State of Georgia
Department of Community Health

External Quality Review of Compliance With Standards

for

WellCare of Georgia, Inc.

December 2016

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Overview

Background

The Georgia Department of Community Health (DCH) is responsible for administering the Medicaid program and the Children's Health Insurance Program (CHIP) in the State of Georgia. The State refers to its CHIP program as PeachCare for Kids®. Both programs include fee-for-service and managed care components. The DCH contracts with three privately owned managed care organizations, referred to by the State as care management organizations (CMOs), to deliver services to members who are enrolled in the State's Medicaid and CHIP programs. Children in state custody, children receiving adoption assistance, and certain children in the juvenile justice system are enrolled in the Georgia Families 360° (GF 360°) managed care program. The Georgia Families (GF) program serves all other Medicaid and CHIP managed care members not enrolled in the GF 360º program. Approximately 1.3 million beneficiaries are enrolled in the GF program.[1-1]

According to federal requirements located within the Code of Federal Regulations (CFR), 42 CFR §438.358, the state, an agent that is not a Medicaid MCO, or its external quality review organization (EQRO) must conduct a review to determine a Medicaid MCO's compliance with standards established by the state related to member rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards. These standards must be at least as stringent as the federal Medicaid managed care standards described in 42 CFR §438—Managed Care.

To comply with the federal requirements, DCH contracted with Health Services Advisory Group, Inc. (HSAG), as its EQRO to conduct compliance reviews of the Georgia Families CMOs. The DCH uses HSAG to review one-third of the full set of standards each year over a three-year cycle.

Description of the External Quality Review of Compliance with Standards

The DCH requires its CMOs to undergo annual compliance reviews that cover a third of the federal standards each year. This ensures that within a three-year period, a full comprehensive assessment is conducted to meet federal requirements. The review presented in this report covered the period of July 1, 2015–June 30, 2016, and marked the third year of the current three-year cycle of external quality reviews.

HSAG performed a desk review of WellCare of Georgia, Inc.'s (WellCare's) documents and an on-site review that included reviewing additional documents, conducting interviews with key WellCare staff members, and conducting file reviews. HSAG evaluated the degree to which WellCare complied with federal Medicaid managed care regulations and the associated DCH contract requirements in three performance categories. All three review areas included requirements associated with federal Medicaid managed care structure and operation standards found at 42 CFR §438.236–§438.240, and §438.242. A

[1-1] Georgia Department of Community Health. "Georgia Families Monthly Adjustment Summary Report, Report Period: 12/2015."

fourth performance category focused specifically on noncompliant standards from the prior review periods. The standards HSAG evaluated included requirements that addressed the following areas:

- Clinical Practice Guidelines
- Quality Assessment and Performance Improvement (QAPI)
- Health Information Systems
- Re-review of *Not Met* elements from the prior years' review

Following this overview (Section 1), the report includes:

- Section 2—A summary of HSAG's findings regarding WellCare's performance results, strengths, and areas requiring corrective action.
- Section 3—A description of the process and timeline WellCare will follow for submitting to DCH its corrective action plan (CAP) addressing each requirement for which HSAG scored WellCare's performance as noncompliant.
- Appendix A—The completed review tool HSAG used to:
  - Evaluate WellCare's compliance with each of the requirements contained within the standards.
  - Document its findings, the scores it assigned to WellCare's performance, and (when applicable) corrective actions required to bring its performance into compliance with the requirements.
- Appendix B—The completed review tool HSAG used to evaluate WellCare's performance in each of the areas identified as noncompliant from the prior year's review.
- Appendix C—The dates of the on-site review and a list of HSAG reviewers, DCH observers, and all WellCare staff members who participated in the interviews that HSAG conducted.
- Appendix D—A description of the methodology HSAG used to conduct the review and to draft its findings report.
- Appendix E—A template for WellCare to use in documenting its CAP for submission to DCH within 30 days of receiving the final report.

2. Performance Strengths and Areas Requiring Corrective Action

Summary of Overall Strengths and Areas Requiring Corrective Action

HSAG determined findings for the compliance review from its:

- Desk review of the documents WellCare submitted to HSAG prior to the on-site review.
- On-site review of additional documentation provided by WellCare.
- Interviews of key WellCare administrative and program staff members.
- File reviews during the on-site review.

HSAG assigned a score of *Met* or *Not Met* for each of the individual elements it reviewed based on a scoring methodology, which is detailed in Appendix D—Review Methodology. If a requirement was not applicable to WellCare during the period covered by the review, HSAG used a *Not Applicable* designation. HSAG then calculated a total percentage-of-compliance score for each of the standards and an overall percentage-of-compliance score across the standards as well as the follow-up review.

Table 2-1 presents a summary of WellCare's performance results.

Table 2-1—Standards and Compliance Scores

Standard #	Standard Name	# of Elements*	# of Applicable Elements**	# *Met*	# *Not Met*	# *Not Applicable*	Total Compliance Score***
I	Clinical Practice Guidelines	**11**	**11**	**9**	**2**	**0**	**81.8%**
II	Quality Assessment and Performance Improvement (QAPI)	**32**	**30**	**16**	**14**	**2**	**53.3%**
III	Health Information Systems	**8**	**8**	**7**	**1**	**0**	**87.5%**
NA	Follow-up Reviews From Previous Noncompliant Review Findings	**6**	**6**	**5**	**1**	**0**	**83.3%**
	Total Compliance Score	**57**	**55**	**37**	**18**	**2**	**67.3%**

*** Total # of Elements**: The total number of elements in each standard.

**** Total # of Applicable Elements**: The total number of elements within each standard minus any elements that received a designation of *NA*.

***** Total Compliance Score**: Elements that were *Met* were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.

The remainder of this section provides a high-level summary of WellCare's performance noted in each of the areas reviewed. In addition, the summary describes any areas that were not fully compliant with the requirements and the follow-up corrective actions recommended for WellCare.

Standard I—Clinical Practice Guidelines

Performance Strengths

WellCare adopted 41 evidence-based, clinical practice guidelines (CPGs) in the areas of chronic care conditions and preventive and behavioral health. WellCare adopted CPGs in consultation with network providers. WellCare included community providers and medical societies in the review and adoption of CPGs. The CMO made decisions regarding the CPGs through its committee meetings.

WellCare implemented processes to consider the needs of its members when identifying CPG topics.

Areas Requiring Corrective Action

WellCare had inconsistencies in its methodology for measuring and assessing CPGs as documented in the policy, the compliance audit tools, and in the Quality Improvement (QI) Program Description. WellCare did not create a distinct linkage between the DCH CPG audit process for monitoring the three mandated CPGs and the compliance tools, or include a consistent description of the DCH CPG audit process for measuring and assessing provider compliance in its documents.

WellCare did not document how it ensured that decisions made regarding utilization management or coverage of service were consistent with CPGs. WellCare has not implemented a process to ensure staff decisions involving utilization management and coverage of services are consistent with the guidelines.

Standard II—Quality Assessment and Performance Improvement

Performance Strengths

During the interview session, WellCare described its pilot program for member advocacy. This program included the development of a database containing more than 10,000 community organizations and community events that focused on assisting members in the areas of housing, food, jobs, and access to healthcare services. WellCare's healthcare advocacy associates provided assistance to members to ensure that the basic needs of members and their families were met (e.g., a place to live, the ability to pay for utilities), and that they were connected to food and clothing resources. By meeting these basic needs, WellCare stated that members were then able to focus on meeting their healthcare needs. The healthcare advocacy associates' efforts are showing positive preliminary results. For example, the performance measure rates for breast cancer screening have improved. WellCare was working with the Robert Wood Johnson Foundation to evaluate the results of the healthcare advocacy associates' work, which WellCare described as an investment in the health of members and in the Georgia community.

WellCare expanded the role of its staff members who work with provider practices to improve Healthcare Effectiveness Data and Information Set (HEDIS®)[2-1] scores to include discussions on overutilization, underutilization, member care needs, and healthcare advocacy.

WellCare used demographic information, as well as various clinical and behavioral health utilization patterns, to identify members who might benefit from disease management or case management programs. Disease management and case management services were made available to identified at-risk members as a result of a review of relevant data.

WellCare worked directly with providers and the community on quality improvement initiatives such as use of telemedicine and access to school-based care. Other quality improvement initiatives focused on improving the quality of care coordination and care transitions in efforts to reduce gaps in care.

WellCare implemented quality improvement processes based on patient safety data and trends. For example, WellCare used its peer review process for a substantiated quality of care concern that resulted in the termination of a provider. The CMO stated that the medical director may bring in three specialty network or community providers to review care concerns through the peer review process. Another example discussed how a network monitoring activity identified an opportunity to improve the therapy network. The quality improvement activity included gathering more data on referral patterns and implementing interventions that resulted in an improved therapy network. WellCare implemented a Pharmacy Lock-In Report it used to identify opportunities to address overutilization, pharmacy issues, and drug-seeking behaviors, as well as prescribing pattern deviations.

WellCare reviewed disease management statistics, clinical quality initiatives, quality of care and quality of service issues, complaints, grievances and adverse event data, and member and provider satisfaction survey results in its committees and work groups, and the CMO recommended strategies to improve compliance. WellCare initiated performance improvement projects to address trends identified through monitoring activities, review of complaints and allegations of abuse, provider satisfaction, and utilization management reviews.

WellCare described its use of the Coleman Model for transitions in care in its discharge planning and how WellCare worked with the developer to allow a hybrid model that reflected the Medicaid population served by the CMO. Another example was the CMO's use of the Lace Tool for readmission risk assessments.

Areas Requiring Corrective Action

WellCare must develop a comprehensive QAPI Program Description. The QAPI Program Description must be developed according to the DCH guidelines. The QAPI Program Description must be approved by DCH as meeting the DCH guidelines. The documentation submitted by WellCare did not include the QAPI Program Description that is required by DCH. The documentation submitted by the CMO indicated that the CMO had developed and implemented some of the elements required by DCH in the

[2-1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

QAPI Program Description. The CMO must develop and submit as evidence of compliance with the QAPI Standards a QAPI Program Description that is comprehensive and meets the DCH guidelines.

The documentation provided by WellCare included information on various activities related to quality assessment and performance improvement, but the information was not in the format required by DCH. For example, QAPI strengths identified in other documents reviewed indicated that WellCare's QAPI Program was enhanced by provider participation and information received from members and their families and guardians. As an example, WellCare implemented processes and committees to involve members, providers, and community organizations in quality improvement. During the compliance review interviews, WellCare staff discussed examples that included a Health Connections Council and Provider Advisory Board. In addition, the CMO staff members highlighted their work with the medical societies to receive input and feedback prior to implementing an activity or program. This work should have been included in the required QAPI Program Description and should have been tied to goals, objectives, interventions, and activities. WellCare should also have a process to measure outcomes related to this work. While WellCare involved members, providers, and community organizations in quality improvement, the CMO did not include this information in the QAPI Program Description.

As mentioned earlier, WellCare's health care advocacy associates worked with members to ensure that the basic needs of members and their families were met. This work should have been included in the required QAPI Program Description and tied to goals, objectives, interventions, and activities. WellCare should also have a process to measure outcomes related to this work.

WellCare must develop a process to better document and show in its QAPI Program Description all of the quality improvement processes it has developed and implemented. WellCare should include the comprehensive quality improvement processes used in its QAPI Program Description. This may include a review of information and data available to the CMO through claims/encounters, grievances and appeals, quality of care cases, care management including disease management, case management and care coordination, and member and provider input to identify quality improvement opportunities and gaps in care or service delivery. The QAPI Evaluation should provide a complete summary of how the quality improvement goals, objectives, and related initiatives were identified; which data were used in the selection process; which interventions were considered (and implemented); how the initiatives were resourced, including specific, assigned individuals and their qualifications; and how the results or outcomes were measured in order to provide a comprehensive story of the effectiveness of WellCare's QAPI work.

WellCare must document how it monitors and evaluates its own processes for quality management and performance improvement. WellCare must also update its policies, program descriptions, and/or program evaluations to describe how, as a result of data analysis or evaluation, indicated recommendations are implemented.

WellCare must strengthen its provider profiling activities. Data and information (e.g., trends in utilization, complaints and grievances, prescribing, and member satisfaction) may be opportunities for the CMO to use provider profile information in its operational, network development, or other activities. The DCH instructed the CMO, as the foundation of its QAPI Program, to focus on the CMO's members. Focus areas should include identifying member demographics and needs. This work should have been

included in the required QAPI Program Description and tied to goals, objectives, interventions, and activities. The CMO should also have a process to measure outcomes related to this work.

WellCare must document the methodology and process used for conducting and maintaining provider profiling in its policies. WellCare must develop provider profiling activities that include information such as tracked and trended data regarding utilization, complaints and grievances, prescribing, and member satisfaction. The CMO's implementation or use of provider profiling information must be included in the QAPI Program Description to guide decisions in network development.

The QM Patient Safety Plan must clearly distinguish between grievances and the grievance process. The QM Patient Safety Plan was not developed or structured according to DCH guidelines. The QM Patient Safety Plan must be approved by DCH. WellCare used the Georgia Registry of Immunization Transactions and Services (GRITS) system to collect additional information related to performance measures. WellCare would strengthen its quality improvement processes by developing a process to use data from the GRITS system to facilitate performance improvement, such as identifying provider reporting and immunization patterns.

WellCare did not provide evidence that it used the latest available research in the area of quality assurance. The CMO must base its QAPI Program on the latest available research in the area of quality assurance.

Standard III—Health Information Systems

Performance Strengths

WellCare used an integrated application suite to support its Medicaid line of business. The health information system, or core processing system (CPS), was based on the Dell Services Xcelys platform. WellCare's system allowed for a seamless integration with other applications and supported all member, provider, benefit, and claims processing applications. The Enterprise Medical Management Application (EMMA) supported case management, utilization management, disease management, and care coordination processes. WellCare's Quality Reporting System used McKesson's CareEnhance Resource Management Software (CRMS), which centralized claims, membership, medical record, and other narrative information for HEDIS reporting. WellCare managed reporting functions through the Enterprise Data Warehouse.

Areas Requiring Corrective Action

WellCare did not provide evidence that it had processes to review data received from providers to ensure that the data were complete, logical, and consistent with those services provided to the member. WellCare must update its process descriptions to detail how the CMO ensures that data received from providers are complete, logical, and consistent.

Follow-Up Reviews From Previous Noncompliant Review Findings

Performance Strengths

WellCare abandoned its pilot program to use Southwest Georgia Health Care, Inc.'s, after-hours line because there was a barrier to ensuring continuity of care. Instead, WellCare offered its after-hours nurse advice line to providers who failed the after-hours audit. The advice line allowed offices in rural areas that had limited staff or availability for after-hours triage to provide WellCare members access to a nurse to determine if the member needed to seek care immediately or if the member should call his or her primary care provider (PCP) the next day for an appointment.

WellCare's data indicated that it met the timely after-hours return call time frames for nonurgent and urgent calls. Timely access reports submitted by WellCare indicated that in first quarter 2016, after-hours urgent return calls were received within the required time frame 96 percent of the time. After-hours nonurgent return calls were received within the required time frame 91 percent of the time. In Quarter 4 2015, the reports indicated that after-hours urgent return calls were received within the required time frame 99 percent of the time and after hours nonurgent return calls were received within the required time frame 94 percent of the time.

Areas Requiring Corrective Action

Although WellCare has found a workaround solution to ensure that its members have access to a nurse advice line if they are patients of a provider who has failed the after-hours audit, the CMO must continue to work with the providers to meet the after-hours line and access to care requirements.

WellCare did not consistently meet the geographic access standards for both urban and rural areas for PCPs, specialists, dental subspecialty providers, and pharmacies. WellCare must continue efforts to close its network adequacy gaps and meet the GeoAccess standards.

3. Corrective Action Plan Process

WellCare is required to submit to DCH its corrective action plan (CAP) addressing all requirements receiving an HSAG finding of *Not Met*. WellCare must submit its CAP to DCH within 30 calendar days of receipt of HSAG's final External Quality Review of Compliance with Standards Report. WellCare must identify, for each requirement that requires corrective action, the interventions it plans to implement to achieve compliance with the requirement, including how the CMO will measure the effectiveness of the intervention, the individuals responsible, and the timelines proposed for completing the planned activities.

The DCH, in consultation with HSAG, will review, and when deemed sufficient, approve WellCare's CAP to ensure the CAP sufficiently addresses the interventions needed to bring performance into compliance with the requirements.

Appendix A. Review of the Standards

Following this page is the completed review tool that HSAG used to evaluate WellCare's performance and to document its findings; the scores it assigned associated with the findings; and, when applicable, corrective actions required to bring WellCare's performance into full compliance.

Appendix A. State of Georgia
Department of Community Health (DCH)
External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
for **WellCare of Georgia, Inc.**

Note about the Citations: Unless otherwise specified, the federal Medicaid managed care references for the following requirements are those contained in 42 CFR §438, which describes requirements applicable to Medicaid Managed Care Organizations (MCOs).

Standard I—Clinical Practice Guidelines		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
1. The CMO has a minimum of three practice guidelines. *42CFR438.236(b)* *Contract: 4.12.7.1*	• C7QI-026 Provider Clinical Practice Guidelines, p.4 • Attention-Deficit Hyperactivity Disorder • Management of Asthma in Children and Adults • Management of Diabetes Mellitus in Adults 18-75 Years of Age	☒ Met ☐ Not Met ☐ N/A
Findings: WellCare had a Provider Clinical Practice Guideline Policy (CPG Policy). WellCare included a summary of its clinical practice guidelines (CPGs) in its Quality Improvement (QI) Program Evaluation. WellCare implemented 41 Georgia-specific CPGs in the areas of chronic care conditions and preventive and behavioral health.		
Required Actions: None.		
2. The guidelines: *42CFR438.236(b)* *Contract: 4.12.7.1*		
a. Are based on the health needs and opportunities for improvement identified as part of the quality assessment and performance improvement (QAPI) program. *Contract: 4.12.7.1*	• C7QI-026 Provider Clinical Practice Guidelines p.4 • C7QI-026-PR-001 Provider Clinical Practice Guidelines, p.2 • 2015 GA Medicaid QI Program Description, p.5 • Provider Handbook, p.33-34 • Attention-Deficit Hyperactivity Disorder • Management of Asthma in Children and Adults • Management of Diabetes Mellitus in Adults 18-75 Years of Age	☒ Met ☐ Not Met ☐ N/A
Findings: WellCare documented in its CPG Policy that the CPGs were based on the health needs of the population and opportunities for improvement were identified as part of the QAPI Program. The Georgia Medicaid QAPI Program Description referenced the development and review of CPGs related to the health needs of the population served. WellCare described in the compliance review interview session how it used data to identify the most prevalent diseases/conditions within its population for purposes of CPG selection.		
Required Actions: None.		

Standard I—Clinical Practice Guidelines		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
b. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. *Contract: 4.12.7.1*	• C7QI-026 Provider Clinical Practice Guidelines, p.4 • C7QI-026-PR-001 Provider Clinical Practice Guidelines, p.2 • Provider Handbook, p.36-37 • Attention-Deficit Hyperactivity Disorder, p.2 • Management of Asthma in Children and Adults, p.1 • Management of Diabetes Mellitus in Adults, p.1 • GA UMAC Meeting Minutes August 19, 2015, p.28-31 • Charter-GA Utilization Management Medical Advisory Committee	☒ Met ☐ Not Met ☐ N/A
Findings: The WellCare CPG Policy stated that the CPGs were based on valid and reliable clinical evidence and/or a consensus of healthcare professionals in a particular field. The provider handbook stated that WellCare adopted valid, evidence-based CPGs. The Georgia Utilization Management Medical Advisory Committee (UMAC) meeting minutes dated August 19, 2015, provided an example of a discussion regarding changes and updates to the adopted CPGs with providers serving on the committee. The Georgia UMAC included a variety of network provider specialties from across the regions of the State who provided input and approved the adoption of CPGs.		
Required Actions: None.		
c. Consider the needs of the CMO's members. *Contract: 4.12.7.1*	• C7QI-025 Member Educational Guidelines, p.1,3 • C7QI-026 Provider Clinical Practice Guidelines, p.4 • C7QI-026-PR-001 Provider Clinical Practice Guidelines, p.2 • C7QI-033 Quality Improvement Program and Provider Involvement, p.6 • 2016 GA Medicaid QI Work Plan, Executive Summary Tab • CPG Screenshot	☒ Met ☐ Not Met ☐ N/A
Findings: The Member Educational Guidelines Policy indicated that the CPGs were appropriate to the population served. The CPG Policy stated that the CPGs were relevant to the population served. The Georgia Quality Improvement Work Plan included documentation about prevalent conditions for which CPGs had been adopted. WellCare stated in several polices and related documents that CPGs were appropriate or relevant to the populations served. WellCare's processes would be strengthened by stating in the policies that member needs are considered, which may be different than whether a CPG is relevant or appropriate for a population served.		
Required Actions: None.		

Standard I—Clinical Practice Guidelines		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
d. Are adopted in consultation with network providers. *Contract: 4.12.7.1*	• C7QI-026 Provider Clinical Practice Guidelines, p.4 • C7QI-026-PR-001 Provider Clinical Practice Guidelines, p.3 • GA UMAC Meeting Minutes August 19, 2015, p.1 • GA Medicaid UMAC Physician Roster November 17, 2015 • Provider Handbook, p.36-37	☒ Met ☐ Not Met ☐ N/A
Findings: The WellCare CPG Policy stated that CPGs were adopted in consultation with network providers. WellCare provided evidence that this policy was implemented in the Georgia UMAC meeting minutes dated August 19, 2015. Minutes verified participation of network providers from across the regions within Georgia. The meeting minutes reflected a committee discussion of the changes and updates to the adopted CPGs, as well as a discussion on proposed CPGs. During the compliance review interviews, WellCare discussed its process to inform and seek feedback on recommended CPGs from medical societies to receive support and buy-in prior to adoption.		
Required Actions: None.		
e. Are reviewed and updated periodically, as appropriate. *Contract: 4.12.7.1*	• C7QI-026 Provider Clinical Practice Guidelines, p.4 • C7QI-026-PR-001 Provider Clinical Practice Guidelines, p.2 • 2015 GA Medicaid QI Program Evaluation, p.48 • GA UMAC Meeting Minutes August 19, 2015, p.31	☒ Met ☐ Not Met ☐ N/A
Findings: The WellCare CPG Policy specified that the guidelines were reviewed at a minimum every two years and updated as appropriate. The 2015 Georgia Medicaid QI Program Evaluation also stated that CPGs were reviewed every two years or more frequently if national guidelines changed more frequently.		
Required Actions: None.		
3. The practice guidelines include a methodology for measuring and assessing compliance. *Contract: 4.12.7.2*	• C7QI-026 Provider Clinical Practice Guidelines, p.4 • C7QI-026-PR-001 Provider Clinical Practice Guidelines, p.1-3 • Attention-Deficit Hyperactivity Disorder, p.4 • Management of Asthma in Children and Adults, p.6 • Management of Diabetes Mellitus in Adults, p.3-4, 6-7 • 2015 ADHD CPG Compliance Tool • 2015 Asthma CPG Compliance Tool 2015 Diabetes CPG Compliance Tool	☐ Met ☒ Not Met ☐ N/A

Standard I—Clinical Practice Guidelines		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
Findings: The WellCare CPG Policy stated that a methodology for measuring and assessing compliance with CPGs would be submitted as part of the QI Program Description. The QI Program Description did not include a methodology for measuring and assessing compliance with CPGs. WellCare submitted CPGs which included sections that addressed the methodology for measurement. Examples of CPG compliance tools submitted followed the described methodologies specified within the CPGs.		
Required Actions: In its documents, WellCare must create a distinct linkage between the DCH CPG audit process for monitoring the three mandated CPGs and the compliance tools, and include a consistent description of the DCH CPG audit process for measuring and assessing provider compliance.		
4. The CMO submitted clinical practice guidelines to DCH for review and approval as part of the QAPI Program. *Contract: 4.12.7.2*	• CPG Submission Email 1 • CPG Submission Email 2 • CPG Approval Email	☒ Met ☐ Not Met ☐ N/A
Findings: WellCare submitted documentation that verified submission of CPGs to DCH for review and approval as part of the QAPI Program.		
Required Actions: None.		
5. The CMO disseminates the guidelines to all affected providers, and upon request, to members. *42CFR438.236(c)* *Contract: 4.12.7.3*	Providers • C7QI-026 Provider Clinical Practice Guidelines, p.4 • C7QI-026-PR-001 Provider Clinical Practice Guidelines, p.3 • CPG Screenshot • Provider Handbook, p.37 • GA 2015 Issue II Provider Newsletter, p.2 • GA 2015 Issue III Provider Newsletter, p.6 Members • C7QI-025 Member Educational Guidelines, p.4 • Member Handbook, p.50 • GA Medicaid Member Newsletter, Issue 3, p.2 GA Medicaid Member Newsletter, Issue 4, p.6	☒ Met ☐ Not Met ☐ N/A

Standard I—Clinical Practice Guidelines		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
Findings: The WellCare CPG Policy stated that WellCare disseminated CPGs to providers on its website. The provider handbook directed providers to the WellCare website for current, recommended CPGs. The Georgia 2015 Issue III Provider Newsletter also provided information to providers regarding the availability of CPGs on the WellCare website. The Member Educational Guidelines Policy stated that CPGs would be available to members but did not specify where, how, or in what format they would be available. The member handbook provided a limited summary of care recommendations but did not inform members where they may receive or from whom they may request CPG information. The member newsletter examples submitted referenced care recommendations and that members may request additional information. During the compliance review interviews, WellCare indicated that members were able to access the CPGs on an unsecured portion of the CMO's website. The CMO's process would be strengthened if it informed members regarding how they may access or receive copies of CPGs.		
Required Actions: None.		
6. The CMO ensures that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42CFR438.236(d)* *Contract: 4.12.7.4*	• C7QI-026 Provider Clinical Practice Guidelines, p.4 • C7QI-025 Member Educational Guidelines, p.4 • GA Medicaid UMAC CCG CPG Timeline Presentation, p.5 • Medical Policy Committee Meeting Minutes July 9, 2015 p.3 • MPC CPG SharePoint Screenshot	☐ Met ☒ Not Met ☐ N/A
Findings: The WellCare CPG Policy and the Member Educational Guidelines Policy stated that WellCare would ensure that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply were consistent with the guidelines. The documentation submitted did not describe how WellCare ensured that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply were implemented in order to be consistent with the guidelines. The WellCare program descriptions and evaluations included references to other WellCare programs. For example, the QI Program Evaluation submitted referenced the outcome measurement of another WellCare program, WellCare of Kentucky.		
Required Actions: WellCare must describe how it ensures that the decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. The QI Program Evaluation must be updated to reflect only Georgia WellCare information and data.		
7. In order to ensure consistent application of the guidelines, the CMO encourages providers to utilize the guidelines and measures compliance with the	• C7QI-026 Provider Clinical Practice Guidelines, p.4 • 2015 ADHD CPG Compliance Tool • 2015 Asthma CPG Compliance Tool • 2015 Diabetes CPG Compliance Tool	☒ Met ☐ Not Met ☐ N/A

Standard I—Clinical Practice Guidelines		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
guidelines until 90 percent or more of the providers are consistently in compliance. *Contract: 4.12.7.5*	• 2015 CPG Report, All Tabs 2015 CPG Report Analysis	
Findings: The WellCare CPG Policy established a threshold of 80 percent for provider compliance with CPGs. The CPG Policy encouraged utilization and measures compliance until 90 percent or more of the providers were consistently in compliance.		
Required Actions: None.		

Results for Standard I—Practice Guidelines							
Total	Met	=	9	X	1.00	=	9
	Not Met	=	2	X	.00	=	0
	Not Applicable	=	0	X	N/A	=	N/A
Total Applicable		=	11	**Total Score**		=	9
				Total Score ÷ Total Applicable		=	81.8%

Standard II—Quality Assessment and Performance Improvement (QAPI)		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
1. The CMO provides for the delivery of quality care with the primary goal of improving the health status of members and, where the member's condition is not amenable to improvement, maintain the member's current health status by implementing measures to prevent any further decline in condition or deterioration of health status. This includes the identification of members at risk of developing conditions, the implementation of appropriate interventions, and designation of adequate resources to support the intervention(s). *Contract: 4.12.1.1*	• 2015 GA QI Program Description, p.12 • 2015 GA QI Program Evaluation, p.3 • GA UMAC Minutes August 19, 2015, p.33-45 • GA Medicaid QIC Minutes September 15, 2015, p.42-59	☒ Met ☐ Not Met ☐ N/A
Findings: The WellCare 2015 Georgia QI Program Description described the process used to evaluate the quality of care delivered in order to identify opportunities and implement interventions to improve the healthcare and service delivered to members. The Georgia QI Program Evaluation summarized the results of the prior year's quality improvement activities. The UMAC meeting minutes from August 19, 2015, described how WellCare identified members based on demographic information, as well as various clinical and behavioral health utilization patterns. In addition, the documents described how disease management and care management were made available to identified at-risk members. WellCare did not describe in its program documents how the information is used to develop interventions aimed at improving the health status of members or to maintain or prevent further decline in a member's health status. During the compliance review interview, the CMO described its implementation of a member advocacy program that was focused on removing barriers and impacting the social determinants of health. The CMO described the need for member advocacy in the areas of housing, food, utility payment, and clothing. WellCare stated that members would be able to focus on health and medical care once the social determinants of health were addressed. The Member Advocacy Program allowed WellCare, with the use of health advocates, to maintain or prevent further declines in the health of members. WellCare indicated that preliminary results of the program demonstrated the ability of the member advocacy work to close gaps in care, as evidenced by improvement in the breast cancer screening rate.		
Required Actions: None.		

Standard II—Quality Assessment and Performance Improvement (QAPI)		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
2. The CMO seeks input from and works with members, providers, and community resources and agencies to actively improve the quality of care provided to members. *Contract: 4.12.1.2*	• 2015 GA QI Program Description, p.3-7 • 2015 Medicaid Adult CAHPS®® 5.0H • Member Experience Meeting Minutes March 1, 2016, p.4-6 • GA Medicaid QIC Minutes September 15, 2015, p.6-10 • GA Medicaid QIC Minutes March 8, 2016, p.47-48 • Provider Advisory Council Minutes March 14, 2016 • GA UMAC Minutes August 19, 2015, p.11-14 • Member Handbook, p.78-79 • Georgia Community Advocacy Report	☒ Met ☐ Not Met ☐ N/A
Findings: The 2015 Georgia QI Program Description stated that WellCare's quality improvement program was enhanced by provider participation and information received from members, their families, and their guardians. WellCare utilized committees and quality improvement activities to seek input from members, providers, and community resources and agencies concerning its quality improvement program. WellCare described in its documents how it used information received from these sources to modify policies and member information material. The Georgia Medicaid Member Experience meeting minutes from March 1, 2016, described how WellCare worked with non-profit and community-based initiatives to improve access to care and services for members. The Medicaid Quality Improvement Committee (QIC) meeting minutes reflected that WellCare actively requested input from practitioner experiences in the delivery of healthcare services. The Georgia Community Advocacy Report referenced community agencies to which WellCare members were referred for additional services, but the report did not document that input was sought from the community agencies. The Provider Advisory Council meeting minutes referenced work with providers on telemedicine, school-based care, care coordination, and care transition quality improvement initiatives. During the compliance review interviews, the CMO described other avenues used to solicit member involvement, such as the Health Connections Council.		
Required Actions: None.		
3. The CMO has a multidisciplinary Quality Oversight Committee to oversee all quality functions and activities. This committee meets at least quarterly, but more often if warranted. *Contract: 4.12.1.3*	• 2015 GA QI Program Description, p.5-10 • GA Medicaid QIC Agenda September 15, 2015 • GA Medicaid QIC Minutes September 15, 2015 • GA Medicaid QIC Agenda December 22, 2015 • GA Medicaid QIC Minutes December 22, 2015 • GA UMAC Agenda August 19, 2015 • GA UMAC Minutes August 19, 2015	☒ Met ☐ Not Met ☐ N/A

Standard II—Quality Assessment and Performance Improvement (QAPI)		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
Findings WellCare had a QIC that oversaw quality functions and activities. The QIC had subcommittees that were also involved in quality improvement activities, including the Customer Service Quality Improvement Committee, Delegation Oversight Committee, UMAC, Credentialing Committee, Quality and Member Access Committee, Medical Policy Committee, Pharmacy and Therapeutics Committee, Appeals Committee, Pharmacy and Therapeutics Advisory Committee, and the Pharmacy Quality Oversight Committee. Meeting minutes reflected a multidisciplinary QIC membership. Meeting agendas and minutes included updates from subcommittees. Meeting minutes, as well as the Georgia QI Program Description, reflected that the QIC met at least quarterly.		
Required Actions: None.		
4. The CMO supports and complies with the Georgia Families Quality Strategic Plan by: *42CFR438.240(b)(1) through (4)* *Contract: 4.12.2.1*		
a. Monitoring and evaluating its service delivery system and provider network, as well as its own processes for quality management and performance improvement. *Contract: 4.12.2.2*	• 2015 GA QI Program Evaluation, p.10-13, 56 • 2015 GA QI Workplan, Network Adequacy Tab • GA Medicaid QIC Minutes September 15, 2015, p.34-58	☐ Met ☒ Not Met ☐ N/A
Findings: The 2015 Georgia QI Program Evaluation documented examples of WellCare's monitoring of credentialing timeliness, as well as opportunities to address identified barriers. The QI Program Evaluation also stated that WellCare used quality of care complaints to identify trends and opportunities for quality improvement activities or interventions. The 2015 QI Workplan, Network Adequacy Tab provided an example of how WellCare monitored and evaluated its service delivery system and provider network, including appointment access and network availability for primary care, dental care, behavioral healthcare, and vision care. The Georgia Medicaid QIC meeting minutes connected the data collection related to complaints, network access, and availability to QIC discussions on barriers, gaps, and opportunities. Meeting minutes of multiple subcommittees also reflected committee discussions on quality management and performance improvement opportunities and interventions. However, documentation submitted did not fully describe how WellCare monitored or evaluated its own processes for quality management and performance improvement.		
Required Actions: WellCare must document how it monitors and evaluates its own processes for quality management and performance improvement.		

Standard II—Quality Assessment and Performance Improvement (QAPI)		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
b. Implementing action plans and activities to correct deficiencies and/or increase the quality of care provided to enrolled members. *Contract: 4.12.2.2*	• 2015 GA QI Program Evaluation • GA UMAC Minutes August 19, 2015, p.2-4 • 2015 GA QI Workplan, All Tabs • GA HEDIS® Action Plan, All Tabs • 2015 Performance Measures Report, All Tabs • 2015 Performance Measures Report Analysis	☒ Met ☐ Not Met ☐ N/A
Findings: The 2015 Georgia QI Program Evaluation described the interventions and activities implemented to correct deficiencies and/or improve the quality of care provided to members. The QI Program Evaluation documented the effectiveness of the interventions and activities implemented. The UMAC meeting minutes from August 19, 2015, included an update on action plans that were implemented to correct deficiencies and improve quality of care. WellCare discontinued quality improvement activities when goals were achieved. WellCare provided additional evidence of interventions and activities implemented to improve HEDIS and performance measure results. WellCare conducted an analysis of the effectiveness of the interventions implemented and reported the results in the 2015 Performance Measures Report Analysis. During the compliance review interviews, WellCare described its use of interdepartmental meetings, work groups, and interdisciplinary teams that were used to address cross-cutting opportunities for quality improvement. An example provided identified the positive results of a cross-functional work group in reducing infant mortality rates. WellCare also described its UM rounds, which are led by the chief medical officer. The rounds included 34–40 WellCare staff and medical directors who participated in a review of quality of care opportunities, such as with behavioral health, high-risk maternity, neonatal intensive care, and medically fragile populations. WellCare's documentation did not describe the use of data (e.g., utilization, care management, and disease management) in implementing action plans and activities to correct deficiencies and/or increase the quality of care provided to members in its QI Program.		
Required Actions: None.		
c. Initiating performance improvement projects to address trends identified through monitoring activities, reviews of complaints and allegations of abuse, provider credentialing and profiling, and utilization management reviews. *Contract: 4.12.2.2*	<u>Monitoring Activities & Process Improvement Projects</u> • 2015 GA QI Program Evaluation • ADHD Module 4 • ADHD Module 5 • Provider Satisfaction Module 4, Intervention 1 • Provider Satisfaction Module 4, Intervention 1 Attachment A • Provider Satisfaction Module 4, Intervention 1 Attachment B • Provider Satisfaction Module 5	☒ Met ☐ Not Met ☐ N/A

Standard II—Quality Assessment and Performance Improvement (QAPI)		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	Reviews of Complaints and Allegations of Abuse • Q3 2015 Grievance Presentation • Q3 2015 UMAC QOCS Patient Safety Presentation • GA Peer Review Committee Minutes January 25, 2016, p.2-4 Utilization Management Reviews • GA UMAC Minutes August 19, 2015, p.11-14 • GA Medicaid UMAC Presentation Q4 2015, p.2-3 • ADHD Module 4 • ADHD Module 5	
Findings: WellCare discussed some of the performance improvement projects (PIPs) that were initiated to address trends identified through monitoring activities, reviews of complaints and allegations of abuse, provider satisfaction, and utilization management reviews. As an example, WellCare implemented PIPs related to attention deficit hyperactivity disorder (ADHD) and provider satisfaction. In addition to the active PIPs, WellCare documented interventions and activities that were implemented based on data and trends related to patient safety. Documentation submitted also described a peer review process for a substantiated quality of care concern for which action was taken to terminate the provider. In another example, network monitoring activities identified an opportunity to improve the therapy network, which resulted in the implementation of a PIP. The PIP included gathering more data on referral patterns and implementing interventions based on the results of the data to enhance the therapy network. The WellCare Georgia QI Program Evaluation discussed the results of the PIP. Although self-selected PIP topics are not required, it is recommended that WellCare review data and trends of complaints and allegations of abuse, utilization, provider credentialing, and provider profiling to identify performance improvement opportunities.		
Required Actions: None.		
d. Describing in the CMO's QAPI program description how the CMO complies with Federal, State, and Georgia Families requirements. *Contract: 4.12.2.2*	• C7QI-033 Quality Improvement Program and Provider Involvement, p.1 • C7QI-033-PR-001 Quality Improvement Program and Provider Involvement, p.1 • 2015 GA QI Program Description, p.8 • 2015 GA QI Program Evaluation	☒ Met ☐ Not Met ☐ N/A

Standard II—Quality Assessment and Performance Improvement (QAPI)		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• 2015 GA QI Work Plan, All Tabs	
Findings: The WellCare QI Program Description and the Quality Improvement Program and Provider Involvement Policy included language regarding compliance with federal and State requirements. The 2015 Georgia QI Program Description stated that the CMO would be in compliance with federal and State requirements. The 2015 Georgia QI Program Evaluation also documented monitoring activities for compliance with federal and State requirements.		
Required Actions: None.		
e. Coordinating with State registries. *Contract: 4.12.2.2*	• GRITS User Manual, p.8-9 • GRITS from GA to WCG Workflow • Inovalon Care Gap Report	☒ Met ☐ Not Met ☐ N/A
Findings: WellCare coordinated with the State's immunization registry, GRITS. The documentation submitted indicated that coordination occurred primarily for purposes of the immunization audit. WellCare used the GRITS system to abstract missing immunization records for its members and submitted the data received to Inovalon for inclusion in HEDIS reporting. WellCare used the GRITS system as a data source for performance measure reporting. During the compliance review interview, the CMO stated that it anticipated coordinating with the State immunization, cancer, and sudden infant death syndrome registries. The CMO would strengthen its processes by considering additional opportunities, based on the capabilities of the system, to coordinate with and use information from the GRITS system (e.g., to identify providers that are not reporting administered immunizations to the registry, to identify members who are in need of immunizations, and to enhance the information in its systems to reflect a more complete immunization status of its members).		
Required Actions: None.		
f. Including CMO executive and management staff participation in the quality management and performance improvement processes. *Contract: 4.12.2.2*	• 2015 GA QI Program Description, p.10-11 • GA Medicaid QIC Minutes September 15, 2015, p.1	☒ Met ☐ Not Met ☐ N/A
Findings: WellCare's 2015 Georgia QI Program Description described the role of the medical director, the behavioral health medical director, and the Quality Improvement Department in the quality management and performance improvement process. The Georgia Medicaid QIC meeting minutes from September 15, 2015, indicated that the medical director, two QI managers, and the region president participated in the meetings. Committee membership included senior managers and managers of several of the WellCare operational departments. During the compliance review interview, the chief medical officer described an active involvement and leadership role in quality management and performance improvement processes.		

Standard II—Quality Assessment and Performance Improvement (QAPI)		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
Required Actions: None.		
g. Including information from participating providers and information from members, their families, and their guardians in the development and implementation of quality management and performance improvement activities. *Contract: 4.12.2.2*	• C7QI-055 Healthcare Effectiveness Data & Information Set (HEDIS®), p.1 • C7QI-055-PR-001 Healthcare Effectiveness Data & Information Set (HEDIS®), p.1 • 2015 GA QI Program Description, p.3-4 • 2015 Medicaid Adult CAHPS® 5.0H • GA Medicaid QIC Minutes September 15, 2015, p.53-58 • GA UMAC Minutes August 19, 2015, p.59-60	☒ Met ☐ Not Met ☐ N/A
Findings WellCare's HEDIS Policy described the use of claims and encounter data for calculation of HEDIS rates. The 2015 Georgia QI Program Description stated that WellCare's quality management program was developed and implemented using information obtained from provider participation and information from members, their families, and their guardians. WellCare used information gathered from committee participation and quality improvement work to develop and implement quality management and performance improvement projects. The documents did not specify how information from providers and members was obtained for consideration in the development and implementation of quality management and performance improvement activities. During compliance review interviews, the CMO described other avenues used to solicit member involvement, such as the Health Connections Council, Member Advisory Council, direct interaction with members, grievances, and member advocacy work.		
Required Actions: None.		
h. Using the CMO's best practices for performance and quality improvement. *Contract: 4.12.2.2*	• 2015 GA QI Program Description, p.30 • ADHD Best Practices Tip Sheet • Provider Handbook, p.109 • Pharmacy Lock-In Report	☒ Met ☐ Not Met ☐ N/A
Findings: WellCare included a statement indicating that it distributed CPGs to promote best practices when treating chronic conditions in the 2015 Georgia QI Program Description. WellCare provided the ADHD Best Practices Tip Sheet that was distributed to providers as an example. WellCare described, as a best practice, its requirements for "locking in" members to one prescriber and one pharmacy if the member utilized multiple prescribers or frequented the emergency department seeking pain medications. During the compliance review interview, the CMO described an example of what the CMO considered a best practice—the member community advocacy work and its active involvement in		

Standard II—Quality Assessment and Performance Improvement (QAPI)		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
connecting members with up to 10,000 community organizations and events in order to impact the social determinants of health. The CMO was in the process of measuring initial results of the program and having the results evaluated by the Robert Wood Johnson Foundation.		
Required Actions: None.		
5. The CMO complies with Georgia Families quality management requirements to improve member health outcomes by using DCH-established performance measures to document results. *42CFR438.240(b)(2)* *Contract: 4.12.3.1*	• 2015 GA QI Program Evaluation, p.23-24 • 2015 Performance Measures Report, All Tabs • 2015 Performance Measures Report Analysis	☐ Met ☒ Not Met ☐ N/A
Findings: WellCare did not use the DCH-mandated QAPI Program guidelines for generating its QAPI report. WellCare instead discussed specific quality improvement activities in the 2015 Georgia QI Program Evaluation that used DCH-established performance measures to document improvement in member health outcomes. The WellCare 2015 Performance Measures Report Analysis provided a brief description of the targeted strategies and interventions used to improve member health outcomes, as well as an evaluation of the effectiveness of the strategies implemented. During compliance review interviews, the CMO described its use of quality practice advisors; these staff members worked on-site in provider offices to provide information and education on how to improve performance measure rates and reduce gaps in care.		
Required Actions: WellCare must document results of the DCH-established performance measures in its QAPI report.		
6. The CMO achieved DCH-established performance targets. *State-specified element*	• 2015 GA QI Program Evaluation, p.23-24, 27-28 • 2015 Performance Measures Report, All Tabs • 2015 Performance Measures Report Analysis	☐ Met ☒ Not Met ☐ N/A
Findings: WellCare did not meet all of the DCH-established performance goals for CY 2014 and CY 2015. The CMO showed statistically significant increases in 22 measure rates. The CMO showed statistically significant decreases in 13 measure rates. The following results were noted:		

Standard II—Quality Assessment and Performance Improvement (QAPI)		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**

WellCare Access to Care Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	97.51%	96.90%	↓	NC
25 Months–6 Years	91.23%	89.63%	↓	NC
7–11 Years	92.61%	91.36%	↓	NC
12–19 Years	90.35%	89.09%	↓	93.50%
Adults' Access to Preventive/Ambulatory Health Services				
20–44 Years	81.76%	81.52%	↔	88.52%
Annual Dental Visit				
2–3 Years	46.94%	49.80%	↑	54.20%
4–6 Years	72.25%	76.42%	↑	NC
7–10 Years	75.14%	78.49%	↑	NC
11–14 Years	69.30%	72.49%	↑	NC
15–18 Years	58.65%	61.57%	↑	NC
19–20 Years	—	40.17%	NT	34.04%[4]
Total	66.64%	70.12%	↑	NC
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment				
Initiation of AOD Treatment—Total	32.34%	34.15%	↔	43.48%
Engagement of AOD Treatment—Total	7.02%	7.09%	↔	14.97%
Care Transition—Transition Record Transmitted to Health Care Professional				

Standard II—Quality Assessment and Performance Improvement (QAPI)				
Requirements and References	**Evidence/Documentation as Submitted by the CMO**			**Score**
Care Transition—Transition Record Transmitted to Health Care Professional	0.00%	0.00%	↔	NC
Colorectal Cancer Screening				
Colorectal Cancer Screening	—	46.72%	NT	NC
Adult BMI Assessment				
Adult BMI Assessment	79.94%	82.08%	↔	85.23%

[1] CY 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014 through December 31, 2014.
[2] CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015 through December 31, 2015.
[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.
[4] CY 2015 performance target is derived from previous CY 2014 rates, which included members age 19–21 years rather than 19–20 years.
↑ indicates a statistically significant improvement in performance between CY 2014 and CY 2015.
↓ indicates a statistically significant decline in performance between CY 2014 and CY 2015.
↔ indicates no statistically significant difference in performance between CY 2014 and CY 2015.
— indicates that the CY 2014 rate was not presented in the previous year's technical report; therefore, this rate is not presented in this report.
NA (i.e., Small Denominator) indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.
NC (i.e., Not Compared) indicates that DCH did not establish a performance target for this indicator.
NT (i.e., Not Trended) indicates that statistical significance testing was not performed between CY 2014 and CY 2015.

WellCare Children's Health Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Well-Child/Well-Care Visits				
Well-Child Visits in the First 15 Months of Life				
Six or More Well-Child Visits	66.93%	64.69%	↔	69.98%

Standard II—Quality Assessment and Performance Improvement (QAPI)				
Requirements and References	**Evidence/Documentation as Submitted by the CMO**			**Score**
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	66.93%	68.73%	↔	72.80%
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	49.54%	53.28%	↔	53.47%
Prevention and Screening				
Childhood Immunization Status				
Combination 3	84.03%	82.10%	↔	82.30%
Combination 6	43.06%	44.54%	↔	59.37%
Combination 10	38.66%	41.48%	↔	40.94%
Lead Screening in Children				
Lead Screening in Children	81.35%	83.85%	↔	77.34%
Appropriate Testing for Children with Pharyngitis				
Appropriate Testing for Children with Pharyngitis	79.09%	80.67%	↑	83.66%
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap/Td)	76.33%	89.51%	↑	73.43%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total	63.43%	66.26%	↔	45.86%
Counseling for Nutrition—Total	59.49%	60.39%	↔	46.30%
*Counseling for Physical Activity—Total**	54.63%	54.03%	↔	46.30%
Developmental Screening in the First Three Years of Life				
Total	44.91%	51.82%	↑	46.36%
Percentage Of Eligibles Who Received Preventive Dental Services				

Standard II—Quality Assessment and Performance Improvement (QAPI)				
Requirements and References	**Evidence/Documentation as Submitted by the CMO**			**Score**
Percentage Of Eligibles Who Received Preventive Dental Services	49.93%	52.91%	↑	58.00%
Dental Sealants for 6-9-Year-Old Children at Elevated Caries Risk				
Dental Sealants for 6-9-Year-Old Children at Elevated Caries Risk	—	12.90%	NT	NC
Upper Respiratory Infection				
Appropriate Treatment for Children with Upper Respiratory Infection				
Appropriate Treatment for Children with Upper Respiratory Infection	82.81%	84.42%	↑	86.11%

[1] *CY 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014 through December 31, 2014.*

[2] *CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015 through December 31, 2015.*

[3] *CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.*

** Due to changes in the technical measure specifications, use caution when comparing rates for this measure between CY 2014 and 2015.*

↑ *indicates a statistically significant improvement in performance between CY 2014 and CY 2015.*

↔ *indicates no statistically significant difference in performance between CY 2014 and CY 2015.*

— indicates that the CY 2014 rate was not presented in the previous year's technical report; therefore, this rate is not presented in this report.

NA (i.e., Small Denominator) indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.

NC (i.e., Not Compared) indicates that DCH did not establish a performance target for this indicator.

NT (i.e., Not Trended) indicates that statistical significance testing was not performed between CY 2014 and CY 2015.

WellCare Women's Health Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Prevention and Screening				

Standard II—Quality Assessment and Performance Improvement (QAPI)				
Requirements and References	**Evidence/Documentation as Submitted by the CMO**			**Score**
Cervical Cancer Screening				
Cervical Cancer Screening	74.56%	66.36%	↓	76.64%
Breast Cancer Screening				
Breast Cancer Screening	72.17%	71.61%	↔	71.35%
Chlamydia Screening in Women				
Total	50.26%	53.04%	↑	54.93%
Human Papillomavirus Vaccine for Female Adolescents				
Human Papillomavirus Vaccine for Female Adolescents	20.37%	23.36%	↔	23.62%
Prenatal Care and Birth Outcomes				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	81.27%	72.32%	↓	89.62%
Postpartum Care	64.56%	52.87%	↓	69.47%
Cesarean Section for Nulliparous Singleton Vertex[4]				
Cesarean Section for Nulliparous Singleton Vertex	NR	19.56%	NT	18.08%
Cesarean Delivery Rate, Uncomplicated[4]				
Cesarean Delivery Rate, Uncomplicated	29.73%	28.70%	↑	28.70%
Percentage of Live Births Weighing Less Than 2,500 Grams[4]				
Percentage of Live Births Weighing Less Than 2,500 Grams	9.21%	9.05%	↔	8.02%
Behavioral Health Risk Assessment for Pregnant Women				
Behavioral Health Risk Assessment for Pregnant Women	9.95%	15.33%	↑	NC
Early Elective Delivery[4]				

Standard II—Quality Assessment and Performance Improvement (QAPI)					
Requirements and References	**Evidence/Documentation as Submitted by the CMO**				**Score**
Early Elective Delivery	NR	1.47%	NT	2.00%	
Antenatal Steroids					
Antenatal Steroids	NR	0.00%	NT	NC	
Frequency of Ongoing Prenatal Care					
Frequency of Ongoing Prenatal Care					
≥81 Percent of Expected Visits	58.48%	38.90%	↓	60.10%	

[1] *CY 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014 through December 31, 2014.*

[2] *CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015 through December 31, 2015.*

[3] *CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.*

[4] *A lower rate indicates better performance for this measure.*

↑ *indicates a statistically significant improvement in performance between CY 2014 and CY 2015.*

↓ *indicates a statistically significant decline in performance between CY 2014 and CY 2015.*

↔ *indicates no statistically significant difference in performance between CY 2014 and CY 2015.*

— indicates that the CY 2014 rate was not presented in the previous year's technical report; therefore, this rate is not presented in this report.

NA (i.e., Small Denominator) indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.

NC (i.e., Not Compared) indicates that DCH did not establish a performance target for this indicator.

NT (i.e., Not Trended) indicates that statistical significance testing was not performed between CY 2014 and CY 2015.

NR (i.e., Not Reported) indicates that the CMO produced a CY 2014 rate that was materially biased or chose not to report results for this measure; therefore, the rate was not included in the performance calculation. The auditors confirmed that although the CMO calculated this measure properly and according to CMS specifications, due to limitations with CMS specifications, the eligible population could not be appropriately ascertained. The resulting rate, therefore, was considered biased and not representative of the population.

Standard II—Quality Assessment and Performance Improvement (QAPI)		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**

WellCare Chronic Conditions Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Diabetes				
Comprehensive Diabetes Care*				
Hemoglobin A1c (HbA1c) Testing	83.19%	80.43%	↔	87.59%
HbA1c Poor Control (>9.0%)[4]	48.75%	52.74%	↔	44.69%
HbA1c Control (<8.0%)	43.26%	39.80%	↔	46.43%
HbA1c Control (<7.0%)	32.43%	32.39%	↔	36.27%
Eye Exam (Retinal) Performed	35.44%	39.64%	↔	54.14%
Medical Attention for Nephropathy	76.71%	90.88%	↑	80.05%
Blood Pressure Control (<140/90 mm Hg)	55.74%	49.09%	↓	61.31%
Diabetes Short-Term Complications Admission Rate (Per 100,000 Member Months)[4]				
Diabetes Short-Term Complications Admission Rate	18.36	13.69	NT	--
Respiratory Conditions				
Asthma in Younger Adults Admission Rate (Per 100,000 Member Months)[4]				
Asthma in Younger Adults Admission Rate	5.52	3.38	NT	--
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (Per 100,000 Member Months)[4]				

Standard II—Quality Assessment and Performance Improvement (QAPI)					
Requirements and References	**Evidence/Documentation as Submitted by the CMO**				**Score**
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	41.00	17.30	NT	--	
Pharmacotherapy Management of COPD Exacerbation					
Systemic Corticosteroid	—	69.28%	NT	74.94%	
Bronchodilator	—	82.35%	NT	83.82%	
Cardiovascular Conditions					
Heart Failure Admission Rate (Per 100,000 Member Months)[4]					
Heart Failure Admission Rate	4.28	5.02	NT	--	
Controlling High Blood Pressure					
Controlling High Blood Pressure	43.24%	40.15%	↔	56.46%	
Persistence of Beta-Blocker Treatment After a Heart Attack					
Persistence of Beta-Blocker Treatment After a Heart Attack	—	NA	NT	NC	

[1] CY 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014 through December 31, 2014.

[2] CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015 through December 31, 2015.

[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.

[4] A lower rate indicates better performance for this measure.

** Due to changes in the technical measure specifications, use caution when comparing rates for this measure between CY 2014 and 2015.*

↑ *indicates a statistically significant improvement in performance between CY 2014 and C Y2015.*

↓ *indicates a statistically significant decline in performance between CY 2014 and CY 2015.*

↔ *indicates no statistically significant difference in performance between CY 2014 and CY 2015.*

-- indicates the reporting unit for this measure was reported as per 100,000 member months for CY 2014 and CY 2015, and previous years were reported as per 100,000 members. Since the 2015 performance target was developed based on the previous year's reporting metrics, the 2015 performance target is not presented and caution should be used if comparing the CY 2015 rate to the 2015 performance target for this measure.

— indicates that the CY 2014 rate was not presented in the previous year's technical report; therefore, this rate is not presented in this report.

Standard II—Quality Assessment and Performance Improvement (QAPI)		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**

NA (i.e., Small Denominator) indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.
NC (i.e., Not Compared) indicates that DCH did not establish a performance target for this indicator.
NT (i.e., Not Trended) indicates that statistical significance testing was not performed between CY 2014 and CY 2015.

WellCare Behavioral Health Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	48.92%	47.02%	↓	53.03%
Continuation and Maintenance Phase	63.78%	64.29%	↔	63.10%
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up	50.77%	50.39%	↔	63.21%
30-Day Follow-Up	69.72%	68.75%	↔	80.34%
Antidepressant Medication Management				
Effective Acute Phase Treatment	46.92%	44.77%	↔	54.31%
Effective Continuation Phase Treatment	30.37%	28.35%	↔	38.23%
Screening for Clinical Depression and Follow-Up Plan				
Screening for Clinical Depression and Follow-Up Plan	0.49%	7.18%	↑	NC
Adherence to Antipsychotic Medications for Individuals with Schizophrenia*				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	33.85%	39.23%	↔	61.37%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents				

Standard II—Quality Assessment and Performance Improvement (QAPI)				
Requirements and References	**Evidence/Documentation as Submitted by the CMO**			**Score**
Total	—	1.59%	NT	NC

[1] CY 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014 through December 31, 2014.
[2] CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015 through December 31, 2015.
[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.
** Due to changes in the technical measure specifications, use caution when comparing rates for this measure between CY 2014 and 2015.*
↑ indicates a statistically significant improvement in performance between CY 2014 and CY 2015.
↓ indicates a statistically significant decline in performance between CY 2014 and CY 2015.
↔ indicates no statistically significant difference in performance between CY 2014 and CY 2015.
— indicates that the CY 2014 rate was not presented in the previous year's technical report; therefore, this rate is not presented in this report.
NA (i.e., Small Denominator) indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.
NC (i.e., Not Compared) indicates that DCH did not establish a performance target for this indicator.
NT (i.e., Not Trended) indicates that statistical significance testing was not performed between CY 2014 and CY 2015.

WellCare Medication Management Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Annual Monitoring for Patients on Persistent Medications				
Annual Monitoring for Members on ACE Inhibitors or ARBs	86.72%	89.47%	↑	88.00%
Annual Monitoring for Members on Diuretics	87.27%	88.82%	↔	87.90%
Total	86.86%	89.03%	↑	88.25%
Medication Management for People With Asthma				
Medication Compliance 50%—Ages 5–11 Years	45.62%	47.49%	↔	NC

Standard II—Quality Assessment and Performance Improvement (QAPI)					
Requirements and References	**Evidence/Documentation as Submitted by the CMO**				**Score**
Medication Compliance 50%—Ages 12–18 Years	42.00%	42.44%	↔	NC	
Medication Compliance 50%—Ages 19–50 Years	57.79%	56.15%	↔	NC	
Medication Compliance 50%—Ages 51–64 Years	NA	NA	NT	NC	
Medication Compliance 50%—Total	44.91%	46.08%	↔	NC	
Medication Compliance 75%—Ages 5–11 Years	21.93%	22.99%	↔	32.32%	
Medication Compliance 75%—Ages 12–18 Years	18.25%	19.95%	↔	NC	
Medication Compliance 75%—Ages 19–50 Years	33.61%	34.23%	↔	NC	
Medication Compliance 75%—Ages 51–64 Years	NA	NA	NT	NC	
Medication Compliance 75%—Total	21.17%	22.37%	↔	NC	

[1] CY 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014 through December 31, 2014.

[2] CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015 through December 31, 2015.

[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.

↑ indicates a statistically significant improvement in performance between CY 2014 and CY 2015.

↔ indicates no statistically significant difference in performance between CY 2014 and CY 2015.

— indicates that the CY 2014 rate was not presented in the previous year's technical report; therefore, this rate is not presented in this report.

NA (i.e., Small Denominator) indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.

NC (i.e., Not Compared) indicates that DCH did not establish a performance target for this indicator.

NT (i.e., Not Trended) indicates that statistical significance testing was not performed between CY 2014 and CY 2015.

Standard II—Quality Assessment and Performance Improvement (QAPI)		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**

WellCare Utilization Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Ambulatory Care (Per 1,000 Member Months)—Total				
ED Visits—Total[4]	61.04	60.95	NT	52.31
Outpatient Visits—Total	334.03	327.56	NT	NC
Inpatient Utilization—General Hospital/Acute Care—Total				
Total Inpatient—Average Length of Stay—Total	2.99	3.20	NT	NC
Total Inpatient—Average Length of Stay—<1 Year	—	6.50	NT	NC
Medicine—Average Length of Stay—Total	3.02	3.18	NT	NC
Medicine—Average Length of Stay—<1 Year	—	4.16	NT	NC
Surgery—Average Length of Stay—Total	5.84	5.75	NT	NC
Surgery—Average Length of Stay—<1 Year	—	13.95	NT	NC
Maternity—Average Length of Stay—Total	2.53	2.74	NT	NC
Mental Health Utilization—Total				
Any Service—Total—Total	8.88%	9.25%	NT	NC
Inpatient—Total—Total	0.50%	0.55%	NT	NC
Intensive Outpatient or Partial Hospitalization—Total—Total	0.14%	0.13%	NT	NC
Outpatient or ED—Total—Total	8.77%	9.14%	NT	NC

Standard II—Quality Assessment and Performance Improvement (QAPI)				
Requirements and References	**Evidence/Documentation as Submitted by the CMO**			**Score**
Plan All-Cause Readmission Rate[4]				
Age 18–44	—	11.79%	NT	NC
Age 45–54	—	10.46%	NT	NC
Age 55–64	—	20.95%	NT	NC
Age 18–64—Total	—	11.93%	NT	NC
Age 65–74	—	NA	NT	NC
Age 75–84	—	NA	NT	NC
Age 85 and Older	—	NA	NT	NC
Age 65 and Older—Total	—	NA	NT	NC

[1] CY 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014 through December 31, 2014.

[2] CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015 through December 31, 2015.

[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.

[4] A lower rate indicates better performance for this measure.

— indicates that the CY 2014 rate was not presented in the previous year's technical report; therefore, this rate is not presented in this report.

NA (i.e., Small Denominator) indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.

NC (i.e., Not Compared) indicates that DCH did not establish a performance target for this indicator.

NT (i.e., Not Trended) indicates that statistical significance testing was not performed between CY 2014 and CY 2015.

WellCare Health Plan Descriptive Information Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Increase or Decrease	2015 Performance Target[3]
Weeks of Pregnancy at Time of Enrollment				
<0 Weeks	10.83%	13.79%	↑	NC

Standard II—Quality Assessment and Performance Improvement (QAPI)					
Requirements and References	**Evidence/Documentation as Submitted by the CMO**				**Score**
1–12 Weeks	7.11%	13.70%	↑	NC	
13–27 Weeks	56.69%	52.04%	↓	NC	
28+ Weeks	16.72%	12.33%	↓	NC	
Unknown	8.66%	8.14%	↓	NC	
Race/Ethnicity Diversity of Membership					
Total—White	48.33%	49.04%	↑	NC	
Total—Black or African American	43.96%	44.16%	↑	NC	

[1] CY 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014 through December 31, 2014.

[2] CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015 through December 31, 2015.

[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.

↑ *indicates a statistically significant rate increase between CY 2014 and CY 2015.*

↓ *indicates a statistically significant rate decrease between CY 2014 and CY 2015.*

NC (i.e., Not Compared) indicates that DCH did not establish a performance target for this indicator.

Required Actions: HSAG was concerned that some performance measures experienced significant rate declines. WellCare must meet all DCH-established performance targets before this element will be given a *Met* status.

7. The CMO has an ongoing QAPI program for the services it furnishes to its members. *42CFR438.240(a)* *Contract: 4.12.5.1*	• C7QI-033 Quality Improvement Program, p.1 • C7QI-033-PR-001 Quality Improvement Program and Provider Involvement, p.2 • 2015 GA QI Program Description, p.5-6 • 2015 GA QI Program Evaluation • Bright Futures Module 4, Intervention 1 • Bright Futures Module 4, Intervention 2 • Bright Futures Module 5 • 2015 QAPI Program Description • 2015 QAPI Program Evaluation	☐ Met ☒ Not Met ☐ N/A

Standard II—Quality Assessment and Performance Improvement (QAPI)		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
Findings: The QAPI Program Description did not follow the DCH-required guidelines. The Quality Improvement Program Policy stated that WellCare shall have an ongoing Quality Improvement Program (QIP) that objectively and systematically monitors and evaluates the quality and effectiveness of care and services rendered, thereby promoting quality care and quality patient outcomes in service performance to its members. WellCare described the extent of its QAPI Program in the 2015 Georgia QI Program Description and the 2015 QI Program Evaluation. The scope of the program included the assessment of network adequacy and appointment availability; development and review of CPGs; assessment of member satisfaction; credentialing and recredentialing of primary care providers (PCPs), specialists, and ancillary and allied health providers; assessment of continuity and coordination of care; assessment of provider compliance with national standards of care; assessment of patient safety; assessment of operational service performance; health services programs and activities; ongoing assessment of population changes; assessment of delegation oversight activities; and an assessment of the quality improvement program. WellCare provided the *Bright Futures* PIP with a goal to increase adolescent well-care visits as an example of a quality improvement initiative. However, the QI Evaluation did not provide in-depth analysis or an evaluation reflecting how the CMO used its QAPI Program for the services it furnished to members.		
Required Actions: WellCare must develop a comprehensive QAPI Program Description. The QAPI Program Description must be developed according to the DCH guidelines. The CMO must be approved by DCH as meeting the DCH guidelines.		
8. The CMO's QAPI program is based on the latest available research in the area of quality assurance. *Contract: 4.12.5.2*	• Clinical Practice Guidelines Hierarchy	☐ Met ☒ Not Met ☐ N/A
Findings: WellCare provided the National Committee for Quality Assurance (NCQA) Clinical Practice Guidelines Hierarchy as evidence that the QAPI Program was based on the latest available research in the area of quality assurance. WellCare did not describe how it used the latest available research in the area of quality assurance in its QAPI Program descriptions or policies. During the compliance review interview, the CMO described its discussions with the developers of the Coleman Model for Care Transitions and the Lace Tool regarding discharge planning processes as an example of its use of the latest available research in the CMO's QAPI Program. Discussions with the Coleman Model developer included the development and use of a hybrid model tool which would include factors that were not in the model but were specific to the Georgia Medicaid population.		
Required Actions: The CMO must base its QAPI Program on the latest available research in the area of quality assurance.		
9. The CMO's QAPI program includes mechanisms to detect both underutilization and overutilization. *42CFR438.240(b)(3) Contract: 4.12.5.2*	• C7UM-1.2 Under and Over Utilization of Services, p.1-2 • C7UM-1.2-PR-001 Under and Over Utilization of Services • 2015 GA QI Program Description, p.31 • Provider Handbook, p.106-111	☒ Met ☐ Not Met ☐ N/A

Standard II—Quality Assessment and Performance Improvement (QAPI)		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Pharmacy Lock-In Report	
Findings: WellCare's Under and Over Utilization of Services Policy and the QI Program Description described WellCare's approach to monitoring underutilization and overutilization of healthcare services. WellCare's UMAC oversaw the utilization of healthcare services. WellCare used tools to monitor utilization of healthcare services including inpatient daily census, Cognos data, monthly inpatient utilization reports, pharmacy reports, medical record review reports, physician risk group reports, nationally recognized benchmarks, and historical data. WellCare developed provider utilization profiles and physician risk group reports, as well as conducted medical record reviews to detect overutilization and underutilization using trends in data. The CMO implemented corrective actions to address both provider and member overutilization and underutilization. The provider handbook and the Pharmacy Lock-In Report also described processes implemented to address overutilization issues. WellCare did not describe in its policies or program descriptions how it focuses interventions and activities on underutilization in areas such as chronic disease and preventive health.		
Required Actions: None.		
10. The CMO's QAPI program includes mechanisms to assess the quality and appropriateness of care furnished to all members, including those with special health care needs. *42CFR438.240(b)(4)* *Contract: 4.12.5.2*	• C7CM MD-4.8 Individuals with Special Health Care Needs • 2015 GA QI Program Description, p.7 • 2015 GA QI Program Evaluation, p.6 • 2015 Case Management Program Description, p.32-33 • 2015 QAPI Program Description • 2015 QAPI Program Evaluation	☐ Met ☒ Not Met ☐ N/A
Findings: WellCare includes an assessment of the appropriateness of services through prior authorization and concurrent review processes using national guideline criteria. Documentation was provided in the Individuals with Special Health Care Needs document, QI Program Description, QI Program Evaluation, and the Case Management Program Description. WellCare's UMAC was responsible for promoting the delivery of efficient and appropriate healthcare services to members. The UMAC reviewed and evaluated utilization data to facilitate appropriate and efficient allocation of resources and services; investigated quality-related utilization issues; and analyzed utilization data including overutilization and underutilization, readmissions, and patient safety. During the compliance review interviews, WellCare discussed its use of UM rounds led by the chief medical officer in relation to the quality and appropriateness of services furnished to members. The review included 34–40 WellCare medical directors and staff focused on high-priority areas such as complex care, high-risk maternity, Neonatal Intensive Care Unit, and behavioral health integration. WellCare did not provide documentation of implemented processes to assess the quality of care furnished to members with special healthcare needs.		
Required Actions: WellCare must implement processes to assess the quality of care furnished to members with special healthcare needs.		

Standard II—Quality Assessment and Performance Improvement (QAPI)		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
11. The CMO has a method of monitoring, analysis, evaluation and improvement of the delivery, quality, and appropriateness of health care furnished to all members (including under- and over-utilization of services), including those with special health care needs. *Contract: 4.12.5.2*	• C7UM-1.2 Under and Over Utilization of Services, p.1-2 • C7UM-1.2-PR-001 Under and Over Utilization of Services • 2015 GA QI Program Description, p.7, 18-19 • 2015 GA QI Program Evaluation, p.6	☐ Met ☒ Not Met ☐ N/A
Findings: WellCare has processes focused on monitoring utilization of healthcare services as described in the Under and Over Utilization of Services Policy. The CMO implemented corrective actions to address both provider and member overutilization. The provider handbook and the Pharmacy Lock-In Report also described processes implemented to address overutilization issues. WellCare's UMAC was responsible for promoting the delivery of efficient and appropriate healthcare services to members. The UMAC reviewed disease management statistics, clinical quality initiatives, quality of care and quality of service issues, complaints, grievances and adverse event data, member and provider satisfaction survey results, and recommended strategies to improve compliance.		
Required Actions: WellCare must strengthen its processes for monitoring, analysis, and evaluation of the delivery, quality, and appropriateness of healthcare furnished to members in the areas of underutilization. WellCare must include information on its method of monitoring, analysis, evaluation, and improvement for the delivery, quality, and appropriateness of healthcare furnished for members with special healthcare needs in its policies, program descriptions, and evaluations.		
12. The CMO's QAPI program includes written policies and procedures for quality assessment, utilization management, and continuous quality improvement that are periodically assessed for efficacy. *Contract: 4.12.5.2*	• C7QI-033 Quality Improvement Program and Provider Involvement, p.1 • C7QI-033-PR-001 Quality Improvement Program and Provider Involvement, p.1-2 • C7UM 1.2 Under and Over Utilization of Services • C7UM-1.2-PR-001 Under and Over Utilization of Services	☐ Met ☒ Not Met ☐ N/A
Findings: WellCare did not submit its QAPI Program Description. The QAPI Program Description is required by DCH and must be developed according to the DCH guidelines. The WellCare QI Program Description and Quality Improvement Program and Provider Involvement Policy stated that WellCare shall have an ongoing QIP that objectively and systematically monitors and evaluates the quality and effectiveness of care and services rendered, thereby promoting quality of care and quality patient outcomes in service performance to its members. The QI Annual		

Standard II—Quality Assessment and Performance Improvement (QAPI)		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
Evaluation included a brief description of ongoing and completed quality improvement activities and projects; trended clinical care and service performance measures and progress toward achieving goals; an analysis to identify barriers; and accomplishments and current opportunities for improvement with recommendations for interventions. The Under and Over Utilization of Services Policy described tools used for monitoring the underutilization and overutilization of healthcare services, as well as procedures for identifying patterns and addressing potential problems identified as a result of the analysis. Documentation submitted did not describe how the written policies and procedures were periodically assessed for efficacy.		
Required Actions: WellCare must develop a comprehensive QAPI Program Description. The QAPI Program Description must be developed according to the DCH guidelines. The CMO must be approved by DCH as meeting the DCH guidelines. The CMO must develop policies and procedures that support the implementation of the scope, goals, and objectives of the program including quality assessment, utilization management, and continuous quality improvement. The CMO must also assess the policies and procedures periodically for efficacy.		
13. The CMO's QAPI program includes designated staff members with expertise in quality assessment, utilization management, and continuous quality improvement. *Contract: 4.12.5.2*	• 2015 GA QI Program Description, p.10-12 • 2015 UM Medicaid Program Description, p.3	☒ Met ☐ Not Met ☐ N/A
Findings: The 2015 QI Program Description specified that the WellCare QI Program included designated staff members with expertise in quality assessment, utilization management, and continuous quality improvement. Staff identified with a key role in the QI Program included the medical director who supported and oversaw the development, implementation, and evaluation of all clinical aspects of the QI Program; the behavioral health medical director who was responsible for the development, implementation, and evaluation of all behavioral health aspects of the QI Program; and the senior director of quality who had overall accountability for the day-to-day operations of the QI Program. WellCare documentation described integration of QI Program activities throughout the organization that included all functional areas of the organization. The 2015 UM Medicaid Program Description stated that a team of physicians and nurses with unrestricted licenses, and licensed behavioral health professionals, along with qualified healthcare professionals who were appropriately trained in the principles, procedures, and standards of utilization review, performed utilization management activities. WellCare also indicated that its UM Program was integrated with the QI Program and supported quality of care, service, and continuous quality improvement.		
Required Actions: None.		

Standard II—Quality Assessment and Performance Improvement (QAPI)		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
14. The CMO's QAPI program includes reports that are evaluated, indicated recommendations that are implemented, and feedback provided to providers and members. *Contract: 4.12.5.2*	• 2015 GA QI Program Description, p.14-15 • 2015 GA QI WorkPlan, All Tabs • 2015 GA QI Program Evaluation, p.43-47 • 2015 Medicaid Adult CAHPS® 5.0H • GA UMAC Minutes August 19, 2015, p.59-60 • GA Medicaid QIC Minutes September 15, 2015, p.53-58 • Q3 2015 Provider Newsletter, p.10 • 2015 GA Medicaid Member Newsletter Issue 4, p.6 • ADHD Module 4 • ADHD Module 5 • Provider Satisfaction Module 4, Intervention 1 • Provider Satisfaction Module 4-Intervention 1 Attachment A • Provider Satisfaction Module 4-Intervention 1 Attachment B • Provider Satisfaction Module 5	☐ Met ☒ Not Met ☐ N/A
Findings: The QIC reviewed reports including quality measurement studies and projects, HEDIS performance measure results, member and provider satisfaction survey results, medical record reviews, complaints and grievances, provider network adequacy (availability and accessibility), continuity and coordination of care, cultural competency activities, and patient safety initiatives. The QIC had the primary responsibility for ensuring appropriate follow-up action in order to complete planned program initiatives. The QIC monitored, evaluated, and ensured compliance with the QI Program activities. The QIC also provided guidance on the development and dissemination of information regarding QI activities and outcomes to members and providers. WellCare had a QI WorkPlan that included interventions and activities with measurable goals that were reported to the QIC and to the UMAC. WellCare shared results of certain quality improvement activities with members through the member newsletter and with providers through the provider newsletter. During the compliance review interview, the CMO described the use of quality practice advisors to share HEDIS and utilization results with network providers. The quality practice advisors also worked with providers on opportunities to improve performance rates and to close gaps in care. WellCare's QI Program Description described goals and objectives to track, trend, and report data and outcomes. The WellCare QI Program Description and the QI Program Evaluation did not include information on how, as a result of data analysis or evaluation, indicated recommendations are implemented.		
Required Actions: WellCare must update its policies, program descriptions, and/or program evaluations to describe how, as a result of data analysis or evaluation, indicated recommendations are implemented.		

Standard II—Quality Assessment and Performance Improvement (QAPI)		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
15. The CMO's QAPI program includes a methodology and process for conducting and maintaining provider profiling. *Contract: 4.12.5.2*	• C6CR-001 Credentialing and Re-Credentialing • C7CR-001-PR-001 Credentialing and Re-Credentialing, p.1 • C7QI-053 Quality of Care Issues, p.12 • GA Medicaid QIC Minutes September 15, 2015, p.37-38	☐ Met ☒ Not Met ☐ N/A
Findings: The WellCare Credentialing and Re-Credentialing Policy referenced requesting the provider performance profile information from the QI Department for providers being recredentialed. The Quality of Care Issues Policy included a table with Georgia reporting requirements. The policies did not include a methodology or process for conducting and maintaining provider profiling. The Georgia Medicaid QIC meeting minutes dated September 15, 2015, did not describe a methodology or process for conducting and maintaining provider profiling.		
Required Actions: WellCare must document the methodology and process used for conducting and maintaining provider profiling in its policies. WellCare must develop provider profiling activities that include information such as tracked and trended data regarding utilization, complaints and grievances, prescribing, and member satisfaction. WellCare's implementation or use of provider profiling information must be included in the QM Program Description to guide decisions in network development.		
16. The CMO's QAPI program includes ad-hoc reports to the CMO's multidisciplinary Quality Oversight Committee and DCH on results, conclusions, recommendations, and implemented system changes, including: *Contract: 4.12.5.2*		
a. Annual performance improvement projects (PIPs) that focus on clinical and non-clinical areas; and	• Provider Satisfaction Module 4-Intervention 1 • Provider Satisfaction Module 4-Intervention 1 Attachment A • Provider Satisfaction Module 4-Intervention 1 Attachment B • Provider Satisfaction Module 5 • Dental Module 4 • Dental Module 5	☒ Met ☐ Not Met ☐ N/A
Findings: WellCare's QI Program Description included annual PIPs that focused on clinical and nonclinical areas, as evidenced by the PIP modules that described PIPs aimed at provider satisfaction and dental benefit education. Reports and discussions occurred at committee meetings regarding the PIPs.		

Standard II—Quality Assessment and Performance Improvement (QAPI)		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
Required Actions: None.		
b. Annual Reports on performance improvement projects and a process for evaluation of the impact and assessment of the Contractor's QAPI program.	• 2015 GA QI Program Description, p.4 • 2015 GA QI Program Evaluation • 2015 Performance Measures Report, All Tabs • 2015 Performance Measures Report Analysis	☒ Met ☐ Not Met ☐ N/A
Findings: The 2015 Georgia QI Program Description included a reference to ad hoc reports for the QIC and DCH on results, conclusions, recommendations, and implemented system changes. The 2015 Georgia QI Program Evaluation stated that the QIC provided regular and ad hoc reports on the status of the QI Program with recommendations to the Board of Directors or a committee thereof. WellCare provided an example of an annual report on PIPs and an evaluation of the impact and assessment of the QI Program in the 2015 Performance Measures Report Analysis.		
Required Actions: None.		
17. The CMO has a process for evaluating the impact and effectiveness of the QAPI program. *42CFR438.240(e)(2)* *Contract: 4.12.5.2*	• C7QI-033 Quality Improvement Program and Provider Involvement, p.1 • C7QI-033-PR-001 Quality Improvement Program and Provider Involvement • 2015 GA QI Program Description, p.5 • 2015 GA QI Program Evaluation • 2015 QAPI Program Evaluation	☐ Met ☒ Not Met ☐ N/A
Findings: The 2015 QI Program Description provided a broad overview of overarching goals and objectives for quality assessment and performance improvement. Goals and objectives were based on federal and State requirements. However, the QI Program Description did not describe how WellCare used data and information obtained from utilization management, disease management, case management, grievances and appeals, quality of care case review, and member or provider feedback in its process to identify appropriate goals and objectives for quality improvement that were reflective of the needs of the population served. The QI Program Description did not discuss how analyzed and evaluated data from care and service delivery or information received from members or providers related to WellCare programs or operations were used to evaluate the effectiveness of the QI Program. The 2015 QI Program Description and the QI Evaluation were focused on the success of activities related to meeting regulatory compliance, rather than focusing on an understanding of the population served or an identification of opportunities to improve care, service, or satisfaction through a review of analyzed data. For example, the 2015 QI Program Description stated that the QI Program was considered effective as the CMO had achieved all of its QI Program objectives. The program description stated:		

Standard II—Quality Assessment and Performance Improvement (QAPI)		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
Notable areas of improvement included the following: • Adult CAHPS®,A-1 survey accreditation points increased from 7.8 in 2014 to 11.7 in 2015. • The QI Department was fully staffed with resources to perform provider engagement in collaboration with the provider relations team. • Successful submission and reprocurement of the Medicaid contract • Passed NCQA HEDIS® Compliance Audit™,A-2 • Submitted HEDIS IDSS [Interactive Data Submission System] • Retained NCQA Commendable status The 2015 QI Evaluation included broad statements indicating that areas of the QI Program not meeting goals were analyzed and that activities directed toward identified barriers for improvement had been integrated into the 2016 QI Work Plan. In addition, the evaluation stated that activities included in the 2015 QI Work Plan would continue in 2016, as appropriate. The QI Evaluation did not provide in-depth analysis or an evaluation that would indicate that the CMO used its data to understand where opportunities for quality improvement existed, or that specific outcomes from quality improvement work occurred as a result of implementing CPGs or other interventions.		
Required Actions: WellCare must write the QAPI Program Evaluation based on DCH specifications. The QAPI Program Evaluation must be approved by DCH. WellCare must include additional information in its QI Program Description, such as the comprehensive process used, and may want to begin this process with a review of information and data available to the CMO through claims/encounters, grievance and appeals, quality of care cases, disease management, case management, care coordination, and member and provider input, to identify quality improvement opportunities and gaps in care or service delivery. Quality improvement initiatives must meet regulatory requirements and also demonstrate an understanding of the population served; use data to understand where quality improvement opportunities exist; and include research of potential interventions and activities that may have a positive impact on the care, services, and outcomes for members. The CMO must also consider including in its QI Evaluation a more complete summary of how the quality improvement goals, objectives, and related initiatives were identified; which data were used in the selection process; which interventions were considered; how the interventions were implemented; how the initiatives were resourced, including specific, assigned individuals and their qualifications; and the results or outcomes of		

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A-2 NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

Standard II—Quality Assessment and Performance Improvement (QAPI)		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
the quality improvement work. The QI Evaluation must provide the story of the effectiveness of WellCare's quality assessment and performance improvement work.		
18. The CMO conducts focused studies that examine a specific aspect of health care for a defined point in time. These studies are usually based on information extracted from medical records or CMO administrative data such as enrollment files and encounter/claims data. *Contract: 4.12.8.1*	DCH has not instructed Well Care to conduct focused studies since 2012. • 2015 GA QI Program Description, p.5 • ADHD Module 4 • ADHD Module 5 • Provider Satisfaction Module 4-Intervention 1 • Provider Satisfaction Module 4-Intervention 1 Attachment A • Provider Satisfaction Module 4-Intervention 1 Attachment B • Provider Satisfaction Module 5	☐ Met ☐ Not Met ☒ N/A
Findings: WellCare indicated in its response to the pre-on-site packet document request that DCH has not instructed WellCare to conduct focused studies since 2012. Focused studies should be considered as an opportunity to acquire the information and data needed to determine if interventions are needed in order to improve operations, outcomes, or member/provider satisfaction.		
Required Actions: None.		
19. The CMO follows a structured process for conducting the focused studies, which includes: • Selecting the study topic(s). • Defining the study question(s). • Selecting the study indicator(s). • Identifying a representative and generalizable study population. • Documenting sound sampling techniques utilized (if applicable). • Collecting reliable data. • Analyzing data and interpreting study results. *Contract: 4.12.8.1*	DCH has not instructed Well Care to conduct focused studies since 2012. • ADHD Module 4 • ADHD Module 5 • Provider Satisfaction Module 4-Intervention 1 • Provider Satisfaction Module 4-Intervention 1 Attachment A • Provider Satisfaction Module 4-Intervention 1 Attachment B • Provider Satisfaction Module 5	☐ Met ☐ Not Met ☒ N/A

Standard II—Quality Assessment and Performance Improvement (QAPI)		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
Findings: WellCare indicated in its response to the pre-on-site packet document request that DCH has not instructed WellCare to conduct focused studies since 2012. Focused studies should be considered an opportunity to acquire the information and data needed to determine if interventions are needed in order to improve operations, outcomes, or member/provider satisfaction.		
Required Actions: None.		
20. The CMO has a structured patient safety plan to address concerns or complaints regarding clinical care, which includes written policies and procedures for processing member complaints regarding the care they received. *Contract: 4.12.9.1*	• C7QI-053 Quality of Care Issues, p.1-3, 12 • 2015 GA QI Program Description, p.26-29 • GA Medicaid QIC Minutes September 15, 2015, p.37-38 • PPIR Completed DCH-Approved Provider Performance Issue Referral Form • 2015 Patient Safety Plan	☐ Met ☒ Not Met ☐ N/A
Findings: The WellCare Quality of Care Issues Policy described a process for receipt and processing of member concerns or complaints through the Grievance Department. The QM Patient Safety Plan was written in a manner that may cause confusion between grievances (expressions of dissatisfaction) and the grievance process. The 2015 Georgia QI Program Description described a process for investigation of quality of care concerns conducted by the Grievance Department. It further stated that, should a deviation from standard of care be identified, the case would be referred to the Quality Improvement Department for medical director review. If the medical director determined that there was a need for the case to receive peer review, it was referred to the Credentialing Committee. The Georgia Medicaid QIC minutes dated September 15, 2015, documented a case referred for peer review. The PPIR Completed DCH-Approved Provider Performance Issue Referral Form included a process for referral of cases to the medical director or the QIC. The 2015 Patient Safety Plan further explained the goals and objectives related to patient safety, including the receipt and processing of member complaints regarding the care or services.		
Required Actions: The QM Patient Safety Plan must be structured and approved by DCH. The QM Patient Safety Plan must clearly distinguish between grievances and the grievance process.		
21. Patient safety plan policies and procedures include: *Contract: 4.12.9.1*		
a. A system for classifying complaints according to severity. *Contract: 4.12.9.1*	• C7QI-053 Quality of Care Issues, p.15 • PPIR Completed DCH-Approved Provider Performance Issue Referral Form • 2015 Patient Safety Plan, p.7	☒ Met ☐ Not Met ☐ N/A

Standard II—Quality Assessment and Performance Improvement (QAPI)		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
Findings: The WellCare Quality of Care Issues Policy included severity codes that were categorized according to the impact to the member. WellCare defined Category 0 or None as having no impact on the quality, performance, or functionality of a patient; Category 1 or Minor as having a low-to-medium impact problem, one which allowed the patient to continue to function; Category 2 or Major as a problem where the patient's system is functioning but in a severely reduced capacity, and the situation caused significant impact to portions of the member's health; and Category 3 or Critical as a catastrophic problem which may severely impact the member. WellCare also submitted the PPIR Completed DCH-Approved Provider Performance Issue Referral Form, which included the categories for classification of complaints according to severity. The 2015 Patient Safety Plan included performance metrics that utilized the quality of care severity categorization codes.		
Required Actions: None.		
b. A review by the Medical Director. *Contract: 4.12.9.1*	• C7QI-053 Quality of Care Issues, p.17-19 • 2015 GA QI Program Description, p.30 • PPIR Completed DCH-Approved Provider Performance Issue Referral Form, p.3-4 • 2015 Patient Safety Plan, p.8	☒ Met ☐ Not Met ☐ N/A
Findings: The WellCare Quality of Care Issues Policy included a process to refer a complaint or grievance for medical director review. The PPIR Completed DCH-Approved Provider Performance Issue Referral Form included a section for the medical director to provide direction based on a review of the issue. The 2015 Patient Safety Plan included a review by either the corporate director or the Georgia senior medical director and a mechanism for determining which incidents would be forwarded to the Credentialing Committee. The 2015 Georgia QI Program Description described a process for the medical director to review both the issue and related medical record information and to arrive at findings that would be used in provider education regarding patient safety.		
Required Actions: None.		
c. A mechanism for determining which incidents will be forwarded to the Peer Review and Credentials Committees. *Contract: 4.12.9.1*	• C7QI-053 Quality of Care Issues, p.3 • C6CR-019 Credentialing Peer Review • 2015 Patient Safety Plan, p.5, 8 • GA Peer Review Committee Minutes January 25, 2016, p.2-4	☐ Met ☒ Not Met ☐ N/A
Findings: The WellCare Quality of Care Issues Policy described a process for cases that met the peer review standard of care that allowed the nurse reviewer to close the case under the direction of the medical director. The policy did not establish a process to forward the issue to a formal Peer Review Committee, but rather referred the case to the "Market" for presentation and further assessment. The policy allowed for the Market medical director to refer cases to the Credentialing Committee if the quality review suggested a pattern of inappropriate care or if cases		

Standard II—Quality Assessment and Performance Improvement (QAPI)		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
required further peer review. The Credentialing Peer Review Policy did not discuss a mechanism for determining which incidents would be forwarded to the Credentialing Committee.		
Required Actions: WellCare must include in its quality of care and peer review process a description of how the results of its internal review processes are tracked and trended, substantiated issues are reviewed for appropriate corrective actions, and a decision made whether the issue should be referred to regulatory boards for review.		
d. A summary of incident(s), including the final disposition, included in the provider profile. *Contract: 4.12.9.1*	• C7QI-053 Quality of Care Issues, p.4, 12 • PPIR Completed DCH-Approved Provider Performance Issue Referral Form, p.7-8 • GA Peer Review Committee Minutes January 25, 2016, p.2-4	☐ Met ☒ Not Met ☐ N/A
Findings: The WellCare Quality of Care Issues Policy did not reference the inclusion of a summary of the incident and the final disposition in the provider profile. The PPIR Completed DCH-Approved Provider Performance Issue Referral Form did not include a process to include documentation in the provider profile. The Georgia Peer Review Committee meeting minutes, dated January 25, 2016, indicated an action taken with a provider, but it did not reference inclusion of the disposition or summary of the incident in the provider's profile.		
Required Actions: WellCare must include in its written process how it will include in the provider's profile a summary of the incident(s), including the final disposition.		

Results for Standard II—Quality Assessment and Performance Improvement							
Total	Met	=	16	X	1.00	=	16
	Not Met	=	14	X	.00	=	0
	Not Applicable	=	2	X	N/A	=	N/A
Total Applicable		=	30	**Total Score**		=	16
				Total Score ÷ Total Applicable		=	53.3%

Standard III—Health Information Systems		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
1. The CMO maintains a health information system sufficient to support the collection, integration, tracking, analysis, and reporting of data. *42CFR438.242(a)* *Contract: 4.12.5.2*	• Well Care System Overview Workflow	☒ Met ☐ Not Met ☐ N/A
Findings: WellCare used an integrated application suite to support its Medicaid line of business. The health information system or CPS was based on the Dell Services Xcelys platform. WellCare indicated that the system allowed for a seamless integration with other applications and that it supported all member, provider, benefit, and claims processing applications. A separate Enrollment and Eligibility System (EES) updated the CPS daily. The Enterprise Medical Management Application (EMMA) supported case management, utilization management, disease management, and care coordination processes. The Encounter Processing System (EPS) used data from the other systems, including claims and encounter records. WellCare's Quality Reporting System used McKesson's CareEnhance Resource Management Software (CRMS), which centralized claims, membership, medical record, and other narrative information for HEDIS reporting. WellCare documentation stated that the reporting subsystem supported the grievance and appeal applications. WellCare managed reporting functions through the Enterprise Data Warehouse.		
Required Actions: None.		
2. The CMO's health information system provides information on areas including: *42CFR438.242(a)*		
a. Utilization.	• C7UM MD-1.2 Under and Over Utilization of Services • C7UM MD-1.2-PR-001 Under and Over Utilization of Services • 2015 Georgia UM Medicaid Program Description, p.25-26 • EMMA Data Flow Diagram • EMMA Service Authorization Screen Shot	☒ Met ☐ Not Met ☐ N/A
Findings: WellCare used EMMA for utilization management requirements. Key functions in the EMMA application included care coordination and oversight, member health status assessment, care plan development, service utilization and authorizations, outcomes evaluation and reporting, and EPSDT. The EMMA system worked with CPS, where member, provider, and claims payment data were stored. WellCare's corporate policies stated that its systems allow for monitoring of inpatient daily census, monthly inpatient utilization reports, pharmacy reports, physician profiling, medical record review, and physician risk group reports, and were able to compare these data against nationally recognized benchmarks using the McKesson CareEnhance Resource Management Software.		

Standard III—Health Information Systems		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
Required Actions: None.		
b. Grievances and appeals.	• C7AP-028 Quarterly and Annual Reporting to Regulatory Agencies • GA Q4 2015 Medicaid QIC and UMAC Grievance Report • Monthly Appeals Metrics • Appeals and Grievance Database Screenshot • A&G Summary Field Entry Job Aid, All Tabs	☒ Met ☐ Not Met ☐ N/A
Findings: The WellCare system documentation described an appeal and grievance database which included grievance and appeals intake tools with separate tabs for case-specific information, member correspondence, provider diagnosis, agency documentation, decisions, claims, and notes. The system allowed for data collection, analysis, and reporting.		
Required Actions: None.		
c. Disenrollment for other than loss of Medicaid eligibility.	• GA Disenrollment Process Flow • GA Disenrollment Reports_July 2016-April 2016 • GA Member Disenrollment Screenshot	☒ Met ☐ Not Met ☐ N/A
Findings: WellCare's CPS maintained enrollment and eligibility information. When a disenrollment request was received, the member's eligibility status was changed to "c" in the system. A system report was generated and submitted to DCH that identified all members with the "c" eligibility code.		
Required Actions: None.		
3. The CMO collects data on: *42CFR438.242(b)(1)*		
a. Member characteristics.	• 834 File Member Characteristic Details • WellCare Encounter Data Case Example	☒ Met ☐ Not Met ☐ N/A
Findings: WellCare captured member demographic information received from the State in an 834 file transaction and stored it in CPS. CPS integrated additional member data received from the EMMA system, such as from authorization requests and case management and disease management work. Member characteristics were also captured from provider claims which were housed in CPS.		
Required Actions: None.		

Standard III—Health Information Systems		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
b. Provider characteristics.	• OmniFlow Cactus Xcelys Workflow • Incoming Provider Information Workflow • WellCare Encounter Data Case Example	☒ Met ☐ Not Met ☐ N/A
Findings: WellCare used a contract management system identified as Emptoris. Emptoris maintained information on current and historical contract information. WellCare also used its systems to maintain provider information related to credentialing, recredentialing, and organizational credentialing, payment processing, and network information. Provider information was maintained in CPS.		
Required Actions: None.		
c. Services furnished to members.	• Claims Encounter GA Professional Guide, p.4 • WellCare Encounter Data Case Example • EPSDT CMS 416-Medicaid Q0116 • EPSDT CMS 416-Medicaid Analysis Q0116 • EPSDT CMS 416-PeachCare for Kids Q0116 • EPSDT CMS 416-PeachCare for Kids Analysis Q0116 • EPSDT Informing Activity Report Q0116 • EPSDT Informing Activity Report Analysis Q0116 • EPSDT Initial Screen Report Q0116 • EPSDT Initial Screen Report Analysis Q0116	☒ Met ☐ Not Met ☐ N/A
Findings: WellCare stored data related to services furnished to members such as claims and encounters in CPS. The CMO stored prior authorization, care coordination, disease management, and member health status assessment information in EMMA. WellCare documentation indicated that the systems integration allowed for utilization identification, monitoring, management, profiling, analysis, and reporting.		
Required Actions: None.		
4. The CMO's health information system includes a mechanism to ensure that data received from providers are accurate and complete by: • Verifying the accuracy and timeliness of reported data. • Screening the data for completeness, logic, and consistency.	• C6CL GA-001 Claims Process and Finalize Flow, p.2 • C6CL MD-008 Timely Filing, p.5 • Claims Encounter GA Professional Guide, p.4 • WellCare System Overview Workflow, p.7-8 • Encounters Process Flow through SNIP and Pre-Adj Edits • WellCare Encounter Data Case Example	☐ Met ☒ Not Met ☐ N/A

Standard III—Health Information Systems		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
• Collecting service information in standardized formats to the extent feasible and appropriate. • Making all collected data available to the State and upon request to CMS. *42CFR438.242(b)(2)* *42CFR438.242(b)(3)* *Contract:* *4.17.3.1* *4.17.3.6*	• Provider Contract, p.4,7 • Claims Processing Report M0516, All Tabs	
Findings: WellCare stated that all claims received from providers were run through a series of edits in WellCare's claims pre-adjudication system, known as the Claims Intake System (CIS). In CIS, business rules were applied, which validated the provider, vendor, and member assignments. WellCare's system edits complied with Medicaid timeliness reporting requirements. WellCare's corporate policies, as well as its contracts with providers, required the use of standardized formats. Corporate policies and WellCare's contracts with providers required the provider to make data available to the State or the Centers for Medicare & Medicaid Services (CMS), as requested. Other than standard system edits, WellCare did not provide documentation on how it screened data from providers for completeness, logic, and consistency.		
Required Actions: WellCare must update its process descriptions to describe how the CMO ensures that data received from providers are complete, logical, and consistent.		

Results for Standard III—Health Information Systems							
Total	Met	=	7	X	1.00	=	7
	Not Met	=	1	X	.00	=	0
	Not Applicable	=	0	X	N/A	=	N/A
Total Applicable		=	8	**Total Score**		=	7
				Total Score ÷ Total Applicable		=	87.5%

Appendix B. Follow-Up Review Tool

Following this page is the completed follow-up review tool that HSAG used to evaluate WellCare's performance and to document its findings; the scores it assigned associated with the findings; and, when applicable, corrective actions required to bring WellCare's performance into full compliance.

Standard V—Grievance System			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
Grievance System: *42CFR438.402(b)(2) and 438.420(a), Contract: 4.14.4.2 and 4.14.7.1* 11. For termination, suspension, or reduction of previously authorized services, timely filing is defined as the later of the following: • Within ten (10) days of the Contractor mailing the notice of action, or • The intended effective date of the proposed action. For all other actions, 30 calendar days from the date of the notice of proposed action.			
Findings: The Georgia Administrative Review Procedure indicated that WellCare "allows at least 10 calendar days following an action to terminate, suspend, or reduce services" for the member to file a request for administrative review; however, it did not address the fact that timely filing includes the later of either 10 days or the intended effective date of the proposed action.			
Required Actions: WellCare must include in its policy and procedure the fact that the member may file a request for administrative review by the later of either 10 days after the NOA is mailed or the intended effective date of the proposed action.			
Evidence/Documentation Submitted by the CMO			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**
During the audit readiness review, this was identified as a gap. At this time, staff made the updates to the policy and procedure documents and routed them through the appropriate approval channels.	Annual review of the policy and procedure documents will occur to ensure compliance.	Valda John	6/10/2015: policy and procedure documents updated 7/30/2015: policy and procedure documents approved by DCH
Other Evidence/Documentation: • C7AP-002 Georgia Administrative Review Policy_6-10-15, p.1 & 5 • C7AP-002-PR-001 Georgia Administrative Review Procedure_6-10-15, p.1 & 15			
August 2016 Re-review Findings: WellCare submitted evidence that it updated its policy, C7AP-002 Georgia Administrative Review Policy, and received policy approval from the State on July 30, 2015. The policy now correctly reflects the requirement that for termination, suspension, or reduction of previously authorized services, "timely filing" is defined as the later of the following: • Within 10 days of the contractor mailing the notice of action, or • The intended effective date of the proposed action. For all other actions, 30 calendar days from the date of the notice of proposed action.			
August 2016 Required Actions: None.			

Standard V—Grievance System
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)
Grievance System, Notice of Action: *42CFR438.404(b), Contract: 4.14.3.3* 16. Notices of proposed action must contain: • The action the Contractor has taken or intends to take, including the service or procedure that is subject to the action. • Additional information, if, any that could alter the decision. • The specific reason used as basis for the action (the reasons must have a factual basis and a legal/policy basis). • The member's right to file an appeal (administrative review) through the Contractor's internal Grievance System and how to do so. • The provider's right to file a provider complaint under the Contractor's provider complaint system. • The requirement that a member exhaust the Contractor's internal administrative review process. • The circumstances under which expedited review is available and how to request it. • The member's right to have benefits continue pending resolution of the appeal (administrative review) and how to request that benefits be continued. • The circumstances under which the member may have to pay for the costs of services if benefits are continued during the administrative review process.
Findings: The Adverse Determinations Proposed Actions policy indicated that all adverse determination notices included the requirements listed in this element. WellCare supplied the Notice of Proposed Action form letter, and it did not contain the notice that the member must exhaust WellCare's internal administrative review process.
Required Actions: WellCare must change its Notice of Proposed Action form letter to include a notice that the member must exhaust WellCare's internal administrative review process.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
The Notice of Proposed Action form letter will be updated to include language that notifies the member that they must exhaust WellCare's internal administrative review process.	Annual review of form letter to ensure compliance.	Jennifer Sanzo	1/31/2016

Other Evidence/Documentation:
- GA Notice of Proposed Action Letter_02052016, p.1-2

Standard V—Grievance System
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)
August 2016 Re-review Findings: The sample notice of action letter included language indicating that the member must exhaust WellCare's internal administrative review process. A review of sample case files verified that WellCare included the appropriate language in the notice of action letters.
August 2016 Required Actions: None.

Standard V—Grievance System			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
Grievance System, Handling of Grievances and Appeals: *42CFR438.406(a)(2), Contract: 4.14.1.5* 20. The Contractor acknowledges each grievance and administrative review in writing within ten (10) working days of receipt in the member's primary language.			
Findings: The Georgia Administrative Review policy indicates that WellCare acknowledged receipt of each filed administrative review in writing within 10 calendar days of receipt and that the acknowledgment letter was available in the member's primary language. The Georgia Medicaid Grievance Procedure indicated that WellCare mailed the acknowledgment letter within 10 business days; however, the procedure did not address that the letter would be available in the member's primary language. Three of the 10 grievance acknowledgement letters reviewed during the on-site review were not sent to the member within 10 working days. All 10 administrative review (appeal) files met the acknowledgement timeliness requirement.			
Required Actions: WellCare must revise its Georgia Medicaid Grievance procedure to include the provision that the acknowledgment letter would be available in the member's primary language. WellCare must acknowledge all grievances within 10 working days.			
Evidence/Documentation Submitted by the CMO			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**
Revise the Georgia Medicaid Grievance Procedure to include the provision that the acknowledgment letter will be available in the member's primary language. WellCare will monitor acknowledgment compliance by utilizing a report designed to measure the timeliness of mailing member Acknowledgment letters.	On a daily basis, the acknowledgement report will be sent to the grievance coordinators (GC) specifically assigned to work Georgia Medicaid grievances. The report will list all grievances with the received date and due date for acknowledgment. The report will be sent to all coordinators by 9am daily. All grievances with a current due date for acknowledgment will be followed-up on by 2pm. This is to ensure all acknowledgment letters are mailed timely to meet the 10 business day timeframe. The acknowledgment report will also track the primary language of the	Grant Langan Juan Garcia Katrina Davis	6/30/2016

Standard V—Grievance System			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
	member to ensure the acknowledgment letter is mailed in the member's primary language.		
Other Evidence/Documentation: • C6GR-003-PR-005 Georgia Medicaid Grievance Procedure_10-27-15, p.3 • Acknowledgment Letter Report_1.2016 - 5.2016 • Acknowledgement Letters Due_2.2016 - 6.2016			
August 2016 Re-review Findings: WellCare updated its policy, C6GR-003-PR-005 Georgia Medicaid Grievance Procedure, on October 27, 2015, to include a requirement that the acknowledgement letter would be available in the member's primary language. A review of a sample of grievance cases verified that the acknowledgement letters were made available in the member's primary language and were mailed within 10 days of receipt.			
August 2016 Required Actions: None.			

Standard V—Grievance System			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
Grievance System, Resolution and Notification Grievances and Appeals: *42CFR438.408(e), Contract: 4.14.5.2* 27. The written notice of adverse action shall meet the language and format requirements as specified in Section 4.3 and includes: • The results and date of the adverse action including the service or procedure that is subject to the action. • Additional information, if any, that could alter the decision. • The specific reason used as the basis of the action. • The right to request a State Administrative Law hearing within 30 calendar days – the time for filing will begin when the filing is date stamped. • The right to continue to receive benefits pending a State Administrative Law hearing. • How to request continuation of benefits. • Information explaining that the member may be held liable for the cost of any continued benefits if the Contractor's action is upheld in a State Administrative Law hearing. • Circumstances under which expedited resolution is available and how to request it.			
Findings: The Georgia Administrative Review procedure indicated that the notice of adverse action met the language and format requirements specified in the contract and included the requirements listed in this element. The Administrative Review Determination Final Denial Notice contained the required information. Five of the 10 administrative review (appeal) resolution letters reviewed during the on-site audit did not meet the fifth-grade reading/understandability level. In these cases procedure codes and medical terminology were used, which raised the reading level.			
Required Actions: WellCare must ensure that all administrative review resolution letters are written in easily understood language.			
Evidence/Documentation Submitted by the CMO			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**
A departmental communication will be sent to the team reminding them to utilize the *Reading Level Validation Job-Aid* when completing appeals final decision notices. In addition, training will be conducted with the appeals coordinators and clinical reviewers regarding the job aid and strategies for reducing reading levels. This training educates the staff on the steps to	To monitor the intervention, Administrative Review files are audited on a monthly basis by our internal quality reviewers (QA) team. During the QA process, the QA team will assess if the Coordinators are following the proper procedures to generate resolution letters at the required reading levels. Any defects are tracked. If it is determined that a	Faustino Mayo Valda John	6/30/2016

Standard V—Grievance System			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
take while developing a resolution letter on administrative reviews for the member to ensure the Plan's response meets the required reading level for our GA Medicaid members. WellCare will also use Flesch-Kincaid to assist with the readability level.	resolution letter was generated because someone has not followed the established process, they will be coached and tracked for potential corrective actions.		
Other Evidence/Documentation: • Appeals Reading Level Training Sign-In Sheets • Appeals Reading Level Validation Job-Aid_10-27-15 • Appeals-Strategies for Reducing Reading Level Training • Auditing Memo_10.2015 - 5.2016			
August 2016 Re-review Findings: WellCare updated its strategies and provided training to staff to ensure that notice of action letters were written in easily understood language. The guidance now states, "please ensure you are not including any diagnosis name and/or medication name in the readability testing." A review of a sample of administrative review resolution letters verified that the CMO letters were written in easily understood language.			
August 2016 Required Actions: None.			

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
1. Timely Access: *42 CFR 438.206(c)(1)* The CMO meets and requires its providers to meet DCH standards for timely access to care and services, taking into account the urgency of need for services according to the following standards: (f) **Timelines—Returning Calls After-Hours:** *Contract 4.8.14.4* The CMO ensures that provider response times for returning calls after-hours do not exceed the following: • Urgent Calls—Twenty minutes • Other Calls—One hour			
Findings: **July 2015 Re-review Findings:** WellCare continued to monitor providers returning calls after hours. WellCare provided example letters it sent to noncompliant providers when the provider did not meet the call-back time frames in this element. Specifically, during quarter 4, 2014, pediatric providers achieved 88 percent success rate when addressing after-hours returned calls. During quarter 1, 2015, 88 percent of PCPs returned non-urgent calls within the one-hour requirement.			
July 2015 Required Actions: WellCare must continue to apply current and new interventions with providers until the goal of 90 percent of its providers addressing urgent calls within 20 minutes and other calls within one hour is met.			
Evidence/Documentation Submitted by the CMO			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**
1. The Myers Group (TMG), on WellCare's behalf, conducts quarterly monitoring of after-hours return call times. TMG calls a statistically valid random sample of providers each quarter to specifically find out if urgent after-hours calls are being returned within 20 minutes, and if non-urgent after-hours calls are being returned within one hour. The audit results are sent back to WellCare, along with voice recordings for all provider calls that failed the standards.	1: Review Timely Access All Standards Report. 2: Evaluate the number of responses received and determine barriers/trends that may prohibit providers from meeting the standards. Alert DCH and MDs about trends. 3: Review provider failure rates prior to the intervention and after intervention implementation within counties of the pilot area.	1: Amy House, Amy Tanner & Cynthia Cook 2: Amy House & Cynthia Cook 3: Amy House & Brandi Williams	1: 6/30/2016 2: 6/30/2016 3: 11/1/2016

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
Providers that fail the audit are notified by letter, which includes a reminder of the standards, as well as suggested remediation. WellCare re-audits ALL failed providers the following quarter to determine if the education efforts have been successful. Any provider that fails the re-audit is notified by letter, and the Senior Medical Director makes recommendation for further action, if necessary. The provider relations (PR) representatives personally deliver the first and second "fail" letters to providers. The PR rep will educate the provider and staff on the standards and explain that they are contractually bound to adhere to the standard because it is in place to ensure that our members' medical needs are being met. The PR rep also tries to determine the root cause for the failure and works with the provider to remove barriers. The Senior Medical Director communicates with the providers who fail the second audit via written or			

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
verbal communication. Communication enforces the importance of returning after-hours calls in a timely manner, emphasizes the importance of PCP-centric care and avoidance of unnecessary ER visits, which can be an unintended consequence of untimely after-hours return calls. 2. Providers who fail the audit will be strongly encouraged to respond with written correspondence that outlines the specific reasons for their inability to meet the standard. WellCare will keep DCH apprised of barriers/challenges that providers have with meeting the standard and work together to determine how to assist providers. Pilot a program with Southwest Georgia Health Care, Inc., which is a FQHC and has after-hours phone services at 24 locations in the following southwest Georgia counties: Chattahoochee, Quitman, Stewart, Webster, Sumter, Schley, Macon, Taylor, Upson, Crisp, Tift, Colquitt, Wilcox, Dodge, Bleckley, and Peach. WellCare will refer failed providers from the TMG audit to the			

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
appropriate county after-hour phone service. The failed provider will then change their after-hour phone message to reflect the new number for WellCare members. If this proves successful, both with provider participation and TMG audit improvement, WellCare will explore expanding the pilot with additional larger providers who could offer after-hours phone services to smaller providers.			

Other Evidence/Documentation:

- Timely Access Report Q4 2015
- Timely Access Report Q1 2016
- Timely Access All Standards Report Q4 2015
- Timely Access All Standards Report Q1 2016
- Provider Audit Response Letters
- Intervention 3 Update_June 2016
- Nurse Advice Line Email

August 2016 Re-review Findings:

WellCare abandoned the pilot program to use Southwest Georgia Health Care, Inc.'s, after-hours line because there was a barrier in ensuring continuity of care. Instead, WellCare offered its after-hours nurse advice line to providers who failed the after-hours audit. The advice line provided WellCare members access to a nurse to determine if the member needs to seek care immediately or if the member should call his or her PCP the next day for an appointment in the offices in rural areas with limited staff or availability for after-hours triage. In addition, WellCare Provider Relations staff asked providers that failed the after-hours availability audit if they would add a message on their answering machine to direct members to WellCare's Nurse Advice Line, where members may call and speak with a nurse after the office's normal hours of operation. Timely access reports submitted by WellCare indicated that in first quarter 2016, after-hours urgent return calls were received within the required time frame 96 percent of the time. After-hours nonurgent returns calls were received within the required time frame 91 percent of the time. In Quarter 4 2015, after-hours urgent return calls were received within the required time frame 99 percent of the time, and after hours nonurgent returns calls were received within the required time frame 94 percent of the time. Both monitoring audit results submitted indicated that after-hour return calls met requirements.

August 2016 Required Actions: None.

Standard II—Furnishing of Services

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)

5. Geographic Access: *Contract 4.8.13.1*

The CMO meets the following geographic access standards for all members:

	Urban	Rural
PCPs	Two within eight miles	Two within 15 miles
Specialists	One within 30 minutes or 30 miles	One within 45 minutes or 45 miles
General Dental Providers	One within 30 minutes or 30 miles	One within 45 minutes or 45 miles
Dental Subspecialty Providers	One within 30 minutes or 30 miles	One within 45 minutes or 45 miles
Hospitals	One within 30 minutes or 30 miles	One within 45 minutes or 45 miles
Mental Health Providers	One within 30 minutes or 30 miles	One within 45 minutes or 45 miles
Pharmacies	One 24/7 hours a day, seven (7) days a week within 15 minutes or 15 miles	One 24/7 hours a day (or has an after-hours emergency phone number and pharmacist on call) seven days a week within 30 minutes or 30 miles

July 2015 Re-review Findings: WellCare provided its GeoAccess Deficiencies CAP Reports for three quarters during the review period. WellCare did not meet the requirement to have 90 percent of members with access to providers within the time/distance analysis in the element. HSAG noted that the CMO did not meet the requirements in both urban and rural areas in the following provider categories:

July 2015 Required Actions: WellCare must meet the geographic access standards for both urban and rural areas for PCPs, specialists, dental subspecialty providers, and pharmacies. WellCare must continue efforts to close its network adequacy gaps and keep DCH informed of its progress.

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
Evidence/Documentation Submitted by the CMO			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**
1. The network development team will review the GEO Access CAP Report and the Georgia Medicaid Access Compliance Snapshot report on a quarterly basis to identify opportunities where additional providers are needed and could be recruited in to the network. The network development team will continue to work with the Provider Relations team to learn about new providers who move into an area, and they will also continue to assist case managers and member outreach in contracting providers who are needed for specific member care. WellCare has not been able to list presenting telemedicine sites in our provider directory in the past, and we are working to solution that. Once the capability exists, access will be improved because members will be aware of additional locations where they can access care via telemedicine. At that time we can explore additional reporting capabilities to include telemedicine presenting sites as a supplemental report to the current GEO Access Report.	1: Review GEO Access CAP Report and Georgia Medicaid Access Compliance Snapshot. 2: When additional reporting capabilities relating to Telemedicine sites are possible, review reports to identify trends.	1: Amy Tanner 2: Joshua Luft	1: 6/30/2016 2: Ongoing
Other Evidence/Documentation: • GEO Access CAP Report Q4 2015 • GEO Access CAP Report Q1 2016 • ACS Snapshot January 2016			

Standard II—Furnishing of Services
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)
• ACS Snapshot February 2016 • ACS Snapshot March 2016 • ACS Snapshot April 2016 • ACS Snapshot May 2016 • ACS Snapshot June 2016 • ACS Snapshot-GEO Access CAP Report_Analysis+Barriers_March 2016 • ACS Snapshot-GEO Access CAP Report_Analysis+Barriers_June 2016 • Telemedicine Update_June 2016
August 2016 Re-review Findings Documentation indicated that WellCare continued to not meet the geographic access standards for urban and rural areas for PCPs, specialists, dental subspecialty providers, and pharmacies. WellCare was developing processes to identify telemedicine sites in an effort to fill care gaps in the provider directory. The following examples illustrated the geographic access standard deficiencies: **March 2016** 594 deficiencies **April 2016:** 585 deficiencies **May 2016** 576 deficiencies **June 2016** 595 deficiencies WellCare stated that the largest portion of deficiencies were in rural counties where no specialty providers existed. Information provided included a description of the physician shortage according to the Physician Workforce Study published in 2013, which referenced 99 active allergists in the State of Georgia. The same report stated that there were 278 active dermatologists in Georgia, and only 19 percent accepted Medicaid. The report also stated that Georgia ranked 44th in the number of active PCPs. The national average, according to the report, is 80.7 active PCPs per 100,000 residents compared to Georgia's 68.5 active PCPs per 100,000 residents.
August 2016 Required Actions: WellCare must continue to work to meet the geographic access standards for both urban and rural areas for PCPs, specialists, dental subspecialty providers, and pharmacies. WellCare must continue efforts to close its network adequacy gaps and keep DCH informed of its progress.

Appendix C. On-Site Review Participants

The document following this page includes the dates of HSAG's on-site review, the names/titles of the HSAG reviewers, and the names/titles of other individuals who participated in or observed some or all of the on-site review activities, including WellCare's key staff members who participated in the interviews that HSAG conducted.

Review Dates

The following table shows the dates of HSAG's on-site visit to WellCare.

Table C-1—Review Dates

Date of On-Site Review	August 3, 2016

Participants

The following table lists the participants in HSAG's on-site review for WellCare.

Table C-2—HSAG Reviewers and WellCare of Georgia, Inc./Other Participants

HSAG Review Team		Title
Team Leader	Kim M. Elliott, PhD, CPHQ	Director, State & Corporate Services
Reviewer	Mary Wiley, RN, MEd	Director, State & Corporate Services
WellCare of Georgia, Inc. Participants		**Title**
LaDonna Battle		Vice President, Field Health Services
Heather MacGregor		Behavioral Health Quality Improvement Project Manager
Neana Cannon		Quality Improvement Analyst
Tobechi Eheduru		Senior Quality Improvement Analyst
Heather DiNapoli		Manager, Reporting and Analytics
Margaret Pryce		Quality Improvement Manager
Leila Valdes		Quality Improvement Project Analyst
Burt Walters		Quality Improvement Administrator
Joshua Luft		Director, Reporting and Analytics
Jenni Russ		Senior Clinical HEDIS Practice Advisor
Myra Copeland		Quality Improvement Manager
Kendra Graham		Director, Market Compliance
Katrina Davis		Senior Project Analyst, Grievance
Valda John		Project Manager, Appeals
Tamika Graham		Quality Improvement Manager
Jill Resnikoff		Senior Manager, Utilization Management—Corporate
Jennifer Sanzo		Clinical Program Development Manager
John A. Johnson, MD, MBA		Senior Medical Director
Marla Purvis		Market Vice President
Veatrice Futch		Manager, Community Advocacy

Deirdre Rogers	Director, State Pharmacy
Annette Zerbe	Senior Director, Regulatory Affairs
Faith DeCoster	Director, Credentialing
Jessica White	Senior Director, Strategic Operations
Nikkole Fernandez	Operations Support Specialist
Jean Exum	Quality Improvement Project Analyst
Jitendra Patel	Quality Improvement Project Analyst
Department of Community Health Participants	**Title**
Sandra Middlebrooks	Compliance Manager
Janice Carson, MD, MSA	Assistant Chief, Performance, Quality and Outcomes
Patricia Garcia	Compliance Specialist I

Appendix D. Review Methodology

Introduction

The following description of the manner in which HSAG conducted—in accordance with 42 CFR §438.358—the external quality review of compliance with standards for the DCH Georgia Families CMOs addresses HSAG's:

- Objective for conducting the reviews.
- Activities in conducting the reviews.
- Technical methods of collecting the data, including a description of the data obtained.
- Data aggregation and analysis processes.
- Processes for preparing the draft and final reports of findings.

HSAG followed standardized processes in conducting the review of WellCare's performance.

Objective of Conducting the Review of Compliance with Standards

The primary objective of HSAG's review was to provide meaningful information to DCH and the CMO regarding compliance with State and federal requirements. HSAG assembled a team to:

- Collaborate with DCH to determine the scope of the review as well as the scoring methodology, data collection methods, desk review schedules, on-site review activities schedules, and on-site review agenda.
- Collect and review data and documents before and during the on-site review.
- Aggregate and analyze the data and information collected.
- Prepare the report related to the findings.

To accomplish its objective, and based on the results of collaborative planning with DCH, HSAG developed and used a data collection tool to assess and document the CMO's compliance with certain federal Medicaid managed care regulations, State rules, and the associated DCH contractual requirements. The review tool included requirements that addressed the following performance areas:

- Standard I—Clinical Practice Guidelines
- Standard II—Quality Assessment and Performance Improvement (QAPI)
- Standard III—Health Information Systems
- Follow-up on areas of noncompliance from the prior year's review

The DCH and the CMO will use the information and findings that resulted from HSAG's review to:

- Evaluate the quality and timeliness of, and access to, care and services furnished to members.
- Identify, implement, and monitor interventions to improve these aspects of care and services.

The review was the third year of the current three-year cycle of CMO compliance reviews.

HSAG's Compliance Review Activities and Technical Methods of Data Collection

Before beginning the compliance review, HSAG developed data collection tools to document the review. The requirements in the tools were selected based on applicable federal and State regulations and laws and on the requirements set forth in the contract between DCH and the CMO, as they related to the scope of the review. HSAG also followed the guidelines set forth in CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012[D-1] for the following activities:

Pre-on-site review activities included:

- Developing the compliance review tools.
- Preparing and forwarding to the CMO a customized desk review form and instructions for completing it and for submitting the requested documentation to HSAG for its desk review.
- Scheduling the on-site reviews.
- Developing the agenda for the on-site review.
- Providing the detailed agenda and the data collection (compliance review) tool to the CMO to facilitate preparation for HSAG's review.
- Conducting a pre-on-site desk review of documents. HSAG conducted a desk review of key documents and other information obtained from DCH, and of documents the CMO submitted to HSAG. The desk review enabled HSAG reviewers to increase their knowledge and understanding of the CMO's operations, identify areas needing clarification, and begin compiling information before the on-site review.
- Generating a list of sample cases plus an oversample for notice of action, grievances and appeal cases for the on-site CMO audit from the list submitted to HSAG from the CMO.

[D-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: Feb 19, 2013.

On-site review activities: HSAG reviewers conducted an on-site review for the CMO, which included:

- An opening conference, with introductions and a review of the agenda and logistics for HSAG's review activities.
- A review of the documents and files HSAG requested that the CMO have available on-site.
- Interviews conducted with the CMO's key administrative and program staff members.
- A closing conference during which HSAG reviewers summarized their preliminary findings.

HSAG documented its findings in the data collection (compliance review) tool, which now serves as a comprehensive record of HSAG's findings, performance scores assigned to each requirement, and the actions required to bring the CMO's performance into compliance for those requirements that HSAG assessed as less than fully compliant.

Description of Data Obtained

To assess the CMO's compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by the CMO, including, but not limited to, the following:

- Committee meeting agendas, minutes, and handouts
- Written policies and procedures
- The provider manual and other CMO communication to providers/subcontractors
- The member handbook and other written informational materials
- Narrative and/or data reports across a broad range of performance and content areas

HSAG obtained additional information for the compliance review through interaction, discussions, and interviews with the CMO's key staff members.

Table D-1 lists the major data sources HSAG used in determining the CMO's performance in complying with requirements and the time period to which the data applied.

Table D-1—Description of the CMO's Data Sources

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG's desk review and additional documentation available to HSAG during the on-site review	July 1, 2015–June 30, 2016
Information obtained through interviews	August 3, 2016—the last day of the CMO's on-site review
Information obtained from a review of a sample of the CMO's records for file reviews	July 1, 2015–June 30, 2016

Data Aggregation and Analysis

HSAG used scores of *Met* and *Not Met* to indicate the degree to which the CMO's performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to a CMO during the period covered by HSAG's review. This scoring methodology is consistent with CMS' final protocol, *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. The protocol describes the scoring as follows:

Met indicates full compliance defined as *both* of the following:

- All documentation listed under a regulatory provision, or component thereof, is present.
- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.

Not Met indicates noncompliance defined as *either* of the following:

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.
- Staff members can describe and verify the existence of processes during the interview, but documentation is incomplete or inconsistent with practice.
- No documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.
- For those provisions with multiple components, key components of the provision could be identified and any findings of Not Met would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

From the scores it assigned for each of the requirements, HSAG calculated a total percentage-of-compliance score for each of the standards and an overall percentage-of-compliance score across the standards. HSAG calculated the total score for each of the standards by adding the weighted score for each requirement in the standard receiving a score of *Met* (value: 1 point), *Not Met* (0 points), and *Not Applicable* (0 points) and dividing the summed weighted scores by the total number of applicable requirements for that standard.

HSAG determined the overall percentage-of-compliance score across the areas of review by following the same method used to calculate the scores for each standard (i.e., by summing the weighted values of the scores and dividing the result by the total number of applicable requirements).

To draw conclusions about the quality and timeliness of, and access to, care and services the CMO provided to members, HSAG aggregated and analyzed the data resulting from its desk and on-site review activities. The data that HSAG aggregated and analyzed included:

- Documented findings describing the CMO's performance in complying with each of the requirements.

- Scores assigned to the CMO's performance for each requirement.
- The total percentage-of-compliance score calculated for each of the standards.
- The overall percentage-of-compliance score calculated across the standards.
- Documentation of the actions required to bring performance into compliance with the requirements for which HSAG assigned a score of *Not Met*.

Based on the results of the data aggregation and analysis, HSAG prepared and forwarded the draft reports to DCH and to the CMO for their review and comment prior to issuing a final report.

Appendix E. Corrective Action Plan

Following this page is a document HSAG prepared for WellCare to use in preparing its corrective action plan (CAP). The template includes each of the requirements for which HSAG assigned a performance score of *Not Met*, and for each of the requirements, HSAG's findings and the actions required to bring the organization's performance into full compliance with the requirement.

Instructions for completing and submitting the CAP are included on the first page of the CAP document that follows.

Criteria that will be used in evaluating the sufficiency of the CAP are:

- The completeness of the CAP document in addressing each required action and assigning a responsible individual, a timeline/completion date, and specific actions/interventions that the organization will take.
- The degree to which the planned activities/interventions meet the intent of the requirement.
- The degree to which the planned interventions are anticipated to bring the organization into compliance with the requirement.
- The appropriateness of the timeline for correcting the deficiency.

A CAP that does not meet the above criteria will require resubmission of the CAP by the organization until it is approved by DCH. Implementation of the CAP may begin once approval is received.

Appendix E. State of Georgia
Department of Community Health (DCH)
Corrective Action Plan
for WellCare of Georgia, Inc.

Instructions: For each of the requirements listed below that HSAG scored as *Not Met*, identify the following:

- Intervention(s) planned by your organization to achieve compliance with the requirement, including how the CMO will measure the effectiveness of the intervention
- Individual(s) responsible for ensuring that the planned interventions are completed
- Proposed timeline for completing each planned intervention

This plan is due to DCH no later than 30 calendar days following receipt of this final External Quality Review of Compliance with Standards report. The DCH, in consultation with HSAG, will review and approve the CAP to ensure that it sufficiently addresses the interventions needed to bring performance into compliance with the requirements. Approval of the CAP will be communicated in writing. Once approved, CAP activities and interventions may begin. Follow-up monitoring will occur to ensure that all planned activities and interventions were completed.

Standard I—Clinical Practice Guidelines			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
3. The practice guidelines include a methodology for measuring and assessing compliance. *Contract: 4.12.7.2*			
Findings: The WellCare CPG Policy stated that a methodology for measuring and assessing compliance with CPGs would be submitted as part of the QI Program Description. The QI Program Description did not include a methodology for measuring and assessing compliance with CPGs. WellCare submitted CPGs which included sections that addressed the methodology for measurement. Examples of CPG compliance tools submitted followed the described methodologies specified within the CPGs.			
Recommendations: In its documents, WellCare must create a distinct linkage between the DCH CPG audit process for monitoring the three mandated CPGs and the compliance tools, and include a consistent description of the DCH CPG audit process for measuring and assessing provider compliance.			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**

Standard I—Clinical Practice Guidelines			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
6. The CMO ensures that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42CFR438.236(d)* *Contract:* *4.12.7.4*			
Findings: The WellCare CPG Policy and the Member Educational Guidelines Policy stated that WellCare would ensure that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply were consistent with the guidelines. The documentation submitted did not describe how WellCare ensured that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply were implemented in order to be consistent with the guidelines. The WellCare program descriptions and evaluations included references to other WellCare programs. For example, the QI Program Evaluation submitted referenced the outcome measurement of another WellCare program, WellCare of Kentucky.			
Required Actions: WellCare must describe how it ensures that the decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. The QI Program Evaluation must be updated to reflect only Georgia WellCare information and data.			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**

Standard II—Quality Assessment and Performance Improvement (QAPI)			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
4. The CMO supports and complies with the Georgia Families Quality Strategic Plan by: *42CFR438.240(b)(1) through (4)* *Contract:* *4.12.2.1* a. Monitoring and evaluating its service delivery system and provider network, as well as its own processes for quality management and performance improvement. *Contract:* *4.12.2.2*			
Findings: The 2015 Georgia QI Program Evaluation documented examples of WellCare's monitoring of credentialing timeliness, as well as opportunities to address identified barriers. The QI Program Evaluation also stated that WellCare used quality of care complaints to identify trends and opportunities for quality improvement activities or interventions. The 2015 QI Workplan, Network Adequacy Tab provided an example of how WellCare monitored and evaluated its service delivery system and provider network, including appointment access and network availability for primary care, dental care, behavioral healthcare, and vision care. The Georgia Medicaid QIC meeting minutes connected the data collection related to complaints, network access, and availability to QIC discussions on barriers, gaps, and opportunities. Meeting minutes of multiple subcommittees also reflected committee discussions on quality management and performance improvement opportunities and interventions. However, documentation submitted did not fully describe how WellCare monitored or evaluated its own processes for quality management and performance improvement.			
Recommendations: WellCare must document how it monitors and evaluates its own processes for quality management and performance improvement.			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**

Standard II—Quality Assessment and Performance Improvement (QAPI)			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
5. The CMO complies with Georgia Families quality management requirements to improve member health outcomes by using DCH-established performance measures to document results. *42CFR438.240(b)(2)* *Contract:* *4.12.3.1*			
Findings: WellCare did not use the DCH-mandated QAPI Program guidelines for generating its QAPI report. WellCare instead discussed specific quality improvement activities in the 2015 Georgia QI Program Evaluation that used DCH-established performance measures to document improvement in member health outcomes. The WellCare 2015 Performance Measures Report Analysis provided a brief description of the targeted strategies and interventions used to improve member health outcomes, as well as an evaluation of the effectiveness of the strategies implemented. During compliance review interviews, the CMO described its use of quality practice advisors; these staff members worked on-site in provider offices to provide information and education on how to improve performance measure rates and reduce gaps in care.			
Recommendations: WellCare must document results of the DCH-established performance measures in its QAPI report.			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**

Standard II—Quality Assessment and Performance Improvement (QAPI)

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)

6. The CMO achieved DCH-established performance targets.

State-specified element

Findings: WellCare did not meet all of the DCH-established performance goals for CY 2014 and CY 2015. The CMO showed statistically significant increases in 22 measure rates. The CMO showed statistically significant decreases in 13 measure rates. The following results were noted:

WellCare Access to Care Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	97.51%	96.90%	↓	NC
25 Months–6 Years	91.23%	89.63%	↓	NC
7–11 Years	92.61%	91.36%	↓	NC
12–19 Years	90.35%	89.09%	↓	93.50%
Adults' Access to Preventive/Ambulatory Health Services				
20–44 Years	81.76%	81.52%	↔	88.52%
Annual Dental Visit				
2–3 Years	46.94%	49.80%	↑	54.20%
4–6 Years	72.25%	76.42%	↑	NC
7–10 Years	75.14%	78.49%	↑	NC
11–14 Years	69.30%	72.49%	↑	NC
15–18 Years	58.65%	61.57%	↑	NC
19–20 Years	—	40.17%	NT	34.04%[4]
Total	66.64%	70.12%	↑	NC
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment				
Initiation of AOD Treatment—Total	32.34%	34.15%	↔	43.48%

Standard II—Quality Assessment and Performance Improvement (QAPI)

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)

Engagement of AOD Treatment—Total	7.02%	7.09%	↔	14.97%
Care Transition—Transition Record Transmitted to Health Care Professional				
Care Transition—Transition Record Transmitted to Health Care Professional	0.00%	0.00%	↔	NC
Colorectal Cancer Screening				
Colorectal Cancer Screening	—	46.72%	NT	NC
Adult BMI Assessment				
Adult BMI Assessment	79.94%	82.08%	↔	85.23%

[1] CY 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014 through December 31, 2014.
[2] CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015 through December 31, 2015.
[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.
[4] CY 2015 performance target is derived from previous CY 2014 rates, which included members age 19–21 years rather than 19–20 years.
↑ indicates a statistically significant improvement in performance between CY 2014 and CY 2015.
↓ indicates a statistically significant decline in performance between CY 2014 and CY 2015.
↔ indicates no statistically significant difference in performance between CY 2014 and CY 2015.
— indicates that the CY 2014 rate was not presented in the previous year's technical report; therefore, this rate is not presented in this report.
NA (i.e., Small Denominator) indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.
NC (i.e., Not Compared) indicates that DCH did not establish a performance target for this indicator.
NT (i.e., Not Trended) indicates that statistical significance testing was not performed between CY 2014 and CY 2015.

WellCare Children's Health Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Well-Child/Well-Care Visits				
Well-Child Visits in the First 15 Months of Life				

Standard II—Quality Assessment and Performance Improvement (QAPI)				
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)				
Six or More Well-Child Visits	66.93%	64.69%	↔	69.98%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	66.93%	68.73%	↔	72.80%
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	49.54%	53.28%	↔	53.47%
Prevention and Screening				
Childhood Immunization Status				
Combination 3	84.03%	82.10%	↔	82.30%
Combination 6	43.06%	44.54%	↔	59.37%
Combination 10	38.66%	41.48%	↔	40.94%
Lead Screening in Children				
Lead Screening in Children	81.35%	83.85%	↔	77.34%
Appropriate Testing for Children with Pharyngitis				
Appropriate Testing for Children with Pharyngitis	79.09%	80.67%	↑	83.66%
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap/Td)	76.33%	89.51%	↑	73.43%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total	63.43%	66.26%	↔	45.86%
Counseling for Nutrition—Total	59.49%	60.39%	↔	46.30%
*Counseling for Physical Activity—Total**	54.63%	54.03%	↔	46.30%
Developmental Screening in the First Three Years of Life				
Total	44.91%	51.82%	↑	46.36%
Percentage Of Eligibles Who Received Preventive Dental Services				

Standard II—Quality Assessment and Performance Improvement (QAPI)

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)

Percentage Of Eligibles Who Received Preventive Dental Services	49.93%	52.91%	↑	58.00%
Dental Sealants for 6-9-Year-Old Children at Elevated Caries Risk				
Dental Sealants for 6-9-Year-Old Children at Elevated Caries Risk	—	12.90%	NT	NC
Upper Respiratory Infection				
Appropriate Treatment for Children with Upper Respiratory Infection				
Appropriate Treatment for Children with Upper Respiratory Infection	82.81%	84.42%	↑	86.11%

[1] *CY 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014 through December 31, 2014.*

[2] *CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015 through December 31, 2015.*

[3] *CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.*

** Due to changes in the technical measure specifications, use caution when comparing rates for this measure between CY 2014 and 2015.*

↑ *indicates a statistically significant improvement in performance between CY 2014 and CY 2015.*

↔ *indicates no statistically significant difference in performance between CY 2014 and CY 2015.*

— indicates that the CY 2014 rate was not presented in the previous year's technical report; therefore, this rate is not presented in this report.

NA (i.e., Small Denominator) indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.

NC (i.e., Not Compared) indicates that DCH did not establish a performance target for this indicator.

NT (i.e., Not Trended) indicates that statistical significance testing was not performed between CY 2014 and CY 2015.

WellCare Women's Health Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Prevention and Screening				
Cervical Cancer Screening				
Cervical Cancer Screening	74.56%	66.36%	↓	76.64%

Standard II—Quality Assessment and Performance Improvement (QAPI)				
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)				
Breast Cancer Screening				
Breast Cancer Screening	72.17%	71.61%	↔	71.35%
Chlamydia Screening in Women				
Total	50.26%	53.04%	↑	54.93%
Human Papillomavirus Vaccine for Female Adolescents				
Human Papillomavirus Vaccine for Female Adolescents	20.37%	23.36%	↔	23.62%
Prenatal Care and Birth Outcomes				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	81.27%	72.32%	↓	89.62%
Postpartum Care	64.56%	52.87%	↓	69.47%
Cesarean Section for Nulliparous Singleton Vertex[4]				
Cesarean Section for Nulliparous Singleton Vertex	NR	19.56%	NT	18.08%
Cesarean Delivery Rate, Uncomplicated[4]				
Cesarean Delivery Rate, Uncomplicated	29.73%	28.70%	↑	28.70%
Percentage of Live Births Weighing Less Than 2,500 Grams[4]				
Percentage of Live Births Weighing Less Than 2,500 Grams	9.21%	9.05%	↔	8.02%
Behavioral Health Risk Assessment for Pregnant Women				
Behavioral Health Risk Assessment for Pregnant Women	9.95%	15.33%	↑	NC
Early Elective Delivery[4]				
Early Elective Delivery	NR	1.47%	NT	2.00%
Antenatal Steroids				
Antenatal Steroids	NR	0.00%	NT	NC

Standard II—Quality Assessment and Performance Improvement (QAPI)

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Frequency of Ongoing Prenatal Care				
Frequency of Ongoing Prenatal Care				
≥81 Percent of Expected Visits	58.48%	38.90%	↓	60.10%

[1] CY 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014 through December 31, 2014.

[2] CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015 through December 31, 2015.

[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.

[4] A lower rate indicates better performance for this measure.

↑ indicates a statistically significant improvement in performance between CY 2014 and CY 2015.

↓ indicates a statistically significant decline in performance between CY 2014 and CY 2015.

↔ indicates no statistically significant difference in performance between CY 2014 and CY 2015.

— indicates that the CY 2014 rate was not presented in the previous year's technical report; therefore, this rate is not presented in this report.

NA (i.e., Small Denominator) indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.

NC (i.e., Not Compared) indicates that DCH did not establish a performance target for this indicator.

NT (i.e., Not Trended) indicates that statistical significance testing was not performed between CY 2014 and CY 2015.

NR (i.e., Not Reported) indicates that the CMO produced a CY 2014 rate that was materially biased or chose not to report results for this measure; therefore, the rate was not included in the performance calculation. The auditors confirmed that although the CMO calculated this measure properly and according to CMS specifications, due to limitations with CMS specifications, the eligible population could not be appropriately ascertained. The resulting rate, therefore, was considered biased and not representative of the population.

WellCare Chronic Conditions Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Diabetes				
Comprehensive Diabetes Care*				
Hemoglobin A1c (HbA1c) Testing	83.19%	80.43%	↔	87.59%
HbA1c Poor Control (>9.0%)[4]	48.75%	52.74%	↔	44.69%

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HbA1c Control (<8.0%)	43.26%	39.80%	↔	46.43%
HbA1c Control (<7.0%)	32.43%	32.39%	↔	36.27%
Eye Exam (Retinal) Performed	35.44%	39.64%	↔	54.14%
Medical Attention for Nephropathy	76.71%	90.88%	↑	80.05%
Blood Pressure Control (<140/90 mm Hg)	55.74%	49.09%	↓	61.31%
Diabetes Short-Term Complications Admission Rate (Per 100,000 Member Months)[4]				
Diabetes Short-Term Complications Admission Rate	18.36	13.69	NT	--
Respiratory Conditions				
Asthma in Younger Adults Admission Rate (Per 100,000 Member Months)[4]				
Asthma in Younger Adults Admission Rate	5.52	3.38	NT	--
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (Per 100,000 Member Months)[4]				
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	41.00	17.30	NT	--
Pharmacotherapy Management of COPD Exacerbation				
Systemic Corticosteroid	—	69.28%	NT	74.94%
Bronchodilator	—	82.35%	NT	83.82%
Cardiovascular Conditions				
Heart Failure Admission Rate (Per 100,000 Member Months)[4]				
Heart Failure Admission Rate	4.28	5.02	NT	--
Controlling High Blood Pressure				
Controlling High Blood Pressure	43.24%	40.15%	↔	56.46%
Persistence of Beta-Blocker Treatment After a Heart Attack				

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Persistence of Beta-Blocker Treatment After a Heart Attack	—	NA	NT	NC

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[2] CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015 through December 31, 2015.

[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.

[4] A lower rate indicates better performance for this measure.

** Due to changes in the technical measure specifications, use caution when comparing rates for this measure between CY 2014 and 2015.*

↑ *indicates a statistically significant improvement in performance between CY 2014 and C Y2015.*

↓ *indicates a statistically significant decline in performance between CY 2014 and CY 2015.*

↔ *indicates no statistically significant difference in performance between CY 2014 and CY 2015.*

-- indicates the reporting unit for this measure was reported as per 100,000 member months for CY 2014 and CY 2015, and previous years were reported as per 100,000 members. Since the 2015 performance target was developed based on the previous year's reporting metrics, the 2015 performance target is not presented and caution should be used if comparing the CY 2015 rate to the 2015 performance target for this measure.

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NC (i.e., Not Compared) indicates that DCH did not establish a performance target for this indicator.

NT (i.e., Not Trended) indicates that statistical significance testing was not performed between CY 2014 and CY 2015.

WellCare Behavioral Health Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	48.92%	47.02%	↓	53.03%
Continuation and Maintenance Phase	63.78%	64.29%	↔	63.10%
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up	50.77%	50.39%	↔	63.21%

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30-Day Follow-Up	69.72%	68.75%	↔	80.34%
Antidepressant Medication Management				
Effective Acute Phase Treatment	46.92%	44.77%	↔	54.31%
Effective Continuation Phase Treatment	30.37%	28.35%	↔	38.23%
Screening for Clinical Depression and Follow-Up Plan				
Screening for Clinical Depression and Follow-Up Plan	0.49%	7.18%	↑	NC
Adherence to Antipsychotic Medications for Individuals with Schizophrenia*				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	33.85%	39.23%	↔	61.37%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents				
Total	—	1.59%	NT	NC

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[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.

** Due to changes in the technical measure specifications, use caution when comparing rates for this measure between CY 2014 and 2015.*

↑ indicates a statistically significant improvement in performance between CY 2014 and CY 2015.

↓ indicates a statistically significant decline in performance between CY 2014 and CY 2015.

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Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)

WellCare Medication Management Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Annual Monitoring for Patients on Persistent Medications				
Annual Monitoring for Members on ACE Inhibitors or ARBs	86.72%	89.47%	↑	88.00%
Annual Monitoring for Members on Diuretics	87.27%	88.82%	↔	87.90%
Total	86.86%	89.03%	↑	88.25%
Medication Management for People With Asthma				
Medication Compliance 50%—Ages 5–11 Years	45.62%	47.49%	↔	NC
Medication Compliance 50%—Ages 12–18 Years	42.00%	42.44%	↔	NC
Medication Compliance 50%—Ages 19–50 Years	57.79%	56.15%	↔	NC
Medication Compliance 50%—Ages 51–64 Years	NA	NA	NT	NC
Medication Compliance 50%—Total	44.91%	46.08%	↔	NC
Medication Compliance 75%—Ages 5–11 Years	21.93%	22.99%	↔	32.32%
Medication Compliance 75%—Ages 12–18 Years	18.25%	19.95%	↔	NC
Medication Compliance 75%—Ages 19–50 Years	33.61%	34.23%	↔	NC

Medication Compliance 75%—Ages 51–64 Years	NA	NA	NT	NC
Medication Compliance 75%—Total	21.17%	22.37%	⇔	NC

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[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.

↑ indicates a statistically significant improvement in performance between CY 2014 and CY 2015.

⇔ indicates no statistically significant difference in performance between CY 2014 and CY 2015.

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WellCare Utilization Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Ambulatory Care (Per 1,000 Member Months)—Total				
ED Visits—Total[4]	61.04	60.95	NT	52.31
Outpatient Visits—Total	334.03	327.56	NT	NC
Inpatient Utilization—General Hospital/Acute Care—Total				
Total Inpatient—Average Length of Stay—Total	2.99	3.20	NT	NC
Total Inpatient—Average Length of Stay—<1 Year	—	6.50	NT	NC
Medicine—Average Length of Stay—Total	3.02	3.18	NT	NC
Medicine—Average Length of Stay—<1 Year	—	4.16	NT	NC
Surgery—Average Length of Stay—Total	5.84	5.75	NT	NC
Surgery—Average Length of Stay—<1 Year	—	13.95	NT	NC

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Maternity—Average Length of Stay—Total	2.53	2.74	NT	NC
Mental Health Utilization—Total				
Any Service—Total—Total	8.88%	9.25%	NT	NC
Inpatient—Total—Total	0.50%	0.55%	NT	NC
Intensive Outpatient or Partial Hospitalization—Total—Total	0.14%	0.13%	NT	NC
Outpatient or ED—Total—Total	8.77%	9.14%	NT	NC
Plan All-Cause Readmission Rate[4]				
Age 18–44	—	11.79%	NT	NC
Age 45–54	—	10.46%	NT	NC
Age 55–64	—	20.95%	NT	NC
Age 18–64—Total	—	11.93%	NT	NC
Age 65–74	—	NA	NT	NC
Age 75–84	—	NA	NT	NC
Age 85 and Older	—	NA	NT	NC
Age 65 and Older—Total	—	NA	NT	NC

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[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.

[4] A lower rate indicates better performance for this measure.

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NA (i.e., Small Denominator) indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.

NC (i.e., Not Compared) indicates that DCH did not establish a performance target for this indicator.

NT (i.e., Not Trended) indicates that statistical significance testing was not performed between CY 2014 and CY 2015.

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Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)

WellCare Health Plan Descriptive Information Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Increase or Decrease	2015 Performance Target[3]
Weeks of Pregnancy at Time of Enrollment				
<0 Weeks	10.83%	13.79%	↑	NC
1–12 Weeks	7.11%	13.70%	↑	NC
13–27 Weeks	56.69%	52.04%	↓	NC
28+ Weeks	16.72%	12.33%	↓	NC
Unknown	8.66%	8.14%	↓	NC
Race/Ethnicity Diversity of Membership				
Total—White	48.33%	49.04%	↑	NC
Total—Black or African American	43.96%	44.16%	↑	NC

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[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.

↑ *indicates a statistically significant rate increase between CY 2014 and CY 2015.*

↓ *indicates a statistically significant rate decrease between CY 2014 and CY 2015.*

NC (i.e., Not Compared) indicates that DCH did not establish a performance target for this indicator.

Required Actions: HSAG was concerned that some performance measures experienced significant rate declines. WellCare must meet all DCH-established performance targets before this element will be given a *Met* status.

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date

Standard II—Quality Assessment and Performance Improvement (QAPI)			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
7. The CMO has an ongoing QAPI program for the services it furnishes to its members. *42CFR438.240(a)* *Contract: 4.12.5.*			
Findings: The QAPI Program Description did not follow the DCH-required guidelines. The Quality Improvement Program Policy stated that WellCare shall have an ongoing Quality Improvement Program (QIP) that objectively and systematically monitors and evaluates the quality and effectiveness of care and services rendered, thereby promoting quality care and quality patient outcomes in service performance to its members. WellCare described the extent of its QAPI Program in the 2015 Georgia QI Program Description and the 2015 QI Program Evaluation. The scope of the program included the assessment of network adequacy and appointment availability; development and review of CPGs; assessment of member satisfaction; credentialing and recredentialing of primary care providers (PCPs), specialists, and ancillary and allied health providers; assessment of continuity and coordination of care; assessment of provider compliance with national standards of care; assessment of patient safety; assessment of operational service performance; health services programs and activities; ongoing assessment of population changes; assessment of delegation oversight activities; and an assessment of the quality improvement program. WellCare provided the *Bright Futures* PIP with a goal to increase adolescent well-care visits as an example of a quality improvement initiative. However, the QI Evaluation did not provide in-depth analysis or an evaluation reflecting how the CMO used its QAPI Program for the services it furnished to members.			
Required Actions: WellCare must develop a comprehensive QAPI Program Description. The QAPI Program Description must be developed according to the DCH guidelines. The CMO must be approved by DCH as meeting the DCH guidelines.			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**

Standard II—Quality Assessment and Performance Improvement (QAPI)			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
8. The CMO's QAPI program is based on the latest available research in the area of quality assurance. *Contract: 4.12.5.2*			
Findings: WellCare provided the National Committee for Quality Assurance (NCQA) Clinical Practice Guidelines Hierarchy as evidence that the QAPI Program was based on the latest available research in the area of quality assurance. WellCare did not describe how it used the latest available research in the area of quality assurance in its QAPI Program descriptions or policies. During the compliance review interview, the CMO described its discussions with the developers of the Coleman Model for Care Transitions and the Lace Tool regarding discharge planning processes as an example of its use of the latest available research in the CMO's QAPI Program. Discussions with the Coleman Model developer included the development and use of a hybrid model tool which would include factors that were not in the model but were specific to the Georgia Medicaid population.			
Required Actions: The CMO must base its QAPI Program on the latest available research in the area of quality assurance.			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**

Standard II—Quality Assessment and Performance Improvement (QAPI)			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
10. The CMO's QAPI program includes mechanisms to assess the quality and appropriateness of care furnished to all members, including those with special health care needs. *42CFR438.240(b)(4)* *Contract:* *4.12.5.2*			
Findings: WellCare includes an assessment of the appropriateness of services through prior authorization and concurrent review processes using national guideline criteria. Documentation was provided in the Individuals with Special Health Care Needs document, QI Program Description, QI Program Evaluation, and the Case Management Program Description. WellCare's UMAC was responsible for promoting the delivery of efficient and appropriate healthcare services to members. The UMAC reviewed and evaluated utilization data to facilitate appropriate and efficient allocation of resources and services; investigated quality-related utilization issues; and analyzed utilization data including overutilization and underutilization, readmissions, and patient safety. During the compliance review interviews, WellCare discussed its use of UM rounds led by the chief medical officer in relation to the quality and appropriateness of services furnished to members. The review included 34–40 WellCare medical directors and staff focused on high-priority areas such as complex care, high-risk maternity, Neonatal Intensive Care Unit, and behavioral health integration. WellCare did not provide documentation of implemented processes to assess the quality of care furnished to members with special healthcare needs.			
Required Actions: WellCare must implement processes to assess the quality of care furnished to members with special healthcare needs.			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**

Standard II—Quality Assessment and Performance Improvement (QAPI)			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
11. The CMO has a method of monitoring, analysis, evaluation and improvement of the delivery, quality, and appropriateness of health care furnished to all members (including under- and over-utilization of services), including those with special health care needs. *Contract: 4.12.5.2*			
Findings: WellCare has processes focused on monitoring utilization of healthcare services as described in the Under and Over Utilization of Services Policy. The CMO implemented corrective actions to address both provider and member overutilization. The provider handbook and the Pharmacy Lock-In Report also described processes implemented to address overutilization issues. WellCare's UMAC was responsible for promoting the delivery of efficient and appropriate healthcare services to members. The UMAC reviewed disease management statistics, clinical quality initiatives, quality of care and quality of service issues, complaints, grievances and adverse event data, member and provider satisfaction survey results, and recommended strategies to improve compliance.			
Required Actions: WellCare must strengthen its processes for monitoring, analysis, and evaluation of the delivery, quality, and appropriateness of healthcare furnished to members in the areas of underutilization. WellCare must include information on its method of monitoring, analysis, evaluation, and improvement for the delivery, quality, and appropriateness of healthcare furnished for members with special healthcare needs in its policies, program descriptions, and evaluations.			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**

Standard II—Quality Assessment and Performance Improvement (QAPI)			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
12. The CMO's QAPI program includes written policies and procedures for quality assessment, utilization management, and continuous quality improvement that are periodically assessed for efficacy. *Contract: 4.12.5.2*			
Findings: WellCare did not submit its QAPI Program Description. The QAPI Program Description is required by DCH and must be developed according to the DCH guidelines. The WellCare QI Program Description and Quality Improvement Program and Provider Involvement Policy stated that WellCare shall have an ongoing QIP that objectively and systematically monitors and evaluates the quality and effectiveness of care and services rendered, thereby promoting quality of care and quality patient outcomes in service performance to its members. The QI Annual Evaluation included a brief description of ongoing and completed quality improvement activities and projects; trended clinical care and service performance measures and progress toward achieving goals; an analysis to identify barriers; and accomplishments and current opportunities for improvement with recommendations for interventions. The Under and Over Utilization of Services Policy described tools used for monitoring the underutilization and overutilization of healthcare services, as well as procedures for identifying patterns and addressing potential problems identified as a result of the analysis. Documentation submitted did not describe how the written policies and procedures were periodically assessed for efficacy.			
Required Actions: WellCare must develop a comprehensive QAPI Program Description. The QAPI Program Description must be developed according to the DCH guidelines. The CMO must be approved by DCH as meeting the DCH guidelines. The CMO must develop policies and procedures that support the implementation of the scope, goals, and objectives of the program including quality assessment, utilization management, and continuous quality improvement. The CMO must also assess the policies and procedures periodically for efficacy.			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**

Standard II—Quality Assessment and Performance Improvement (QAPI)			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
14. The CMO's QAPI program includes reports that are evaluated, indicated recommendations that are implemented, and feedback provided to providers and members. *Contract: 4.12.5.2*			
Findings: The QIC reviewed reports including quality measurement studies and projects, HEDIS performance measure results, member and provider satisfaction survey results, medical record reviews, complaints and grievances, provider network adequacy (availability and accessibility), continuity and coordination of care, cultural competency activities, and patient safety initiatives. The QIC had the primary responsibility for ensuring appropriate follow-up action in order to complete planned program initiatives. The QIC monitored, evaluated, and ensured compliance with the QI Program activities. The QIC also provided guidance on the development and dissemination of information regarding QI activities and outcomes to members and providers. WellCare had a QI WorkPlan that included interventions and activities with measurable goals that were reported to the QIC and to the UMAC. WellCare shared results of certain quality improvement activities with members through the member newsletter and with providers through the provider newsletter. During the compliance review interview, the CMO described the use of quality practice advisors to share HEDIS and utilization results with network providers. The quality practice advisors also worked with providers on opportunities to improve performance rates and to close gaps in care. WellCare's QI Program Description described goals and objectives to track, trend, and report data and outcomes. The WellCare QI Program Description and the QI Program Evaluation did not include information on how, as a result of data analysis or evaluation, indicated recommendations are implemented.			
Required Actions: WellCare must update its policies, program descriptions, and/or program evaluations to describe how, as a result of data analysis or evaluation, indicated recommendations are implemented.			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**

Standard II—Quality Assessment and Performance Improvement (QAPI)			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
15. The CMO's QAPI program includes a methodology and process for conducting and maintaining provider profiling. *Contract: 4.12.5.2*			
Findings: The WellCare Credentialing and Re-Credentialing Policy referenced requesting the provider performance profile information from the QI Department for providers being recredentialed. The Quality of Care Issues Policy included a table with Georgia reporting requirements. The policies did not include a methodology or process for conducting and maintaining provider profiling. The Georgia Medicaid QIC meeting minutes dated September 15, 2015, did not describe a methodology or process for conducting and maintaining provider profiling.			
Required Actions: WellCare must document the methodology and process used for conducting and maintaining provider profiling in its policies. WellCare must develop provider profiling activities that include information such as tracked and trended data regarding utilization, complaints and grievances, prescribing, and member satisfaction. WellCare's implementation or use of provider profiling information must be included in the QM Program Description to guide decisions in network development.			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**

Standard II—Quality Assessment and Performance Improvement (QAPI)
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)
17. The CMO has a process for evaluating the impact and effectiveness of the QAPI program. *42CFR438.240(e)(2)* *Contract: 4.12.5.2*
Findings: The 2015 QI Program Description provided a broad overview of overarching goals and objectives for quality assessment and performance improvement. Goals and objectives were based on federal and State requirements. However, the QI Program Description did not describe how WellCare used data and information obtained from utilization management, disease management, case management, grievances and appeals, quality of care case review, and member or provider feedback in its process to identify appropriate goals and objectives for quality improvement that were reflective of the needs of the population served. The QI Program Description did not discuss how analyzed and evaluated data from care and service delivery or information received from members or providers related to WellCare programs or operations were used to evaluate the effectiveness of the QI Program. The 2015 QI Program Description and the QI Evaluation were focused on the success of activities related to meeting regulatory compliance, rather than focusing on an understanding of the population served or an identification of opportunities to improve care, service, or satisfaction through a review of analyzed data. For example, the 2015 QI Program Description stated that the QI Program was considered effective as the CMO had achieved all of its QI Program objectives. The program description stated: Notable areas of improvement included the following: • Adult CAHPS survey accreditation points increased from 7.8 in 2014 to 11.7 in 2015. • The QI Department was fully staffed with resources to perform provider engagement in collaboration with the provider relations team. • Successful submission and reprocurement of the Medicaid contract • Passed NCQA HEDIS Compliance Audit • Submitted HEDIS IDSS [Interactive Data Submission System] • Retained NCQA Commendable status The 2015 QI Evaluation included broad statements indicating that areas of the QI Program not meeting goals were analyzed and that activities directed toward identified barriers for improvement had been integrated into the 2016 QI Work Plan. In addition, the evaluation stated that activities included in the 2015 QI Work Plan would continue in 2016, as appropriate. The QI Evaluation did not provide in-depth analysis or an evaluation that would indicate that the CMO used its data to understand where opportunities for quality improvement existed, or that specific outcomes from quality improvement work occurred as a result of implementing CPGs or other interventions.
Required Actions: WellCare must write the QAPI Program Evaluation based on DCH specifications. The QAPI Program Evaluation must be approved by DCH. WellCare must include additional information in its QI Program Description, such as the comprehensive process used, and may want to begin this process with a review of information and data available to the CMO through claims/encounters, grievance and appeals, quality of care cases, disease management, case management, care coordination, and member and provider input, to identify quality improvement opportunities and gaps in care or service delivery. Quality

Standard II—Quality Assessment and Performance Improvement (QAPI)			
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improvement initiatives must meet regulatory requirements and also demonstrate an understanding of the population served; use data to understand where quality improvement opportunities exist; and include research of potential interventions and activities that may have a positive impact on the care, services, and outcomes for members. The CMO must also consider including in its QI Evaluation a more complete summary of how the quality improvement goals, objectives, and related initiatives were identified; which data were used in the selection process; which interventions were considered; how the interventions were implemented; how the initiatives were resourced, including specific, assigned individuals and their qualifications; and the results or outcomes of the quality improvement work. The QI Evaluation must provide the story of the effectiveness of WellCare's quality assessment and performance improvement work.			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**

Standard II—Quality Assessment and Performance Improvement (QAPI)			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
20. The CMO has a structured patient safety plan to address concerns or complaints regarding clinical care, which includes written policies and procedures for processing member complaints regarding the care they received. *Contract: 4.12.9.1*			
Findings: The WellCare Quality of Care Issues Policy described a process for receipt and processing of member concerns or complaints through the Grievance Department. The QM Patient Safety Plan was written in a manner that may cause confusion between grievances (expressions of dissatisfaction) and the grievance process. The 2015 Georgia QI Program Description described a process for investigation of quality of care concerns conducted by the Grievance Department. It further stated that, should a deviation from standard of care be identified, the case would be referred to the Quality Improvement Department for medical director review. If the medical director determined that there was a need for the case to receive peer review, it was referred to the Credentialing Committee. The Georgia Medicaid QIC minutes dated September 15, 2015, documented a case referred for peer review. The PPIR Completed DCH-Approved Provider Performance Issue Referral Form included a process for referral of cases to the medical director or the QIC. The 2015 Patient Safety Plan further explained the goals and objectives related to patient safety, including the receipt and processing of member complaints regarding the care or services.			
Required Actions: The QM Patient Safety Plan must be structured and approved by DCH. The QM Patient Safety Plan must clearly distinguish between grievances and the grievance process.			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**

Standard II—Quality Assessment and Performance Improvement (QAPI)			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
21. Patient safety plan policies and procedures include: *Contract: 4.12.9.1* c. A mechanism for determining which incidents will be forwarded to the Peer Review and Credentials Committees. *Contract: 4.12.9.1*			
Findings: The WellCare Quality of Care Issues Policy described a process for cases that met the peer review standard of care that allowed the nurse reviewer to close the case under the direction of the medical director. The policy did not establish a process to forward the issue to a formal Peer Review Committee, but rather referred the case to the "Market" for presentation and further assessment. The policy allowed for the Market medical director to refer cases to the Credentialing Committee if the quality review suggested a pattern of inappropriate care or if cases required further peer review. The Credentialing Peer Review Policy did not discuss a mechanism for determining which incidents would be forwarded to the Credentialing Committee.			
Required Actions: WellCare must include in its quality of care and peer review process a description of how the results of its internal review processes are tracked and trended, substantiated issues are reviewed for appropriate corrective actions, and a decision made whether the issue should be referred to regulatory boards for review.			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**

Standard II—Quality Assessment and Performance Improvement (QAPI)			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
21. Patient safety plan policies and procedures include: *Contract: 4.12.9.1* d. A summary of incident(s), including the final disposition, included in the provider profile. *Contract: 4.12.9.1*			
Findings: The WellCare Quality of Care Issues Policy did not reference the inclusion of a summary of the incident and the final disposition in the provider profile. The PPIR Completed DCH-Approved Provider Performance Issue Referral Form did not include a process to include documentation in the provider profile. The Georgia Peer Review Committee meeting minutes, dated January 25, 2016, indicated an action taken with a provider, but it did not reference inclusion of the disposition or summary of the incident in the provider's profile.			
Required Actions: WellCare must include in its written process how it will include in the provider's profile a summary of the incident(s), including the final disposition.			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**

Standard III—Health Information Systems
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)
4. The CMO's health information system includes a mechanism to ensure that data received from providers are accurate and complete by: • Verifying the accuracy and timeliness of reported data. • Screening the data for completeness, logic, and consistency. • Collecting service information in standardized formats to the extent feasible and appropriate. • Making all collected data available to the State and upon request to CMS. *42CFR438.242(b)(2)* *42CFR438.242(b)(3)* *Contract:* *4.17.3.1* *4.17.3.6*
Findings: WellCare stated that all claims received from providers were run through a series of edits in WellCare's claims pre-adjudication system, known as the Claims Intake System (CIS). In CIS, business rules were applied, which validated the provider, vendor, and member assignments. WellCare's system edits complied with Medicaid timeliness reporting requirements. WellCare's corporate policies, as well as its contracts with providers, required the use of standardized formats. Corporate policies and WellCare's contracts with providers required the provider to make data available to the State or the Centers for Medicare & Medicaid Services (CMS), as requested. Other than standard system edits, WellCare did not provide documentation on how it screened data from providers for completeness, logic, and consistency.
Required Actions: WellCare must update its process descriptions to describe how the CMO ensures that data received from providers are complete, logical, and consistent.

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date

The following pages are for WellCare's use in preparing its corrective action plan (CAP) for the element scored *Not Met* in the "Follow-Up on Reviews From Previous Noncompliant Review Findings" section of this report. The element that follows retains the numbering and labeling that was used when the element was originally scored for the CMO's ease in comparing to prior years' reports.

Standard II—Furnishing of Services
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)

5. **Geographic Access:** *Contract 4.8.13.1*

The CMO meets the following geographic access standards for all members:

	Urban	Rural
PCPs	Two within eight miles	Two within 15 miles
Specialists	One within 30 minutes or 30 miles	One within 45 minutes or 45 miles
General Dental Providers	One within 30 minutes or 30 miles	One within 45 minutes or 45 miles
Dental Subspecialty Providers	One within 30 minutes or 30 miles	One within 45 minutes or 45 miles
Hospitals	One within 30 minutes or 30 miles	One within 45 minutes or 45 miles
Mental Health Providers	One within 30 minutes or 30 miles	One within 45 minutes or 45 miles
Pharmacies	One 24/7 hours a day, seven (7) days a week within 15 minutes or 15 miles	One 24/7 hours a day (or has an after-hours emergency phone number and pharmacist on call) seven days a week within 30 minutes or 30 miles

August 2016 Re-review Findings: Documentation indicated that WellCare continued to not meet the geographic access standards for urban and rural areas for primary care providers (PCPs), specialists, dental subspecialty providers and pharmacies. WellCare was developing processes to identify telemedicine sites in an effort to fill care gaps in the provider directory. The following examples illustrated the geographic access standard deficiencies:

March 2016
594 deficiencies
April 2016:

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
585 deficiencies **May 2016** 576 deficiencies **June 2016** 595 deficiencies WellCare stated that the largest portion of deficiencies were in rural counties where no specialty providers existed. Information provided included a description of the physician shortage according to the Physician Workforce Study published in 2013, which referenced 99 active allergists in the state of Georgia. The same report stated that there were 278 active dermatologists in Georgia, and only 19% accepted Medicaid. The report also stated that Georgia ranked 44 in the number of active PCPs. The national average, according to the report, is 80.7 active PCP's per 100,000 residents compared to Georgia's 68.5 active PCP's per 100,000 residents.			
August 2016 Required Actions: WellCare must continue to work to meet the geographic access standards for both urban and rural areas for PCPs, specialists, dental subspecialty providers, and pharmacies. WellCare must continue efforts to close its network adequacy gaps and keep DCH informed of its progress.			
Evidence/Documentation Submitted by the CMO			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**