive to have all corrected letters in place within 30 days of the focus audit findings. EviCore confirmed the updated letters were placed into production in July 2018. WellCare has pulled random samples to verify that EviCore has completed the corrective steps for full remediation of this issue. We have attached 3 recently issued ABD letters as evidence that this issue had been remediated. In addition, WellCare will be conducting another focus audit on the ABD letters within	by our delegation oversight team once the issue was uncovered. WellCare would like to note that both the identification as well as the corrective action steps all occurred during the time period of the IPRO Audit (July 1, 2017 – June 20, 2018). WellCare supplied randomly selected ABD letter samples from July, August and September 2018 (post audit review period) to IPRO during the onsite review to verify that eviCore has completed the corrective steps and ABD letters contained the correct 1557 language block. All letters were compliant. WellCare performed another focus audit in January 2019 to evaluate compliance with the corrective action steps. A review of ABD letters issued in Q4 2018 was conducted. The focus audit concluded that all letters reviewed were compliant with the 1557 disclaimer language. As this issue was both identified and fully remediated within the IPRO audit review timeframe, WellCare would respectfully request reconsideration of the non-compliant finding.

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			the next 30 days." IPRO has reviewed the sample ABD letters from the post-remediation period and found them to be compliant with this requirement. **Recommendation for MCO** The MCO should continue to monitor EviCore to ensure compliance with the multi-language notification requirements. **Final Determination** No change in final determination. While we acknowledge WellCare has corrected the problem with Evicore, there was a period during the contract period in which this contract requirement was not met.	
L. Be available in alternative formats for persons with special needs; and	Deemed for 2017		Includes UM file review results.	
M. Be easily understood in language and format.	Deemed for 2017		Includes UM file review results.	
The Contractor must give notice at least: A. Ten (10) days before the date of an adverse Action when the Action is a termination, suspension, or reduction of a covered service authorized by the Department, its agent or Contractor, except the period of advanced notice is shortened to five (5) days if Member Fraud or Abuse has been determined.	Deemed for 2017			
B. The Contractor must give notice by the date of				

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
the adverse Action for the following:				
1. In the death of a Member;	Deemed for 2017			
2. A signed written Member statement requesting service termination or giving information requiring termination or reduction of services (where he understands that this must be the result of supplying that information);	Deemed for 2017			
3. The Member's admission to an institution where he is ineligible for further services;	Deemed for 2017			
4. The Member's address is unknown and mail directed to him has no forwarding address;	Deemed for 2017			
5. The Member has been accepted for Medicaid services by another local jurisdiction;	Deemed for 2017			
6. The Member's physician prescribes the change in the level of medical care;	Deemed for 2017			
7. An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1, 1989;	Deemed for 2017			
8. The safety or health of individuals in the facility would be endangered, the Member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the member's urgent medical needs, or a Member has not resided in the nursing facility for thirty (30) days.	Deemed for 2017			
C. The Contractor must give notice on the date of	Deemed for 2017			

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
the adverse Action when the Action is a denial of payment.				
D. The Contractor must give notice as expeditiously as the Member's health condition requires and within State-established timeframes that may not exceed two (2) business days following receipt of the request for service, with a possible extension of up to fourteen (14) additional days, if the Member, or the Provider, requests an extension, or the Contractor justifies a need for additional information and how the extension is in the Member's interest.	Deemed for 2017		Includes UM file review results.	
If the Contractor extends the timeframe for an appeal or expedited appeal, and the extension was not at the request of the enrollee, the Contractor must make reasonable efforts to give the Member prompt oral notice of the delay; give the Member written notice within two (2) calendar days, of the reason for the decision to extend the timeframe and inform the Member of the right to file a Grievance if he or she disagrees with that decision; and resolve the appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires.	New Requirement	Full	Includes UM file review results. This requirement is addressed in the C7-UM-MD-2.2 - Adverse Benefit Determinations Policy. **File Review Results** None of the 10 files contained extension requests.	
E. For cases in which a Provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the Member's health condition	Deemed for 2017			

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
requires and no later than two (2) business days after receipt of the request for service.				
F. The Contractor shall give notice on the date that the timeframes expire when service authorization decisions not reached within the timeframes for either standard or expedited service authorizations. An untimely service authorization constitutes a denial and is thus and adverse benefit determination.	Deemed for 2017			
21.4 Prior Authorizations				
The Department shall provide a common Prior Authorization Form for all Contractors to utilize for a Provider to initiate its prior authorization process. The Contractor shall give the Provider the option to use the common form or the Contractor specific form.	Deemed for 2017			

Quality Assessment and Performance Improvement: Access – Utilization Management

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	8	0	0	1
Total Points	24	0	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.67**		

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

Reviewer Decision:

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

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

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management

Suggested Evidence

Documents

Policies/procedures for:

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

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

Reports

UM Program Evaluation
Monitoring of consistent application of review criteria and any follow-up actions
CAHPS Report (MCO Report #94)
Provider Satisfaction Survey Report (MCO Report #95)
Prior Authorizations (MCO Report #59)

File Review

Sample of UM files selected by EQRO

Final Findings

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
37.0 Program Integrity				
The Contractor shall have arrangements and policies and procedures that comply with all state and federal statutes and regulations including 42 CFR 438.608 and Section 6032 of the Federal Deficit Reduction Act of 2005, governing fraud, waste and abuse requirements. The Contractor shall have a sufficient number of investigators as is necessary to detect fraud, waste and abuse.	Deemed for 2017			
37.1 Program Integrity Plan	New Heading			
The Contractor shall develop in accordance with Appendix N, a Program Integrity plan for the Commonwealth of Kentucky of internal controls and policies and procedures for preventing, identifying and investigating enrollee and provider fraud, waste and abuse. If the Department changes its program integrity activities, the Contractor shall have up to three (3) months to provide a new or revised program. This plan shall include, at a minimum:	Deemed for 2017	Full	This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy.	
A. Written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable requirements and standards under the contract as well as all federal and state requirements and standards;	Deemed for 2017	Full	This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy.	
B. The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures and practices designed to ensure compliance with the requirements of the contract and who reports directly to the Chief Executive Officer and the Board of Directors;	Deemed for 2017	Full	This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy.	

Final Findings

Program Integrity *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
C. A Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the Contractor's compliance program and its compliance with the requirements under this Contract;	New Requirement	Full	This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy.	
D. Effective training and education for the Contractor's Compliance Officer, senior management, employees, subcontractors, providers and enrollees for federal and state standards and requirements under the contract including; 1.Training and education regarding fraud, waste, and abuse; and 2 Detailed information about the False Claims Act (FCA), rights of employees to be protected as whistleblowers, and other federal and state laws described in Section 1902 of the Act (42 USC 1396a(a)(68));	Deemed for 2017	Full	This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy. The MCO provided employee and provider training materials as evidence of compliance with this standard.	
E. Effective lines of communication between the Compliance Officer and the contractor's employees;	Deemed for 2017	Full	This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy.	
F. Enforcement of standards through written and publicized disciplinary guidelines;	Deemed for 2017	Full	This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy. WellCare provided sample provider contracts which each contained strict requirements to comply with federal and state law as relates to the False Claims Act and other OIG regulations and guidelines. Contracts further outline disciplinary actions such as suspension of payments, revocation of credentials for individual providers or termination of provider agreements in whole.	

Final Findings

Program Integrity *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
F. Provision for internal monitoring and auditing of the member and provider;	Deemed for 2017	Full	This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy.	
G. Written procedures and an operational system that include but are not limited to the following:				
1. Routine internal monitoring and auditing of member, provider and compliance risks by dedicated staff for the Contractor and any Subcontractor;	New Requirement	Full	This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy. WellCare provided SUR reports which showed evidence of use algorithms to mine internal data for potential cases of fraud, waste or abuse	
2. Prompt investigation, response and development of corrective action initiatives to compliance risks or issues as they are raised or identified in the course of self-evaluation or audit, including coordination with law enforcement agencies for suspected criminal acts to reduce potential recurrence and ensure ongoing compliance under the contract;	New Requirement	Full	This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy.	
3. Provision for immediate notification to the Department's Program Quality & Outcomes Division Director and Program Integrity Division Director should any employee of the Contractor, Subcontractors or agents seek protection under the False Claims Act;	New Requirement	Full	This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy.	
4. Provision for prompt reporting to the Department of all overpayments identified or recovered, specifying the overpayments due to potential fraud, in a manner as determined by the Department;	New Requirement	Full	This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy.	
5. Prompt referral of any potential fraud, waste or	New Requirement	Full	This requirement is addressed in the C13-SIU-	

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
abuse that the Contractor identifies to the Department's program integrity unit or any potential fraud directly to the state Medicaid Fraud Control Unit in the form of an investigative report or in another manner as prescribed by the Department;			FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy.	
6. Provision for network providers to report and return to the Contractor any overpayment within sixty (60) calendar days of identification and to notify Contractor in writing of the reason for the overpayment;	New Requirement	Full	This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy.	
7. Suspension and escrow of payments to a network provider for which the Department has notified the Contractor that there is a credible allegation of fraud in accordance with 42 CFR 455.23 and report payment suspension information quarterly in a manner determined by the Department;	New Requirement	Full	This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy.	
8. Prompt notification to the Department when it receives information about a change in a Member's circumstances that may affect the Member's eligibility including changes in the Member's residence or the death of the Member;	New Requirement	Full	This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy.	
9. Notification to the Department when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the Contractor;	New Requirement	Full	This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy.	
10. Method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers have been delivered to Members and the application of such verification processes on a regular basis;	New Requirement	Full	This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy. The MCO provided Report #73, which	

Final Findings

Program Integrity *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			identifies random sampling for the purpose of verifying services, per requirements.	
11. Ensure all of Contractor's network providers are enrolled with the Department consistent with the provider disclosure, screening and enrollment requirements of 42 CFR 455;	New Requirement	Full	This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy.	
12. An accounts receivable process to collect outstanding debt from enrollees or providers and provide monthly reports of activities and collections to the Department in a manner determined by the Department;	New Requirement	Full	This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy. The MCO provided Report #71 addressing receivables.	
13. An appeal process;	New Requirement	Full	This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy.	
14. Process for card sharing cases;	New Requirement	Full	This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy.	
15. Conducting a minimum of three (3) on-site visits per quarter related to investigations of fraud, waste and abuse and reporting related information to the Department in a manner determined by the Department;	New Requirement	Full	This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy.	
16. Tracking the disposition of all member and provider cases (initial and preliminary) as well as case management that allows for ad hoc reporting or case status	New Requirement	Full	This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy.	
17. A prepayment review process in accordance with this contract; and	New Requirement	Full	This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy.	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
18. Two (2) full-time investigators with a minimum of three (3) years Medicaid fraud, waste and abuse investigatory experience located in Kentucky dedicated 100% to the Kentucky Medicaid Program, and notification to the Department's Program Integrity Director if there is any absence or vacancy that is more than thirty (30) days with a contingency plan to remain compliant with the other contract requirements in the interim.	New Requirement	Full	This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy.	
H. Contractor shall be subject to on-site review; and comply with requests from the department to supply documentation and records;	Deemed for 2017	Full	This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy.	
I. 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;	Deemed for 2017	Full	This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy.	
J. 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 identified and collected;	Deemed for 2017	Full	Includes review of MCO Report #75 SUR Algorithms. This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy. The MCO provided monthly algorithm reports, per the requirements.	
K. Contractor shall follow cases from the time they are opened until they are closed following written protocol regarding submission of investigative reports to the Department;	Deemed for 2017	Full	This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy. In addition to the policy review this was met through the review of sample files.	
L. Contractor shall notify Department within fifteen	New Requirement	Full	This requirement is addressed in the C13-SIU-	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
(15) business days in a manner determined by the Department of any provider placed on prepayment review related to fraud, waste and abuse. The information shall include at a minimum the following: 1. Case Number; 2. Provider Name; 3. Medicaid Provider ID; 4. NPI; 5. Summary of Concern; and 6. Date action taken. The Contractor shall submit an annual listing of providers that were under prepayment review during the state fiscal year in a manner determined by the Department; and			FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy. There were no providers on prepayment during the review period.	
M. Contractor shall attend any training given by the Commonwealth, Department, its Fiscal Agent or other Contractor's organizations provided reasonable advance notice is given to Contractor of the scheduled training.	Deemed for 2017	Full	This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy.	
The plan shall be made available to the Department for review and approval.	Deemed for 2017	Full	This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy.	
9.2 Administration/Staffing				
The Contractor shall provide the following functions that shall be staffed by a sufficient number of qualified persons to adequately provide for the Contractor's enrollment or projected enrollment.				
P. A Compliance Director who shall maintain current	Deemed for 2017			

Final Findings

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
knowledge of Federal and State legislation, legislative initiatives, and regulations relating to Contractors and oversee the Contractor's compliance with the laws and 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.				
N. A Program Integrity Coordinator, who shall be located in Kentucky and whose job duties are dedicated exclusively to the coordination, management, and oversight of the Contractor's Program Integrity unit to reduce fraud, waste and abuse of Medicaid services within Kentucky.	Full - This requirement is addressed in the job description for the Senior Special Investigations Unit (SIU) Investigator, and confirmed by the reviewer's meeting with the SIU Investigator on-site. In addition, the Fraud Waste and Abuse Policy C13SIU FWA-001 indicates that a Special Investigations Unit (SIU) reports to the Vice President, Corporate Compliance Investigations, who in turn reports to the Chief Compliance Officer who is located at WellCare Corporate Headquarters in Tampa, Florida. Fraud Waste and Abuse Procedures Kentucky Procedure C13SIU=FWA-001-KY states that WellCare's SIU functions as the Program Integrity Unit (PIU) and, as such, conducts a preliminary inquiry into all complaints or indications of potential RWA, and, as appropriate, will refer cases to the Commonwealth of Kentucky for further direction and resolution.			-

Final Findings

Program Integrity *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
37.2 Prepayment Review				
The Contractor shall have policies and procedures for a prepayment review process in accordance with the requirements of this contract, and should perform a review when there is a sustained or high level of payment error or data analysis identifies a problem area. The Contractor shall have discretion on when to utilize prepayment review, but should consider such review due to a high volume of services, high cost, dramatic change in frequency of use, high risk problem-prone area, complaints, or if the Department or any other federal or state agency has identified a certain vulnerability in a service area. The Contractor shall not use prepayment review to hold claims for an indefinite period of time. The Contractor shall review the documentation submitted within a reasonable amount of time to determine whether the claim should be paid. Claims under prepayment review are not subject to prompt payment or timely filing requirements.	New Requirement	Full	This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy.	
Notice shall be sent to the provider in writing on or before the date a prepayment review is started. The written notice shall contain the following: A. Specific reason for the review; B. Complete description of the specific documentation needed for the review and method of submission; C. Timeframe for returning the documentation, and information that the claim will be denied if documentation is not returned timely; D. Length of time the prepayment review will be conducted if the Contractor has determined	New Requirement	Full	This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy.	

Final Findings

Program Integrity *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
one at its discretion; E. Contact information if there are questions related to the prepayment review; and F. Information on how the provider may request removal of a prepayment review.				
The Provider shall be given forty-five (45) calendar days to submit documents in support of claims under prepayment review. The Contractor shall deny claims for which the requested documentation was not received by day forty-six (46). The Contractor shall deny a claim when the submitted documentation lacks evidence to support the service or code. The Contractor shall follow Contract Provision 28.9 for any appeals related to the prepayment process. The Contractor may extend the length of a prepayment review when it is determined necessary to prevent improper payments.	New Requirement	Full	This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy.	
38.14 Ownership and Financial Disclosure				
The Contractor agrees to comply with the provisions of 42 CFR 455.104. The Contractor shall provide true and complete disclosures of the following information to Finance, the Department, CMS, and/or their agents or designees, in a form designated by the Department (1) at the time of each annual audit, (2) at the time of each Medicaid survey, (3) prior to entry into a new contract with the Department, (4) upon any change in operations which affects the most recent disclosure report, or (5) within thirty-five (35) days following the date of each written request for such information:	Deemed for 2017		Includes review of individual disclosures.	
A. The name and address of each person with an	Substantial Includes review of	Full	Includes review of individual disclosures.	

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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;	individual disclosures Page 1 of the Legal Services Medicaid Agency Disclosures Procedure defines a "Beneficial Owner" as an entity with ownership interest in the Company of five percent or more, and on page 2 indicates that a Medicaid Contract applies to the KY Medicaid Contract (Original) and to the KY Medicaid Contract (Region 3). Page 4 states that a Relevant Party includes any spouse, child, or parent. However, sibling is not indicated. Recommendation for WellCare Add "sibling" to the appropriate section of the Legal Services Medicaid Agency Disclosures Procedure. WellCare Response WellCare appreciates IPRO's recommendation and is currently updating our legal procedure, C13-LG-033-PR-001, to include the term "sibling" as a "Beneficial Owner".		This requirement is addressed in the C13-LG-033-PR-001 – Legal Services Medicaid Agency Disclosures Procedure. The MCO provided KY ADO form and attachment October 2017 listing all required disclosures.	
B. The name of any other entity receiving reimbursement through the Medicare or Medicaid programs in which a person listed in response to subsection (a) has an ownership or control interest;	Full - Includes review of individual disclosures This requirement is addressed in the KY ADO June 2016 and attachments.pdf and in the April 2016 KY ADO Form and Attachments documents, which are "Disclosure of Ownership" forms that list entity names and "significant business transactions" with subcontractors with significant business transaction amounts through 12/31/15. Those subsidiaries/entities listed with		Includes review of individual disclosures.	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	significant business transactions in 2016 will be listed in next year's report.			
C. The same information requested in subsections (A) and (B) for any Subcontractors or suppliers with whom the Contractor has had business transactions totaling more than $25,000 during the immediately preceding twelve-month period;	Full - Includes review of individual disclosures This requirement is addressed in the Subcontractor Ownership Disclosure Policy (C13LG-038 Sub ADO.pdf) under "Background" on page 1.		Includes review of individual disclosures.	
D. A description of any significant business transactions between the Contractor and any wholly-owned supplier, or between the Contractor and any Subcontractor, during the immediately preceding five-year period;	Full - Includes review of individual disclosures This requirement is addressed in the Subcontractor Ownership Disclosure Policy (C13LG-038 Sub ADO.pdf) on page 2.		Includes review of individual disclosures.	
E. The identity of any person who has an ownership or control interest in the Contractor, any Subcontractor or supplier, or is an agent or managing employee of the Contractor, any Subcontractor or supplier, who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the services program under Title XX of the Act, since the inception of those programs;	Substantial Includes review of individual disclosures The prior results indicate that this requirement is addressed in the Legal Services Medicaid Agency Disclosures Procedure (7); however, in the Legal Services Medicaid Agency disclosures document provided this year, that language applies to the State of Florida, not Kentucky. Page 14 of the Legal Services Medicaid Agency Disclosures Procedure (C13LG-033-PR-001 ADOP Procedure.pdf) states that the Contractor shall provide written notice to Finance of any legal action with regard to the payment of a civil fine or conviction of any person who has an ownership interest, or any subcontractor, specifically for the KY Medicaid Contract; however there is no statement that applies to KY Medicaid regarding the requirement to	Full	Includes review of individual disclosures. This requirement is addressed in the C13-LG-033-PR-001 – Legal Services Medicaid Agency Disclosures Procedure. The MCO provided KY ADO form and attachment October 2017 listing all required disclosures.	

Final Findings

Program Integrity ***(See Final Page for Suggested Evidence)***				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	disclose the identity of any such entity with a history, "who has been convicted of a criminal offense", of a criminal offense related to their involvement in any program under Medicare or Medicaid. Recommendation for WellCare The requirement to disclose the identity of any such entity with a history, "who has been convicted of a criminal offense", of a criminal offense related to their involvement in any program under Medicare or Medicaid should be added to the Legal Services Medicaid Agency Disclosures Procedure (C13LG-033-PR-001 ADOP Procedure WellCare Response WellCare appreciates IPRO's recommendation and our legal procedure C13-LG-033-PR-001, is currently being updated to reflect the recommended language to disclose the identity of any such entity with a history, "who has been convicted of a criminal offense".			
F. The name of any officer, director, employee or agent of, or any person with an ownership or controlling interest in, the Contractor, any Subcontractor or supplier, who is also employed by the Commonwealth or any of its agencies; and	Deemed for 2017			
G. The Contractor shall be required to notify the Department immediately when any change in ownership is anticipated. The Contractor shall submit	Deemed for 2017			

Final Findings

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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.				
State Contract, Appendix N				
ORGANIZATION: The Contractor shall establish a Program Integrity Unit (PIU) to identify Fraud, Waste and Abuse and refer to the Department any suspected Fraud or Abuse of Members and Providers. The Program Integrity Unit (PIU) shall be organized so that:				
A. Required Fraud, Waste and Abuse activities are conducted by staff with separate authority to direct PIU activities and functions specified in this Appendix on a continuous and on-going basis;	Deemed for 2017			
B. Written policies, procedures, and standards of conduct demonstrate the organization's commitment to comply with all applicable contract requirements and standards and federal and state laws, regulations and standards;	Deemed for 2017			
C. The unit establishes, controls, evaluates and revises Fraud, Waste and Abuse detection, deterrent and prevention procedures to ensure compliance with all applicable contract requirements and standards and Federal and State laws, regulations and requirements;	Deemed for 2017			
D. The staff consists of a compliance officer in addition to auditing and clinical staff;	Deemed for 2017			
E. The unit prioritizes work coming into the unit to	Full - This requirement is addressed on page 2			-

Final Findings

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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:	of the KY Fraud Waste and Abuse Policy (C13SIU-FWA-001-KY).			
(1) Multi-State fraud or problems of national scope, or Fraud or Abuse crossing partnership boundaries;	Full - This requirement is addressed on page 2 of the KY Fraud Waste and Abuse Policy (C13SIU-FWA-001-KY).			
(2) High dollar amount of potential overpayment; or	Full - This requirement is addressed on page 2 of the KY Fraud Waste and Abuse Policy (C13SIU-FWA-001-KY).			
(3) Likelihood for an increase in the amount of Fraud or Abuse or enlargement of a pattern.	Full - This requirement is addressed on page 2 of the KY Fraud Waste and Abuse Policy (C13SIU-FWA-001-KY).			
F. Ongoing education is provided to Contractor staff on Fraud, Waste and Abuse trends including CMS initiatives; and	Deemed for 2017			
G. Contractor attends any training given by the Commonwealth/Fiscal Agent, its designees, or other Contractor's organizations provided reasonable advance notice is given to Contractor of the scheduled training.	Deemed for 2017			
H. There are a minimum of two (2) full-time investigators: **(1) With a minimum of three (3) years of Medicaid fraud, waste and abuse investigatory experience** **(2) Located in Kentucky; and** **(3) Dedicated 100% to the Kentucky Medicaid Program**	New Requirement	Full	This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy. WellCare provided their Kentucky Market organization chart which included two local SIU investigators.	
FUNCTION: Contractor and/or Contractor's PIU shall:				

Final Findings

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
A. Prevent Fraud, Waste and Abuse by identifying vulnerabilities in the Contractor's program including identification of Member and Provider Fraud, Waste and Abuse and taking appropriate action including but not limited to the following: (1) Recoupment of overpayments; (2) Changes to policy; (3) Dispute resolution meetings; and (4) Appeals.	Deemed for 2017			
B. Proactively detect incidents of Fraud, Waste and Abuse that exist within the Contractor's program through the use of algorithms, investigations and record reviews;	Deemed for 2017			
C. Determine the factual basis of allegations concerning Fraud or Abuse made by Members, Providers and other sources;	Deemed for 2017			
D. Initiate appropriate administrative actions to collect overpayments;	Deemed for 2017			
E. Refer potential Fraud, Waste and Abuse cases to the Department after an initial investigation for possible referral for civil and criminal prosecution and administrative sanctions, or for the Department's permission to collect overpayments in excess of $500 as an administrative recoupment or for investigation or case closure;	Deemed for 2017			
F. Initiate and maintain network and outreach activities to ensure effective interaction and exchange of information with all internal components of the Contractor as well as outside groups;	Deemed for 2017			
G. Make and receive recommendations to enhance	Deemed for 2017			

Final Findings

Program Integrity *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
the ability of the Parties to prevent, detect and deter Fraud, Waste or Abuse;				
H. Provide for prompt response to detected offenses and for development of corrective action initiatives relating to the Contractor's contract;	Deemed for 2017			
I. Provide for internal monitoring and auditing of Contractor and it subcontractors; and supply the Department with reports on a quarterly basis or as-requested basis on its activity and ad hocs as necessary;	Deemed for 2017			
J. Be subject to on-site reviews and fully comply with requests from the Department to supply documentation and records;	Deemed for 2017			
K. Collect outstanding debt owed to the Department from members or providers; and provide monthly reports of activity and collections to the Department;	Deemed for 2017		Includes review of MCO Report #71 Provider Outstanding Account Receivables.	
L. Allow the Department to collect and retain any overpayments if the Contractor has not taken appropriate action to collect the overpayment after 180 days;	Deemed for 2017			
M. The Contractor shall, as requested by the Department, recoup on any outstanding provider overpayments not identified by the Contractor if the provider has exhausted all appeals and the provider fails to pay the Department within sixty (60) days, and remit the amount or balance within sixty (60) days of notification by the Department;	New Requirement	Full	This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy.	
N. Conduct continuous and on-going reviews of all MIS data including Member and Provider Grievances and Appeals, for the purpose of identifying	Deemed for 2017			

Final Findings

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
potentially fraudulent acts;				
O. Conduct regular post-payment audits of Provider billings, investigate payment errors, produce printouts and queries of data and report the results of their work to the Department;	Deemed for 2017			
P. Conduct onsite and desk audits of Providers and report the results including identified overpayments and recommendations to the Department;	Deemed for 2017			
Q. Locally maintain cases under investigation for possible Fraud, Waste or Abuse activities and provide these lists and entire case files to the Department and OIG upon demand;	Deemed for 2017			
R. Designate a contact person to work with staff investigators and attorneys from the Department OIG and any other agent or contractor of the Department;	Deemed for 2017			
S. Ensure the integrity of PIU referrals to the Department and shall not subject referrals to the approval of the Contractor's management or officials;	Deemed for 2017			
T. Comply with the expectations of 42 CFR 455.20 by employing a method of verifying with a Member whether the services billed by Provider were received by randomly selecting a minimum sample of 500 claims on a monthly basis;	Deemed for 2017		Includes review of MCO Report # 73 Explanation of Member Benefits (EOMB).	
U. Run algorithms on billed claims data over a time span sufficient to identify potential fraudulent billing patterns and develop a process and report quarterly or as otherwise requested to the Department all algorithms, issues identified, actions taken to	Deemed for 2017		Includes review of MCO Report #75 SUR Algorithms.	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
address those issues and the overpayments collected;				
V. Collect administratively from Members for overpayments that were declined prosecution for Medicaid Program Violations (MPV);	Deemed for 2017			
W. Comply with the program integrity requirements set forth in the Patient Protection and Affordable Care Act, specifically 42 CFR 438.608, and all applicable requirements and standards under this contract and any federal and state laws and regulations, and provide policies and procedures to the Department for review and approval;	Deemed for 2017			
X. Report to the Department any Provider denied enrollment by Contractor for any reason, including those contained in 42 CFR 455.106, within 5 days of the enrollment denial;	Deemed for 2017			
Y. Recover overpayments from providers;	Deemed for 2017			
Z. Identify Providers for pre-payment review as a result of the Provider's activities in accordance with the contract;	Deemed for 2017			
AA. Conduct a minimum of three (3) on-site visits per quarter related to investigations of suspected fraud and abuse. The site visit shall be approved within a minimum of ten (10) calendar days by the Department;	Deemed for 2017			
BB. Notify the Department if there is an absence or vacancy in an investigator position that is longer	New Requirement	Full	This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
than thirty (30) days, and include a contingency plan to remain compliant with the contract requirements in the interim; and			Abuse Policy.	
CC. Correct any weaknesses, deficiencies, or noncompliance items identified as a result of a review or audit conducted by the Department, CMS, or by any other State or Federal Agency or agents thereof that has oversight of the Medicaid program. Corrective action shall be completed the earlier of thirty (30) calendar days or the timeframes established by Federal and state laws and regulations.	Deemed for 2017			
PATIENT ABUSE: Incidents or allegations concerning physical or mental abuse of Members shall be immediately reported to the Department for Community Based Services in accordance with state law with copy to the Department and OIG. Potential Member safety issues related to investigations shall be reported in accordance with state law with a copy to the Department's Program Integrity Division Director and Program Quality & Outcomes Division Director.	Deemed for 2017			
COMPLAINT SYSTEM: The Contractor's PIU shall have an operational system to receive, investigate and track the status of Fraud, Waste and Abuse complaints from Members, Providers and all other sources which may be made against the Contractor, Providers or Members. The system shall contain the following:	Deemed for 2017			
A. Upon receipt of a complaint or other indication of potential Fraud or Abuse, the Contractor's PIU shall conduct an initial investigation to determine the	Deemed for 2017			

Final Findings

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
validity of the complaint;				
B. The PIU should review background information and MIS data; however, the initial investigation should not include interviews with the subject concerning the alleged instance of Fraud or Abuse;	Deemed for 2017			
C. If the initial investigation results in a reasonable belief that the complaint does not constitute Fraud or Abuse, the PIU should not refer the case to the Department; however, the PIU shall take whatever remedial actions may be necessary, up to and including administrative recovery of identified overpayments;	Deemed for 2017			
D. If the initial investigation results in a reasonable belief that Fraud or Abuse has occurred, the PIU shall refer the case and all supporting documentation to the, the Department;	Deemed for 2017			
E. The Department will review the referral and attached documentation, make a determination and notify the PIU as to whether the OIG will investigate the case or return it to the PIU for appropriate administrative action;	Deemed for 2017			
F. If in the process of conducting a initial 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 of their findings and proceed only in accordance with instructions received from the Department;	Deemed for 2017			
G. If the Department determines that it will keep a case referred by the PIU to the OIG, the OIG will conduct a preliminary investigation review the PIU's				

Final Findings

Program Integrity *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
report and evidence, gather additional evidence if needed, and forward information if warranted, to the Attorney General's Medicaid Fraud Control Unit, for appropriate action;				
H. If the OIG opens an investigation based on a complaint received from a source other than the Contractor, OIG will, upon completion of the preliminary investigation, provide a copy of the investigative report to the Department, the PIU, or if warranted, to MFCU, for appropriate actions;				
I. If the OIG investigation results in a referral to the MFCU and/or the U.S. Attorney, the OIG will notify the Department and the PIU of the referral. The Department and the PIU shall only take actions concerning these cases in coordination with the law enforcement agencies that received the OIG referral;				
J. Upon approval of the Department, Contractor shall suspend and escrow 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;	Deemed for 2017			
K. Upon completion of the PIU's initial investigation, the PIU shall provide the Department a copy of their investigative report, which shall contain the following elements:	Deemed for 2017			
(1) Name and address of subject,	Deemed for 2017		Includes program integrity file review results.	
(2) Medicaid identification number,	Deemed for 2017		Includes program integrity file review results.	
(3) Source of complaint,	Deemed for 2017		Includes program integrity file review results.	
(4) State the complaint/allegation,	Deemed for 2017		Includes program integrity file review results.	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
(5) Date assigned to the investigator,	Deemed for 2017		Includes program integrity file review results.	
(6) Name of investigator,	Deemed for 2017		Includes program integrity file review results.	
(7) Date of completion,	Deemed for 2017		Includes program integrity file review results.	.
(8) Detail as to what timeframe was reviewed;	New Requirement	Full	Includes program integrity file review results. **Program Integrity File Review Results** Ten (10) of 10 files met the requirements.	
(9) How many member records were reviewed for that timeframe and the total of number of claims;	New Requirement	Full	Includes program integrity file review results. **Program Integrity File Review Results** Ten (10) of 10 files met the requirements.	
(10) The issues identified;	New Requirement	Full	Includes program integrity file review results. **Program Integrity File Review Results** Ten (10) of 10 files met the requirements.	
(11) Methodology used during investigation,	Deemed for 2017		Includes program integrity file review results.	.
(12) Facts discovered by the investigation as well as the full case report and supporting documentation,	Full - Includes Program Integrity file review results This requirement is addressed on page 2 of the KY Fraud Waste and Abuse Policy (C13SIU-FWA-001-KY). Program Integrity File Review Results 9 of 10 files met this requirement. One file received an NA determination for this requirement due to the fact that two unsuccessful attempts to obtain pertinent facts from the complainant were made. The telephone number was no longer in service		Includes program integrity file review results.	

Final Findings

Program Integrity *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	and no claims were found in the file.			
(13) Attach all exhibits or supporting documentation,	Deemed for 2017		Includes program integrity file review results.	
(14) Include recommendations as considered necessary, for administrative action or policy revision,	Full - Includes Program Integrity file review results This requirement is addressed on page 3 of the KY Fraud Waste and Abuse Policy (C13SIU-FWA-001-KY). Program Integrity File Review Results 4 of 10 files met this requirement and this requirement was Not Applicable for the remaining 6 files as no recommendations for administrative action or policy revision were needed.		Includes program integrity file review results.	
(15) Identify overpayment, if any, and recommendation concerning collection,	Deemed for 2017		Includes program integrity file review results.	
(16) Reason for closure of the report, if applicable;	New Requirement	Full	Includes program integrity file review results. **Program Integrity File Review Results** Ten (10) of 10 files met the requirements.	
(17) Request to send as a referral for a preliminary investigation for a credible allegation of fraud, if applicable; and	New Requirement	Full	Includes program integrity file review results. **Program Integrity File Review Results** Ten (10) of 10 files met the requirements.	
(18) Any other elements identified by CMS for fraud referral;	Deemed for 2017			
L. The Contractor's PIU shall provide the OIG and the Department a quarterly Member and Provider status	Deemed for 2017		Includes review of MCO Report #76 Provider Fraud Waste Abuse Report and #77 Member	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
report of all cases including actions taken to implement recommendations and collection of overpayments, or case information shall be made available to the Department upon request;			Fraud Waste Abuse Report.	
M. The Contractor's PIU shall maintain access to a follow-up system which can report the status of a particular complaint or grievance process or the status of a specific recoupment; and	Deemed for 2017			
N. The Contractor's PIU shall assure a Grievance and Appeal process for Members and Providers in accordance with 907 KAR 1:671.	Deemed for 2017			
CASE TRACKING AND CASE MANAGEMENT (a) The Contactor shall have a case tracking and case management system to track member and provider cases; (b) The Contractor shall have the ability to query for ad hoc reporting or case status through the case tracking system for any period of time and shall be able to report the following for provider cases: (1) PIU Case number, (2) Provider name, (3) Provider number, (4) NPI (if applicable), (6) Source of Complaint, (7) OIG Referral Number (if applicable), (8) MAT Case Y/N (if applicable to report), (9) Date complaint received by Contractor, (10) Date opened, (11) Name of PIU investigator assigned, (12) Summary of Complaint,	New Requirement	Full	This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy.	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
(13) Justification that a referral for a preliminary investigation was not warranted based upon the evidence in the case file, (14) PIU action(s) taken and date(s), (15) Amount of overpayment if any (please note potential overpayments of $500 or more should be referred for preliminary investigation), (16) Administrative actions (if any) or referral with description, and (17) Closure Date* (if applicable) of initial investigation with approval from supervisor. Supervisor approval should demonstrate/attest verification of each component in the case file. (c) The Contractor shall have the ability to query for ad hoc reporting or case status through the case tracking system for any period of time and shall be able to report the following for member cases: (1) PIU Case number, (2) Member name, (3) Member number, (4) Date of Birth (if known), (5) Social Security Number (if known), (6) Source of Complaint, (7) OIG Referral Number (if applicable), (8) Date complaint received by Contractor, (9) Date opened, (10) Name of PIU investigator assigned, (11) Summary of Complaint, (12) Justification that a preliminary investigation was not warranted based upon the evidence in the case file, (13) PIU action(s) taken and date(s) within the ten				

Final Findings

Program Integrity *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
(10) day review period, (14) Amount of overpayment if any, (15) Administrative actions (if any) or referral with description, (16) Closure Date* (if applicable) of initial investigation with approval from supervisor. Supervisor approval should demonstrate/attest verification of each component in the case file.				
REPORTING: A. The Contractor's PIU shall report on a monthly basis provider internal referrals (tips) and the disposition of the prior month's internal referrals, and on a quarterly basis in a narrative report format, as required by the Department, all activities and processes for each investigative case (for that quarter to the Department. The Contractor shall have the ability to report all aspects of a member or provider file from opening to closure) to the Department upon request, including overpayments identified, overpayment adjusted and recoupments of overpayments;	Deemed for 2017 New Requirement	Substantial	Includes review of MCO Report #76 and Report #77. This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy. A review of reports #76 and #77 identified missing data in the fields Date complaint or referral received; MAT related (Y or N);Initial investigation (Y or N);Referred to DMS (with appropriate code);Date referred to DMS (if applicable) and Provider on prepayment (Y or N). <u>Recommendation for WellCare</u> WellCare should update its reporting templates for reports #76 and #77 to include all of the required data elements. Final Review Determination No change in determination as there are several required fields that are not on the reports.	WellCare respectfully requests that IPRO reevaluate the score of "substantial" for this requirement. WellCare appreciates IPRO's recommendation to update its reporting templates but would like to note that DMS sets for the format and specifications for all of our regulatory reports. The templates given to MCOs by DMS for this reporting requirement does not contain all of the specified elements therefore MCO's should not be assessed an adverse finding. WellCare received the last report template from DMS Program Integrity in October 2017. This information was supplied to IPRO during the onsite review and is embedded herein. **FW KY - TIPS report Reporting of Full Tir**
B. If any employee or subcontractor employee of the	New Requirement	Full	This requirement is addressed in the C13-SIU-	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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			FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy.	
C. The Contractor's PIU shall immediately report all cases of suspected Fraud, Waste, Abuse or inappropriate practices by Subcontractors, Members or employees to the Department and the Department in adherence to state requirements.	New Requirement	Full	This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy.	
D. The Contractor shall adhere to all ad hoc reporting requests whether one time or recurring in accordance with Section 38.1 of this contract;	New Requirement	Full	This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy.	
E. The Contractor shall report all overpayments identified as prescribed by the Department;	New Requirement	Full	This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy.	
F. The Contractor shall report the collection of provider overpayments and the prepayment cost avoidance in relation to the quarterly total of Monthly Benefit Payments;	New Requirement	Full	This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy.	
G. The Contractor shall report the escrow of provider payments in adherence to state requirements;	New Requirement	Full	This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy.	
H. The Contractor shall report site visits conducted in adherence to state requirements; and	New Requirement	Full	This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy.	
I. The Contractor is required to report the following data elements to the Department and the OIG on a quarterly basis, in an excel format:	Deemed for 2017	Full	This requirement is addressed in the C13-SIU-FWA-001-KY – Kentucky – Fraud Waste and Abuse Policy.	
(1) PIU Case number;	Deemed for 2017	Full	The MCO provided reports #76 and #77, which included this data element.	

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: WellCare of Kentucky

Final Findings

Program Integrity *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
(2) Provider /Member name;	Deemed for 2017	Full	The MCO provided reports #76 and #77, which included this data element.	
(3) Provider Medicaid ID /Member Medicaid number;	Deemed for 2017	Full	The MCO provided reports #76 and #77, which included this data element.	
(4) Date complaint received by Contractor;	Deemed for 2017	Full	The MCO provided reports #76 and #77, which included this data element.	
(5) Provider NPI (if nonmember case);	New Requirement	Full	The MCO provided reports #76, which included this data element.	
(6) Source of complaint	Deemed for 2017	Full	The MCO provided reports #76 and #77, which included this data element.	
(7) OIG Case Number	New Requirement	Full	The MCO provided reports #76, which included this data element.	
(8) Date complaint or referral received	New Requirement	Non-Compliance	The MCO provided reports #76 and #77, which did not include this data element. Final Review Determination No change in determination. After review with DMS and a review of the WellCare reports, we did not find this field in the monthly report.	WellCare respectfully requests that IPRO reevaluate the score of "non-compliant" for this requirement. WellCare appreciates IPRO's recommendation to update its reporting templates but would like to note that DMS sets for the format and specifications for all of our regulatory reports. The templates given to MCOs by DMS for this reporting requirement does not contain all of the specified elements therefore MCO's should not be assessed an adverse finding. WellCare received an updated template for Report #76 on 10/19/17 with instructions to submit the first report on January 30th 2018 (email from Department attached).

Final Findings

Program Integrity *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
				FW KY - TIPS report Reporting of Full Tir Since that time, WellCare has been producing the report in accordance to this guidance. The template does not contain all the elements referenced within Appendix N. The updated Report #76 template was supplied to IPRO during the onsite review and is also attached herein. WellCare believes that IRPO's initial finding should be reconsidered based on the documentation and evidence provided during the on-site review. Report 76 Revised 10-19-17.docx
(9) Date opened	Deemed for 2017	Full	The MCO provided reports #76 and #77, which included this data element.	
(10) MAT related (Y or N);	New Requirement	Non-Compliance	The MCO provided reports #76 and #77, which did not include this data element. Final Review Determination No change in determination. After review with DMS and a review of the WellCare reports, we did not find this field in the	WellCare respectfully requests that IPRO reevaluate the score of "non-compliant" for this requirement. WellCare appreciates IPRO's recommendation to update its reporting templates but would like to note that DMS sets for the format and specifications for all of our regulatory

Program Integrity *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			monthly report.	reports. The templates given to MCOs by DMS for this reporting requirement does not contain all of the specified elements therefore MCO's should not be assessed an adverse finding. WellCare received an updated template for Report #76 on 10/19/17 with instructions to submit the first report on January 30th 2018 (email from Department attached). FW KY - TIPS report Reporting of Full Tir Since that time, WellCare has been producing the report in accordance to this guidance. The template does not contain all the elements referenced within Appendix N. The updated Report #76 template was supplied to IPRO during the onsite review and is also attached herein. WellCare believes that IRPO's initial finding should be reconsidered based on the documentation and evidence provided during the on-site review. Report 76 Revised 10-19-17.docx

Final Findings

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
(11) Summary of complaint with timeframe reviewed;	New Requirement	Full	The MCO provided reports #76 and #77, which included this data element.	
(12) Initial investigation (Y or N);	New Requirement	Non-Compliance	The MCO provided reports #76 and #77, which did not include this data element. Final Review Determination No change in determination. After review with DMS and a review of the WellCare reports, we did not find this field in the monthly report.	WellCare respectfully requests that IPRO reevaluate the score of "non-compliant" for this requirement. WellCare appreciates IPRO's recommendation to update its reporting templates but would like to note that DMS sets forth the format and specifications for all of our regulatory reports. The templates given to MCOs by DMS for this reporting requirement does not contain all of the specified elements therefore MCO's should not be assessed an adverse finding. WellCare received an updated template for Report #76 on 10/19/17 with instructions to submit the first report on January 30th 2018 (email from Department attached). FW KY - TIPS report Reporting of Full Tir Since that time, WellCare has been producing the report in accordance to this guidance. The template does not contain all the elements referenced within Appendix N. The updated Report #76 template was supplied to IPRO during the onsite review and is also attached herein. WellCare believes that IRPO's initial finding should be

Final Findings

Program Integrity *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
				reconsidered based on the documentation and evidence provided during the on-site review. Report 76 Revised 10-19-17.docx
(13) Actions taken;	New Requirement	Full	The MCO provided reports #76 and #77, which included this data element.	
(14) Referred to DMS (with appropriate code);	New Requirement	Non-Compliance	The MCO provided reports #76 and #77, which did not include this data element. Final Review Determination No change in determination. After review with DMS and a review of the WellCare reports, we did not find this field in the monthly report.	WellCare respectfully requests that IPRO reevaluate the score of "non-compliant" for this requirement. WellCare appreciates IPRO's recommendation to update its reporting templates but would like to note that DMS sets for the format and specifications for all of our regulatory reports. The templates given to MCOs by DMS for this reporting requirement does not contain all of the specified elements therefore MCO's should not be assessed an adverse finding. WellCare received an updated template for Report #76 on 10/19/17 with instructions to submit the first report on January 30th 2018 (email from Department attached). FW KY - TIPS report Reporting of Full Tir

Final Findings

Program Integrity *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
				Since that time, WellCare has been producing the report in accordance to this guidance. The template does not contain all the elements referenced within Appendix N. The updated Report #76 template was supplied to IPRO during the onsite review and is also attached herein. WellCare believes that IRPO's initial finding should be reconsidered based on the documentation and evidence provided during the on-site review. Report 76 Revised 10-19-17.docx
(15) Date referred to DMS (if applicable)	New Requirement	Non-Compliance	The MCO provided reports #76 and #77, which did not include this data element. Final Review Determination No change in determination. After review with DMS and a review of the WellCare reports, we did not find this field in the monthly report.	WellCare respectfully requests that IPRO reevaluate the score of "non-compliant" for this requirement. WellCare appreciates IPRO's recommendation to update its reporting templates but would like to note that DMS sets for the format and specifications for all of our regulatory reports. The templates given to MCOs by DMS for this reporting requirement does not contain all of the specified elements therefore MCO's should not be assessed an adverse finding. WellCare received an updated template for Report #76 on 10/19/17 with instructions to

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
				submit the first report on January 30th 2018 (email from Department attached). FW KY - TIPS report Reporting of Full Tir Since that time, WellCare has been producing the report in accordance to this guidance. The template does not contain all the elements referenced within Appendix N. The updated Report #76 template was supplied to IPRO during the onsite review and is also attached herein. WellCare believes that IRPO's initial finding should be reconsidered based on the documentation and evidence provided during the on-site review. Report 76 Revised 10-19-17.docx
(16) Provider on prepayment (Y or N);	New Requirement	Non-Compliance	The MCO provided reports #76 and #77, which did not include this data element. Final Review Determination No change in determination. After review with DMS and a review of the WellCare reports, we did not find this field in the monthly report.	WellCare respectfully requests that IPRO reevaluate the score of "non-compliant" for this requirement. WellCare appreciates IPRO's recommendation to update its reporting templates but would like to note that DMS sets for the format and specifications for all of our regulatory reports. The templates given to MCOs by

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
				DMS for this reporting requirement does not contain all of the specified elements therefore MCO's should not be assessed an adverse finding. WellCare received an updated template for Report #76 on 10/19/17 with instructions to submit the first report on January 30th 2018 (email from Department attached). FW KY - TIPS report Reporting of Full Tir Since that time, WellCare has been producing the report in accordance to this guidance. The template does not contain all the elements referenced within Appendix N. The updated Report #76 template was supplied to IPRO during the onsite review and is also attached herein. WellCare believes that IRPO's initial finding should be reconsidered based on the documentation and evidence provided during the on-site review. Report 76 Revised 10-19-17.docx
(17) Overpayment identified, and	New Requirement	Full	The MCO provided reports #76 and #77,	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			which included this data element.	
(18) Date case closed (if applicable).	New Requirement	Full	The MCO provided reports #76 and #77, which included this data element.	
AVAILABILITY AND ACCESS TO DATA: The Contractor shall:				
A. Gather, produce, and maintain records including, but not limited to, ownership disclosure for all Providers and subcontractors, submissions, applications, evaluations, qualifications, member information, enrollment lists, grievances, Encounter data, desk reviews, investigations, investigative supporting documentation, finding letters and subcontracts for a period of 5 years after contract end date;	Full - This requirement is addressed in the Policy on Fraud, Waste and Abuse Procedures-Kentucky (C13SIU-FWA-001-KY) on page 1.			
B. Regularly report enrollment, Provider and Encounter data in a format that is useable by the Department the OIG and any other agent or contractor of the Department;	Deemed for 2017			
C. Backup, store or be able to recreate reported data upon demand for the Department the OIG and any other agent or contractor of the Department;	Deemed for 2017			
D. Permit reviews, investigations or audits of all books, records or other data, at the discretion of the Department the OIG any other agent or contractor of the Department, 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;	Deemed for 2017			
E. Produce records in electronic format for review	Deemed for 2017			

Final Findings

Program Integrity *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
and manipulation by the Department the OIG and any other agent or contractor of the Department;				
F. Allow designated Department staff, the OIG, and any other agent or contractor of the Department read access to ALL data in the Contractor's MIS systems;	Deemed for 2017			
G. Provide the Contractor's PIU access to any and all records and other data of the Contractor for purposes of carrying out the functions and responsibilities specified in this Contract;	Deemed for 2017			
H. Fully cooperate with the Department, the OIG any other agent or contractor of the Department, the United States Attorney's Office and other law enforcement agencies in the investigation or Fraud or Abuse cases; and	Deemed for 2017			
I. Provide identity and cover documents and information for law enforcement investigators under cover.	Deemed for 2017			

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: WellCare of Kentucky

Program Integrity

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	67	1	0	6
Total Points	201	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		**2.74**		

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

Reviewer Decision:

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

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

Final Findings

Program Integrity

Suggested Evidence

Documents

Policies/Procedures for:

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

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

Reports

Evidence of PIU preventive actions and ongoing monitoring of MIS data
SUR Algorithms (MCO Report #75)
Quarterly Program Integrity Reports (MCO Reports #76 and 77)
Provider Outstanding Account Receivables (MCO Report #71)
Explanation of Member Benefits (MCO Report #73)

File Review

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

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: WellCare of Kentucky

Final Findings

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

State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
33.1 EPSDT Early and Periodic Screening, Diagnosis and Treatment				
The Contractor shall provide all Members under the age of twenty-one (21) years except those eligible pursuant to 907 KAR 4:030, 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 M. The Contractor shall comply with 907 KAR 1:034 that delineates the requirements of all EPSDT providers participating in the Medicaid program.	Deemed for 2017		Includes review of MCO Report #93 EPSDT CMS-416 and MCO Report #24.	
Health care professionals who meet the standards established in the above-referenced regulation shall provide EPSDT services. Additionally, the Contractor shall:	Deemed for 2017			
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.	Deemed for 2017			
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.	Deemed for 2017			
Members and their families shall be informed about EPSDT and	Deemed for 2017		Includes file review results for EPSDT	

Final Findings

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
the 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.			utilization management (UM) files and EPSDT appeal files.	
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 M.	Deemed for 2017			
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.	Deemed for 2017			
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 treatment, and/or Out-of-Network Providers shall provide treatment if the service is not available with the Contractor's Network.	Deemed for 2017			
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 M.	Deemed for 2017			
G. Establish and maintain a tracking system to monitor acceptance and refusal of EPSDT services, whether eligible	Deemed for 2017			

Final Findings

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Members are receiving the recommended health assessments and all necessary diagnosis and treatment, including EPSDT Special Services when needed.				
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.	Deemed for 2017			
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.	Deemed for 2017			
J. Establish and maintain a protocol for coordination of physical health services and Behavioral Health Services for eligible members with behavioral health or developmentally disabling conditions.	Deemed for 2017			
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	Deemed for 2017			

Final Findings

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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.	Deemed for 2017			
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.	Deemed for 2017			
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.	Deemed for 2017			
N. Provide an EPSDT Coordinator staff function with adequate staff or subcontract personnel to serve the Contractor's enrollment or projected enrollment.	Deemed for 2017			
9.2 Administration/Staffing				
I. The Contractor shall provide the functions and positions that shall be staffed by a sufficient number of qualified individuals to adequately provide for the Contractor's enrollment or projected enrollment.	New Requirement	Full	This requirement is addressed by in Quality Improvement Specialist Job Description and in CM to Member Ratio.	

Final Findings

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
An Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Coordinator, who shall coordinate and arrange for the provision of EPSDT services and EPSDT special services for Members.				
23.1 Required Functions				
N. 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;	Deemed for 2017			
38.9 EPSDT Reports				
The Contractor shall submit Encounter Files to the Department's Fiscal Agent for each Member who receives EPSDT Services. This Encounter File 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.	Full - Evidence in support of the requirement for utilization reporting was found in the MCO Report #93 EPSDT CMS-416. On-site documentation supported use of specified EPSDT procedure codes.		Includes review of MCO Report #93 EPSDT CMS-416.	

Final Findings

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Scoring Grid:

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

Overall Compliance Determination:

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

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

Reviewer Decision:

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

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

Final Findings
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

Reports

EPSDT CMS-416 report (MCO Report #93)
Quarterly reports of EPSDT activities, utilization and services (MCO Report #24)

File Review

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

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: WellCare of Kentucky

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.230)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
4.3 Delegations of Authority				
The Contractor shall oversee and remain accountable for any functions and responsibilities that it delegates to any Subcontractor. In addition to the provision set forth in the Subcontracts section, Contractor agrees to the following provisions.				
A. There shall be a written agreement that specifies			Includes review results for each subcontractor.	
1. Delegated activities and reporting responsibilities of the Subcontractor	Deemed for 2017		Includes review results for each subcontractor.	
2. Subcontractor agrees to comply with all applicable Medicaid laws and regulations including applicable sub-regulatory guidance and contract provisions;	New Requirement	Full	Includes review results for each subcontractor. This requirement is addressed in the C13-AO-023 - Delegation Oversight Policy. Nine (9) of nine (9) contracts reviewed contain the required language.	
3. The right of the state, CMS, HHS Inspector General, the Comptroller General or their designee to audit, evaluate and inspect any books, records, contracts, computer or other electronic systems of the Subcontractor, or of the Subcontractor's contractor, that pertain to any aspect of services and activities performed, determination of amounts payable under the MCO's contract with the State, or for reasonable possibility of fraud or similar risk;	New Requirement	Full	Includes review results for each subcontractor. This requirement is addressed in the C13-AO-023 - Delegation Oversight Policy. Nine (9) of nine (9) contracts reviewed contain the required language.	

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
4. Subcontractor will make its premises, physical facilities, equipment, books records, contracts, computer or other electronic systems relating to its Medicaid enrollees available;	New Requirement	Full	Includes review results for each subcontractor. This requirement is addressed in the C13-AO-023 - Delegation Oversight Policy. Nine (9) of nine (9) contracts reviewed contain the required language.	
5. The right to audit through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later; and	New Requirement	Full	Includes review results for each subcontractor. This requirement is addressed in the C13-AO-023 - Delegation Oversight Policy. Nine (9) of nine (9) contracts reviewed contain the required language.	
6. provides for revocation of the delegation or imposition of other sanctions if the Subcontractor's performance is inadequate	Deemed for 2017		Includes review results for each subcontractor.	
B. Before any delegation, the Contractor shall evaluate the prospective Subcontractor's ability to perform the activities to be delegated.	Deemed for 2017		Includes review results for each subcontractor.	
C. The Contractor shall monitor the Subcontractor's performance on an ongoing basis and subject the Subcontractor to a formal review at least once a year.	Deemed for 2017		Includes review results for each subcontractor.	
D. If the Contractor identifies deficiencies or areas for improvement, the Contractor and the Subcontractor shall take corrective action.	Deemed for 2017		Includes review results for each subcontractor.	
E. If the Contractor delegates selection of providers to another entity, the Contractor retains the right to approve, suspend, or terminate any provider selected	Deemed for 2017		Includes review results for each subcontractor.	

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
by that Subcontractor.				
F. The Contractor shall assure that the Subcontractor is in compliance with all Medicaid laws and regulations including applicable subregulatory guidance and contract provisions.	Deemed for 2017			
6.1 Subcontractor Indemnity				
Except as otherwise provided in this Contract, all Subcontracts between the Contractor and its Subcontractors for the provision of Covered Services, shall contain an agreement by the Subcontractor to indemnify, defend and hold harmless the Commonwealth, its officers, agents, and employees, and each and every Member from any liability whatsoever arising in connection with this Contract for the payment of any debt of or the fulfillment of any obligation of the Subcontractor.	Full - This requirement is addressed in the Delegation Oversight Policy, Addendum D. Kentucky, page 30. During the onsite, the MCO provided the subcontractor template that met this requirement in 2016.		Includes review results for each subcontractor.	
Each such Subcontractor shall further covenant and agree that in the event of a breach of the Subcontract by the Contractor, termination of the Subcontract, or insolvency of the Contractor, each Subcontractor shall provide all services and fulfill all of its obligations pursuant to the Subcontract for the remainder of any month for which the Department has made payments to the Contractor, and shall fulfill all of its obligations respecting the transfer of Members to other Providers, including record maintenance, access and reporting requirements all such covenants, agreements, and obligations of which shall survive the termination of this Contract and any Subcontract.	Full - This requirement is addressed in the Delegation Oversight Policy, Addendum D. Kentucky on page 30. During the onsite, the MCO provided the subcontractor template that met this requirement in 2016.		Includes review results for each subcontractor.	
6.2 Requirements				

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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 with a Member, except the Contractor shall not enter into any Subcontract with Subcontractors outside the United States. Such Subcontractors must be eligible for participation in the Medicaid program as applicable. Each such Subcontract and any amendment to such Subcontract shall be in writing, and in form and content approved by the Department. The Contractor shall submit for review to the Department a template of each type of such Subcontract referenced herein. The Department may approve, approve with modification, or reject the templates if they do not satisfy the requirements of this Contract. In determining whether the Department will impose conditions or limitations on its approval of a Subcontract, the Department may consider such factors as it deems appropriate to protect the Commonwealth and Members, including but not limited to, the proposed Subcontractor's past performance. In the event the Department has not approved a Subcontract referenced herein prior to its scheduled effective date, Contractor agrees to execute said Subcontract contingent upon receiving the Department's approval. No Subcontract shall in any way relieve the Contractor of any responsibility for the performance of its duties pursuant to this Contract. The Contractor shall notify the Department in writing of the status of all Subcontractors on a quarterly basis and of the termination of any approved Subcontractors within ten (10) days following termination.	Deemed for 2017			

Final Findings

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

(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.230)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
The Department's subcontract review shall assure that all Subcontracts:				
A. Identify the population covered by the Subcontract;	Deemed for 2017		Includes review results for each subcontractor.	
B. Specify the amount, duration and scope of services to be provided by the Subcontractor;	Deemed for 2017		Includes review results for each subcontractor.	
C. Specify procedures and criteria for extension, renegotiation, and termination;	Full - This requirement is addressed in the Delegation Oversight Policy, Addendum D. Kentucky on page 29. During the onsite, the MCO provided the subcontractor template that met this requirement in 2016.		Includes review results for each subcontractor.	
D. Specify that Subcontractors use only Medicaid enrolled providers in accordance with this Contract;	Deemed for 2017		Includes review results for each subcontractor.	
E. Make full disclosure of the method of compensation or other consideration to be received from the Contractor;	Deemed for 2017		Includes review results for each subcontractor.	
F. Provide for monitoring by the Contractor of the quality of services rendered to Members in accordance with the terms of this Contract;	Deemed for 2017		Includes review results for each subcontractor.	
G. Contain no provision that provides incentives, monetary or otherwise, for the withholding from Members of Medically Necessary Covered Services;	Deemed for 2017		Includes review results for each subcontractor.	
H. Contain a prohibition on assignment, or on any further subcontracting, without the prior written consent of the Department;	Deemed for 2017		Includes review results for each subcontractor.	

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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;	Deemed for 2017		Includes review results for each subcontractor.	
J. Specify that Subcontractor where applicable, agrees to submit Encounter Records in the format specified by the Department so that the Contractor can meet the specifications required by this Contract;	Deemed for 2017		Includes review results for each subcontractor.	
K. Incorporate all provisions of this Contract to the fullest extent applicable to the service or activity delegated pursuant to the Subcontract, including, without limitation,	Deemed for 2017		Includes review results for each subcontractor.	
(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,	Deemed for 2017		Includes review results for each subcontractor.	
(2) all QAPI requirements,	Deemed for 2017		Includes review results for each subcontractor.	
(3) all record keeping and reporting requirements,	Deemed for 2017		Includes review results for each subcontractor.	
(4) all obligations to maintain the confidentiality of information,	Deemed for 2017		Includes review results for each subcontractor.	
(5) all rights of Finance, the Department, the Office of the Inspector General, the Attorney General, Auditor of Public Accounts and other authorized federal and Commonwealth agents to inspect, investigate, monitor	Deemed for 2017		Includes review results for each subcontractor.	

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
and audit operations,				
(6) all indemnification and insurance requirements, and	Full - This requirement is addressed in the Delegation Oversight Policy, Addendum D. Kentucky on page 30. During the onsite, the MCO provided the subcontractor template that met this requirement in 2016.		Includes review results for each subcontractor.	
(7) all obligations upon termination;	Full - This requirement is addressed in the Delegation Oversight Policy, Addendum D. Kentucky on page 30. During the onsite, the MCO provided the subcontractor template that met this requirement in 2016.		Includes review results for each subcontractor.	
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;	Deemed for 2017		Includes review results for each subcontractor.	
M. A Subcontractor with NCQA/URAC or other national accreditation shall provide the Contractor with a copy of its' current certificate of accreditation together with a copy of the survey report.	Deemed for 2017		Includes review results for each subcontractor.	
N. Provide a process for the Subcontractor to identify deficiencies or areas of improvement, and any necessary corrective action.	Deemed for 2017		Includes review results for each subcontractor.	

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
O. The remedies up to, and including, revocation of the Subcontract available to the Contractor if the Subcontractor does not fulfill its obligations.	Deemed for 2017		Includes review results for each subcontractor.	
P. Contain provisions that suspected fraud and abuse be reported to the contractor.	Deemed for 2017		Includes review results for each subcontractor.	
The requirements would be applicable to Subcontractors characterized as Risk contracts. The requirements of this section shall not apply to Subcontracts for administrative services or other vendor contracts that do not provide Covered Services to Members.	Deemed for 2017			
6.3 Disclosure of Subcontractors				
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 $25,000 or five percent (5%) of the Subcontractor's operating expense.	Deemed for 2017			

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

Scoring Grid:

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

Overall Compliance Determination:

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

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

Reviewer Decision:

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

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

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

Documents

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

Reports

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

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: WellCare of Kentucky

Final Findings

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

State Contract Requirements (Federal Regulations 438.242)	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
16.1 Encounter Data Submission				
The Contractor shall have a computer and data processing system sufficient to accurately produce the data, reports and Encounter Files set in formats and timelines prescribed by the Department as defined in the Contract.	Full - The item is addressed in addressed in the Encounters Policy on page 3. The encounter data submission and timeline is discussed in "KY 837 Process Steps" document. Additionally, page 2 of the Encounter Policy C7ENC-001 Stated "The Company shall comply with applicable encounter reporting requirements (regulatory and contractual)."			
The system shall be capable of following or tracing an Encounter within its system using a unique Encounter identification number for each Encounter.	Full- The item is addressed on page 4 of the Kentucky Submissions Policy (C7ENC-001-PR-015). References to using claim numbers to help update rejected encounters claim status from state given 837 response files shows compliance with the listed regulation.			
At a minimum, the Contractor shall be required to electronically provide Encounter Files to the Department, on a weekly schedule.	Full- This item is addressed in the "KY 837 Process Steps" on page 13. Files can be submitted to the state at any time but the preferred window is Sunday through			

Final Findings

Quality Assessment and Performance Improvement: Health Information Systems (HIS) (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.242)	**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**
	Wednesday. The submissions schedule is provided on page 2 of the C7ENC-001-PR-015 Kentucky Submissions Policy.			
Encounter Files must follow the format, data elements and method of transmission specified by the Department.	Full- The item is addressed by the various claims processing documents listed in the policies and procedures folder in the zip file Kentucky Compliance Audit 2017 for various claims processing and edit checks. The method of transmission, which is an automated transfer of copied files to "KY FTP", is addressed briefly in the 'KY 837 Process Steps" on pages 13-14.			
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. Other edits and processing requirements shall be provided to the Contractor in writing no less than thirty (30) business days prior to implementation.				
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.	Full- The document "Kentucky Submission Procedure" addresses this regulation. The log from the MCO and the State Testing File support this			

Final Findings

Quality Assessment and Performance Improvement: Health Information Systems (HIS) (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.242)	**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**
	requirement.			
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- Two sample reports for erred encounters were provided to show proof of MCO's reporting and tracking of erred records. The document C7ENC-001-PR-015 Kentucky Submission Procedure addressed this item on page 4.			
The Contractor shall be required to use procedure codes, diagnosis codes and other codes used for reporting Encounters in accordance with guidelines defined by the Department in writing. The Contractor must also use appropriate NPI/Provider numbers for Encounters as directed by the Department.	Full- Task and procedure documents verifying claim edits and checks as well as the Encounter Data Submissions Report provide proof of the listed regulation.			
All Subcontracts with Providers or other vendors of service must have provisions requiring that an Encounter is reported/submitted in an accurate and timely fashion.	Full- This item is address in the Timely Filing policy on page 11.			
The Contractor shall specify to the Department the name of the primary contract person assigned responsibility for submitting and correcting Encounters, and a secondary contact person in the event the primary contract person is not available.	Full- MCO provided email showing the primary/secondary contact for encounter data submissions at the onsite audit.			
16.2 Technical Workgroup				

Final Findings

Quality Assessment and Performance Improvement: Health Information Systems (HIS) (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.242)	**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 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 submission.	Full- The health MCO sent an email from DMS verifying the MCO's participation in the Technical Workgroup.			
17.0 Kentucky Health Information Exchange (KHIE)				
The Contractor shall encourage all Providers in their Network to establish connectivity with the KHIE. For newly contracted providers, the Contractor shall notify the Provider within one month of the recommendation to sign a Participation Agreement with KHIE for the purpose of connecting their electronic health records system to the health information exchange to share their patient electronic records. The data set required for submission is a Summary of Care Record.	Full- The participating provider agreement document on page 32 shows the health MCO requires providers connect to KHIE "within one year of the effect date of its provider agreement or other schedule as determined by the Department." New Requirement	NA	This requirement is NA for 2018 since the KHIE was not available to providers during the review period. We have included the findings for informational purposes. This requirement is addressed in the sample provider agreement letter and the document titled, "An Introduction to the Kentucky Health Information Exchange"; these documents are included in the provider orientation packets.	
For hospitals, the Contractor shall also recommend the submission of ADTs (Admission, Discharge, Transfer messages) to KHIE.	New Requirement	NA	This requirement is NA for 2018 since the KHIE was not available to providers during the review period. We have included the findings for informational purposes. This requirement is addressed in the policy C6-ND-MD-001 Network Development – Medicaid Regulatory Requirements on pages 79-80. However, this policy and procedure document has seen multiple revisions since the audit time period end (revision dates in July 2018 and	

Final Findings

Quality Assessment and Performance Improvement: Health Information Systems (HIS) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.242)	**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**
			September 2018), so it is not clear if the updates regarding the new contract language were within the scope of the audit time frame, which would show compliance. **Recommendation for MCO** The MCO's provider materials (contract, letter, manual) should reflect the current contract language for hospitals to submit their admissions, discharge, transfer messages (ADTs).	
If the provider does not have an electronic health record the Contractor will encourage the Provider to sign a Participation Agreement with KHIE as well as sign up for Direct Secure Messaging services so that clinical information can be shared securely with other providers in their community of care.	New Requirement	NA	This requirement is NA for 2018 since the KHIE was not available to providers during the review period. We have included the findings for informational purposes. This requirement is partially addressed on page 34: "vii. Health Plan encourages Provider to establish connectivity with the Kentucky Health Information Exchange. [KY Medicaid Contract § 17]" of the sample provider agreement and on pages 79-80 in policy C6-ND-MD-001 Network Development – Medicaid Regulatory Requirements. However, the Network Development –Medicaid Regulatory Requirements policy and procedure document has seen multiple revisions since the audit time period end (revision dates in July 2018 and September 2018), so it is not clear if the updates regarding the new contract language were within the scope of the audit time frame, which would show compliance.	

Final Findings

Quality Assessment and Performance Improvement: Health Information Systems (HIS) (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.242)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Recommendation for MCO The MCO's provider materials (contract, letter, manual) should reflect the current contract language and this information should be shared with providers upon site visits.	
30.2 Prompt Payment of Claims				
In accordance with 42 CFR 447.46, the Contractor shall implement Claims payment procedures that ensure 90% of all Provider Claims, including I/T/Us, 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 - This item is addressed in the Prompt Pay policy on page 15. Prompt pay supplemental reports and Report60 samples provide proof of the MCO's regular monitoring and reporting of timely payments for claims received.			
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. The date of receipt is the date the MCO receives the claim, as indicated by its date stamp on the claim or other notation as appropriate to the medium used to file a claim and the date of payment is the date of the check or other form of payment.	Full- This item is addressed in the Prompt Pay policy on page 15. New Requirement	Full	This requirement is addressed in the Prompt Pay Policy on page 10.	
The Contractor shall notify the requesting provider of any decision to deny a Claim or to authorize a service in an amount, duration, or scope that is less than requested.	New Requirement	Full	This requirement is addressed on page 10 of the C6-CS-041 Medicaid Referral and Authorization Guidelines Policy.	

Final Findings

Quality Assessment and Performance Improvement: Health Information Systems

Scoring Grid:

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

Overall Compliance Determination:

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

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

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable	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

Final Findings

Quality Assessment and Performance Improvement: Health Information Systems

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

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: WellCare of Kentucky

Final Findings

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

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
amount beyond that required by children generally and who may be enrolled in a Children with Special Health Care Needs program operated by a local Title V funded Maternal and Child Health Program.				
CHIPRA means the Children's Health Insurance Program Reauthorization Act of 2009 which reauthorized the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act. It assures that a State is able to continue its existing program and expands insurance coverage to additional low-income, uninsured children.				
Comprehensive Assessment means the detailed assessment of the nature and cause of a person's specific conditions and needs as well as personal resources and abilities. This is generally performed by an individual or a team of specialists and may involve family, or other significant people. The assessment may be done in conjunction with care planning.				
35.2 Care Management System				
As part of the Care Management System, the 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.	Deemed for 2017			
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.	Deemed for 2017		Includes review of MCO Report #79 Health Risk Assessments (HRAs; see Quarterly Desk Audit results).	

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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.	Deemed for 2017			
Care coordination shall be linked to other Contractor systems, such as QI, Member Services and Grievances.	Deemed for 2017			
35.3 Care Coordination				
The care coordinators and case managers will work with the primary care providers as teams to provide appropriate services for Members.	Deemed for 2017			
Care coordination is a process to assure that the physical and behavioral health needs of Members are identified and services are facilitated and coordinated with all service providers, individual Members and family, if appropriate, and authorized by the Member.				
The Contractor shall identify the primary elements for care coordination and submit the plan to the Department for approval.	Deemed for 2017			
The Contractor shall identify a Member with special physical and behavioral health care needs and 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	Deemed for 2017			

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
with the Primary Care Provider's clinical treatment plan and medical diagnosis.				
The Contractor shall first complete a Care Coordination Assessment for these Members the elements of which shall comply with policies and procedures approved by the Department.	Full - Includes review results for Care Coordination and Complex Case Management files. Care Coordination files were deemed for this review period. This requirement is met in the 2016 Case Management Program Description (FKA: Integrated Care Management Program Description). Evidence in support of the requirement for elements of the Care Coordination Assessment to comply with policies and procedures approved by the Department was found in C7CM MD-1.2-PR-004 Case Management Medical Comprehensive Assessment and Planning - Addendum A. Complex Case Management File Review 10/10 reviewed Complex Case Management files included a comprehensive needs assessment and care plan, all		Includes review results for care coordination and complex case management files.	

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	with evidence of identification of physical and behavioral health needs and care coordination.			
The Care Plan shall be developed in accordance with 42 CFR 438.208.	Deemed for 2017		Includes review results for care coordination and complex case management files.	
The Contractor shall develop and implement policies and procedures to ensure access to care coordination for all DCBS clients. The Contractor shall track, analyze, report, and when indicated, develop corrective action plans on indicators that measure utilization, access, complaints and grievances, and services specific to the DCBS population.	Deemed for 2017			
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.	Deemed for 2017			
36.1 Individuals with Special Health Care Needs (ISHCN)				
ISHCN are persons who have or are at high risk for chronic physical, developmental, behavioral, neurological, or emotional condition and who may require a broad range of primary, specialized medical, behavioral health, and/or related services. ISCHN may have an increased need for healthcare or related services due to their respective conditions. The primary purpose of the definition is to identify these individuals so the Contractor can facilitate access to appropriate services.				
As per the requirement of 42 CFR 438.208, the Department has defined the following categories of	Deemed for 2017			

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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.	Deemed for 2017			
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.	Deemed for 2017			
The Contractor shall employ reasonable efforts to identify ISHCN's based on the following populations: A. Children in/or receiving Foster Care or adoption assistance; B. Blind/Disabled Children under age 19 and Related Populations eligible for SSI; C. Adults over the age of 65; D. Homeless (upon identification); E. Individuals with chronic physical health illnesses; F. Individuals with chronic behavioral health illnesses; G. Children receiving EPSDT Special Services.	Full - This requirement is addressed in the C7CM MD 4.8 ISHCN Policy on page 8.			
The Contractor shall develop and distribute to ISHCN Members, caregivers, parents and/or legal guardians, information and materials specific to the needs of the	Deemed for 2017			

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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.	Deemed for 2017			
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.	Deemed for 2017			
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.	Deemed for 2017			
36.2 DCBS and DAIL Protection and Permanency Clients				
Members who are adult guardianship clients or foster care children shall be identified as ISHCN. The Contractor shall attempt to obtain the service plan which will be completed by DCBS or DAIL. The service plan will used by DCBS and/or DAIL and the Contractor to determine the individual's medical needs and identify the need for placement in case management. The Contractor shall be responsible for the ongoing care coordination of these members whether or not enrolled in case management to ensure access to needed social, community, medical and behavioral health services. A monthly report of Foster Care and Adult Guardianship Cases shall be sent	Full - Includes review results for DCBS Service Plan and DCBS Claims/Case Management files This requirement is addressed in the DCBS_DAIL Service Plan step action document, and the DCBS Service Plans files. This requirement is also addressed in the MCO Policy C7CM MD-1.2 Case Management		Includes review results for DCBS service plan and DCBS claims/case management files	

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
to Department thirty (30) days after the end of each month.	Program Description – Addendum D - DCBS and DAIL Protection and Permanency Clients, Adult Guardianship Clients and Children in Foster Care on pages 30-31. DCBS Service Plan and DCBS Claims/Case Management file review The requirements for (1) ongoing care coordination and (2) referral to case management were met for 10 of 10 files.			
36.3 Adult Guardianship Clients				
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 determine what level of case management is needed.	Deemed for 2017			
36.4 Children in Foster Care				
No less than quarterly, Contractor's staff shall meet with DCBS staff to identify, discuss and resolve any health care issues and needs of the Contractor's Foster Care membership. 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	Full - This requirement is addressed in the C7CM MD 1.2 PR 017 Behavioral Health Comprehensive Assessment and Planning DCBS.			

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Network.				
If DCBS service plan identifies the need for case management or DCBS staff requests case management for a Member, the Contractor's staff will work with the foster parent and/or DCBS staff to develop a case management plan.	Full - Includes review results for DCBS Service Plan files This requirement is addressed in the C7CM MD 1.2 PR 017 Behavioral Health Comprehensive Assessment and Planning DCBS. DCBS Service Plan and DCBS Claims/Case Management file review 10 of 10 files also met the requirements for coordination with DCBS staff regarding development of the care plan. 10 of 10 files included documentation of EPSDT services/physician well child visits provided.		Includes review results for DCBS service plan files.	
The Contractor's staff will consult with DCBS staff before the development of a new case management care plan (on a newly identified health care issue) or modification of an existing case management care plan.	Full - Includes review results for DCBS Service Plan files This requirement is addressed in the C7CM MD 1.2 PR 017 Behavioral Health Comprehensive Assessment and Planning DCBS. DCBS Service Plan and DCBS		Includes review results for DCBS service plan files.	

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Claims/Case Management file review 10 of 10 files also met the requirements for consultation with DCBS staff regarding modification of the care plan.			
The designated Contractor staff will sign each service plan made available by DCBS 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 Department representative.	Full - This requirement is addressed in the C7CM MD 1.2 PR 017 Behavioral Health Comprehensive Assessment and Planning DCBS.			
The Contractor shall notify the Department and DCBS no later than three (3) business days prior to the decertification of a foster child for services at a hospital or other residential facility located in Kentucky and no later than seven (7) business days prior to the decertification of a foster child for services at a hospital or other residential facility located out of state. Written documentation of an upcoming medical necessity review does not qualify as a decertification notification. The Department shall provide the Contractor with the office or division, the individual(s) and the contact information for such notification and provide updated contact information as necessary.	New Requirement	Full	This requirement is addressed in FCAG DCBS Notification Process 2018 Main Version and in WellCare of Kentucky DCBS Notification of Decertification Email.	
The decertification notification shall include: A. the Member name, B. Member ID,	New Requirement	Full	This requirement is addressed in FCAG DCBS Notification Process 2018 Main Version and in WellCare of Kentucky DCBS	

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
C. facility name, D. level of care, E. discharge plan and F. date of next follow-up appointment.			Notification of Decertification Email.	
If the Contractor fails to notify the Department and DCBS at least three (3) business days or seven (7) business days, as applicable, prior to the decertification and the foster child remains in the facility because arrangements for placement cannot be made, the Contractor shall be responsible for the time the foster child remains in the facility prior to notification and up to three (3) business days or seven (7) business days, as applicable, after notification.	New Requirement	Full	This requirement is addressed in Discharge Planning Procedure on page 5.	
The Contractor shall require in its contracts with Providers that the Provider provides basic, targeted or intensive case management services as medically necessary to foster children who are discharged from a hospital or other residential facility. The Contractor, case manager and Provider shall participate in appropriate discharge planning, focused on ensuring that the needed supports and services to meet the Member's behavioral and physical health needs will be provided outside of the hospital or other residential facility.	New Requirement	Full	This requirement is addressed in Discharge Planning Procedure on pages 4–5.	
33. 9 Pediatric Sexual Abuse Examination				
Contractor shall have Providers in its network that have the capacity to perform a forensic pediatric sexual abuse examination. This examination must be conducted for Members at the request of the DCBS.	Full - This requirement is addressed in the policy C6ND MD 001 PedAbuseExam on page 50.			
33.8 Pediatric Interface				

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
School-Based Services provided by school personnel are excluded from Contractor coverage and are paid by the Department through fee-for-service Medicaid.				
Preventive and remedial services as contained in 907 KAR 1:360 and the Kentucky State Medicaid Plan provided by the Department of Public Health through public health departments in schools by a Physician, Physician's Assistant, Advanced Registered Nurse Practitioner, Registered Nurse, or other appropriately supervised health care professional are included in Contractor coverage. Service provided under a child's IEP should not be duplicated. However, in situations where a child's course of treatment is interrupted due to school breaks, after school hours or during summer months, the Contractor is responsible for providing all Medically Necessary Covered Services to eligible Members.	Deemed for 2017			
Services provided under HANDS shall be excluded from Contractor coverage.				
Pediatric Interface Services includes pediatric concurrent care as mandated by the ACA. The Contractor shall simultaneously provide palliative hospice services in conjunction with curative services and medications for pediatric patients diagnosed with life-threatening/terminal illnesses.	Deemed for 2017			
38.11 DCBS and DAIL Service Plans Reporting				
Thirty (30) days after the end of each quarter, the Contractor shall submit a quarterly report detailing the number of service plan reviews conducted for Guardianship, Foster and Adoption assistance Members	Deemed for 2017		Includes review of MCO Reports #65 Foster Care and #66 Guardianship (see Quarterly Desk Audit results).	

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
outcome decisions, such as referral to case management, and rationale for decisions.				

Case Management/Care Coordination

Scoring Grid:

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

Overall Compliance Determination:

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

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

Reviewer Decision:

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

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

Final Findings
Case Management/Care Coordination
Suggested Evidence

Documents

Policies/Procedures for:

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

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

Reports

Reports of service plan reviews conducted for DCBS and DAIL clients (MCO Reports #65 and 66)
HRAs (MCO Report #79)

File Review

Care Coordination and Complex Case Management files for a random sample of cases selected by EQRO
DCBS Service Plans and DCBS Claims/Case Management files for a random sample of cases selected by EQRO

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: WellCare of Kentucky

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
23.7 Member Rights and Responsibilities				
The Contractor shall have written policies and procedures that are designed to protect the rights of Members and enumerate the responsibilities of each Member. A written description of the rights and responsibilities of Members shall be included in the Member information materials provided to new Members.	Deemed for 2017			
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.	Deemed for 2017			
The Contractor's written policies and procedures that are designed to protect the rights of Members shall include, without limitation, the right to:				
A. Respect, dignity, privacy, confidentiality and nondiscrimination;	Deemed for 2017			
B. A reasonable opportunity to choose a PCP and to change to another Provider in a reasonable manner;	Deemed for 2017			
C. Consent for or refusal of treatment and active participation in decision choices;	Deemed for 2017			
D. Ask questions and receive complete information relating to the Member's medical condition and treatment options, including specialty care;	Deemed for 2017			
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;	Deemed for 2017			
F. Timely access to care that does not have any	Deemed for 2017			

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
communication or physical access barriers;				
G. Prepare Advance Medical Directives pursuant to KRS 311.621 to KRS 311.643;	Deemed for 2017			
H. Assistance with Medical Records in accordance with applicable federal and state laws;	Deemed for 2017			
I. Timely referral and access to medically indicated specialty care; and	Deemed for 2017			
J. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.	Deemed for 2017			
K. Any Indian enrolled with the Contractor eligible to receive services from a participating I/T/U provider or a I/T/U primary care provider shall be allowed to receive services from that provider if part of Contractor's network.	Deemed for 2017			
The Contractor shall also have policies addressing the responsibility of each Member to:				
A. Become informed about Member rights:	Deemed for 2017			
B. Abide by the Contractor's and Department's policies and procedures;	Deemed for 2017			
C. Become informed about service and treatment options;	Deemed for 2017			
D. Actively participate in personal health and care decisions, practice healthy life styles;	Deemed for 2017			
E. Report suspected Fraud and Abuse; and	Deemed for 2017			
F. Keep appointments or call to cancel.	Deemed for 2017			
23.2 Member Handbook				

Final Findings

Enrollee Rights and Protection: Enrollee Rights *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The 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. With the exception of a new Member assigned to the Contractor, the Contractor is in compliance with this requirement if the Member's handbook is: A. Mailed within five (5) business days by a method that will not take more than three (3) days to reach the Member. B. Provided by email after obtaining the Member's agreement to receive the information by email; C. Posted on the Contractor's website and the Contractor advises the Member in paper or electronic form that the information is available on the internet and includes the internet address, provided that Member's with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or D. Provided by any other method that can reasonably be expected to result in the Member receiving that information.	New Requirement	Substantial	The majority of this requirement is addressed in the C6-MMO-022 Medicaid Post Enrollment Member Materials Policy. The requirement that the handbook is mailed in 5 days is addressed in the New Member Materials Policy. As discussed on site, currently the MCO does not email the handbook to members; it is not a method of delivery requested by members. Email addresses are not provided readily to the MCO unless the member volunteers that information. The handbook is publicly viewable to all members online on the MCO's Medicaid website, which is also referenced in the hardcopy of the handbook. For members who are deaf or blind, Braille, large print and audio options are available. Page 17 of the member handbook also directs members to the online site where they can find an online version of the handbook. **<u>Recommendation for MCO</u>** The MCO should communicate with members via the handbook that if they would like to receive an electronic copy of the handbook via email, they may do so as long as they provide a valid email address for outreach and consent to receiving the information by email.	WellCare appreciates IPROs recommendation and will make the updates to our handbook accordingly.
For any new Member assigned to the Contractor, the Contractor shall mail a hard copy of the Member Handbook within five (5) business days of notification of the assignment.	New Requirement	Full	This requirement is addressed in the Medicaid Post-Enrollment Member Materials Policy on page 5.	
If the information is provided electronically, it must be in a format that is readily accessible, is placed in a location on the website that is prominent and easily accessible,	New Requirement	Full	This requirement is addressed in the C6-MMO-022 Medicaid Post Enrollment Member Materials Policy on page 14.	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
can be electronically retained and printed, and that the information is available in paper form without charge upon request within five (5) business days.				
The Member Handbook shall be available in English, Spanish and each prevalent non-English language.	Deemed for 2017 New Requirement	Full	This requirement is addressed in the C6-MMO-022 Medicaid Post Enrollment Member Materials Policy on page 14.	
The Member Handbook shall be available in a hardcopy format as well as an electronic format online.	Deemed for 2017		Includes review of online member handbook to confirm posting of current handbook.	
The Contractor shall review the handbook at least annually and shall be updated as necessary to maintain accuracy, particularly with regard to the list of participating providers, covered services and any service not covered by the Contractor because of moral or religious objections. Contractor shall communicate any changes to Members in written form at least thirty (30) days before the intended effective date of the change. Revision dates shall be added to the Member Handbook so that it is evident which version is the most current. Changes shall be approved by the Department prior to printing. The Department has the authority to review the Contractor's Member Handbook at any time.	Deemed for 2017 New Requirement	Full	This requirement is addressed in the C6-MMO-022 Medicaid Post Enrollment Member Materials Policy on page 14.	
The handbook shall be written at the sixth grade reading comprehension level and shall include at a minimum the following information:	Deemed for 2017			
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;	Deemed for 2017			

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
B. How to access a list of network providers for covered services in paper form, upon request, or electronic form containing information required in 42 CFR 438.10(h);	New Requirement	Full	This requirement is addressed in the C6-MMO-022 Medicaid Post Enrollment Member Materials Policy on page 15 and the member handbook on page 15.	
C. Any restrictions on a Member's freedom of choice among network providers;	New Requirement	Full	This requirement is addressed in the C6-MMO-022 Medicaid Post Enrollment Member Materials Policy on page 15 and the member handbook on page 25 under the Services Covered Section.	
D. The procedures for selecting a PCP and scheduling an initial health appointment or requesting a change of PCP and specialists; reasons for which a request may be denied; and reasons a Provider may request a change;	New Requirement	Full	This requirement is addressed in the C6-MMO-022 Medicaid Post Enrollment Member Materials Policy on page 15 and the member handbook on pages 13–15.	
E. The availability of oral interpretation services for all languages, written translations in English, Spanish, and each prevalent non- English language as well as for the top 15 non-English languages as released by the U.S. Department of Health and Human Services, Office for Civil Rights, alternative formats, and other auxiliary aids and services as well as how to access those services;	New Requirement	Full	This requirement is addressed in the C6-MMO-022 Medicaid Post Enrollment Member Materials Policy on page 16 and the member handbook on page 17.	
F. 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;	Deemed for 2017			
G. 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;	Deemed for 2017			

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
H. Member rights and responsibilities including reporting suspected fraud and abuse;	Deemed for 2017			
I. Procedures for obtaining Emergency Care and non-emergency care after hours, what constitutes an emergency medical condition, the fact that a prior authorization is not required for emergency services and the right to use any hospital or other setting for emergency care. For a life-threatening situation, instruct Members to use the emergency medical services available or to activate emergency medical services by dialing 911;	Deemed for 2017 New Requirement	Full	This requirement is addressed in the C6-MMO-022 Medicaid Post Enrollment Member Materials Policy on pages 17–18 and the member handbook on pages 16 and 45.	
J. Procedures for obtaining transportation for both emergency and non-emergency situations;	Deemed for 2017			
K. Information on the availability of maternity, family planning and sexually transmitted disease services and methods of accessing those services;	Deemed for 2017			
L. Procedures for arranging EPSDT for persons under the age of 21 years;	Deemed for 2017			
M. Procedures for obtaining access to Long Term Care Services;	Deemed for 2017			
N. Procedures for notifying the Department for Community Based Services (DCBS) of family size changes, births, address changes, death notifications;	Deemed for 2017			
O. A list of direct access services that may be accessed without the authorization of a PCP;	Deemed for 2017			
P. Information about how to access care before a PCP is assigned or chosen;	Deemed for 2017			
Q. A Member's right to obtain second opinion in or	Deemed for 2017			

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
out of the Contractor's Provider network and information on obtaining second opinions related to surgical procedures, complex and/or chronic conditions;				
R. Procedures for obtaining Covered Services from non-network providers;	Deemed for 2017			
S. Procedures and timelines for filing a Grievance or Appeal. This shall include the title, address and telephone number of the person responsible for processing and resolving Grievances and Appeals, the availability of assistance in the filing process, the right of the Member to a State Fair Hearing and that benefits will continue while under appeal if MCO decision is to reduce or terminate services;	New Requirement	Full	This requirement is addressed in the C6-MMO-022 Medicaid Post Enrollment Member Materials Policy on page 16 and the member handbook on pages 78–84.	
T. Information about the Cabinet for Health and Family Services' independent ombudsman program for Members;	Deemed for 2017			
U. Information on the availability of, and procedures for obtaining behavioral health/substance abuse health services;	Deemed for 2017			
V. Information on the availability of health education services;	Deemed for 2017			
W. Any cost sharing imposed;	New Requirement	Full	This requirement is addressed in the C6-MMO-022 Medicaid Post Enrollment Member Materials Policy on page 18 and the member handbook on pages 76–77. Cost sharing is communicated in the handbook. There were two cost sharing items discussed on page 35 in the handbook of all the various services, description, and costs.	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
X. How to exercise an advance directive;	New Requirement	Full	This requirement is addressed in the member handbook on page 76.	
Y. Information deemed mandatory by the Department; and	Deemed for 2017			
Z. The availability of care coordination, case management and disease management provided by the Contractor.	Deemed for 2017			
31.3 Second Opinions				
At the Member's request, 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, or arrange for the Member to obtain a second opinion outside the network without cost to the Member. The Contractor shall inform the Member, in writing, at the time of Enrollment, of the Member's right to request a second opinion.	Deemed for 2017			
23.1 Required Functions				
The Contractor shall have a Member Services function that includes a call center which is staffed and available by telephone Monday through Friday 7 am to 7 pm Eastern Time (ET). The call center shall meet the current American Accreditation Health Care Commission/URAC-designed Health Call Center Standard (HCC) for call center abandonment rate, blockage rate and average speed of answer for all Contractor programs with the exception of behavioral health. If a Contractor has separate telephone lines for different Medicaid populations, the Contractor shall report performance for each individual line separately.	Deemed for 2017		Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results).	
The Contractor shall also provide access to medical	Deemed for 2017			

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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).				
The Contractor shall self-report their prior month performance in the three areas listed above, call center abandonment rate, blockage rate and average speed of answer, for their member services and twenty-four/seven (24/7) hour toll-free medical call-in system to the Department.	Deemed for 2017		Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results).	
Appropriate foreign language interpreters shall be provided by the Contractor and available free of charge and as necessary to ensure availability of effective communication regarding treatment, medical history, or health education. Member written materials shall be provided and English, Spanish, and each prevalent non-English language. Oral interpretation shall be provided for all non-English languages. 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.	Deemed for 2017 New Requirement	Full	This requirement is addressed in the Medicaid Interpreter Services Policy, as well as the member handbook on page 17.	
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	Deemed for 2017			

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
procedures applicable to health care facilities. The Contractor shall cooperate with the Cabinet for Health and Family Services' independent ombudsman program, including providing immediate access to a Member's records when written Member consent is provided.				
The Contractor's Member Services function shall also be responsible for:				
A. Ensuring that Members are informed of their rights and responsibilities;	Deemed for 2017			
B. Ensure each Member is free to exercise his or her rights without the Contractor or its Providers treating the Member adversely.	Deemed for 2017			
C. Guaranteeing each Member's right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand.	Deemed for 2017			
D. Monitoring the selection and assignment process of PCPs;	Deemed for 2017			
E. Identifying, investigating, and resolving Member Grievances about health care services;	Deemed for 2017			
F. Assisting Members with filing formal Appeals regarding plan determinations;	Deemed for 2017			
G. Providing each Member with an identification card that identifies the Member as a participant with the Contractor, unless otherwise approved by the Department;	Deemed for 2017			
H. Explaining rights and responsibilities to members or to those who are unclear about their rights or responsibilities including reporting of suspected	Deemed for 2017			

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
fraud and abuse;				
I. 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;	Deemed for 2017			
J. 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);	Deemed for 2017			
K. Explaining or answering any questions regarding the Member Handbook;	Deemed for 2017			
L. 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)	Deemed for 2017			

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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;				
M. Facilitating direct access to specialty physicians in the circumstances of: (1) Members with long-term, complex health conditions; (2) Aged, blind, deaf, or disabled persons; and (3) Members who have been identified as having special healthcare needs and who require a course of treatment or regular healthcare monitoring. This access can be achieved through referrals from the Primary Care Provider or by the specialty physician being permitted to serve as the Primary Care Provider.	Deemed for 2017			
N. 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;	Deemed for 2017			
O. 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;	Deemed for 2017			
P. Facilitating direct access to primary care vision services; primary dental and oral surgery services, and evaluations by orthodontists and prosthodontists; women's health specialists; voluntary family planning; maternity care for Members under age 18; childhood immunizations; sexually transmitted disease screening, evaluation	Deemed for 2017			

Final Findings

Enrollee Rights and Protection: Enrollee Rights *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
and treatment; tuberculosis screening, evaluation and treatment; and testing for HIV, HIV-related conditions and other communicable diseases.				
Q. Facilitating access to behavioral health services and pharmaceutical services;	Deemed for 2017			
R. 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;	Deemed for 2017			
S. 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;	Deemed for 2017			
T. Assisting members in obtaining transportation for both emergency and appropriate non-emergency situations;	Deemed for 2017			
U. 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;	Deemed for 2017			
V. Facilitating access to Member Health Education Programs;	Deemed for 2017			
W. Assisting members in completing the Health Risk Assessment (HRA) upon any telephone contact; and referring Members to the appropriate areas to	Deemed for 2017			

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
learn how to access the health education and prevention opportunities available to them including referral to case management or disease management; and				
X. The Member Services staff shall be responsible for making an annual report to management about any changes needed in member services functions to improve either the quality of care provided or the method of delivery. A copy of the report shall be provided to the Department.	Deemed for 2017			
31.4 Billing Members for Covered Services				
The Contractor and its Providers and Subcontractors shall not bill a Member for Medically Necessary Covered Services with the exception of applicable co-pays or other cost sharing requirements provided under this contract. Any Provider who knowingly and willfully bills a Member 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.	Deemed for 2017			
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.	Deemed for 2017			

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
24.0 Member Selection of Primary Care Provider (PCP)				
24.1 Members Not Required to have a PCP				
Dual Eligible Members, Members who are presumptively eligible, adults for whom the state is appointed guardian, disabled children, and foster care children are not required to have a PCP.	Deemed for 2017			
24.2 Member Choice of Primary Care Provider				
Members shall choose or have the Contractor select a PCP for their medical home.	Deemed for 2017			
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.	Deemed for 2017			
24.6 Primary Care Provider (PCP) Changes				
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.	Deemed for 2017			
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.	Deemed for 2017			
A Member shall have the right to change the PCP ninety (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	Deemed for 2017			

Final Findings

Enrollee Rights and Protection: Enrollee Rights
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
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 same Medicaid 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.	Deemed for 2017			
PCPs shall have the right to request a Member's Disenrollment from his/her practice and be reassigned to a new PCP in the following circumstances: incompatibility of the PCP/patient relationship Member has not utilized a service within one year of enrollment in the PCP's practice and the PCP has documented unsuccessful contact attempts by mail and phone on at least six (6) separate occasions during the year; or inability to meet the medical needs of the Member.	Deemed for 2017 New Requirement	Full	This requirement is addressed in the C6-6-CS-075 Provider Request to Transfer a Member Policy on page 5 and the provider manual on page 28.	
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	Deemed for 2017			

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
have authority to approve all transfers.				
The initial PCP must serve until the new PCP begins serving the Member, barring ethical or legal issues. The Member has the right to a grievance regarding such a transfer. The PCP shall make the change for request in writing. Member may request a PCP change in writing, face to face or via telephone.	Deemed for 2017			
31.5 Referrals for Services not Covered by Contractor				
When it is necessary for a Member to receive a Medicaid service that is outside the scope of the Covered Services provided by the Contractor, the Contractor shall refer the Member to a provider enrolled in the Medicaid fee-for-service program. The Contractor shall have written policies and procedures for the referral of Members for Non-Covered Services that shall provide for the transition to a qualified health care provider and, where necessary, assistance to Members in obtaining a new Primary Care Provider. The Contractor shall submit any desired changes to the established written referral policies and procedures to the Department for review and approval.	Deemed for 2017			

Enrollee Rights and Protection: Enrollee Rights

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	14	1	0	0
Total Points	42	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		**2.93**		

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

Reviewer Decision:

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

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

Final Findings

Enrollee Rights and Protection: Enrollee Rights

Suggested Evidence

Documents

Policies/Procedures for:

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

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

Reports

Census information on common ethnicities and languages other than English spoken by 5% or more of the enrolled population in a county
Annual Member Services Report
Call center metrics (MCO Report #11)

Final Findings

Enrollee Rights and Protection: Member Education and Outreach
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.206, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
23.3 Member Education and Outreach				
The Contractor shall develop, administer, implement, monitor and evaluate a Member and community education and outreach program that incorporates information on the benefits and services of the Contractor's Program to its Members. The Outreach Program shall encourage Members and community partners to use the information provided to best utilize services and benefits.	Deemed for 2017			
Creative methods should be used to reach Contractor's Members and community partners. These will include but not be limited to collaborations with schools, homeless centers, youth service centers, family resource centers, public health departments, school-based health clinics, chamber of commerce, faith-based organizations, and other appropriate sites.	Deemed for 2017			
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.	Deemed for 2017			
23.4 Outreach to Homeless Persons				
The Contractor shall assess the homeless population by implementing and maintaining a customized outreach plan for Homeless Persons population, including victims of domestic violence.	Deemed for 2017			
The plan shall include: (A) utilizing existing community resources such as shelters and clinics; and (B) Face-to-Face encounters.	Deemed for 2017			
The Contractor will not provide a differentiation of services for Members who are homeless. Victims of	Deemed for 2017			

Enrollee Rights and Protection: Member Education and Outreach *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.206, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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.				
23.5 Member Information Materials				
All written materials provided to Members that are critical to obtaining services, including, at a minimum, marketing materials, new member information, provider directories, handbooks, denial and termination notices, and grievance and appeal information shall comply with 42 CFR 438.10(d) and 45 CFR 92 unless otherwise specifically addressed in this Contract. The information shall at a minimum:	Full - This requirement is addressed on page 14 of the New Member Materials Policy New Requirement	Full	This requirement is addressed in the C6-MMO-022 Medicaid Post Enrollment Member Material Policy on page 14.	
A. Be geared toward persons who read at a sixth-grade level and use easily understood language and format;	Full- This requirement is addressed on page 14 of the New Member Materials Policy New Requirement	Full	This requirement is addressed in the C6-MMO-022 Medicaid Post Enrollment Member Material Policy on page 16.	
B. Be published in at least a twelve (12) point font size, and available in large print in a font size no smaller than 18 point, except font size requirements shall not apply to Member Identification Cards;	Full- This requirement is addressed on page 11 of the New Member Materials Policy. New Requirement	Full	This requirement is addressed in the C6-MMO-022 Medicaid Post Enrollment Member Material Policy on page 16.	
C. Comply with the Americans with Disabilities Act of 1990 (Public Law USC 101-336).	Full- This requirement is addressed on page 11 of the New Member Materials Policy.			
D. Be available through auxiliary aids and services, upon request of the Member at no cost;	New Requirement	Full	This requirement is addressed in the C6-MMO-022 Medicaid Post Enrollment Member Material Policy on page 16.	
E. Be available in alternative formats, upon request of the Member at no cost;	New Requirement	Full	This requirement is addressed in the C6-MMO-022 Medicaid Post Enrollment Member Material Policy on page 16.	

Final Findings

Enrollee Rights and Protection: Member Education and Outreach (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.206, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
F. Be available in English, Spanish and each prevalent non-English language	New Requirement	Full	This requirement is addressed in the C6-MMO-022 Medicaid Post Enrollment Member Material Policy on page 16.	
G. Be provided through oral interpretation services for any language;	New Requirement	Full	This requirement is addressed in the C6-MMO-022 Medicaid Post Enrollment Member Material Policy on page 16.	
H. Must include taglines in the top 15 non-English languages as released by the U.S. Department of Health and Human Services Office of Civil Rights, as well as large print, explaining the availability of written translation or oral interpretation and the toll-free telephone number of the Contractor's entity providing those services and how to request services.	New Requirement	Full	This requirement is addressed in the C6-MMO-022 Medicaid Post Enrollment Member Material Policy on page 16. The HHS top non-English 15 languages are addressed in the member handbook.	
All written materials provided to Members, including forms used to notify Members of Contractor actions and decisions, with the exception of written materials unique to individual Members, unless otherwise required by the Department shall be submitted to the Department for review and approval prior to publication and distribution to Members.	Full - This requirement is addressed in the New Member Materials Policy as well as in the Enrollment Member Materials Policy.			
29.14 Cultural Consideration and Competency				
The Contractor shall participate in the Department's effort to promote the delivery of services in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities and regardless of gender, sexual orientation or gender identity. 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	Full- This requirement is addressed in the Cultural Competency Policy. New Requirement	Substantial	This requirement is partially addressed in the Cultural Competency Plan. However, the new language addressing disabilities and delivery of services to all regardless of gender, sexual orientation or gender identity was provided in an updated policy, GOV18-PA-007 Cultural Competency Plan, after the review period. There is no recommendation to update the current policy, since the MCO has already implemented the new language in the current policy for the next audit timeframe.	WellCare appreciates IPRO's recommendation and will provide the updated policy for the next review period.

Final Findings

Enrollee Rights and Protection: Member Education and Outreach (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.206, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
interpersonal communication styles which respect Member's cultural background.			Although language was missing for the policy during the audit time period, staff discussed activities that occurred during the time frame that satisfied the new language requirement. As discussed on site, some of the activities the MCO conducts are corporate trainings on cultural competency, internal groups for women's leadership meetings, outreach and activities for the LGBTQ community. The MCO also participates in health fairs with organizations that provide assistance for those with disabilities. Post-onsite audit documentation included 2017 New Provider Cultural Competency Training. **Recommendation for MCO** The MCO provided the updated Cultural Competency Plan that included the new language requirement, but it was outside the scope of the audit time period. The MCO should provide this updated policy for the next audit period.	
The Contractor shall communicate such policies to Subcontractors.	Full- The MCO discussed on site it has a training program to address cultural competencies for providers and subcontractors. The policy Exactus Pharmacy Solutions-Cultural Awareness document also shows evidence of this requirement.			

Enrollee Rights and Protection: Member Education and Outreach

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	8	1	0	0
Total Points	24	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		**2.89**		

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

Reviewer Decision:

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

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

Final Findings

Enrollee Rights and Protection: Member Education and Outreach

Suggested Evidence

Documents

Policies/procedures for Member informational materials
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

Final Findings

Pharmacy Benefits (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
32.1 Pharmacy General Requirements				
The Contractor shall administer pharmacy benefits in accordance with this section, other requirements specified in this contract, and in accordance with all applicable State and Federal laws and regulations. In accordance with the Contractor's Formulary and/or Preferred Drug List, the Contractor shall provide coverage for all medically necessary legend and non-legend drugs once a drug becomes FDA approved and eligible for manufacturer federal rebates in accordance with Section 1927 of the Social Security Act, and ensure the availability of quality pharmacy services for all enrollees. 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 (ProDUR) and edits;	Deemed for 2017			
B. An accounts receivable (A/R) process that includes records for the Department to systematically track adjustments, recoupments, manual payments, and other required identifying A/R and claim information;	Deemed for 2017			
C. Retrospective drug utilization review (RetroDUR) services;	Deemed for 2017			
D. Formulary and non-formulary services, including but not limited to, prior authorization (PA) services, a PA escalation process and procedure, an appeals process, and a Pharmacy and Therapeutics	Deemed for 2017		Includes review of MCO Reports #39 Monthly Formulary Management and #59 Prior Authorizations (see Quarterly	

Final Findings

Pharmacy Benefits (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Committee (P&T);			Desk Audit Reports. Q4 2015 results were not reviewed since they were not available at the time of the compliance review).	
E. Pharmacy Provider relations and education, and call center services (member and provider), in addition to provider services specified elsewhere;	Deemed for 2017			
F. Seamless interfaces with the information systems of the Department and as needed, any related vendors;	Deemed for 2017			
G. Claims payment services;	Deemed for 2017			
H. Reporting and analysis to assist in monitoring and managing the pharmacy program and ensuring compliance with all Federal and State requirements;	Deemed for 2017			
I. Assisting the Department by cooperating and providing support during internal and external audits, including CMS certification or reviews, or transitions or upgrades of any MMIS/MEMS systems; and	New Requirement	Full	This requirement is addressed in C20-RX-152 Pharmacy Benefit Manager Vendor Relationship Policy on page 5.	

Final Findings

Pharmacy Benefits (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
J. Pursuant to Section 1903(i) of the Social Security Act, all handwritten or computer generated/printed Medicaid prescriptions shall require one or more approved industry-recognized tamper-resistant features to prevent all three (3) of the following: 1. Copying of a completed or blank prescription form; 2. Erasure or modification of information written on the prescription pad by the prescriber; AND 3. Use of counterfeit prescription forms. This requirement does not pertain to prescriptions received by fax, telephone, or electronically.	New Requirement	Full	This requirement is addressed in C20-RX-152 Pharmacy Benefit Manager Vendor Relationship Policy on page 6.	
32.5 Formulary and/or Preferred Drug List				
The Contractor shall maintain a drug formulary and/or preferred drug list (PDL) which follows the general and minimum requirements herein:	Full - This requirement is addressed in Corporate Policy and Procedure (Preferred Drug List Procedure), pages 1-7.			
A. The formulary and/or PDLshall: 1) Be made available to Providers and Members, including the tier for each medication and other information as necessary; 2) Only exclude coverage of drugs or drug categories permitted under Section 1927(d) of the Social Security Act as amended by the Omnibus Budget Reconciliation Act (OBRA) of 1993; 3) Be developed by a P&T that shall	New Requirement	Full	This requirement is addressed in C20-RX-134 PR 001 Corporate Pharmacy Committees Procedure on page 10.	

Final Findings

Pharmacy Benefits (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
represent the enrollees including those with special needs; 4) For each therapeutic drug class, the selection of drugs included shall be sufficient to ensure the availability of covered drugs with the least need for prior authorization; and 5) Not be used for the sole purpose to deny coverage of any Medicaid covered outpatient drug. 6) Be reviewed on a rolling basis so that all represented classes are reviewed within at least a three (3) year period.				
B. If the formulary and/or PDL prefers generic equivalents, Contractor shall provide a brand name exception process for prescribers to use when medically necessary.	New Requirement	Full	This requirement is addressed in C20-RX-134 PR 001 Corporate Pharmacy Committees Procedure on page 10.	
C. Publication of formulary and/or PDL: 1) Contractor shall publish and make available via hard copy upon request, online/webpage or web portal, or by other relevant means of communication its current formulary and/or PDL to all Providers and Members. 2) Formulary and/or PDL drug lists shall be made available on Contractor's web site in a machine readable file and format as specified in 42 CFRC.F.R. section 438.10. 3) The formulary and/or PDL shall be updated by the Contractor throughout the year and shall reflect changes such as, status of a drug, adds or deletes.	New Requirement	Full	This requirement is addressed in C20-RX-134 PR 001 Corporate Pharmacy Committees Procedure on pages 10-11.	

Final Findings

Pharmacy Benefits (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Updates to the formulary and/or PDL shall be distributed in the formats herein mentioned no later than the effective date of changes.				
32.4 Pharmacy and Therapeutics Committee				
The Contractor shall utilize a Pharmacy and Therapeutics Committee (P&T) in accordance with KAR Title 907. The P&T shall meet in Kentucky periodically throughout the calendar year as necessary and make recommendations to the Contractor for changes to the PDL or drug formulary. The P&T shall be considered an advisory committee to a public body thereby making it subject to Kentucky's Open Meetings Law. Prior to each new calendar year, the Contractor shall give notice to the Department of the time, date and location of the P&T meetings.	Full - This requirement is addressed in Corporate Pharmacy Committees Policy, page 2.			
32.7 Pharmacy Claims Payment Administration				
The Contractor shall: Process, adjudicate, and pay Kentucky Medicaid pharmacy claims, including voids and full or partial adjustments, via an online, real-time POS system by:	Full - This requirement is addressed in Corporate Pharmacy Committees Policy, page 3.			
32.6 Pharmacy Drug Rebate Administration				
The Affordable Care Act requires 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	Full - This requirement is addressed in Corporate Policy and Procedure; Pharmacy Rebates and Pharmaceutical Manufacturer Relations pages 2-4.			

Final Findings

Pharmacy Benefits (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
submit NDC level information on drugs and diabetic supplies, including J-code conversions consistent with CMS requirements. The Department or its designated contractor 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 manufacturer. The Contractor also shall be responsible for rebate administration for pharmacy services provided through other settings such as physician services.				

Final Findings

Pharmacy Benefits

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	5	0	0	0
Total Points	15	0	0	0

Overall Compliance Determination:

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

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

Reviewer Decision:

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

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

Final Findings
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
- Medicaid prescriptions

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
Process for monitoring and managing the pharmacy program

Reports

Evidence of reporting and analysis of the pharmacy program to ensure compliance with Federal and State requirements
Monthly Formulary Management (MCO Report #39)
Prior Authorizations (MCO Report #59)