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**LOUISIANA COORDINATED CARE NETWORK PROGRAM  
CCN-P PROPOSAL SUBMISSION AND EVALUATION REQUIREMENTS  
RFP # 305PUR-DHHRFP-CCN-P-MVA**

**PROPOSER  
NAME**

WellCare of Louisiana, Inc.

**THE PROPOSER MUST COMPLETE THIS FORM AND SUBMIT WITH THEIR PROPOSAL.**

**PART II: TECHNICAL PROPOSAL & EVALUATION GUIDE**

The Proposer should adhere to the specifications outlined in Section §21 of the RFP in responding to this RFP. The Proposer should address ALL section items and provide, in sequence, the information and documentation as required (referenced with the associated item references and text and complete all columns marked in **ORANGE ONLY**).

\*If the Proposer is proposing to provide services in all GSAs, Proposer may respond by stating “all” in the Specify Applicable GSA Area column. If not, Proposer must specify the specific GSA(s).

Proposal Evaluation Teams, made up of teams of State employees, will evaluate and score the proposal’s responses.

For those items in Part II that state “Included/Not Included” the proposals will be scored as follows:

- a. All items scored Included = 0 points
- b. If 1-3 items are scored “Not Included” = -10 points
- c. If 4-5 items are scored “Not Included” = -20 points
- d. If more than 6 items are scored “Not Included” = -30 points

Any contract resulting from this RFP process shall incorporate by reference the respective proposal responses to all items below as a part of said contract.

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		<b>B.</b> <b>Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)</b>	345		
Section B Page 1	All	<b>B.1</b> Indicate your organization’s legal name, trade name, <i>dba</i> , acronym, and any other name under which you do business; the physical address, mailing address, and telephone number of your headquarters office. Provide the legal name for your organization’s ultimate parent ( <i>e.g.</i> , publicly traded corporation).  Describe your organization’s form of business ( <i>i.e.</i> , individual, sole proprietor, corporation, non-profit corporation, partnership, limited liability company) and detail the names, mailing address, and telephone numbers of its officers and directors and any partners (if applicable). Provide the name and address of any health professional that has at least a five percent (5%) financial interest in your organization, and the type of financial interest.  Provide your federal taxpayer identification number and Louisiana taxpayer identification number.  Provide the name of the state in which you are incorporated and the state in which you are commercially domiciled. If out-of-state, provide the name and address of the local representative; if none, so state.  If you have been engaged by DHH within the past twenty-four (24) months, indicate the contract number and/or any other information available to identify the engagement; if not, so state.	Included/Not Included		
Section B Page 4	All	<b>B.2</b> Provide a statement of whether there have been any mergers, acquisitions, or sales of your organization within the last ten years, and if so, an explanation providing relevant details. If any change of ownership is anticipated during the 12 months following the Proposal Due Date, describe the circumstances of such change and indicate when the change is likely to occur. Include your organization’s parent organization, affiliates, and subsidiaries.	Included/Not Included		

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Section B Page 5	All	<p><b>B.3</b></p> <p>Provide a statement of whether you or any of your employees, agents, independent contractors, or subcontractors have ever been convicted of, pled guilty to, or pled nolo contendere to any felony and/or any Medicaid or health care related offense or have ever been debarred or suspended by any federal or state governmental body. Include an explanation providing relevant details and the corrective action plan implemented to prevent such future offenses. Include your organization's parent organization, affiliates, and subsidiaries.</p>	0 to -25		
Section B Page 6	All	<p><b>B.4</b></p> <p>Provide a statement of whether there is any pending or recent (within the past five years) litigation against your organization. This shall include but not be limited to litigation involving failure to provide timely, adequate or quality physical or behavioral health services. You do not need to report workers' compensation cases. If there is pending or recent litigation against you, describe the damages being sought or awarded and the extent to which adverse judgment is/would be covered by insurance or reserves set aside for this purpose. Include a name and contact number of legal counsel to discuss pending litigation or recent litigation. Also include any SEC filings discussing any pending or recent litigation. Include your organization's parent organization, affiliates, and subsidiaries.</p>	0 to -25		
Section B Page 26	All	<p><b>B.5</b></p> <p>Provide a statement of whether, in the last ten years, you or a predecessor company has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors. If so, provide an explanation providing relevant details including the date in which the Proposer emerged from bankruptcy or expects to emerge. If still in bankruptcy, provide a summary of the court-approved reorganization plan. Include your organization's parent organization, affiliates, and subsidiaries.</p>	0 to -25		

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Section B Page 27	All	<p><b>B.6</b></p> <p>If your organization is a publicly-traded (stock-exchange-listed) corporation, submit the most recent United States Securities and Exchange Commission (SEC) Form 10K Annual Report, and the most-recent 10-Q Quarterly report.</p> <p>Provide a statement whether there have been any Securities Exchange Commission (SEC) investigations, civil or criminal, involving your organization in the last ten (10) years. If there have been any such investigations, provide an explanation with relevant details and outcome. If the outcome is against the Proposer, provide the corrective action plan implemented to prevent such future offenses. Also provide a statement of whether there are any current or pending Securities Exchange Commission investigations, civil or criminal, involving the Proposer, and, if such investigations are pending or in progress, provide an explanation providing relevant details and provide an opinion of counsel as to whether the pending investigation(s) will impair the Proposer's performance in a contract/Agreement under this RFP. Include your organization's parent organization, affiliates, and subsidiaries.</p>	0 to -25		
Section B Page 28	All	<p><b>B.7</b></p> <p>If another corporation or entity either substantially or wholly owns your organization, submit the most recent detailed financial reports for the parent organization. If there are one (1) or more intermediate owners between your organization and the ultimate owner, this additional requirement is applicable only to the ultimate owner.</p> <p>Include a statement signed by the authorized representative of the parent organization that the parent organization will unconditionally guarantee performance by the proposing organization of each and every obligation, warranty, covenant, term and condition of the Contract.</p>	Included/Not Included		
Section B Page 29	All	<p><b>B.8</b></p> <p>Describe your organization's number of employees, client base, and location of offices. Submit an organizational chart (marked as Chart A of your response) showing the structure and</p>	Included/Not Included		

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		lines of responsibility and authority in your company. Include your organization's parent organization, affiliates, and subsidiaries.			
Section B Page 32	All	<p><b>B.9</b></p> <p>Provide a narrative description of your proposed Louisiana Medicaid Coordinated Care Network project team, its members, and organizational structure including an organizational chart showing the Louisiana organizational structure, including staffing and functions performed at the local level. If proposing for more than one (1) GSA, include in your description and organizational chart if: 1) the team will be responsible for all GSAs or 2) if each GSA will differ provide details outlining the differences and how it will differ.</p>	15		
Section B Page 40	All	<p><b>B.10</b></p> <p>Attach a personnel roster and resumes of key people who shall be assigned to perform duties or services under the Contract, highlighting the key people who shall be assigned to accomplish the work required by this RFP and illustrate the lines of authority. Submit current resumes of key personnel documenting their educational and career history up to the current time. Include information on how long the personnel have been in these positions and whether the position included Medicaid managed care experience.</p> <p>If any of your personnel named is a current or former Louisiana state employee, indicate the Agency where employed, position, title, termination date, and last four digits of the Social Security Number.</p> <p>If personnel are not in place, submit job descriptions outlining the minimum qualifications of the position(s). Each resume or job description should be limited to 2 pages.</p> <p>For key positions/employees which are not full time provide justification as to why the position is not full time. Include a description of their other duties and the amount of time allocated to each.</p>	40		

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Section B Page 42	All	<p><b>B.11</b></p> <p>Provide a statement of whether you intend to use major subcontractors (as defined in the RFP Glossary), and if so, the names and mailing addresses of the subcontractors and a description of the scope and portions of the work for each subcontractor with more than \$100,000 annually. Describe how you intend to monitor and evaluate subcontractor performance. Also specify whether the subcontractor is currently providing services for you in other states and where the subcontractor is located.</p> <p>In addition, as part of the response to this item, for each major subcontractor that is not your organization's parent organization, affiliate, or subsidiary, restate and respond to items B.1 through B.7, B10 and, B.16 through B.27</p> <p>If the major subcontractor is your organization's parent organization, affiliate, or subsidiary, respond to items B.1, B.8 and B.9. You do not need to respond to the other items as part of the response to B11; note, however, responses to various other items in Section B must include information on your organization's parent organization, affiliates, and subsidiaries, which would include any major subcontractors that are your organization's parent organization, affiliate, or subsidiary.</p>	10		
Section B Page 48	All	<p><b>B.12</b></p> <p>Provide a description your Corporate Compliance Program including the Compliance Officer's levels of authority and reporting relationships. Include an organizational chart of staff (marked as Chart B in your response) involved in compliance along with staff levels of authority.</p>	15		
Section B Page 55	All	<p><b>B.13</b></p> <p>Provide copies of any press releases in the twelve (12) months prior to the Deadline for Proposals, wherein the press release mentions or discusses financial results, acquisitions, divestitures, new facilities, closures, layoffs, significant contract awards or losses, penalties/fines/ sanctions, expansion, new or departing officers or directors, litigation, change of ownership, or other very similar issues, Do not</p>	10		

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		include press releases that are primarily promotional in nature.			
Section B Page 56	All	<b>B.14</b> Describe your plan for meeting the Performance Bond, other bonds, and insurance requirements set forth in this RFP requirement including the type of bond to be posted and source of funding.	Included/Not Included		
Section B Page 57	All	<b>B.15</b> Provide the following information (in Excel format) based on each of the financial statements provided in response to item B:31: (1) Working capital; (2) Current ratio; (3) Quick ratio; (4) Net worth; and (5) Debt-to-worth ratio.	20		
Section B Page 59	All	<b>B.16</b> Identify, in Excel format, all of your organization's publicly-funded managed care contracts for Medicaid/CHIP and/or other low-income individuals within the last five (5) years. In addition, identify, in Excel format your organization's ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP and/or other low-income individuals within the last five (5) years. For each prior experience identified, provide the trade name, a brief description of the scope of work, the duration of the contract, the contact name and phone number, the number of members and the population types (e.g., TANF, ABD, duals, CHIP), the annual contract payments, whether payment was capitated or other, and the role of subcontractors, if any. If your organization has not had any publicly-funded managed care contracts for Medicaid/SCHIP individuals within the last five (5) years, identify the Proposer's ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP individuals within the last five (5) years and provide the information requested in the previous sentence. Include your organization's parent organization, affiliates, and subsidiaries.	75		
Section B Page 82	All	<b>B.17</b> Identify whether your organization has had any contract terminated or not renewed within the	Included/Not Included		

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		past five (5) years. If so, describe the reason(s) for the termination/nonrenewal, the parties involved, and provide the address and telephone number of the client. Include your organization's parent organization, affiliates, and subsidiaries.			
Section B Page 85	All	<p><b>B.18</b></p> <p>If the contract was terminated/non-renewed in B.17 above, based on your organization's performance, describe any corrective action taken to prevent any future occurrence of the problem leading to the termination/non-renewal. Include your organization's parent organization, affiliates, and subsidiaries.</p>	0 to -25		
Section B Page 86	All	<p><b>B. 19</b></p> <p>As applicable, provide (in table format) the Proposer's current ratings as well as ratings for each of the past three years from each of the following:</p> <ul style="list-style-type: none"> <li>• AM Best Company (financial strengths ratings);</li> <li>• TheStreet.com, Inc. (safety ratings); and</li> <li>• Standard &amp; Poor's (long-term insurer financial strength).</li> </ul>	Included/Not Included		
Section B Page 87	All	<p><b>B.20</b></p> <p>For any of your organization's contracts to provide physical health services within the past five years, has the other contracting party notified the Proposer that it has found your organization to be in breach of the contract? If yes: (1) provide a description of the events concerning the breach, specifically addressing the issue of whether or not the breach was due to factors beyond the Proposer's control. (2) Was a corrective action plan (CAP) imposed? If so, describe the steps and timeframes in the CAP and whether the CAP was completed. (3) Was a sanction imposed? If so, describe the sanction, including the amount of any monetary sanction (e.g., penalty or liquidated damage) (4) Was the breach the subject of an administrative proceeding or litigation? If so, what was the result of the proceeding/litigation? Include your organization's parent organization, affiliates, and subsidiaries.</p>	0 to -25		

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Section B Page 89	All	<p><b>B.21</b></p> <p>Indicate whether your organization has ever sought, or is currently seeking, National Committee for Quality Assurance (NCQA) or American Accreditation HealthCare Commission (URAC) accreditation status. If it has or is, indicate current NCQA or URAC accreditation status and accreditation term effective dates if applicable.</p>	Included/Not Included		
Section B Page 90	All	<p><b>B.22</b></p> <p>Have you ever had your accreditation status (e.g., NCQA, URAC,) in any state for any product line adjusted down, suspended, or revoked? If so, identify the state and product line and provide an explanation. Include your organization's parent organization, affiliates, and subsidiaries.</p>	0 to -5		
Section B Page 91	All	<p><b>B.23</b></p> <p>If you are NCQA accredited in any state for any product line, include a copy of the applicable NCQA health plan report cards for your organization. Include your organization's parent organization, affiliates, and subsidiaries.</p>	Included/Not Included		
Section B Page 94	All	<p><b>B.24</b></p> <p>Provide (as an attachment) a copy of the most recent external quality review report (pursuant to Section 1932(c)(2) of the Social Security Act) for the Medicaid contract identified in response to item B.16 that had the largest number of enrollees as of January 1, 2011. Provide the entire report. In addition, provide a copy of any corrective action plan(s) requested of your organization (including your organization's parent organization, affiliates, and subsidiaries) in response to the report.</p>	25		
Section B Page 95	All	<p><b>B.25</b></p> <p>Identify and describe any regulatory action, or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity against your organization within the last five (5) years. In addition, identify and describe any letter of deficiency issued by as well as any corrective actions requested or required by any federal or state regulatory entity</p>	0 to -50		

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		within the last five (5) years that relate to Medicaid or CHIP contracts. Include your organization's parent organization, affiliates, and subsidiaries.			
Section B Page 150	All	<p><b>B.26</b></p> <p>Provide a statement of whether your organization is currently the subject or has recently (within the past five (5) years) been the subject of a criminal or civil investigation by a state or federal agency other than investigations described in response to item B.6. If your organization has recently been the subject of such an investigation, provide an explanation with relevant details and the outcome. If the outcome is against your organization, provide the corrective action plan implemented to prevent such future offenses. Include your organization's parent company, affiliates and subsidiaries.</p>	0 to -25		
Section B Page 154	All	<p><b>B.27</b></p> <p>Submit client references (minimum of three, maximum of five) for your organization for major contracts; with at least one reference for a major contract you have had with a state Medicaid agency or other large similar government or large private industry contract. Each reference must be from contracts within the last five (5) years. References for your organization shall be submitted to the State using the questionnaire contained in RFP Appendix PP. You are solely responsible for obtaining the fully completed reference check questionnaires, and for submitting them sealed by the client providing the reference, with your Proposal, as described herein. You should complete the following steps:</p> <ul style="list-style-type: none"> <li>• Make a duplicate (hard copy or electronic document) of the appropriate form, as it appears in RFP Appendix PP (for your organization or for subcontractors, adding the following customized information: <ul style="list-style-type: none"> <li>• Your/Subcontractor's name;</li> <li>• Geographic Service Area(s) for which the reference is being submitted;</li> <li>• Reference organization's name;</li> </ul> </li> </ul>	35		

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		<p>and</p> <ul style="list-style-type: none"> <li>• Reference contact's name, title, telephone number, and email address.</li> <li>• Send the form to each reference contact along with a new, sealable standard #10 envelope;</li> <li>• Give the contact a deadline that allows for collection of all completed questionnaires in time to submit them with your sealed Proposal;</li> <li>• Instruct the reference contact to:               <ul style="list-style-type: none"> <li>• Complete the form in its entirety, in either hard copy or electronic format (if completed electronically, an original should be printed for submission);</li> <li>• Sign and date it;</li> <li>• Seal it in the provided envelope;</li> <li>• Sign the back of the envelope across the seal; and</li> <li>• Return it directly to you.</li> </ul> </li> <li>• Enclose the unopened envelopes in easily identifiable and labeled larger envelopes and include these envelopes as a part of the Proposal. When DHH the opens your Proposal, it should find clearly labeled envelope(s) containing the sealed references.</li> </ul> <p>THE STATE WILL NOT ACCEPT LATE REFERENCES OR REFERENCES SUBMITTED THROUGH ANY OTHER CHANNEL OF SUBMISSION OR MEDIUM, WHETHER WRITTEN, ELECTRONIC, VERBAL, OR OTHERWISE.</p> <p>Each completed questionnaire should include:</p> <ul style="list-style-type: none"> <li>• Proposing Organization/Subcontractor's name;</li> <li>• GSA (s) for which the reference is being submitted;</li> <li>• Reference Organization's name;</li> <li>• Name, title, telephone number, and email address of the organization contact knowledgeable about the scope</li> </ul>			

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		<p>of work;</p> <ul style="list-style-type: none"> <li>• Date reference form was completed; and</li> <li>• Responses to numbered items in RFP Attachment # (as applicable).</li> </ul> <p>DHH reserves the authority to clarify information presented in questionnaires and may consider clarifications in the evaluation of references. However DHH is under no obligation to clarify any reference check information.</p>			
Section B Page 156	All	<p><b>B.28</b></p> <p>Indicate the website address (URL) for the homepage(s) of any website(s) operated, owned, or controlled by your organization, including any that the Proposer has contracted to be run by another entity as well as details of any social media presence ( e.g., Facebook, Twitter). If your organization has a parent, then also provide the same for the parent, and any parent(s) of the parent. If no websites and/or social media presence, so state.</p>	Included/Not Included		
Section B Page 160	All	<p><b>B.29</b></p> <p>Provide evidence that the Proposer has applied to Louisiana Department of Insurance for a certificate of authority (COA) to establish and operate a prepaid entity as defined in RS 22:1016 and in accordance with rules and regulations as defined by the Department of Health and Hospitals.</p>	0 to -25		
Section B Page 161	All	<p><b>B.30</b></p> <p>Provide the following as documentation of financial responsibility and stability:</p> <ul style="list-style-type: none"> <li>• a current written bank reference, in the form of a letter, indicating that the Proposer's business relationship with the financial institution is in positive standing;</li> <li>• two current written, positive credit references, in the form of a letters, from vendors with which the Proposer has done business or, documentation of a positive credit rating determined by a accredited credit bureau within the last 6 months;</li> <li>• a copy of a valid certificate of insurance</li> </ul>	50		

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		<p>indicating liability insurance in the amount of at least one million dollars (\$1,000,000) per occurrence and three million dollars (\$3,000,000) in the aggregate; and</p> <ul style="list-style-type: none"> <li>a letter of commitment from a financial institution (signed by an authorized agent of the financial institution and detailing the Proposer's name) for a general line of credit in the amount of five-hundred thousand dollars (\$500,000.00).</li> </ul>			
Section B Page 169	All	<p><b>B.31</b></p> <p>Provide the following as documentation of the Proposer's sufficient financial strength and resources to provide the scope of services as required:</p> <ul style="list-style-type: none"> <li>The two most recent independently audited financial statements and associated enrollment figures from the Proposer. Compiled or reviewed financial statements will not be accepted. The audited financial statements must be: <ul style="list-style-type: none"> <li>Prepared with all monetary amounts detailed in U.S. currency;</li> <li>Prepared under U.S. generally accepted accounting principles; and</li> <li>Audited under U.S. generally accepted auditing standards. The audited financial statements must include the auditor's opinion letter, financial statements, and the notes to the financial statements.</li> </ul> </li> <li>The Proposer's four (4) most recent internally prepared unaudited quarterly financial statements (and Year-to- Date), with preparation dates indicated. The statements must include documentation disclosing the amount of cash flows from operating activities. This documentation must indicate whether the cash flows are positive or negative, and if the cash flows are negative for the quarters, the documentation must include a detailed explanation of the factors contributing to the negative cash flows.</li> <li>Verification of any contributions made to</li> </ul>	50		

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		<p>the Proposer to improve its financial position after its most recent audit (e.g., copies of bank statements and deposit slips), if applicable</p> <p>Proposer shall include the Proposer's parent organization.</p>			

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		<b>Section C: Planned Approach to Project</b>	<b>100</b>		
<b>Section C Page 1</b>	<b>All</b>	<p>Describe how you will launch a network and set up operations capable of supporting its membership and meeting the requirements of the RFP by January 1, 2012 for GSA "A", March 1 of 2012 for GSA "B", and May 1 of 2012 for GSA "C".</p> <p><b>C.1</b> Discuss your approach for meeting the implementation requirements and include:</p> <ul style="list-style-type: none"> <li>• A detailed description of your project management methodology. The methodology should address, at a minimum, the following: <ul style="list-style-type: none"> <li>○ Issue identification, assessment, alternatives analysis and resolution;</li> <li>○ Resource allocation and deployment;</li> <li>○ Reporting of status and other regular communications with DHH, including a description of your proposed method for ensuring adequate and timely reporting of information to DHH project personnel and executive management; and</li> <li>○ Automated tools, including use of specific software applications.</li> </ul> </li> </ul>	<b>20</b>		
<b>Section C Page 11</b>	<b>All</b>	<p><b>C.2</b> Provide a work plan for the implementation of the Louisiana Medicaid CCN Program. At a minimum the work plan should include the following:</p> <ul style="list-style-type: none"> <li>• Tasks associated with your establishment of a "project office" or similar organization by which you will manage the implementation of the CCN Program;</li> <li>• An itemization of activities that you will undertake during the period between the awarding of this procurement and the start date of the CCN Program. These activities shall have established</li> </ul>	<b>25</b>		

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		<p>deadlines and timeframes and as needed conform to the timelines established under this RFP for deliverables.</p> <ul style="list-style-type: none"> <li>○ All activities to prepare for and participate in the Readiness Review Process; and</li> <li>○ All activities necessary to obtain required contracts for mandatory health care providers as specified in this RFP.</li> </ul> <ul style="list-style-type: none"> <li>● An estimate of person-hours associated with each activity in the Work Plan;</li> <li>● Identification of interdependencies between activities in the Work Plan; and</li> <li>● Identification of your expectations regarding participation by DHH and/or its agents in the activities in the Work Plan and dependencies between these activities and implementation activities for which DHH will be responsible. (In responding the CCN shall understand DHH shall not be obligated to meet the CCN's expectation.)</li> </ul>			
Section C Page 17	All	<p><b>C.3</b> Describe your Risk Management Plan.</p> <ul style="list-style-type: none"> <li>● At a minimum address the following contingency scenarios that could be encountered during implementation of the program: <ul style="list-style-type: none"> <li>○ Delays in building the appropriate Provider Network as stipulated in this RFP;</li> <li>○ Delays in building and/or configuring and testing the information systems within your organization's Span of Control required to implement the CCN program;</li> <li>○ Delays in hiring and training of the staff required to operate program functions;</li> <li>○ Delays in the construction and/or acquisition of office space and the delivery of office equipment for staff required to operate program functions;</li> </ul> </li> </ul>	25		

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		<ul style="list-style-type: none"> <li>○ Delays in enrollment processing during the implementation of CCN; and</li> <li>○ Delays in the publication of marketing and related materials and/or the delivery of these materials to DHH and/or its agents.</li> <li>● For each contingency scenario identified in the Proposal, at a minimum the Risk Management Plan must include the following:               <ul style="list-style-type: none"> <li>○ Risk identification and mitigation strategies;</li> <li>○ Risk management implementation plans; and</li> <li>○ Proposed or recommended monitoring and tracking tools.</li> </ul> </li> </ul>			
<b>Section C Page 28</b>	<b>All</b>	<b>C.4</b> Provide a copy of the Work Plan, generated in Microsoft Project or similar software product that includes the aforementioned implementation activities along with the timeframes, person-hours, and dependencies associated with these activities.	<b>20</b>		
<b>Section C Page 29</b>	<b>All</b>	<b>C.5</b> Provide a roster of the members of the proposed implementation team including the group that will be responsible for finalizing the Provider network.	<b>5</b>		
<b>Section C Page 33</b>	<b>All</b>	<b>C.6</b> Provide the resume of the Implementation Manager (the primary person responsible for coordinating implementation activities and for allocating implementation team resources).	<b>5</b>		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		<b>Section D: Member Enrollment and Disenrollment</b>	<b>25</b>		
<b>Section D Page 1</b>	<b>All</b>	<b>D.1</b> Describe your enrollment procedure requirements, including how you will ensure that you will coordinate with DHH and its Agent.	<b>5</b>		
<b>Section D Page 3</b>	<b>All</b>	<b>D.2</b> Describe your enrollment procedure requirements, including how you will ensure that you will coordinate with DHH and its Agent.\	<b>5</b>		
<b>Section D Page 5</b>	<b>All</b>	<b>D.3</b> Describe your enrollment procedure requirements, including how you will ensure that you will coordinate with DHH and its Agent.	<b>10</b>		
<b>Section D Page 7</b>	<b>All</b>	<b>D.4</b> Describe your enrollment procedure requirements, including how you will ensure that you will coordinate with DHH and its Agent.	<b>5</b>		

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		<b>Section E: Chronic Care/Disease Management (Section § 6 of RFP)</b>	<b>100</b>		
<b>Section E Page 1</b>	<b>All</b>	<b>E.1</b> Describe existing (other state Medicaid or CHIP contracts) and planned Chronic Care/Disease Management programs for the Louisiana CCN Program that are designed to improve health care outcomes for members with one or more chronic illnesses. Describe how the Chronic Care/Disease Management programs' data are analyzed and the results utilized by your organization to improve member outcomes.	<b>50</b>		
<b>Section E Page 10</b>	<b>All</b>	<b>E.2</b> Describe how recipients will be identified for inclusion into the Chronic Care/Disease Management program. Identify which disease states/ recipient types will be targeted for the Chronic Care/Disease Management program. Describe how the Chronic Care/Disease Management program will coordinate information and services with the PCP.	<b>50</b>		

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			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		<b>Section F: Service Coordination (Section § 14 of RFP)</b>	<b>170</b>		
<b>Section F Page 1</b>	<b>All</b>	<p><b>F.1</b></p> <p>DHH intends to provide CCNs with two years of historic claims data for members enrolled in the CCN effective the start date of operations. Describe how you will ensure the continuation of medically necessary services for members with special health needs who are enrolled in your CCN effective the start date of operations. The description should include:</p> <ul style="list-style-type: none"> <li>• How you will identify these enrollees, and how you will uses this information to identify these enrollees, including enrollees who are receiving regular ongoing services;</li> <li>• What additional information you will request from DHH, if any, to assist you in ensuring continuation of services;</li> <li>• How you will ensure continuation of services, including prior authorization requirements, use of non-contract providers, and transportation;</li> <li>• What information, education, and training you will provide to your providers to ensure continuation of services; and</li> <li>• What information you will provide your members to assist with the transition of care.</li> </ul>	<b>10</b>		
<b>Section F Page 7</b>	<b>All</b>	<p><b>F.2</b></p> <p>Describe your approach to CCN case management. In particular, describe the following:</p> <ul style="list-style-type: none"> <li>• Characteristics of members that you will target for CCN case management services;</li> <li>• How you identify these members;</li> <li>• How you encourage member participation;</li> <li>• How you assess member needs;</li> <li>•</li> </ul>	<b>85</b>		

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			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		<ul style="list-style-type: none"> <li>• How you develop and implement individualized plans of care, including coordination with providers and support services;</li> <li>• How you coordinate your disease management and CCN case management programs;</li> <li>• How you will coordinate your case management services with the PCP; and</li> <li>• How you will incorporate provider input into strategies to influence behavior of members.</li> </ul>			
Section F Page 17	All	<p><b>F.3</b></p> <p>Describe your approach for coordinating the following carved out services which will continue to be provided by the Medicaid fee-for-service program:</p> <ul style="list-style-type: none"> <li>• Dental</li> <li>• Specialized Behavioral Health</li> <li>• Personal Care Services</li> <li>• Targeted Case Management</li> </ul>	5		
Section F Page 21	All	<p><b>F.4</b></p> <p>For members who need home health services upon discharge from an acute care hospital, explain how you will coordinate service planning and delivery among the hospital's discharge planner(s), your case manager(s), your disease management staff member(s), and the home health agency. Further, explain how you will monitor the post-discharge care of enrollees receiving home health services in remote areas.</p>	10		
Section F Page 23	All	<p><b>F.5</b></p> <p>Aside from transportation, what specific measures will you take to ensure that members in rural parishes are able to access specialty care? Also address specifically how will you ensure members with disabilities have access?</p>	10		

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Section F Page 25	All	<p><b>F.6</b></p> <p>Detail the strategies you will use to influence the behavior of members to access health care resources appropriately and adapt healthier lifestyles. Include examples from your other Medicaid/CHIP managed care contracts as well as your plan for Louisiana Medicaid CCN members.</p>	40		
Section F Page 32	All	<p><b>F.7</b></p> <p>Many faith based, social and civic groups, resident associations, and other community-based organizations now feature health education and outreach activities, incorporate health education in their events, and provide direct medical services (e.g., through visiting nurses, etc.). Describe what specific ways would you leverage these resources to support the health and wellness of your members.</p>	10		
Section F Page 36	All	<p><b>F.8</b></p> <p>Submit a statement of any moral and religious objections to providing any services covered under Section §6 of RFP. If moral and religious objections are identified describe, in as much detail as possible, all direct and related services that are objectionable. Provide a listing of the codes impacted including but not limited to CPT codes, HCPCS codes, diagnosis codes, revenue codes, modifier codes, etc. If none, so state. Describe your plans to provide these services (e.g., birth control) to members who are entitled to such services.</p>	Included/Not Included		

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		<b>Section G: Provider Network (Section § 7 of RFP)</b>	<b>200</b>		
<b>Section G Page 1</b>	<b>All</b>	<p><b>G.1</b></p> <p>Provide a listing of the proposed provider network using the List of Required In-Network Providers as described in this RFP, including only those providers with whom you have obtained a signed LOI or executed subcontract. LOIs and signed subcontracts will receive equal consideration. LOIs and subcontracts should NOT be submitted with the proposal. DHH may verify any or all referenced LOIs or contracts. Along with the provider listing, provide the number of potential linkages per PCP.</p> <p>Using providers with whom you have signed letters of intent or executed contracts, provide individual GeoAccess maps and coding by GSA for: 1) hospitals, 2) primary care providers, FQHCs, and RHCs; and 3) Specialists. You should provide individual maps as well as overlay maps to demonstrate distance relationships between provider types.</p> <p>The CCN should provide an Excel spreadsheet of their proposed provider network and include the following information: (Sample spreadsheet is available in the Procurement Library)</p> <ol style="list-style-type: none"> <li>1. Practitioner Last Name, First Name and Title - For types of service such as primary care providers and specialist, list the practitioner's name and practitioner title such as MD, NP (Nurse Practitioner), PA (Physician Assistant), etc.</li> <li>2. Practice Name/Provider Name - - Indicate the name of the provider. For practitioners indicate the professional association/group name, if applicable.</li> <li>3. Business Location Address - Indicate the business location address where services are provided including but not limited to, 1st line of address, 2nd line of address, City, State, Postal Code</li> <li>4. Provider Type and Specialty Code - Indicate the practitioner's specialty using Medicaid Provider Type and Specialty Codes.</li> </ol>	<b>50</b>		

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		5. New Patient - Indicate whether or not the provider is accepting new patients. 6. Age Restriction - Indicate any age restrictions for the provider's practice. For instance, if a physician only sees patients up to age 19, indicate < 19; if a physician only sees patients age 13 or above, indicate > 13. 7. If PCP - the number of potential linkages. 8. If LOI or contract executed. 9. Designate if Significant Traditional Provider. 10. GEO coding for this location.			
Section G Page 3	All	<b>G.2</b> Describe how you will provide tertiary care providers including trauma centers, burn centers, children's hospital, Level III maternity care; Level III (high risk) nurseries, rehabilitation facilities, and medical sub-specialists available twenty-four (24) hours per day in the GSA. If you do not have a full range of tertiary care providers describe how the services will be provided including transfer protocols and arrangements with out of network facilities.	15		
Section G Page 6	All	<b>G.3</b> Describe how you will handle the potential loss (i.e., contract termination, closure) in a GSA of a) a hospital and b) all providers within a certain specialty.	10		
Section G Page 9	All	<b>G.4</b> The CCN is encouraged to offer to contract with Significant Traditional Providers (STPs) who meet your credentialing standards and all the requirements in the CCN's subcontract. DHH will make available on <a href="http://www.MakingMedicaidBetter.com">www.MakingMedicaidBetter.com</a> a listing of STPs by provider type by GSA. Describe how you will encourage the enrollment of STPs into your network; and indicate on a copy of the listing which of the providers included in your listing of network providers (See G.1) are STPs.	20		

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Section G Page 11	All	<p><b>G.5</b></p> <p>Based on discussions with providers in obtaining Letters of Intent and executed subcontracts as well as other activities you have undertaken to understand the delivery system and enrollee population in the GSA(s) for which a proposal is being submitted, discuss your observations and the challenges you have identified in terms of developing and maintaining a provider network. Provide a response tailored to each GSA of the following provider types/services:</p> <ul style="list-style-type: none"> <li>• Primary Care</li> <li>• Specialty Care</li> <li>• Prenatal Care Services</li> <li>• Hospital, including Rural Hospital</li> <li>• Office of Public Health</li> <li>• Private Duty Nursing/Home Health Services;</li> <li>• FQHC</li> <li>• School Based Health Clinic</li> </ul>	5		
Section G Page 21	All	<p><b>G.6</b></p> <p>Describe your process for monitoring and ensuring adherence to DHH's requirements regarding appointments and wait times.</p>	20		
Section G Page 23	All	<p><b>G.7</b></p> <p>Describe your PCP assignment process and the measures taken to ensure that every member in your CCN is assigned a PCP in a timely manner. Include your process for permitting members with chronic conditions to select a specialist as their PCP and whether you allow specialists to be credentialed to act as PCPs.</p>	10		
Section G Page 26	All	<p><b>G.8</b></p> <p>Describe your plan for working with PCPs to obtain NCQA medical home recognition or JHCAO Primary Home accreditation and meeting the requirements of Section § 14.</p>	5		
Section G Page 29	All	<p><b>G.9</b></p> <p>Describe how you will monitor providers and ensure compliance with provider subcontracts. In addition to a general description of your approach, address each of the following:</p>	5		

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		<ul style="list-style-type: none"> <li>• Compliance with cost sharing requirements;</li> <li>• Compliance with medical record documentation standards;</li> <li>• Compliance with conflict of interest requirements;</li> <li>• Compliance with lobbying requirements;</li> <li>• Compliance with disclosure requirements; and</li> <li>• Compliance with marketing requirements.</li> </ul>			
Section G Page 34	All	<p><b>G.10</b></p> <p>Provide an example from your previous experience of how you have handled provider noncompliance with contract requirements.</p>	5		
Section G Page 36		<p><b>G.11</b></p> <p>Describe in detail how you will educate and train providers about billing requirements, including both initial education and training prior to the start date of operations and ongoing education and training for current and new providers.</p>	10		
Section G Page 39		<p><b>G.12</b></p> <p>Describe how you will educate and train providers that join your network after program implementation. Identify the key requirements that will be addressed.</p>	15		
Section G Page 41		<p><b>G.13</b></p> <p>Describe your practice of profiling the quality of care delivered by network PCPs, and any other acute care providers (e.g., high volume specialists, hospitals), including the methodology for determining which and how many Providers will be profiled.</p> <ul style="list-style-type: none"> <li>• Submit sample quality profile reports used by you, or proposed for future use (identify which).</li> <li>• Describe the rationale for selecting the performance measures presented in the sample profile reports.</li> <li>• Describe the proposed frequency with which you will distribute such reports to network providers, and identify which</li> </ul>	15		

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			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		providers will receive such profile reports.			
Section G Page 51		<p><b>G.14</b></p> <p>Describe the process for accepting and managing provider inquiries, complaints, and requests for information that are received outside the provider grievance and appeal process.</p>	10		
Section G Page 53		<p><b>G.15</b></p> <p>Describe in detail your proposed approach to providing non-emergency medical transportation (NEMT) services, including, at a minimum:</p> <ul style="list-style-type: none"> <li>• What administrative functions, if any, you will subcontract to another entity;</li> <li>• How you will determine the appropriate mode of transportation (other than fixed route) for a member;</li> <li>• Your proposed approach to covering fixed route transportation;</li> <li>• How you will ensure that pick-up and delivery standards are met by NEMT providers, including training, monitoring, and sanctions;</li> <li>• How you will ensure that vehicles (initially and on an ongoing basis) meet vehicle standards, including inspections and other monitoring;</li> <li>• Your approach to initial and ongoing driver training;</li> <li>• How you will ensure that drivers meet initial and ongoing driver standards;</li> <li>• How your call center will comply with the requirements specific to NEMT calls; and</li> <li>• Your NEMT quality assurance program (excluding vehicle inspection).</li> </ul>	5		

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		<b>Section H: Utilization Management (UM) (Section § 8 of RFP)</b>	<b>80</b>		
<b>Section H Page 1</b>	<b>All</b>	<b>H.1</b> Describe how you will ensure that services are not arbitrarily or inappropriately denied or reduced in amount, duration or scope as specified in the Louisiana Medicaid State Plan.	<b>30</b>		
<b>Section H Page 4</b>	<b>All</b>	<b>H.2</b> If the UM guidelines were developed internally, describe the process by which they were developed and when they were developed or last revised.	<b>10</b>		
<b>Section H Page 5</b>	<b>All</b>	<b>H.3</b> Regarding your utilization management (UM) staff: <ul style="list-style-type: none"> <li>• Provide a detailed description of the training you provide your UM staff;</li> <li>• Describe any differences between your UM phone line and your provider services line;</li> <li>• If your UM phone line will handle both Louisiana CCN and non-Louisiana CCN calls, <ul style="list-style-type: none"> <li>○ explain how you will track CCN calls separately; and</li> <li>○ how you will ensure that applicable DHH timeframes for prior authorization decisions are met.</li> </ul> </li> </ul>	<b>20</b>		
<b>Section H Page 5</b>	<b>All</b>	<b>H.4</b> Describe how utilization data is gathered, analyzed, and reported. Include the process for monitoring and evaluating the utilization of services when a variance has been identified (both under- and over- utilization) in the utilization pattern of a provider and a member. Provide an example of how your analysis of data resulted in successful interventions to alter unfavorable utilization patterns in the system. Individuals who will make medical necessity determinations must be identified if the criteria are based on the medical training, qualifications, and experience of the CCN medical director or other qualified and trained professionals	<b>20</b>		

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		<b>Section I: EPSDT(Section § 6 of RFP)</b>	<b>25</b>		
<b>Section I Page 1</b>	<b>All</b>	<b>I.1</b> Describe your system for tracking each member's screening, diagnosis, and treatment including, at minimum, the components of the system, the key features of each component, the use of technology, and the data sources for populating the system.	<b>5</b>		
<b>Section I Page 4</b>	<b>All</b>	<b>I.2</b> Describe your approach to member education and outreach regarding EPSDT including the use of the tracking system described in I.1 above and any innovative/non-traditional mechanisms. Include: <ul style="list-style-type: none"> <li>• How you will conduct member education and outreach regarding EPSDT including any innovative/non-traditional methods that go beyond the standard methods;</li> <li>• How you will work with members to improve compliance with the periodicity schedule, including how you will motivate parents/members and what steps you will take to identify and reach out to members (or their parents) who have missed screening appointments (highlighting any innovative/non-traditional approaches); and</li> </ul> How you will design and monitor your education and outreach program to ensure compliance with the RFP.	<b>10</b>		
<b>Section I Page 8</b>	<b>All</b>	<b>I.3</b> Describe your approach to ensuring that providers deliver and document all required components of EPSDT screening.	<b>5</b>		
<b>Section I Page 10</b>	<b>All</b>	<b>I.4</b> Describe how you will ensure that needs identified in a screening are met with timely and appropriate services.	<b>5</b>		

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		<b>Section J: Quality Management (Section 14 of RFP)</b>	<b>125</b>		
<b>Section J Page 1</b>	<b>All</b>	<p><b>J.1</b></p> <p>Document experience in other States to positively impact the healthcare status of Medicaid and or CHIP populations. Examples of areas of interest include, but are not limited to the following:</p> <ul style="list-style-type: none"> <li>• Management of high risk pregnancy</li> <li>• Reductions in low birth weight babies</li> <li>• Pediatric Obesity (children under the age of 19)</li> <li>• Reduction of inappropriate utilization of emergent services</li> <li>• EPSDT</li> <li>• Children with special health care needs</li> <li>• Asthma</li> <li>• Diabetes</li> <li>• Cardiovascular diseases</li> <li>• Case management</li> <li>• Reduction in racial and ethnic health care disparities to improve health status</li> <li>• Hospital readmissions and avoidable hospitalizations</li> </ul>	<b>30</b>		
<b>Section J Page 18</b>	<b>All</b>	<p><b>J.2</b></p> <p>Describe the policies and procedures you have in place to reduce health care associated infection, medical errors, preventable serious adverse events (never events) and unnecessary and ineffective performance in these areas.</p>	<b>10</b>		
<b>Section J Page 22</b>	<b>All</b>	<p><b>J.3</b></p> <p>Describe how you will identify quality improvement opportunities. Describe the process that will be utilized to select a performance improvement project, and the process to be utilized to improve care or services. Include information on how interventions will be evaluated for effectiveness. Identify proposed members of the Quality Assessment Committee.</p>	<b>15</b>		

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Section J Page 30	All	<p><b>J.4</b></p> <p>Provide a description of focus studies performed, quality improvement projects, and any improvements you have implemented and their outcomes. Such outcomes should include cost savings realized, process efficiencies, and improvements to member health status. Such descriptions should address such activities since 2001 and how issues and root causes were identified, and what was changed.</p>	15		
Section J Page 51	All	<p><b>J.5</b></p> <p>Describe your proposed Quality Assessment and Performance Improvement (QAPI). Such description should address:</p> <ul style="list-style-type: none"> <li>• The Performance Improvement Projects (PIPs) proposed to be implemented during the term of the contract.</li> <li>• How the proposed PIPs will expand quality improvement services.</li> <li>• How the proposed PIPs will improve the health care status of the Louisiana Medicaid population.</li> <li>• Rationale for selecting the particular PIPs including the identification of particular health care problems and issues identified within the Louisiana Medicaid population that each program will address and the underlying cause(s) of such problems and issues.</li> <li>• How you will keep DHH informed of QAPI program actions, recommendations and outcomes on an ongoing and timely manner.</li> <li>• How the proposed PIPs may include, but is not necessarily, limited to the following:               <ul style="list-style-type: none"> <li>○ New innovative programs and processes.</li> <li>○ Contracts and/or partnerships being established to enhance the delivery of health care such as contracts/partnerships with school districts and/or School Based Health Clinics.</li> </ul> </li> </ul>	20		

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Section J Page 58	All	<p><b>J.6</b></p> <p>Describe how feedback (complaints, survey results etc.) from members and providers will be used to drive changes and/or improvements to your operations. Provide a member and a provider example of how feedback has been used by you to drive change in other Medicaid managed care contracts.</p>	10		
Section J Page 65	All	<p><b>J.7</b></p> <p>Provide, in Excel format, the Proposer's results for the HEDIS measures specified below for the last three measurement years (2007, 2008, and 2009) for each of your State Medicaid contracts.</p> <ul style="list-style-type: none"> <li>• If you do not have results for a particular measure or year, provide the results that you do have.</li> <li>• If you do not have results for your Medicaid product line in a state where you have a Medicaid contract, provide the commercial product line results with an indicator stating the product line.</li> <li>• If you do not have Medicaid HEDIS results for at least five states, provide your commercial HEDIS measures for your largest contracts for up to five states (e.g., if you have HEDIS results for the three states where you have a Medicaid contract, you only have Medicare HEDIS for one other state, provide commercial HEDIS results for another state).</li> <li>• If you do not have HEDIS results for five states, provide the results that you do have.</li> <li>• In addition to the spreadsheet, please provide an explanation of how you selected the states, contracts, product lines, etc. that are included in the spreadsheet and explain any missing information (measure, year, or Medicaid contract). Include the Proposer's parent organization, affiliates, and subsidiaries.</li> </ul> <p>Provide results for the following HEDIS measures:</p> <ul style="list-style-type: none"> <li>• Adults' Access to Preventive/Ambulatory</li> </ul>	25		

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		<p>Health Services</p> <ul style="list-style-type: none"> <li>• Comprehensive Diabetes Care- HgbA1C component</li> <li>• Chlamydia Screening in Women</li> <li>• Well-Child Visits in the 3,4,5,6 years of life</li> <li>• Adolescent well-Care.</li> <li>• Ambulatory Care - ER utilization</li> <li>• Childhood Immunization status</li> <li>• Breast Cancer Screening</li> <li>• Prenatal and Postpartum Care (Timeliness of Prenatal Care and Postpartum Care)</li> <li>• Weight Assessment and Counseling for Nutrition and Physical Activity in Children/Adolescents</li> </ul> <p>Include the Proposer's parent organization, affiliates, and subsidiaries</p>			

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		<b>Section K: Member Materials (Section § 12 of RFP)</b>	<b>50</b>		
<b>Section K Page 1</b>	<b>All</b>	<b>K.1</b> Describe proposed content for your member educational materials) and attach a examples used with Medicaid or CHIP populations in other states.	<b>15</b>		
<b>Section K Page 6</b>	<b>All</b>	<b>K.2</b> Describe how you will ensure that all written materials meet the language requirements and which reference material you anticipate you will use to meet the sixth (6 <sup>th</sup> ) grade reading level requirement.	<b>5</b>		
<b>Section K Page 9</b>	<b>All</b>	<b>K.3</b> Describe your process for producing Member ID cards and information that will accompany the card. Include a layout of the card front and back. Explain how you will ensure that a Member receives a new Member ID Card whenever there has been a change in any of the information appearing on the Member ID Card.	<b>10</b>		
<b>Section K Page 11</b>	<b>All</b>	<b>K.4</b> Describe your strategy for ensuring the information in your provider directory is accurate and up to date, including the types and frequency of monitoring activities and how often the directory is updated.	<b>10</b>		
<b>Section K Page 12</b>	<b>All</b>	<b>K.5</b> Describe how you will fulfill Internet presence and Web site requirements, including: <ul style="list-style-type: none"> <li>• Your procedures for up-dating information on the Web site;</li> <li>• Your procedures for monitoring e-mail inquiries and providing accurate and timely responses; and</li> <li>• The procedures, tools and reports you will use to track all interactions and transactions conducted via the Web site activity including the timeliness of response and resolution of said interaction/transaction.</li> </ul>	<b>10</b>		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		<b>Section L: Customer Service (Section §12 of RFP)</b>	<b>100</b>		
<b>Section L Page 1</b>	<b>All</b>	<b>L.1</b> Provide a narrative with details regarding your member services line including: <ul style="list-style-type: none"> <li>• Training of customer service staff (both initial and ongoing);</li> <li>• Process for routing calls to appropriate persons, including escalation; The type of information that is available to customer service staff and how this is provided (e.g., hard copy at the person's desk or on-line search capacity);</li> <li>• Process for handling calls from members with Limited English Proficiency and persons who are hearing impaired;</li> <li>• Monitoring process for ensuring the quality and accuracy of information provided to members;</li> <li>• Monitoring process for ensuring adherence to performance standards;</li> <li>• How your customer service line will interact with other customer service lines maintained by state, parish, or city organizations (e.g., Partners for Healthy Babies, WIC, housing assistance, and homeless shelters); and</li> <li>• After hours procedures.</li> </ul>	<b>25</b>		
<b>Section L Page 12</b>	<b>All</b>	<b>L.2</b> Provide member hotline telephone reports for your Medicaid or CHIP managed care contract with the largest enrollment as of January 1, 2011 for the most recent four (4) quarters, with data that show the monthly call volume, the trends for average speed of answer (where answer is defined by reaching a live voice, not an automated call system) and the monthly trends for the abandonment rate.	<b>25</b>		
<b>Section L Page 14</b>	<b>All</b>	<b>L.3</b> Describe the procedures a Member Services representative will follow to respond to the following situations:	<b>20</b>		

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		<ul style="list-style-type: none"> <li>• A member has received a bill for payment of covered services from a network provider or out-of-network provider;</li> <li>• A member is unable to reach her PCP after normal business hours;</li> <li>• A Member is having difficulty scheduling an appointment for preventive care with her PCP; and</li> <li>• A Member becomes ill while traveling outside of the GSA.</li> </ul>			
Section L Page 17	All	<p><b>L.4</b></p> <p>Describe how you will ensure culturally competent services to people of all cultures, races, ethnic backgrounds, and religions as well as those with disabilities in a manner that recognizes values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each.</p>	15		
Section L Page 21	All	<p><b>L.5</b></p> <p>Describe how you will ensure that covered services are provided in an appropriate manner to members with Limited English proficiency and members who are hearing impaired, including the provision of interpreter services.</p>	15		

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		<b>Section M: Emergency Management Plan (Section § 2 of RFP)</b>	<b>25</b>		
<b>Section M Page 1</b>	<b>All</b>	<p><b>M.1</b></p> <p>Describe your emergency response continuity of operations plan. Attach a copy of your plan or, at a minimum, summarize how your plan addresses the following aspects of pandemic preparedness and natural disaster recovery:</p> <ul style="list-style-type: none"> <li>• Employee training;</li> <li>• Identified essential business functions and key employees within your organization necessary to carry them out;</li> <li>• Contingency plans for covering essential business functions in the event key employees are incapacitated or the primary workplace is unavailable;</li> <li>• Communication with staff and suppliers when normal systems are unavailable;</li> <li>• Specifically address your plans to ensure continuity of services to providers and members; and</li> <li>• How your plan will be tested.</li> </ul>	<b>15</b>		
<b>Section M Page 3</b>	<b>All</b>	<p><b>M.2</b></p> <p>Describe your plan in the following Emergency Management Plan scenario for being responsive to DHH, to members who evacuate, to network providers, and to the community.</p> <ul style="list-style-type: none"> <li>• You have thirty thousand (30,000) or more CCN members residing in hurricane prone parishes. All three GSAs include coastal parish and inland parishes subject to mandatory evacuation orders during a major hurricane. A category 5 hurricane is approaching, with landfall predicted in 72 hours and parishes within the GSA are under a mandatory evacuation order. State assisted evacuations and self evacuations are underway. Members are evacuated to or have evacuated themselves to not only all other areas of Louisiana, but to other States.</li> </ul>	<b>10</b>		

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		<ul style="list-style-type: none"> <li>Your provider call center and member call center are both located in Baton Rouge and there is a high likelihood of high winds, major damage and power outages for 4 days or more in the Baton Rouge Area (reference Hurricane Gustav impact on Baton Rouge). It is expected that repatriation of the evacuated, should damages be minimal, will not occur for 14 days. If damage is extensive, there may be limited repatriation, while other members may be indefinitely relocated to other areas in Louisiana or other states.</li> </ul>			

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		<b>Section N: Grievances and Appeals (Section § 13 of RFP )</b>	<b>25</b>		
<b>Section N Page 1</b>	<b>All</b>	<p><b>N.1</b></p> <p>Provide a flowchart (marked as Chart C) and comprehensive written description of your member grievance and appeals process, including your approach for meeting the general requirements and plan to:</p> <ul style="list-style-type: none"> <li>• Ensure that the Grievance and Appeals System policies and procedures, and all notices will be available in the Member’s primary language and that reasonable assistance will be given to Members to file a Grievance or Appeal;</li> <li>• Ensure that individuals who make decisions on Grievances and Appeals have the appropriate expertise and were not involved in any previous level of review; and</li> <li>• Ensure that an expedited process exists when taking the standard time could seriously jeopardize the Member’s health. As part of this process, explain how you will determine when the expedited process is necessary.</li> </ul> <p>Include in the description how data resulting from the grievance system will be used to improve your operational performance.</p>	<b>25</b>		

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		<b>Section O: Fraud &amp; Abuse (Section § 15 of RFP)</b>	25		
<b>Section O Page 1</b>	<b>All</b>	<b>O.1</b> Describe your approach for meeting the program integrity requirements including a compliance plan for the prevention, detection, reporting, and corrective action for suspected cases of Fraud and Abuse in the administration and delivery of services. Discuss your approach for meeting the coordination with DHH and other agencies requirement.	25		

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		<b>Section P: Third Party Liability (Section § 5 of RFP)</b>	25		
<b>Section P Page 1</b>	<b>All</b>	<p><b>P.1</b></p> <p>Describe how you will coordinate with DHH and comply with the requirements for cost avoidance and the collection of third party liability (TPL), including:</p> <ul style="list-style-type: none"> <li>• How you will conduct diagnosis and trauma edits, including frequency and follow-up action to determine if third party liability exists; (2) How you will educate providers to maximize cost avoidance;</li> <li>• Collection process for pay and chase activity and how it will be accomplished;</li> <li>• How subrogation activities will be conducted;</li> <li>• How you handle coordination of benefits in your current operations and how you would adapt your current operations to meet contract requirements;</li> <li>• Whether you will use a subcontractor and if so, the subcontractor's responsibilities; and</li> <li>• What routine systems/business processes are employed to test, update and validate enrollment and TPL data.</li> </ul>	25		

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		<b>Section Q: Claims Management (Section § 17 of RFP)</b>	<b>80</b>		
<b>Section Q Page 1</b>	<b>All</b>	<b>Q.1</b> Describe the capabilities of your claims management systems as it relates to each of the requirements as specified in Electronic Claims Management Functionality Section and the Adherence to Key Claims Management Standards Section. In your response explain whether and how your systems meet (or exceed) each of these requirements. Cite at least three examples from similar contracts.	<b>30</b>		
<b>Section Q Page 10</b>	<b>All</b>	<b>Q.2</b> Describe your methodology for ensuring that claims payment accuracy standards will be achieved per, Adherence to Key Claims Management Standards Section. At a minimum address the following in your response: <ul style="list-style-type: none"> <li>• The process for auditing a sample of claims as described in Key Claims Management Standards Section;</li> <li>• The sampling methodology itself;</li> <li>• Documentation of the results of these audits; and</li> <li>• The processes for implementing any necessary corrective actions resulting from an audit.</li> </ul>	<b>25</b>		
<b>Section Q Page 12</b>	<b>All</b>	<b>Q.3</b> Describe your methodology for ensuring that the requirements for claims processing, including adherence to all service authorization procedures, are met.	<b>25</b>		

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		<b>Section R: Information Systems (Section § 16 of RFP)</b>	<b>200</b>		
<b>Section R Page 1</b>	<b>All</b>	<p><b>R.1</b> Describe your approach for implementing information systems in support of this RFP, including:</p> <ul style="list-style-type: none"> <li>• Capability and capacity assessment to determine if new or upgraded systems, enhanced systems functionality and/or additional systems capacity are required to meet contract requirements;</li> <li>• Configuration of systems (e.g., business rules, valid values for critical data, data exchanges/interfaces) to accommodate contract requirements;</li> <li>• System setup for intake, processing and acceptance of one-time data feeds from the State and other sources, e.g., initial set of CCN enrollees, claims/service utilization history for the initial set of CCN enrollees, active/open service authorizations for the initial set CCN enrollees, etc.; and</li> <li>• Internal and joint (CCN and DHH) testing of one-time and ongoing exchanges of eligibility/enrollment, provider network, claims/encounters and other data.</li> <li>• Provide a Louisiana Medicaid CCN-Program-specific work plan that captures:               <ul style="list-style-type: none"> <li>○ Key activities and timeframes and</li> <li>○ Projected resource requirements from your organization for implementing information systems in support of this contract.</li> </ul> </li> <li>• Describe your historical data process including but not limited to:               <ul style="list-style-type: none"> <li>○ Number of years retained;</li> <li>○ How the data is stored; and</li> <li>○ How accessible is it.</li> </ul> </li> </ul> <p>The work plan should cover activities from contract award to the start date of operations.</p>	<b>25</b>		

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Section R Page 12	All	<p><b>R.2</b></p> <p>Describe your processes, including procedural and systems-based internal controls, for ensuring the integrity, validity and completeness of all information you provide to DHH (to their Fiscal Intermediary and the Enrollment Broker). In your description, address separately the encounter data-specific requirements in, Encounter Data Section of the RFP as well as how you will reconcile encounter data to payments according to your payment cycle, including but not limited to reconciliation of gross and net amounts and handling of payment adjustments, denials and pend processes. Additionally, describe how you will accommodate DHH-initiated data integrity, validity and provide independent completeness audits.</p>	15		
Section R Page 18	All	<p><b>R.3</b></p> <p>Describe in detail how your organization will ensure that the availability of its systems will, at a minimum, be equal to the standards set forth in the RFP. At a minimum your description should encompass: information and telecommunications systems architecture; business continuity/disaster recovery strategies; availability and/or recovery time objectives by major system; monitoring tools and resources; continuous testing of all applicable system functions, and periodic and ad-hoc testing of your business continuity/disaster recovery plan.</p> <p>Identify the timing of implementation of the mix of technologies and management strategies (policies and procedures) described in your response to previous paragraph, or indicate whether these technologies and management strategies are already in place.</p> <p>Elaborate, if applicable, on how you have successfully implemented the aforementioned mix of technologies and management strategies with other clients.</p>	15		

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Section R Page 23	All	<p><b>R.4</b> Describe in detail:</p> <ul style="list-style-type: none"> <li>• How your <i>key production systems</i> are designed to <i>interoperate</i>. In your response address all of the following:               <ul style="list-style-type: none"> <li>○ How identical or closely related data elements in different systems are named, formatted and maintained:                   <ul style="list-style-type: none"> <li>- Are the data elements named consistently;</li> <li>- Are the data elements formatted similarly (# of characters, type-text, numeric, etc.);</li> <li>- Are the data elements updated/refreshed with the same frequency or in similar cycles; and</li> <li>- Are the data elements updated/refreshed in the same manner (manual input, data exchange, automated function, etc.).</li> </ul> </li> <li>○ All exchanges of data between key production systems.                   <ul style="list-style-type: none"> <li>- How each data exchange is triggered: a manually initiated process, an automated process, etc.</li> <li>- The frequency/periodicity of each data exchange: “real-time” (through a live point to-point interface or an interface “engine”), daily/nightly as triggered by a system processing job, biweekly, monthly, etc.</li> </ul> </li> </ul> </li> <li>• As part of your response, provide diagrams that illustrate:               <ul style="list-style-type: none"> <li>○ point-to-point interfaces,</li> <li>○ information flows,</li> <li>○ internal controls and</li> <li>○ the networking arrangement (AKA “network diagram”) associated with the information systems profiled.</li> </ul> </li> </ul>	15		

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		These diagrams should provide insight into how your Systems will be organized and interact with DHH systems for the purposes of exchanging Information and automating and/or facilitating specific functions associated with the Louisiana Medicaid CCN Program.			
Section R Page 34	All	<p><b>R.5</b></p> <p>Describe your ability to provide and store encounter data in accordance with the requirements in this RFP. In your response:</p> <ul style="list-style-type: none"> <li>• Explain whether and how your systems meet (or exceed) each of these requirements.</li> <li>• Cite at least three currently-live instances where you are successfully providing encounter data in accordance with DHH coding, data exchange format and transmission standards and specifications or similar standards and specifications, with at least two of these instances involving the provision of encounter information from providers with whom you have capitation arrangements. In elaborating on these instances, address all of the requirements in Section 17. Also, explain how that experience will apply to the Louisiana Medicaid CCN Program.</li> <li>• If you are not able at present to meet a particular requirement contained in the aforementioned section, identify the applicable requirement and discuss the effort and time you will need to meet said requirement.</li> <li>• Identify challenges and “lessons learned” from your implementation and operations experience in other states and describe how you will apply these lessons to this contract.</li> </ul>	15		
Section R Page 38	All	<p><b>R.6</b></p> <p>Describe your ability to receive, process, and update eligibility/enrollment, provider data, and encounter data to and from the Department and its agents. In your response:</p>	15		

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		<ul style="list-style-type: none"> <li>• Explain whether and how your systems meet (or exceed) each of these requirements.</li> <li>• Cite at least three currently-live instances where you are successfully receiving, processing and updating eligibility/enrollment data in accordance with DHH coding, data exchange format and transmission standards and specifications or similar standards and specifications. In elaborating on these instances, address all of the requirements in Sections 16 and 17, and CCN-P Systems Companion Guide. Also, explain how that experience will apply to the Louisiana Medicaid CCN Program.</li> <li>• If you are not able at present to meet a particular requirement contained in the aforementioned sections, identify the applicable requirement and discuss the effort and time you will need to meet said requirement.</li> <li>• Identify challenges and “lessons learned” from implementation in other states and describe how you will apply these lessons to this contract.</li> </ul>			
Section R Page 41	All	<p><b>R.7</b></p> <p>Describe the ability within your systems to meet (or exceed) each of the requirements in Section §16. Address each requirement. If you are not able at present to meet a particular requirement contained in the aforementioned section, identify the applicable requirement and discuss the effort and time you will need to meet said requirement.</p>	15		
Section R Page 43	All	<p><b>R.8</b></p> <p>Describe your information systems change management and version control processes. In your description address your production control operations.</p>	10		

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Section R Page 45	All	<p><b>R.9</b></p> <p>Describe your approach to demonstrating the readiness of your information systems to DHH prior to the start date of operations. At a minimum your description must address:</p> <ul style="list-style-type: none"> <li>• provider contract loads and associated business rules;</li> <li>• eligibility/enrollment data loads and associated business rules;</li> <li>• claims processing and adjudication logic; and</li> <li>• encounter generation and validation prior to submission to DHH.</li> </ul>	15		
Section R Page 47	All	<p><b>R.10</b></p> <p>Describe your reporting and data analytic capabilities including:</p> <ul style="list-style-type: none"> <li>• generation and provision to the State of the management reports prescribed in the RFP;</li> <li>• generation and provision to the State of reports on request;</li> <li>• the ability in a secure, inquiry-only environment for authorized DHH staff to create and/or generate reports out of your systems on an <i>ad-hoc</i> basis; and</li> <li>• Reporting back to providers within the network.</li> </ul>	15		
Section R Page 49		<p><b>R.11</b></p> <p>Provide a detailed profile of the key information systems within your span of control.</p>	5		
Section R Page 63		<p><b>R.12</b></p> <p>Provide a profile of your current and proposed Information Systems (IS) organization.</p>	5		
Section R Page 64		<p><b>R.13</b></p> <p>Describe what you will do to promote and advance electronic claims submissions and assist providers to accept electronic funds transfers.</p>	5		

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Section R Page 66		<b>R.14</b> Indicate how many years your IT organization or software vendor has supported the current or proposed information system software version you are currently operating. If your software is vendor supported, include vendor name(s), address, contact person and version(s) being used.	Included/Not Included		
Section R Page 67		<b>R.15</b> Describe your plans and ability to support network providers' "meaningful use" of Electronic Health Records (EHR) and current and future IT Federal mandates. Describe your plans to utilizing ICD-10 and 5010.	15		
Section R Page 82		<b>R.16</b> Describe the procedures that will be used to protect the confidentiality of records in DHH databases, including records in databases that may be transmitted electronically via e-mail or the Internet.	10		

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		<p><b>Section S: Added Value to Louisiana Providers and CCN Members</b></p> <p>If you are awarded a contract, the response to this section will become part of your contract with DHH and DHH will confirm your compliance. The incentives and enhanced payments, for providers and expanded benefits to members proposed herein cannot be revised downward during the initial thirty-six (36) month term of the contract, as such programs were considered in the evaluation of the Proposal. Increases in payments or benefits during the term of the contract may be implemented.</p>	200		
Section S Page 1	All	<p><b>S.1</b></p> <p>The “value added” from Provider Incentive Payments and Enhanced Payments (above the Medicaid rate floor) will be considered in the evaluation of Proposals. Responses to this section (which can be considered Proprietary) will be evaluated based solely on the quantified payment amounts reported herein, based on projected utilization for 75,000 members, and within the guidelines of the CCN program. Any health benefits or cost savings associated with any quality or incentive program shall not be included in this response and will not be considered in the evaluation of this factor.</p> <p>Pursuant to State Rules, the default payments between CCNs and providers are Louisiana Medicaid’ rates and the CCN must contract at no less than Medicaid rate in effect on the date of service; for example the Medicaid physician fee schedule or Medicaid hospital per diem amounts or FQHC/RHC PPS amounts.</p> <p>Complete RFP <b>Appendix OO</b> to identify circumstances where you propose to vary from the floor reimbursement mechanism.</p> <ul style="list-style-type: none"> <li>For increased provider payments to be considered in the evaluation, they must represent an increase in the minimum payment rates for all providers associated with the CCN’s operating policies and not negotiated rates for a subset of the providers. As an example, if the CCN’s physician payment policy is</li> </ul>	100		

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		<p>to pay Medicare rates, and possibly negotiate payments above that rate on a case-by-case basis, then the difference between the published Medicaid rate and the Medicare rate would be the quantifiable variance to be reported in this section; if the Medicaid rate was the base rate and anything above that rate subject to negotiation, then such amounts would not qualify for inclusion herein.</p> <ul style="list-style-type: none"> <li>• If you propose to contract with any providers using methodologies or rates that differ from the applicable Medicaid fee schedules, include such arrangements. By provider type, describe the proposed payment methodologies/rates and quantify the projected per member per month benefit.</li> <li>• The quantified incentives and enhanced payments reported should only represent the value exceeding the minimum Medicaid payment equivalent. If any proposals are not explicitly above the Medicaid rates, include a detailed calculation documenting how the minimum Medicaid equivalent was considered in the determination of the incentive/enhanced amount. For example, if the CCN proposes to pay physicians at the Medicare fee schedule during calendar year 2012, the amount reported in the attached would be determined as the projected difference between payments at the Medicare fee schedule and the Medicaid fee schedule, documenting the projected value using the Medicaid fees. Further, if capitation or alternative payments are proposed, the equivalent value of Medicaid fee payments based on projected utilization would be removed in the determination of the enhanced value.</li> <li>• Do not include payments for services where Federal or State requirements are currently scheduled to increase payments at a future date. In such</li> </ul>			

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		<p>circumstances, maintenance of effort will be expected of the CCN. For example, some Medicaid primary care rates are projected to increase to Medicare n rates in January of 2013, and the variance between the two types of rates would not qualify as an enhanced/incentive payment after January 1, 2013.</p> <ul style="list-style-type: none"> <li>• During the evaluation of the proposals, preferences will be given to plans based upon the cumulative amount of quantified provider benefit associated with the following:               <ul style="list-style-type: none"> <li>○ higher payment rates than the required Medicaid default rate (fee for service or per diem or PPS or sub-capitated/other alternative rate);</li> <li>○ bonus payments above the required Medicaid default rate;</li> <li>○ pay for performance incentive payments above the required Medicaid default rate; and</li> <li>○ other payment arrangements above the required Medicaid “floor” rate.</li> </ul> </li> <li>• Payments for case management services may be included if paid to unrelated practitioners, e.g., physicians, clinics, etc.</li> <li>• For bonus pools or Pay For Performance (P4Q) programs, describe the eligible categories of provider, the basis for paying the applicable bonus pools and the proposed terms and conditions in the template. You may attach additional information, as appropriate.</li> <li>• Indicate if any bonus pool is to be held in escrow, and if so who will be the escrow agent.</li> </ul> <p>If any part of the proposed bonus pool is to be funded by withhold from subcontracted provider payments, confirm that the initial provider payment net of withhold would not be less than the Medicaid rate.</p>			

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Section S Page 7	All	<p><b>S.2</b></p> <p>Provide a listing, description, and conditions under which you will offer additional health benefits: 1) not included in the Louisiana Medicaid State Plan or 2) beyond the amount, duration and scope in the Louisiana Medicaid State Plan to members.</p> <ul style="list-style-type: none"> <li>• For each expanded benefit proposed: <ul style="list-style-type: none"> <li>○ Define and describe the expanded benefit;</li> <li>○ Identify the category or group of Members eligible to receive the expanded service if it is a type of service that is not appropriate for all Members;</li> <li>○ Note any limitations or restrictions that apply to the expanded benefit</li> <li>○ Identify the types of providers responsible for providing the expanded benefit, including any limitations on Provider capacity if applicable.</li> <li>○ Propose how and when Providers and Members will be notified about the availability of such expanded benefits;</li> <li>○ Describe how a Member may obtain or access the Value-added</li> </ul> </li> <li>• Include a statement that you will provide the expanded benefits for the entire thirty six (36) month term of the initial contract.</li> <li>• Describe if, and how, you will identify the expanded benefit in administrative data (encounter Data).</li> </ul> <p>Indicate the PMPM actuarial value of expanded benefits assuming enrollment of 75,000 members, accompanied by a statement from the preparing/consulting actuary who is a member of the American Academy of Actuaries certifying the accuracy of the information.</p>	100		

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Section B  
Qualifications and Experience

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			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		<b>B.</b> <b>Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)</b>	345		
<b>Section B Page 1</b>	<b>All</b>	<p><b>B.1</b></p> <p>Indicate your organization’s legal name, trade name, <i>dba</i>, acronym, and any other name under which you do business; the physical address, mailing address, and telephone number of your headquarters office. Provide the legal name for your organization’s ultimate parent (e.g., publicly traded corporation).</p> <p>Describe your organization’s form of business (i.e., individual, sole proprietor, corporation, non-profit corporation, partnership, limited liability company) and detail the names, mailing address, and telephone numbers of its officers and directors and any partners (if applicable). Provide the name and address of any health professional that has at least a five percent (5%) financial interest in your organization, and the type of financial interest.</p> <p>Provide your federal taxpayer identification number and Louisiana taxpayer identification number.</p> <p>Provide the name of the state in which you are incorporated and the state in which you are commercially domiciled. If out-of-state, provide the name and address of the local representative; if none, so state.</p> <p>If you have been engaged by DHH within the past twenty-four (24) months, indicate the contract number and/or any other information available to identify the engagement; if not, so state.</p>	<b>Included/Not Included</b>		
<b>Section B Page 4</b>	<b>All</b>	<p><b>B.2</b></p> <p>Provide a statement of whether there have been any mergers, acquisitions, or sales of your organization within the last ten years, and if so, an explanation providing relevant details. If any change of ownership is anticipated during the 12 months following the Proposal Due Date, describe the circumstances of such change and indicate when the change is likely to occur. Include your organization’s parent organization,</p>	<b>Included/Not Included</b>		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		affiliates, and subsidiaries.			
Section B Page 5	All	<p><b>B.3</b></p> <p>Provide a statement of whether you or any of your employees, agents, independent contractors, or subcontractors have ever been convicted of, pled guilty to, or pled nolo contendere to any felony and/or any Medicaid or health care related offense or have ever been debarred or suspended by any federal or state governmental body. Include an explanation providing relevant details and the corrective action plan implemented to prevent such future offenses. Include your organization's parent organization, affiliates, and subsidiaries.</p>	0 to -25		
Section B Page 6	All	<p><b>B.4</b></p> <p>Provide a statement of whether there is any pending or recent (within the past five years) litigation against your organization. This shall include but not be limited to litigation involving failure to provide timely, adequate or quality physical or behavioral health services. You do not need to report workers' compensation cases. If there is pending or recent litigation against you, describe the damages being sought or awarded and the extent to which adverse judgment is/would be covered by insurance or reserves set aside for this purpose. Include a name and contact number of legal counsel to discuss pending litigation or recent litigation. Also include any SEC filings discussing any pending or recent litigation. Include your organization's parent organization, affiliates, and subsidiaries.</p>	0 to -25		
Section B Page 26	All	<p><b>B.5</b></p> <p>Provide a statement of whether, in the last ten years, you or a predecessor company has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors. If so, provide an explanation providing relevant details including the date in which the Proposer emerged from bankruptcy or expects to emerge. If still in bankruptcy, provide a summary of the court-approved reorganization plan. Include your organization's parent</p>	0 to -25		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		organization, affiliates, and subsidiaries.			
Section B Page 27	All	<p><b>B.6</b></p> <p>If your organization is a publicly-traded (stock-exchange-listed) corporation, submit the most recent United States Securities and Exchange Commission (SEC) Form 10K Annual Report, and the most-recent 10-Q Quarterly report.</p> <p>Provide a statement whether there have been any Securities Exchange Commission (SEC) investigations, civil or criminal, involving your organization in the last ten (10) years. If there have been any such investigations, provide an explanation with relevant details and outcome. If the outcome is against the Proposer, provide the corrective action plan implemented to prevent such future offenses. Also provide a statement of whether there are any current or pending Securities Exchange Commission investigations, civil or criminal, involving the Proposer, and, if such investigations are pending or in progress, provide an explanation providing relevant details and provide an opinion of counsel as to whether the pending investigation(s) will impair the Proposer's performance in a contract/Agreement under this RFP. Include your organization's parent organization, affiliates, and subsidiaries.</p>	0 to -25		
Section B Page 28	All	<p><b>B.7</b></p> <p>If another corporation or entity either substantially or wholly owns your organization, submit the most recent detailed financial reports for the parent organization. If there are one (1) or more intermediate owners between your organization and the ultimate owner, this additional requirement is applicable only to the ultimate owner.</p> <p>Include a statement signed by the authorized representative of the parent organization that the parent organization will unconditionally guarantee performance by the proposing organization of each and every obligation, warranty, covenant, term and condition of the Contract.</p>	Included/Not Included		
Section B Page 29	All	<p><b>B.8</b></p> <p>Describe your organization's number of employees, client base, and location of offices.</p>	Included/Not Included		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		Submit an organizational chart (marked as Chart A of your response) showing the structure and lines of responsibility and authority in your company. Include your organization's parent organization, affiliates, and subsidiaries.			
Section B Page 32	All	<p><b>B.9</b></p> <p>Provide a narrative description of your proposed Louisiana Medicaid Coordinated Care Network project team, its members, and organizational structure including an organizational chart showing the Louisiana organizational structure, including staffing and functions performed at the local level. If proposing for more than one (1) GSA, include in your description and organizational chart if: 1) the team will be responsible for all GSAs or 2) if each GSA will differ provide details outlining the differences and how it will differ.</p>	15		
Section B Page 40	All	<p><b>B.10</b></p> <p>Attach a personnel roster and resumes of key people who shall be assigned to perform duties or services under the Contract, highlighting the key people who shall be assigned to accomplish the work required by this RFP and illustrate the lines of authority. Submit current resumes of key personnel documenting their educational and career history up to the current time. Include information on how long the personnel have been in these positions and whether the position included Medicaid managed care experience.</p> <p>If any of your personnel named is a current or former Louisiana state employee, indicate the Agency where employed, position, title, termination date, and last four digits of the Social Security Number.</p> <p>If personnel are not in place, submit job descriptions outlining the minimum qualifications of the position(s). Each resume or job description should be limited to 2 pages.</p> <p>For key positions/employees which are not full time provide justification as to why the position is not full time. Include a description of their other duties and the amount of time allocated to each.</p>	40		

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			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
Section B Page 42	All	<p><b>B.11</b></p> <p>Provide a statement of whether you intend to use major subcontractors (as defined in the RFP Glossary), and if so, the names and mailing addresses of the subcontractors and a description of the scope and portions of the work for each subcontractor with more than \$100,000 annually. Describe how you intend to monitor and evaluate subcontractor performance. Also specify whether the subcontractor is currently providing services for you in other states and where the subcontractor is located.</p> <p>In addition, as part of the response to this item, for each major subcontractor that is not your organization's parent organization, affiliate, or subsidiary, restate and respond to items B.1 through B.7, B10 and, B.16 through B.27</p> <p>If the major subcontractor is your organization's parent organization, affiliate, or subsidiary, respond to items B.1, B.8 and B.9. You do not need to respond to the other items as part of the response to B11; note, however, responses to various other items in Section B must include information on your organization's parent organization, affiliates, and subsidiaries, which would include any major subcontractors that are your organization's parent organization, affiliate, or subsidiary.</p>	10		
Section B Page 48	All	<p><b>B.12</b></p> <p>Provide a description your Corporate Compliance Program including the Compliance Officer's levels of authority and reporting relationships. Include an organizational chart of staff (marked as Chart B in your response) involved in compliance along with staff levels of authority.</p>	15		
Section B Page 55	All	<p><b>B.13</b></p> <p>Provide copies of any press releases in the twelve (12) months prior to the Deadline for Proposals, wherein the press release mentions or discusses financial results, acquisitions, divestitures, new facilities, closures, layoffs, significant contract awards or losses, penalties/fines/ sanctions, expansion, new or departing officers or directors, litigation, change</p>	10		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		of ownership, or other very similar issues, Do not include press releases that are primarily promotional in nature.			
Section B Page 56	All	<b>B.14</b> Describe your plan for meeting the Performance Bond, other bonds, and insurance requirements set forth in this RFP requirement including the type of bond to be posted and source of funding.	Included/Not Included		
Section B Page 57	All	<b>B.15</b> Provide the following information (in Excel format) based on each of the financial statements provided in response to item B:31: (1) Working capital; (2) Current ratio; (3) Quick ratio; (4) Net worth; and (5) Debt-to-worth ratio.	20		
Section B Page 59	All	<b>B.16</b> Identify, in Excel format, all of your organization's publicly-funded managed care contracts for Medicaid/CHIP and/or other low-income individuals within the last five (5) years. In addition, identify, in Excel format your organization's ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP and/or other low-income individuals within the last five (5) years. For each prior experience identified, provide the trade name, a brief description of the scope of work, the duration of the contract, the contact name and phone number, the number of members and the population types (e.g., TANF, ABD, duals, CHIP), the annual contract payments, whether payment was capitated or other, and the role of subcontractors, if any. If your organization has not had any publicly-funded managed care contracts for Medicaid/SCHIP individuals within the last five (5) years, identify the Proposer's ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP individuals within the last five (5) years and provide the information requested in the previous sentence. Include your organization's parent organization, affiliates, and subsidiaries.	75		
Section B Page 82	All	<b>B.17</b>	Included/Not Included		

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			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		Identify whether your organization has had any contract terminated or not renewed within the past five (5) years. If so, describe the reason(s) for the termination/nonrenewal, the parties involved, and provide the address and telephone number of the client. Include your organization's parent organization, affiliates, and subsidiaries.			
Section B Page 85	All	<p><b>B.18</b></p> <p>If the contract was terminated/non-renewed in B.17 above, based on your organization's performance, describe any corrective action taken to prevent any future occurrence of the problem leading to the termination/non-renewal. Include your organization's parent organization, affiliates, and subsidiaries.</p>	0 to -25		
Section B Page 86	All	<p><b>B. 19</b></p> <p>As applicable, provide (in table format) the Proposer's current ratings as well as ratings for each of the past three years from each of the following:</p> <ul style="list-style-type: none"> <li>• AM Best Company (financial strengths ratings);</li> <li>• TheStreet.com, Inc. (safety ratings); and</li> <li>• Standard &amp; Poor's (long-term insurer financial strength).</li> </ul>	Included/Not Included		
Section B Page 87	All	<p><b>B.20</b></p> <p>For any of your organization's contracts to provide physical health services within the past five years, has the other contracting party notified the Proposer that it has found your organization to be in breach of the contract? If yes: (1) provide a description of the events concerning the breach, specifically addressing the issue of whether or not the breach was due to factors beyond the Proposer's control. (2) Was a corrective action plan (CAP) imposed? If so, describe the steps and timeframes in the CAP and whether the CAP was completed. (3) Was a sanction imposed? If so, describe the sanction, including the amount of any monetary sanction (e.g., penalty or liquidated damage) (4) Was the breach the subject of an administrative proceeding or litigation? If so, what was the</p>	0 to -25		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		result of the proceeding/litigation? Include your organization's parent organization, affiliates, and subsidiaries.			
Section B Page 89	All	<b>B.21</b> Indicate whether your organization has ever sought, or is currently seeking, National Committee for Quality Assurance (NCQA) or American Accreditation HealthCare Commission (URAC) accreditation status. If it has or is, indicate current NCQA or URAC accreditation status and accreditation term effective dates if applicable.	Included/Not Included		
Section B Page 90	All	<b>B.22</b> Have you ever had your accreditation status (e.g., NCQA, URAC,) in any state for any product line adjusted down, suspended, or revoked? If so, identify the state and product line and provide an explanation. Include your organization's parent organization, affiliates, and subsidiaries.	0 to -5		
Section B Page 91	All	<b>B.23</b> If you are NCQA accredited in any state for any product line, include a copy of the applicable NCQA health plan report cards for your organization. Include your organization's parent organization, affiliates, and subsidiaries.	Included/Not Included		
Section B Page 94	All	<b>B.24</b> Provide (as an attachment) a copy of the most recent external quality review report (pursuant to Section 1932(c)(2) of the Social Security Act) for the Medicaid contract identified in response to item B.16 that had the largest number of enrollees as of January 1, 2011. Provide the entire report. In addition, provide a copy of any corrective action plan(s) requested of your organization (including your organization's parent organization, affiliates, and subsidiaries) in response to the report.	25		
Section B Page 95	All	<b>B.25</b> Identify and describe any regulatory action, or sanction, including both monetary and non-monetary sanctions imposed by any federal or	0 to -50		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		state regulatory entity against your organization within the last five (5) years. In addition, identify and describe any letter of deficiency issued by as well as any corrective actions requested or required by any federal or state regulatory entity within the last five (5) years that relate to Medicaid or CHIP contracts. Include your organization's parent organization, affiliates, and subsidiaries.			
Section B Page 150	All	<p><b>B.26</b></p> <p>Provide a statement of whether your organization is currently the subject or has recently (within the past five (5) years) been the subject of a criminal or civil investigation by a state or federal agency other than investigations described in response to item B.6. If your organization has recently been the subject of such an investigation, provide an explanation with relevant details and the outcome. If the outcome is against your organization, provide the corrective action plan implemented to prevent such future offenses. Include your organization's parent company, affiliates and subsidiaries.</p>	0 to -25		
Section B Page 154	All	<p><b>B.27</b></p> <p>Submit client references (minimum of three, maximum of five) for your organization for major contracts; with at least one reference for a major contract you have had with a state Medicaid agency or other large similar government or large private industry contract. Each reference must be from contracts within the last five (5) years. References for your organization shall be submitted to the State using the questionnaire contained in RFP Appendix PP. You are solely responsible for obtaining the fully completed reference check questionnaires, and for submitting them sealed by the client providing the reference, with your Proposal, as described herein. You should complete the following steps:</p> <ul style="list-style-type: none"> <li>• Make a duplicate (hard copy or electronic document) of the appropriate form, as it appears in RFP Appendix PP (for your organization or for subcontractors, adding the following customized information:</li> </ul>	35		

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			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		<ul style="list-style-type: none"> <li>• Your/Subcontractor’s name;</li> <li>• Geographic Service Area(s) for which the reference is being submitted;</li> <li>• Reference organization’s name; and</li> <li>• Reference contact’s name, title, telephone number, and email address.</li> </ul> <ul style="list-style-type: none"> <li>• Send the form to each reference contact along with a new, sealable standard #10 envelope;</li> <li>• Give the contact a deadline that allows for collection of all completed questionnaires in time to submit them with your sealed Proposal;</li> <li>• Instruct the reference contact to:               <ul style="list-style-type: none"> <li>• Complete the form in its entirety, in either hard copy or electronic format (if completed electronically, an original should be printed for submission);</li> <li>• Sign and date it;</li> <li>• Seal it in the provided envelope;</li> <li>• Sign the back of the envelope across the seal; and</li> <li>• Return it directly to you.</li> </ul> </li> <li>• Enclose the unopened envelopes in easily identifiable and labeled larger envelopes and include these envelopes as a part of the Proposal. When DHH the opens your Proposal, it should find clearly labeled envelope(s) containing the sealed references.</li> </ul> <p>THE STATE WILL NOT ACCEPT LATE REFERENCES OR REFERENCES SUBMITTED THROUGH ANY OTHER CHANNEL OF SUBMISSION OR MEDIUM, WHETHER WRITTEN, ELECTRONIC, VERBAL, OR OTHERWISE.</p> <p>Each completed questionnaire should include:</p> <ul style="list-style-type: none"> <li>• Proposing Organization/Subcontractor’s</li> </ul>			

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		<p>name;</p> <ul style="list-style-type: none"> <li>GSA (s) for which the reference is being submitted;</li> <li>Reference Organization's name;</li> <li>Name, title, telephone number, and email address of the organization contact knowledgeable about the scope of work;</li> <li>Date reference form was completed; and</li> <li>Responses to numbered items in RFP Attachment # (as applicable).</li> </ul> <p>DHH reserves the authority to clarify information presented in questionnaires and may consider clarifications in the evaluation of references. However DHH is under no obligation to clarify any reference check information.</p>			
Section B Page 156	All	<p><b>B.28</b></p> <p>Indicate the website address (URL) for the homepage(s) of any website(s) operated, owned, or controlled by your organization, including any that the Proposer has contracted to be run by another entity as well as details of any social media presence ( e.g., Facebook, Twitter). If your organization has a parent, then also provide the same for the parent, and any parent(s) of the parent. If no websites and/or social media presence, so state.</p>	Included/Not Included		
Section B Page 160	All	<p><b>B.29</b></p> <p>Provide evidence that the Proposer has applied to Louisiana Department of Insurance for a certificate of authority (COA) to establish and operate a prepaid entity as defined in RS 22:1016 and in accordance with rules and regulations as defined by the Department of Health and Hospitals.</p>	0 to -25		
Section B Page 161	All	<p><b>B.30</b></p> <p>Provide the following as documentation of financial responsibility and stability:</p> <ul style="list-style-type: none"> <li>a current written bank reference, in the form of a letter, indicating that the Proposer's business relationship with the financial institution is in positive</li> </ul>	50		

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			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		<p>standing;</p> <ul style="list-style-type: none"> <li>• two current written, positive credit references, in the form of a letters, from vendors with which the Proposer has done business or, documentation of a positive credit rating determined by a accredited credit bureau within the last 6 months;</li> <li>• a copy of a valid certificate of insurance indicating liability insurance in the amount of at least one million dollars (\$1,000,000) per occurrence and three million dollars (\$3,000,000) in the aggregate; and</li> <li>• a letter of commitment from a financial institution (signed by an authorized agent of the financial institution and detailing the Proposer's name) for a general line of credit in the amount of five-hundred thousand dollars (\$500,000.00).</li> </ul>			
Section B Page 169	All	<p><b>B.31</b></p> <p>Provide the following as documentation of the Proposer's sufficient financial strength and resources to provide the scope of services as required:</p> <ul style="list-style-type: none"> <li>• The two most recent independently audited financial statements and associated enrollment figures from the Proposer. Compiled or reviewed financial statements will not be accepted. The audited financial statements must be: <ul style="list-style-type: none"> <li>○ Prepared with all monetary amounts detailed in U.S. currency;</li> <li>○ Prepared under U.S. generally accepted accounting principles; and</li> <li>○ Audited under U.S. generally accepted auditing standards. The audited financial statements must include the auditor's opinion letter, financial statements, and the notes to the financial statements.</li> </ul> </li> <li>• The Proposer's four (4) most recent internally prepared unaudited quarterly financial statements (and Year-to- Date),</li> </ul>	50		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		<p>with preparation dates indicated. The statements must include documentation disclosing the amount of cash flows from operating activities. This documentation must indicate whether the cash flows are positive or negative, and if the cash flows are negative for the quarters, the documentation must include a detailed explanation of the factors contributing to the negative cash flows.</p> <ul style="list-style-type: none"> <li>• Verification of any contributions made to the Proposer to improve its financial position after its most recent audit (e.g., copies of bank statements and deposit slips), if applicable</li> </ul> <p>Proposer shall include the Proposer's parent organization.</p>			

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## Section B: Qualifications and Experience

### B.1

**Indicate your organization's legal name, trade name, dba, acronym, and any other name under which you do business; the physical address, mailing address, and telephone number of your headquarters office. Provide the legal name for your organization's ultimate parent (e.g., publicly traded corporation).**

**Describe your organization's form of business (i.e., individual, sole proprietor, corporation, non-profit corporation, partnership, limited liability company) and detail the names, mailing address, and telephone numbers of its officers and directors and any partners (if applicable). Provide the name and address of any health professional that has at least a five percent (5%) financial interest in your organization, and the type of financial interest.**

**Provide your federal taxpayer identification number and Louisiana taxpayer identification number.**

**Provide the name of the state in which you are incorporated and the state in which you are commercially domiciled. If out-of-state, provide the name and address of the local representative; if none, so state.**

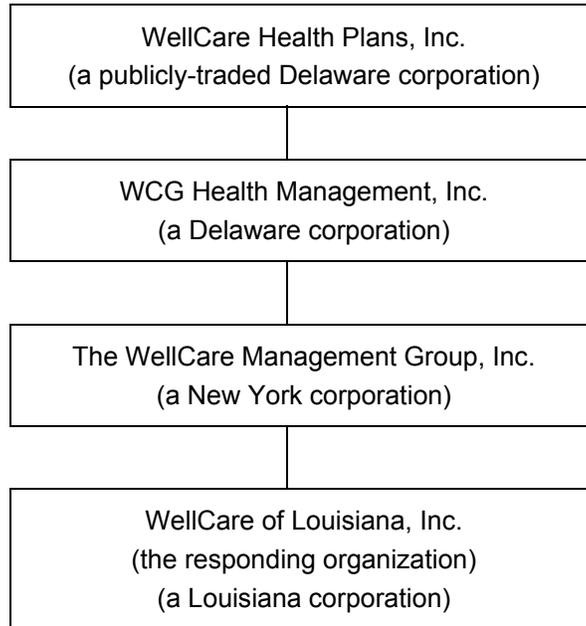
**If you have been engaged by DHH within the past twenty-four (24) months, indicate the contract number and/or any other information available to identify the engagement; if not, so state.**

The legal name of the responding organization is WellCare of Louisiana, Inc. ("**WellCare LA**"). WellCare LA does business under its legal name. The address (both physical and mailing) and phone number of its headquarters office are as follows:

WellCare of Louisiana, Inc.  
11603 Southfork  
Baton Rouge, LA 70816  
(866) 317-1507

WellCare LA, a Louisiana corporation, is a wholly-owned indirect subsidiary of a publicly-traded corporation whose legal name is WellCare Health Plans, Inc. (NYSE: WCG). The ownership path is shown in Exhibit B.1.a on the following page.

**Exhibit B.1.a – WellCare Ownership Path**



The names and titles of WellCare of Louisiana, Inc.’s officers and directors are shown in Exhibit B.1.b below.

**Exhibit B.1.b – WellCare of Louisiana, Inc. Officers and Directors**

Name	Title(s)	Mailing Address & Phone Number
Alec Cunningham	Director, President, Chief Executive Officer	WellCare Health Plans, Inc. 8735 Henderson Road Tampa, FL 33634 (813) 290-6200
Maurice S. Hebert	Director, Assistant Treasurer, Chief Accounting Officer	WellCare Health Plans, Inc. 8735 Henderson Road Tampa, FL 33634 (813) 290-6200
Frank J. Heyliger	Region COO	WellCare of Texas, Inc. 2211 Norfolk Street, Suite 300 Houston, TX 77098
Lisa G. Iglesias	Director, Secretary	WellCare Health Plans, Inc. 8735 Henderson Road Tampa, FL 33634 (813) 290-6200
Jesse L. Thomas, Jr.	Director, President, South Division	WellCare of Georgia, Inc. 211 Perimeter Center, Suite 800 Atlanta, GA 30346 (678) 327-0939

Name	Title(s)	Mailing Address & Phone Number
Thomas L. Tran	Director, Treasurer, Chief Financial Officer	WellCare Health Plans, Inc. 8735 Henderson Road Tampa, FL 33634 (813) 290-6200

As a corporation, WellCare LA does not have any partners.

As noted above, WellCare LA is an indirect wholly-owned subsidiary of a publicly-traded corporation, WellCare Health Plans, Inc. ("**WellCare**"). None of WellCare LA's parent companies is a health professional. However, as a publicly-traded company, WellCare has many passive investors that do not exert control over WellCare or its subsidiaries. Information regarding holders of 5% or more of WellCare's publicly traded stock is available in WellCare's Proxy Statement, Schedule 14A, as filed with the Securities and Exchange Commission ("**SEC**") on April 12, 2011 as well as on Schedules 13G filed by such investors with the SEC with respect to WellCare's stock. Please note that a person is only eligible to file a Schedule 13G with respect to an issuer's securities if such person has acquired the securities in the ordinary course of business and not for the purpose nor with the effect of changing or influencing the control of the issuer.

WellCare LA's federal taxpayer identification number is 90-0247713. WellCare LA had a Louisiana taxpayer identification number, 7264666-001. However, the Louisiana Department of Revenue determined that WellCare LA was not subject to income and franchise tax filing and subsequently this account was closed in January 2009.

WellCare LA is incorporated and domiciled in Louisiana.

WellCare LA has an Agreement with DHH dated December 29, 2010, pursuant to which WellCare LA offers Medicare Advantage special needs plans to individuals in Louisiana eligible for both Medicare and Medicaid (commonly known as D-SNP plans). This agreement does not have a contract number.

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## **B.2**

***Provide a statement of whether there have been any mergers, acquisitions, or sales of your organization within the last ten years, and if so, an explanation providing relevant details. If any change of ownership is anticipated during the 12 months following the Proposal Due Date, describe the circumstances of such change and indicate when the change is likely to occur. Include your organization's parent organization, affiliates, and subsidiaries.***

### **WellCare LA**

WellCare LA has not experienced a merger, acquisition or sale. With respect to WellCare, WellCare LA's ultimate parent company, and WellCare LA's other affiliated companies, please see below. Please note that as a publicly-traded company, shares of WellCare are purchased and sold on a regular basis.

### **WellCare and Other Affiliates**

WellCare Holdings, LLC ("**Holdings**"), the immediate predecessor of WellCare Health Plans, Inc., was formed in May 2002 to acquire the WellCare group of companies. In July 2002, then-current management acquired the WellCare group of companies in two concurrent transactions. In the first transaction, Holdings acquired WellCare's Florida operations, including WellCare of Florida, Inc. and HealthEase of Florida, Inc. subsidiaries, in a stock purchase from a number of individuals. In the second transaction, Holdings acquired The WellCare Management Group, Inc. ("**WMG**"), a publicly-traded holding company and the parent company of WellCare of New York, Inc. and WellCare of Connecticut, Inc. subsidiaries, through a merger of WMG into a wholly-owned subsidiary of Holdings. The purchase price for this transaction was paid in cash

In June 2004, Holdings acquired Harmony Health Systems, Inc., a provider of Medicaid managed care plans in Illinois and Indiana and the parent company of our subsidiaries Harmony Health Management, Inc. and Harmony Health Plan of Illinois, Inc.

WellCare Group, Inc. (n/k/a WellCare Health Plans, Inc.) was incorporated in February 2004. Immediately prior to WellCare's initial public offering in July 2004, Holdings merged with and into WellCare Group, Inc., a wholly-owned subsidiary of Holdings. At that time, the name changed to WellCare Health Plans, Inc. Each outstanding limited liability company unit of WellCare Holdings, LLC was converted into shares of common stock according to the relative rights and preferences of such units and the initial public offering price of the common stock offered.

WellCare acquired Advance Insurance Company (n/k/a WellCare Health Insurance of Arizona, Inc.) in June 2006. This acquisition was consummated through the purchase of 100% of the outstanding stock of Advance Insurance.

WellCare acquired Home Owners Life Insurance Company (n/k/a WellCare Health Insurance of Illinois, Inc.) in July 2006. This acquisition was consummated through the purchase of 100% of the outstanding stock of Home Owners Life.

WellCare acquired Stone Harbor Insurance Company (n/k/a WellCare Health Insurance of New York, Inc.) in August 2006. This acquisition was consummated through the purchase of 100% of the outstanding stock of Stone Harbor.

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**B.3**

***Provide a statement of whether you or any of your employees, agents, independent contractors, or subcontractors have ever been convicted of, pled guilty to, or pled nolo contendere to any felony and/or any Medicaid or health care related offense or have ever been debarred or suspended by any federal or state governmental body. Include an explanation providing relevant details and the corrective action plan implemented to prevent such future offenses. Include your organization's parent organization, affiliates, and subsidiaries.***

WellCare, the parent organization of the Proposer, WellCare LA, together with its subsidiaries and affiliates, constitutes the WellCare group of companies (the "**Company**"). Neither the Company nor any current employee, agent, independent contractor or subcontractor has ever been convicted of, pled guilty to, or pled nolo contendere to any felony and/or any Medicaid or health care related offense or has ever been debarred or suspended by any federal or state governmental body.

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**B.4**

***Provide a statement of whether there is any pending or recent (within the past five years) litigation against your organization. This shall include but not be limited to litigation involving failure to provide timely, adequate or quality physical or behavioral health services. You do not need to report workers' compensation cases. If there is pending or recent litigation against you, describe the damages being sought or awarded and the extent to which adverse judgment is/would be covered by insurance or reserves set aside for this purpose. Include a name and contact number of legal counsel to discuss pending litigation or recent litigation. Also include any SEC filings discussing any pending or recent litigation. Include your organization's parent organization, affiliates, and subsidiaries.***

During the past five years, the Company has been involved in various litigation matters which are depicted in the following Exhibit B.4.a, WellCare Litigation Matters 2007-2011, and are hereby incorporated as part of the Company's response to this section.

The Company regularly accrues reserves that are set aside for probable financial contingencies arising from litigation. In all cases the matters are either accrued for or covered by insurance well in advance of resolution of the matter. If applicable, the Company also places the appropriate insurance carrier on notice.

The Company has attached its most recent Form 10-K and 10-Q filings with the SEC as Attachment B.6.a and Attachment B.6.b. These recent SEC filings describe certain litigation involving the Company and are therefore incorporated as part of the Company's response. Additionally, the Company incorporates by reference, as if set forth fully herein, the Company's response to Sections B.6 and B.26.

Contact

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**Exhibit B.4.a – WellCare Litigation Matters – 2007 - 2011**

Year Opened	Year Resolved	Parties Name	Court	Case No.	Subject Matter	Relief Sought	Final Disposition or Status
<b>Comprehensive Health Management, Inc.</b>							
2007	2007	United Health Group v. MacDonald and WellCare Health Plans, Inc.*	United States District Court Middle District of Florida Orlando Division	6:07-CV-896-ORL-22-KRS	Employment	Plaintiff filed suit alleging violation of non-compete.	Case settled pursuant to a confidential settlement agreement.
2007	2008	O'Neil Data Systems, Inc. v. Comprehensive Health Management, Inc.	Civil Court Fourth Judicial Circuit Duval County, Florida	1b-2007-CA-009961 Division: CV-D	Contractual Dispute	Plaintiff filed suit alleging breach of printing contract.	Case settled pursuant to a confidential settlement agreement.
2005	2007	Alam v. WellCare of New York, Inc.*	United States District Court Southern District of New York	06 CV 3481	Employment	Plaintiff filed suit alleging discrimination based on disability and sex.	Case settled pursuant to a confidential settlement agreement.
2006	2008	Amerigroup Corporation v. Fritsch and WellCare Health Plans, Inc.*	Circuit Court Thirteenth Judicial Circuit Hillsborough County, Florida	06 009414 Division: F	Employment	Plaintiff filed suit alleging violation of non-compete.	Case dismissed for lack of prosecution.
2007	2007	Gambino v. Harmony Health Plan of Illinois, Inc.*	United States District Court Northern District of Illinois Eastern Division	06 CV 1705	Employment	Plaintiff filed suit in Illinois federal court alleging race discrimination.	Case settled pursuant to a confidential settlement agreement.
2006	2008	McKenna v. WellCare Health Plans, Inc.*	United States District Court Middle District of Florida Orlando Division	6:06-cv-1923-Orl-31KRS	Employment	Plaintiff filed suit alleging gender, pregnancy discrimination, sexual harassment and retaliation.	Case settled pursuant to a confidential settlement agreement.
2004	2007	Mian v. WellCare of New York, Inc.*	Supreme Court State of New York County of Bronx	17782/04	Employment	Plaintiff filed suit alleging unlawful termination.	Case settled pursuant to a confidential settlement agreement.
2007	2007	Li v. WellCare Health Plan of New York*	Civil Court City of New York Small Claims Part	NSC 1662/07 6/7	Employment	Plaintiff filed suit alleging unpaid wages for paid time off.	Court entered final order in WellCare's favor Case closed.
2006	2007	Rodriguez v. Harmony Health Plan of Illinois, Inc.*	United States District Court Northern District of Illinois	1:06-cv-05718	Employment	Plaintiff filed suit alleging employment discrimination.	Case settled pursuant to a confidential settlement agreement.
2008	2008	UnitedHealth Group Incorporated and United HealthCare Services, Inc. v. WellCare Health Plans, Inc. and Chomeau*	State of Minnesota District Court County of Hennepin Fourth Judicial District	27 CV 08-3156	Employment	Plaintiff filed suit alleging violation of non-compete.	Case settled pursuant to a confidential settlement agreement.

Year Opened	Year Resolved	Parties Name	Court	Case No.	Subject Matter	Relief Sought	Final Disposition or Status
2008	2011	Omnicare, Inc. v. Comprehensive Health Management, Inc., et al.	Circuit Court Cook County, Illinois County Department, Law Division	07 L 005503	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Case settled pursuant to a confidential settlement agreement.
2008	2008	Sy-Savane Kimbrough v. WellCare of Georgia, Inc.*	United States District Court Northern District of Georgia Atlanta Division	1:08-cv-1746-CAM-ECS	Employment	Plaintiff filed suit alleging wrongful termination, breach of contract, and discrimination based on her race, religion and national origin.	Case dismissed for lack of prosecution.
2008	2009	Xue Lian Lin, Ching Yeung, Chi Yeung, Yu Ting Huang, Yuk Kam Yeung, Yu Zhang and Yan Yun Zhao v. Comprehensive Health Management, Inc., et al.	United States District Court Southern District of New York	08 CV 6519	Employment	Plaintiffs filed suit alleging entitlement to unpaid wages for overtime work and unpaid minimum wages for hours worked.	Case settled pursuant to a confidential settlement agreement.
2008	2009	Tyson v. Comprehensive Health Management, Inc.	State Court of Gwinnett County State of Georgia	08C-15183-06	Employment	Plaintiff filed suit alleging tortious interference with prospective economic advantage, intentional infliction of emotion distress.	Case dismissed with prejudice.
2008	2008	Gonzalez v. WellCare Health Plans, Inc.*	Circuit Court Thirteenth Judicial Circuit Hillsborough County, Florida	08-CA-18488 Division: H	Employment	Plaintiff filed suit alleging violations of the Florida Civil Rights Act of 1992 based on his alleged disability, invasion of privacy and disclosure of private facts.	Case settled pursuant to a confidential settlement agreement.
2008	2009	Urta and Enterlein v. WellCare Health Plans, Inc., et al.	Circuit Court Eleventh Judicial Circuit Miami-Dade County, Florida	08-61731 CA 05	Employment	Plaintiff filed suit alleging 1) breach of contract; 2) breach of implied covenant of good faith and fair dealing; 3) violations of the Florida Deceptive and Unfair Trade Practices Act (FDUTPA); and 4) unjust enrichment.	Case settled pursuant to a confidential settlement agreement.
2008	2008	Fayall, et al. v. Comprehensive Health Management, Inc., et al.	Supreme Court State of New York County of Kings	19629/08	Auto Accident	Plaintiff filed suit seeking recovery for injuries allegedly sustained in an automobile accident involving WellCare associate.	Case settled pursuant to a confidential settlement agreement.

Year Opened	Year Resolved	Parties Name	Court	Case No.	Subject Matter	Relief Sought	Final Disposition or Status
2009	2009	Bartlett v. Comprehensive Health Management, Inc.	Baton Rouge City Court Small Claims Division Louisiana	09-02622-B	Employment	Plaintiff filed suit alleging denial of continued life insurance coverage upon his termination.	Case settled pursuant to a confidential settlement agreement.
2009	2009	Bowman v. WellCare Health Plans, Inc.*	District Court Second Judicial Circuit County of Idaho State of Idaho	CV 09-39454	Employment	Plaintiff filed suit alleging unpaid wages and renewal dues.	Case dismissed for failure to prosecution.
2009	2009	Smith v. WellCare Health Plans, Inc.	Court of Chancery of the State of Delaware	4408-VCL	Indemnification Dispute	Plaintiff filed suit demanding reimbursement of attorney fees and costs related to the government investigation.	Case settled pursuant to a confidential settlement agreement.
2009	2010	Behrens, Bereday and Farha v. WellCare Health Plans, Inc.	Court of Chancery of the State of Delaware	5026-CC	Indemnification Dispute	Plaintiff filed suit demanding reimbursement of attorney fees and costs related to the government investigation.	Case settled pursuant to a confidential settlement agreement.
2009	2010	Kanfer v. WellCare of Florida, Inc.*	United States District Court Southern District of Florida	09-81587-CIV-ZLOCH	Employment	Plaintiff filed suit alleging wrongful termination, whistleblower and retaliation.	Case settled pursuant to a confidential settlement agreement.
2009	2010	Mannie v. Comprehensive Health Management, Inc.	United States District Court Northern District of Illinois Eastern Division	09 CV 6818	Employment	Plaintiff filed suit alleging race, age and gender discrimination.	Case settled pursuant to a confidential settlement agreement.
2009	Open	Viola v. WellCare Health Plans, Inc.*	United States Court of Appeals Eleventh Circuit	11-10349	Employment	Plaintiff filed suit alleging non-payment of overtime for a salaried position.	Summary Judgment won Appeal filed; parties attended mediation but did not settle CHMI has filed its response to Appellant's brief to the 11th Circuit The Court has not rendered a decision.
2009	2010	Montero and Montero v. Comprehensive Health Management, Inc.et al.	Supreme Court State of New York County of Kings	29124/09	Auto Accident	Plaintiff filed suit for damages due to injuries suffered from an automobile accident.	Case settled pursuant to a confidential settlement agreement.
2010	2011	Richard v. Comprehensive Health Management, Inc.	Circuit Court Cook County Illinois County Department Law Division	2010-L-004885	Employment	Plaintiff filed suit alleging breach of an employment agreement and seeks reinstatement of position.	Case settled pursuant to a confidential settlement agreement.

Year Opened	Year Resolved	Parties Name	Court	Case No.	Subject Matter	Relief Sought	Final Disposition or Status
2010	Open	Aponte and Correa, et al. v. Comprehensive Health Management, Inc.	United States District Court Southern District of New York	10-cv-4825	Employment	Plaintiffs filed suit alleging non-payment of overtime pay for Benefit Consultants.	Class Certification Motion and opposition filed Decision by the Court pending.
2010	2010	Rust, et al. v. Comprehensive Health Management, Inc.	United States District Court Middle District of Florida Tampa Division	8:10CV1886 T30 MAP	Employment	Plaintiffs filed suit alleging non-payment of overtime for Provider Relations Representatives.	Case settled pursuant to a confidential settlement agreement.
2010	2011	Jefferson v. WellCare Comprehensive Health Management	United States District Court Middle District of Florida Tampa Division	8:10-CV-2158-T-27AEP	Employment	Plaintiff filed suit alleging retaliatory discharge, disability discrimination and Family and Medical Leave Act Retaliation.	Case dismissed for lack of prosecution.
2011	Open	Otto v. WellCare Health Plans, Inc.*	United States District Court Middle District of Florida Tampa Division	08:11-cv-00088-SDM-MAP	Employment	Plaintiff filed suit alleging breach of contract for unpaid wages, discrimination, unjust enrichment, and unlawful employment practices.	Allegations being investigated Removed case to federal court Discovery ongoing Parties attended mediation on May 18, 2011 Mediation unsuccessful.
2011	Open	Lowe v. WellCare Health Plans, Inc. and Gilbert	United States District Court Northern District of Texas Dallas Division	3-11 CV 0009-L	Broker Commissions	Plaintiff (former independent broker) filed suit alleging breach of contract, unjust enrichment, fraud, extortion, deceptive trading, false and misleading statements of fact, and a violation of the Fair Labor Standards Act of 1938 for unpaid commissions.	Allegations being investigated Motion to Dismiss filed.
2011	Open	Preston v. Comprehensive Health Management, Inc.	United State District Court Middle District of Florida	8:11-cv-1083-T-24TBM	Employment	Plaintiff filed suit alleging non-payment of overtime for Network Relations Representatives.	Allegations being investigated.

\*Cases naming other WellCare entities as defendants are cases where the improper party was named The proper party, Comprehensive Health Management, Inc. was later named in the suit.

Year Opened	Year Resolved	Parties Name	Court	Case No.	Subject Matter	Relief Sought	Final Disposition or Status
<b>Harmony Health Plan of Indiana, Inc.</b>							
2008	2008	Critical Care Systems, Inc. v. Indiana Family and Social Services Administration and Harmony Health Plan of Indiana, Inc.	American Arbitration Association	A122107595	Claims Dispute	Plaintiff filed arbitration alleging incorrectly paid claims.	Case settled pursuant to a confidential settlement agreement.
2006	2007	Harmony Health Plan of Indiana v. Indiana Department of Administration, et al.	State of Indiana Superior Court Civil Division County of Marion	49D03-0609-MI-036297	Bid Award Contestation	Plaintiff filed suit contesting state bid award.	Appeals exhausted. Case closed.
<b>Harmony Health Plan of Illinois, Inc.</b>							
2006	2008	Holy Cross v. Harmony Health Plan of Illinois, Inc.	American Arbitration Association	51 193 Y 01013 06	Claims Dispute	Plaintiff filed arbitration alleging incorrectly paid claims.	Case settled pursuant to a confidential settlement agreement.
<b>HealthEase of Florida, Inc.</b>							
2007	2009	Shands Jacksonville Medical Center, Inc. v. HealthEase of Florida, Inc.	Circuit Court Fourth Judicial Circuit Duval County, Florida	16-2007-CA-002437	Claims Dispute	Plaintiff filed suit alleging HealthEase failed to reimburse Shands at the correct rates for services to HealthEase members.	Case settled pursuant to a confidential settlement agreement.
2007	2008	Sheridan Healthcorp, Inc. v. HealthEase of Florida, Inc.	Circuit Court Seventeenth Judicial Circuit Broward County, Florida	09 07014491	Claims Dispute	Non-participating provider alleges incorrect payment of claims.	Plaintiff dismissed the case. Case closed.
2001	2010	Brodkin v. HealthEase of Florida, Inc.	Circuit Court Twelfth Judicial Circuit Sarasota County, Florida	03-CA12475SC	Claims Dispute	Plaintiff filed suit alleging HealthEase failed to authorize prescriptions and treatment.	Case settled pursuant to a confidential settlement agreement.
2006	2008	Doctors Management Group, Inc. v. HealthEase of Florida, Inc.	American Arbitration Association	33 193 00405 06	Capitation Payment Dispute	Plaintiff filed arbitration alleging unpaid capitation payments and unpaid monthly surplus payments.	Case settled pursuant to a confidential settlement agreement.
2008	2008	Tampa General v. HealthEase of Florida, Inc.	Circuit Court Thirteenth Judicial Circuit Hillsborough County, Florida	08-CA-002305 Division: A	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Case settled pursuant to a confidential settlement agreement.

Year Opened	Year Resolved	Parties Name	Court	Case No.	Subject Matter	Relief Sought	Final Disposition or Status
2008	2009	Shands Teaching Hospitals and Clinics v. HealthEase of Florida, Inc., et al.	Circuit Court Fourth Judicial Circuit Duval County, Florida	16-2008-CA-011388 Division: CV-D	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Case settled pursuant to a confidential settlement agreement.
2009	2009	South Broward v. HealthEase of Florida, Inc.	Circuit Court Seventeenth Judicial Circuit Broward County, Florida	09-05903	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Plaintiff voluntarily dismissed the case with prejudice Case closed.
2009	Open	Perlman v. HealthEase of Florida, Inc.	Circuit Court Seventeenth Judicial Circuit Broward County, Florida	09-32410-12	Claims Dispute	Plaintiff filed suit alleging denial of claim payment.	Discovery ongoing.
2009	Open	Florida Medical Center v. Harmony Behavioral Health, Inc.	Circuit Court Seventeenth Judicial Circuit Broward County, Florida	09-49687	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	An unsuccessful mediation was held on January 7, 2011 Discovery ongoing Trial is set for July 2011.
2009	2009	South Broward Hospital District v. WellCare of Florida, Inc., et al.	Circuit Court Seventeenth Judicial Circuit Broward County, Florida	09-53906	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Plaintiff dismissed the case. Case closed.
2009	2010	Atenda Healthcare Solutions, Inc. and Florida Home Medical Equipment, Inc. v. WellCare Health Plans, Inc.	Circuit Court Thirteenth Judicial Circuit Hillsborough County, Florida	09 26865 Division: D	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Plaintiff dismissed the case. Case closed.
2010	2011	Hialeah Hospital v. WellCare Health Plans, Inc.	Circuit Court Eleventh Judicial Circuit Miami-Dade County, Florida	10-9992 CC 23	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Plaintiff dismissed the case. Case closed.
2010	2011	North Broward Hospital District v. WellCare Health Plans, Inc.	County Court Broward County, Florida	10-09053 COWE(83)	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Plaintiff dismissed the case. Case closed.
2010	Open	Lakeland Regional Medical Center v. HealthEase of Florida, Inc.	Circuit Court Tenth Judicial Circuit Polk County, Florida	53-2010CA-05622 Section 15	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Case settled pursuant to a confidential settlement agreement.
2010	2011	Hialeah Hospital v. WellCare Health Plans, Inc.	County Court Miami-Dade County, Florida	10-26042 SP 23 (2)	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Case settled pursuant to a confidential settlement agreement.
2010	Open	St. Mary's v. HealthEase of Florida, Inc.	County Court Palm Beach County, Florida	2010 SC011220	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Discovery ongoing.

Year Opened	Year Resolved	Parties Name	Court	Case No.	Subject Matter	Relief Sought	Final Disposition or Status
2010	Open	St. Mary's v. HealthEase of Florida, Inc.	County Court Palm Beach County, Florida	2010 CC016051	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Discovery ongoing.
2011	Open	Children's Anesthesia Associates v. WellCare of Florida, Inc.	Circuit Court Eleventh Judicial Circuit Miami-Dade County, Florida	11-13619 CA-4	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Discovery ongoing.
<b>WellCare Health Insurance of Arizona, Inc.</b>							
2009	2010	Henry v. WellCare Health Insurance of Arizona, Inc.	Circuit Court of Benton County Arkansas	CV 2009-422-5	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Motion to Dismiss granted Case closed.
2010	2010	Curtis v. WellCare and Doral National Medicare Plan	Mason County District Court Shelton, Washington	10485/09	Claims Dispute	Plaintiff filed suit alleging non-payment of dental claims.	Case settled pursuant to a confidential settlement agreement.
2010	2010	Reiner v. Ohana Health Plan, Inc.	District Court Second District Small Claims Wailuku Division State of Hawai'i	DC-SC 10-1-0329	Benefits	Plaintiff filed suit alleging Ohana Health Plan, Inc. refused to provide medical services.	Plaintiff failed to appear Court dismissed the matter.
2009	2009	Lee v. WellCare Health Insurance of Arizona, Inc., et al.	District Court Clark County, Nevada	A-09-595144-C	Auto Accident	Plaintiff filed suit for insurance coverage related to an automobile accident.	Plaintiff named WellCare in error Plaintiff filed an Amended Complaint dropping WellCare from the matter.
2008	Open	Alohacare v. JP Schmidt, Insurance Commissioner, State of Hawai'i Department of Commerce and Consumer Affairs, et al.	State of Hawai'i Supreme Court	SCAP-30276	Bid Award Dispute	Plaintiff filed suit contesting state bid award.	Plaintiff claims were denied by the trial court Plaintiff has appealed to the Hawai'i Supreme Court.

Year Opened	Year Resolved	Parties Name	Court	Case No.	Subject Matter	Relief Sought	Final Disposition or Status
2009	Open	G., parent and next friend of K., a disabled minor, et al. v. State of Hawai'i, et al.	United States District Court of Hawai'i	08-00551 ACK/BMK and 09-00044 ACK/BMK (Consolidated)	Qualification of Ohana's and Evercare's adequacy of QExA provider networks	A Declare that the QExA contracts with the entities selected (or other entities now claiming to hold such contracts) are null and void. B Declare that CMS' decision to allow the State of Hawai'i to proceed with the ABD program under the waiver authority of Section 1115 is arbitrary, capricious, and contrary to law particularly insofar as that waiver is relief on to force dual eligibles and children under 19 years of age into managed care. C Declare that defendants' approval of the two contracts is unlawful and enjoin defendants from proceeding with any action based on such approval. D Enjoin CMS from making any payments in support of the unlawful CMS contracts and in support of the QExA program until compliance with applicable Statutory and regulatory requirements can be demonstrated. E Order CMS to reimburse plaintiffs their reasonable attorneys' fees and costs in bringing this case. F Order such other and further relief as the Court deems warranted or just.	The matter is currently being appealed to the Ninth Circuit Court of Appeals.
<b>WellCare Health Plans, Inc.</b>							
2007	2008	Raml and Greenberg v. WellCare Health Plans, Inc.	Circuit Court Sixth Judicial Circuit Pinellas County, Florida	07-10931-CI-8	Breach of Contract	Plaintiff filed suit alleging non-payment for event coordinator work.	Case settled pursuant to a confidential settlement agreement.

Year Opened	Year Resolved	Parties Name	Court	Case No.	Subject Matter	Relief Sought	Final Disposition or Status
2007	2007	PRN Home Care v. WellCare Health Plans, Inc.	County Court Brevard County, Florida	05-2007-SC-009681	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Case settled pursuant to a confidential settlement agreement.
2007	2008	North Broward v. WellCare Health Plans, Inc., et al.	Circuit Court Seventeenth Judicial Circuit Broward County, Florida	07-10875	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Case settled pursuant to a confidential settlement agreement.
2007	2007	Larkin Community Hospital v. WellCare Health Plans, Inc.	United States District Court Southern District of Florida	07-22164-CIV	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Case settled pursuant to a confidential settlement agreement.
2007	2007	Sneed v. WellCare Health Plans, Inc., et al.	In the Marion Superior Court No. 7 of Indiana	49D07-0708-CT-032192	Subrogation	Plaintiff filed suit alleging First Recovery did not properly comply with Indiana Statute to preserve right of subrogation.	Plaintiff dismissed the matter Case closed.
2006	2009	WellCare Health Plans, Inc. v. Emergency Physicians of Central FL	Circuit Court Ninth Judicial Circuit Orange County, Florida	08-CA-3990 Division: 43	Overpayment of Claims	WellCare filed suit against Emergency Physicians for overpayment of claims.	Case settled pursuant to a confidential settlement agreement.
2008	2008	Morales, et al. v. Municipality of Toa Baja	United States District Court District of Puerto Rico	08-1075CCC	Subrogation	Plaintiff filed suit listing WellCare as an interested party as to subrogation.	WellCare dismissed from the matter Case closed.
2008	2008	CGH Hospital d/b/a Coral Gables Hospital v. WellCare Health Plans, Inc.	County Court Miami-Dade County, Florida	08-5005 CC 23 (2)	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Case settled pursuant to a confidential settlement agreement.
2008	2008	Marquette General Hospital v. WellCare Health Plans, Inc., et al.	District Court County of Marquette State of Michigan	M08-0407-GC	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Case settled pursuant to a confidential settlement agreement.
2008	2008	The Staywell Company v. WellCare Health Plans, Inc.	United States District Court Middle District of Florida	8:08-cv-681	Trademark Infringement	Plaintiff filed suit alleging trademark infringement.	Case settled pursuant to a confidential settlement agreement.
2006	Open	U.S. et al. ex rel. Hellein v. WellCare Health Plans, Inc.	United States District Court Middle District of Florida Tampa Division	8:06-cv-01079-T-30-TGW	<i>Qui Tam</i>	Please see Section B.26 for further details regarding this matter.	
2007	Open	U.S. et al. ex rel. Bolton v. WellCare Health Plans, Inc.	United States District Court Middle District of Florida Tampa Division	8:07-cv-01909-T-30-TGW	<i>Qui Tam</i>	Please see Section B.26 for further details regarding this matter.	
2007	Open	Bolton v. WellCare Health Plans, Inc.	Leon County, Florida	37 2007 CA 002961	<i>Qui Tam</i>	This matter is currently under seal.	

Year Opened	Year Resolved	Parties Name	Court	Case No.	Subject Matter	Relief Sought	Final Disposition or Status
2008	Open	U.S. et al. ex rel. Gonzalez v. WellCare Health Plans, Inc.	United States District Court Middle District of Florida Tampa Division	8:08-cv-1691-T-30-TGW	<i>Qui Tam</i>	Please see Section B.26 for further details regarding this matter.	
2007	Open	U.S. et al. ex rel. SF United Partners v. WellCare Health Plans, Inc.	United States District Court District Court of Connecticut	3:07cv1688	<i>Qui Tam</i>	Please see Section B.26 for further details regarding this matter.	
2007	2010	Eastwood Enterprises, LLC v. Farha, et al.	United States District Court Middle District of Florida Tampa Division	8:07-cv-01940-VMC-EAJ	Class Action	Please see Section B.26 for further details regarding this matter.	
2007	2010	Rosky v. Farha, et al.	United States District Court Middle District of Florida Tampa Division	8:07-cv-01952-JSM-EAJ	Class Action	Please see Section B.26 for further details regarding this matter.	
2007	Open	Intermountain Ironworkers Trust Fund, et al. v. Farha, et al.	Circuit Court Thirteenth Judicial Circuit Hillsborough County, Florida	07-CA-015349	Class Action	Please see Section B.26 for further details regarding this matter.	
2009	2010	Lowe v. WellCare Health Plans, Inc. and Gilbert	United States District Court Northern District of Texas Dallas Division	3:09-CV-806-D ECF	Broker Commissions	Plaintiff (former independent broker) filed suit alleging breach of contract, unjust enrichment, fraud, extortion, deceptive trading, false and misleading statements of fact, and a violation of the Fair Labor Standards Act of 1938 for unpaid commissions.	Court dismissed the case. Case closed.
2011	Open	Kale v. WellCare Health Plans, Inc.	Court of Chancery of the State of Delaware	6393-VCS	Indemnification Dispute	Plaintiff filed suit for continued advancement of legal fees associated with representation related to the government investigation.	Allegations being investigated
<b>WellCare of Florida, Inc.</b>							
2007	2007	Hill Dermaceuticals v. WellCare of Florida, Inc.	Circuit Court Eighteenth Judicial Circuit Seminole County, Florida	07-CA-274-16-L	Pharmacy Formulary Dispute	Plaintiff filed suit alleging WellCare's alleged denial improper pharmacy formulary.	Case settled pursuant to a confidential settlement agreement.

Year Opened	Year Resolved	Parties Name	Court	Case No.	Subject Matter	Relief Sought	Final Disposition or Status
2003	2007	WellCare HMO, Inc. v. The Dardick Agency, Inc., et al.	Circuit Court Thirteenth Judicial Circuit Hillsborough County, Florida	02-06130 Division: E	Breach of Contract	WellCare sued alleging Dardick has received funds from members for payment to WellCare that was never provided to WellCare.	Case settled pursuant to a confidential settlement agreement.
2007	2007	C.P. Motion, Inc. v. WellCare of Florida, Inc.	County Court Miami-Dade County, Florida	07-6024SP25	Claims Dispute	Plaintiff filed suit alleging an unsubmitted DME claim.	Plaintiff dismissed the matter Case closed.
2007	2008	Sheridan v. WellCare of Florida, Inc.	Circuit Court Seventeenth Judicial Circuit Broward County, Florida	CACE 07-014491 (09)	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Plaintiff dismissed the matter Case closed.
2007	2008	WellCare of Florida, Inc. v. Fatima P. Regencia-Dompor, MD	Circuit Court Thirteenth Judicial Circuit Hillsborough County, Florida	07-010777 Division: I	Default	WellCare filed suit against provider who defaulted on settlement payments.	Default judgment entered against provider.
2004	2007	Indian River v. WellCare of Florida, Inc.	Circuit Court Nineteenth Judicial Circuit Indian River County, Florida	2004-0376 CA 03	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Case settled pursuant to a confidential settlement agreement.
2007	2008	Vogliano v. WellCare of Florida, Inc.	County Court Miami-Dade County, Florida	07-22575 SP 05	Claims Dispute	Plaintiff filed suit requesting full billed charges for emergency treatment.	Case settled pursuant to a confidential settlement agreement.
2005	2007	WellCare of Florida, Inc. v. Pasteur Medical	American Arbitration Association	33193Y0002506	Breach of Contract	WellCare brought suit/ injunction for solicitation of membership in breach of contract.	Case settled pursuant to a confidential settlement agreement.
2004	2007	Mount Sinai Medical Center of Florida, Inc. v. WellCare of Florida, Inc. v. Miami Beach Healthcare Corp., Ltd.	Circuit Court Eleventh Judicial Circuit Miami-Dade County, Florida	04-19362 CA 32	Claims Dispute	Plaintiff filed suit alleging failure to pay hospital claims at higher contracted rates.	Case settled pursuant to a confidential settlement agreement.
2005	2007	Health Management Associates, Inc. et al. v. WellCare of Florida, Inc.	Circuit Court Thirteenth Judicial Circuit Hillsborough County, Florida	05-11091 Division: E	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Case settled pursuant to a confidential settlement agreement.

Year Opened	Year Resolved	Parties Name	Court	Case No.	Subject Matter	Relief Sought	Final Disposition or Status
1999	2008	ACH Corporation of America, Inc. v. WellCare HMO, Inc.	Circuit Court Ninth Judicial Circuit Orange County, Florida	C10 02-3440 Division: 34	Premiums	ACH filed suit alleging WellCare improperly terminated employees from their health care policy WellCare sent termination letter due to unpaid premiums WellCare counter-sued for payment of premiums.	Case settled pursuant to a confidential settlement agreement.
2002	2008	Osman v. WellCare HMO, Inc.	American Arbitration Association	33 195 00393 02	Provider Termination Dispute	Plaintiff filed suit alleging wrongful termination of provider contract.	Case settled pursuant to a confidential settlement agreement.
2004	2008	Teamcare Infusion Incorporated v. Comprehensive Health Management, Inc., et al.	Circuit Court Eleventh Judicial Circuit Miami-Dade County, Florida	03-30189 CA (32)	Claims Dispute	Plaintiff filed suit alleging non-payment of pharmacy and DME claims from 2002 and 2003.	Case settled pursuant to a confidential settlement agreement.
2004	Open	Wilson and Salmon v. Richard Stone, M.D., et al.	Circuit Court Eleventh Judicial Circuit Miami-Dade County, Florida	04-2996 CA 01 22	Medical Malpractice	Plaintiff's daughter filed suit alleging wrongful death against WellCare and doctor's alleging medical malpractice in not timely diagnosing breast cancer on mother.	Discovery ongoing.
2004	2010	WellCare of Florida, Inc. v. American International Specialty Lines Insurance Company	Circuit Court Thirteenth Judicial Circuit Hillsborough County, Florida	04-10738 Division: H	Breach of Contract	WellCare filed suit alleging refusal to honor insurance coverage.	Case settled pursuant to a confidential settlement agreement.
2006	2008	Amisub (North Ridge Hospital) v. WellCare of Florida, Inc.	County Court Broward County, Florida	06-5737 (49)	Claims Dispute	Plaintiff filed suit alleging non-payment of claims.	Case settled pursuant to a confidential settlement agreement.
2006	2008	Doctors Management Group, Inc. v. WellCare of Florida, Inc.	American Arbitration Association	33 193 00405 06	Capitation Payment Dispute	Plaintiff filed arbitration alleging unpaid capitation payments and unpaid monthly surplus payments.	Case settled pursuant to a confidential settlement agreement.
2006	2008	Health Quality Physicians v. WellCare of Florida, Inc.	Judicial Arbitration and Mediation Services, Inc.	101806A	Capitation Payment Dispute	Plaintiff filed arbitration alleging unpaid monthly capitation payment and surplus payments.	Case settled pursuant to a confidential settlement agreement.
2006	2008	Lexington Insurance v. WellCare of Florida, Inc.	American Arbitration Association	11 195 012373 06	Breach of Contract	Plaintiff filed arbitration to settle dispute regarding IASIS coverage denial.	Case settled pursuant to a confidential settlement agreement.

Year Opened	Year Resolved	Parties Name	Court	Case No.	Subject Matter	Relief Sought	Final Disposition or Status
2008	2008	Careguide v. WellCare of Florida, Inc. and HealthEase of Florida, Inc.	Judicial Arbitration and Mediation Services, Inc.	1410004661	Claims Dispute	Plaintiff filed arbitration alleging incorrect payment of claims.	Case settled pursuant to a confidential settlement agreement.
2005	2007	Washington v. Robert Fenzl, MD., et al.	Circuit Court of the Thirteenth Judicial Circuit Hillsborough County, Florida	CA 05-00856 Division: I	Medical Malpractice	Pro se medical malpractice action.	The Court dismissed WellCare from the matter Case closed.
2007	2008	Indian River v. WellCare of Florida, Inc.	County Court Indian River County, Florida	20072362 CC 10	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Case settled pursuant to a confidential settlement agreement.
2008	2008	Transatlantic Healthcare v. WellCare of Florida, Inc., et al.	Circuit Court Seventeenth Judicial Circuit Broward County, Florida	0800250-18	Contractual Dispute	Plaintiff filed a Complaint for Pure Bill of Discovery.	WellCare dismissed from the matter Case closed.
2008	2008	St. Mary's Hosp. v. WellCare of Florida, Inc.	County Court Palm Beach County, Florida	50 2008 CC 010697XXXXMB Division: RL	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Case settled pursuant to a confidential settlement agreement.
2008	2008	North Broward Hosp. v. Birgs & WellCare of Florida, Inc.	Circuit Court Seventeenth Judicial Circuit Broward County, Florida	08-39594 (21)	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Case settled pursuant to a confidential settlement agreement.
2008	2008	North Broward Hosp. v. WellCare of Florida, Inc.	Circuit Court Seventeenth Judicial Circuit Broward County, Florida	08-39590 (14)	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Case settled pursuant to a confidential settlement agreement.
2008	2009	Shands Jacksonville Medical Center, Inc. v. WellCare of Florida, Inc. d/b/a Staywell	Circuit Court Fourth Judicial Circuit Duval County, Florida	16-2008-CA-011387 Division: CV-F	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Case settled pursuant to a confidential settlement agreement.
2008	2008	Jorgensen, Romanello & Gibbons, PA v. WellCare of Florida, Inc., et al.	Circuit Court Twelfth Judicial Circuit Manatee County, Florida	08CA1425	Subrogation	Plaintiff filed suit naming WellCare as an interested party as to subrogation.	The Court dismissed WellCare from the matter Case closed.
2008	2009	The Public Health Trust of Miami-Dade County, FL d/b/a Jackson Memorial Hospital v. WellCare of Florida, Inc.	County Court Miami-Dade County, Florida	08-6260 SP 26(04)	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Case settled pursuant to a confidential settlement agreement.

Year Opened	Year Resolved	Parties Name	Court	Case No.	Subject Matter	Relief Sought	Final Disposition or Status
2009	2009	North Broward Hospital v. WellCare of Florida	Circuit Court Seventeenth Judicial Circuit Broward County, Florida	08-31859	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Case settled pursuant to a confidential settlement agreement.
2009	2009	North Broward Hospital v. WellCare of Florida	Circuit Court Seventeenth Judicial Circuit Broward County, Florida	858396	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Case settled pursuant to a confidential settlement agreement.
2009	2009	North Broward Hospital v. WellCare of Florida	Circuit Court Seventeenth Judicial Circuit Broward County, Florida	08-30001	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Case settled pursuant to a confidential settlement agreement.
2009	2009	North Broward Hospital v. WellCare of Florida, Inc.	Circuit Court Seventeenth Judicial Circuit Broward County, Florida	09-05888(04)	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Case settled pursuant to a confidential settlement agreement.
2009	Open	Physician Care Network v. WellCare of Florida, Inc. and HealthEase of Florida, Inc.	Judicial Arbitration and Mediation Services, Inc.	1440002593	Claims Dispute	Plaintiff filed suit alleging breach of contract by failing to pay surplus to Plaintiff.	Discovery ongoing Arbitration scheduled for September 2011.
2009	2010	Bontrager v. WellCare of Florida, Inc.	County Court Liberty County, Florida	09-98-SP	Claims Dispute	Plaintiff filed suit alleging denial of claim payment.	Case settled pursuant to a confidential settlement agreement.
2010	2010	Griffin v. WellCare Health Plans, Inc.*	County Court Clay County, Florida	2010-sc-000236	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Case settled pursuant to a confidential settlement agreement.
2010	2010	North Broward Hospital v. WellCare of Florida, Inc.	Circuit Court Seventeenth Judicial Circuit Broward County, Florida	09-53902 CACE 05	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Case settled pursuant to a confidential settlement agreement.
2010	Open	Lakeland Regional Medical Center v. WellCare of Florida, Inc.	Circuit Court Tenth Judicial Circuit Polk County, Florida	53-2010CA-05623 Section 15	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Case settled pursuant to a confidential settlement agreement.
2010	Open	Baptist Memorial of Miami, et al v. WellCare of Florida, Inc. and HealthEase of Florida, Inc.*	Circuit Court Eleventh Judicial Circuit Miami-Dade County, Florida	10-38755 CA 08	Claims Dispute	Plaintiff filed suit alleging incorrectly paid ER claims.	Discovery ongoing.

Year Opened	Year Resolved	Parties Name	Court	Case No.	Subject Matter	Relief Sought	Final Disposition or Status
2010	2010	Putnam Family Medical v. WellCare Health Plans, Inc.	County Court Putnam County, Florida	10000793SC	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Plaintiff dismissed the matter with prejudice Case closed.
2010	Open	St. Mary's v. Harmony Behavioral Health	Circuit Court Fifteenth Judicial Circuit Palm Beach County, Florida	50 2010-CA023874 XXXX MB	Claims Dispute	Plaintiff filed suit alleging denial of claim payment.	Discovery ongoing.
2010	Open	Coral Gables Hospital v. WellCare of Florida, Inc.	County Court Miami-Dade County, Florida	10-25741 CC 23 (2)	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Discovery ongoing.
2011	2011	Griffin v. WellCare Health Plans, Inc.	County Court Nassau County, Florida	11-SC-48	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Case settled pursuant to a confidential settlement agreement.

\*Cases naming other WellCare entities as defendants are cases where the improper party was named The proper party was later changed to the correct entity in the suit.

**WellCare of Georgia, Inc.**

2007	2009	Everest Security Insurance Company v. WellCare of Georgia, Inc., et al.	Superior Court Bibb County, Georgia	08-CV-48746	Subrogation	Plaintiff filed suit listing WellCare as an interested party as to subrogation.	The Court dismissed WellCare from the matter Case closed.
2006	2007	Atlanta Perinatal, et al v. Peach State Health Plan, Inc., et al.	Superior Court Fulton County, Georgia	2006CV121181	Claims Dispute	Class action provider lawsuit alleging non-payment of claims.	Motion to Dismiss granted Case closed.
2007	2007	Ellis, as next friend of minor child, Larios, as next friend of minor child, et al. v. Rhonda Meadows, et al.	United States District Court Northern District of Georgia Rome Division	4:07-CV-167	Provider Termination Dispute	Plaintiffs requested federal TRO to prevent WellCare from terminating dental provider from network.	Court denied TRO Court granted the Agreed Motion to Dismiss with Prejudice.
2008	2009	HCA v. WellCare of Georgia, Inc.	Henning Mediation and Arbitration	08-10528	Claims Dispute	Plaintiff filed an arbitration demand for alleged incorrectly paid claims.	Case settled pursuant to a confidential settlement agreement.
2008	2009	North Fulton Regional Hospital v. WellCare of Georgia, Inc.	American Arbitration Association	30 193 Y 00657 08	Claims Dispute	Plaintiff filed an arbitration demand for alleged incorrectly paid claims.	Case settled pursuant to a confidential settlement agreement.

Year Opened	Year Resolved	Parties Name	Court	Case No.	Subject Matter	Relief Sought	Final Disposition or Status
2008	2008	WellCare of Georgia, Inc. v. Georgia Department of Community Health	Superior Court Fulton County, Georgia	2008-CV-146561	Open Records Request	Temporary Restraining Order requested from Peachtree State and WellCare of Georgia to enjoin DCH from disclosing confidential, proprietary, trade secret and other information.	Case settled pursuant to a confidential settlement agreement.
2008	2009	First Acceptance Insurance Company of Georgia v. WellCare of Georgia, Inc., et al.	Superior Court Cobb County, Georgia	08 1.4278.99	Subrogation	Plaintiff filed suit listing WellCare as an interested party as to subrogation.	The Court dismissed WellCare from the matter Case closed.
<b>WellCare Health Plans of New Jersey, Inc.</b>							
2009	2009	Bennett v. WellCare Health Plans, Inc.*	Superior Court New Jersey Law Division - Essex Vicinage Special Civil Part	SC-3320-09-002	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Case settled pursuant to a confidential settlement agreement.
2009	2009	Bennett v. WellCare Health Plans, Inc.*	Superior Court New Jersey Law Division - Essex Vicinage Special Civil Part	SC-3703-09	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Case settled pursuant to a confidential settlement agreement.
*Cases naming other WellCare entities as defendants are cases where the improper party was named The proper party was later changed to the correct entity in the suit.							
<b>WellCare of New York, Inc.</b>							
2007	2007	Cedarhurst Medical Association v. WellCare of New York, Inc.	Civil Court City of New York Small Claims Part	SCQ 61320/06	Claims Dispute	Plaintiff filed suit alleging denial of claim payments.	Case settled pursuant to a confidential settlement agreement.
2007	2007	Vitale v. WellCare of New York, Inc.	Civil Court City of New York Small Claims Part	NSC 1752/07 6/18	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Plaintiff failed to appear at hearing Case dismissed.
2008	2009	Kahmi v. WellCare of New York, Inc.	Civil Court City of New York Small Claims Part County of Kings	6898 KCS 2008	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Case settled pursuant to a confidential settlement agreement.
2008	2008	Central Park Physician Medicine v. WellCare of New York, Inc.	Civil Court City of New York Small Claims Part	NSC 60838/2008-1 7/22	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Plaintiff failed to appear at hearing Case dismissed.

Year Opened	Year Resolved	Parties Name	Court	Case No.	Subject Matter	Relief Sought	Final Disposition or Status
2008	2009	John Mather Hospital v. WellCare of New York, Inc.	Civil Court City of New York County of New York	63581	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Case settled pursuant to a confidential settlement agreement.
2009	2009	Singal Medical v. WellCare of New York, Inc.	Civil Court City of New York County of Queens	012360/2009	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Case settled pursuant to a confidential settlement agreement.
2009	2009	Fromson, et al. v. WellCare of New York, Inc.	State of New York County of Orange Small Claims	SC-2009-1252	Enrollment	Plaintiff filed suit alleging fraudulent enrollment.	Case settled pursuant to a confidential settlement agreement.
2009	2010	Malhotra v. WellCare of New York, Inc.	Civil Court City of New York County of Kings	036816/09	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Case settled pursuant to a confidential settlement agreement.
2009	2010	Asklipios Medical Group, LLP v. WellCare Health Plans, Inc.	Supreme Court State of New York County of Queens	10485/09	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Case settled pursuant to a confidential settlement agreement.
2009	Open	New York City Health and Hospitals Corporation v. WellCare of New York, Inc.	United States District Court Southern District of New York	10-cv-6748 (SAS)	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Motion practice ongoing.
2009	2009	Perry and Perry v. WellCare of New York, Inc.	Supreme Court of New York County of Ulster	350879	Claims Dispute	Plaintiff filed suit alleging denial of claim payments.	Case settled pursuant to a confidential settlement agreement.
2010	2010	People of New York v. WellCare of New York, Inc.	Village Court Village of Hempstead Nassau County, New York	FA 136-10 - FA 146-10	Miscellaneous	Village of Hempstead filed suit against WellCare of New York, Inc. for multiple police responses to alarm being triggered by associates.	Case settled pursuant to a confidential settlement agreement.
2009	2010	The Commissioner of the Department of Social Services of the City of New York v. Arcabascio v. WellCare of New York, Inc.	Civil Court City of New York County of New York	CV-036392-09	Benefits	Plaintiff filed suit seeking recovery of benefits paid to a Medicaid member who was not eligible for Medicaid benefits.	Case dismissed.
2010	2010	Guarnaccia v. Victoriano v. WellCare of New York, Inc.	Civil Court City of New York County of New York	CV-013812-09/NY	Claims Dispute	Plaintiff filed suit alleging denial of claims payment.	Case settled pursuant to a confidential settlement agreement.
2010	Open	American Home Respiratory v. WellCare of New York, Inc.	Supreme Court State of New York County of Monroe	09-18185	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Discovery ongoing.

Year Opened	Year Resolved	Parties Name	Court	Case No.	Subject Matter	Relief Sought	Final Disposition or Status
2010	Open	Howard v. WellCare of New York, Inc., et al.	Supreme Court State of New York County of Westchester	2958/09	Medical Malpractice	Malpractice action against treating physicians, hospitals and WellCare of New York, Inc.	Discovery ongoing.
2010	Open	Cedarhurst Medical Association v. WellCare of New York, Inc.	Civil Court City of New York County of New York	22009	Claims Dispute	Plaintiff filed suit alleging denial of claim payments.	Discovery ongoing.
<b>WellCare of Ohio, Inc.</b>							
2009	2010	Founders Insurance Company v WellCare of Ohio, Inc., et al.	Court of Common Pleas Cuyahoga County, Ohio	CV 09 706777	Subrogation	Plaintiff filed suit listing WellCare as an interested party as to subrogation.	State of Ohio is the only party allowed to pursue subrogation State of Ohio is pursuing their right to subrogation and handling the matter.
<b>WellCare of Texas, Inc.</b>							
2009	2009	Bethel Home Care v. WellCare of Texas, Inc.	Small Claims Court Dallas County Mesquite, Texas	900289	Claims Dispute	Plaintiff filed suit alleging incorrectly paid claims.	Case settled pursuant to a confidential settlement agreement.
2010	2010	Tenet Healthsystem Desert, Inc. v. WellCare Health Plans, Inc.*	Superior Court State of California County of Riverside	INC 10 002826	Claims Dispute	Plaintiff filed suit alleging denial of claims payment.	Case settled pursuant to a confidential settlement agreement.
*Cases naming other WellCare entities as defendants are cases where the improper party was named The proper party was later changed to the correct entity in the suit.							
<b>WellCare Prescription Insurance, Inc.</b>							
2007	2007	Van Saanen v. WellCare Specialty Pharmacy, Inc.	Superior Court of California East County Division San Diego County, California	37-2007-00005987-SC-SC-EC	Disenrollment	Pro se small claims suit alleging emotional damages for failure to disenroll member.	Trial court ruled in WellCare's favor Case closed.
2008	2008	Ketterman v. WellCare Prescription Insurance	Justice Court Bullhead City Precinct County of Mohave, State of Arizona	CV-2008-0229	Disenrollment	Plaintiff sought emotional distress damages for Company's alleged improper disenrollment.	Case dismissed in favor of the Company.

Year Opened	Year Resolved	Parties Name	Court	Case No.	Subject Matter	Relief Sought	Final Disposition or Status
2008	2008	Bumps v. WellCare Prescription Advantage	Trial Court of Massachusetts Small Claims Session	0726 SC 1379	Disenrollment	Member's son filed small claims action for alleged deceptive business practices for failing to disenroll his parents.	Members submitted proper DE forms Disenrollment processed Case closed.
2008	2008	Underhill v. WCH Health Management	Circuit Court Volusia County, Florida	2008 11722 CODL	Disenrollment	Plaintiff filed suit regarding disenrollment	Case settled pursuant to a confidential settlement agreement.
2009	2010	Place v. WellCare Prescription Insurance, Inc.	United States District Court Southern District of Mississippi Southern District	1:09-cv-422 LG-RHW	Premiums	Plaintiff filed suit alleging incorrectly applied premiums.	Plaintiff voluntarily dismissed the matter No monies were exchanged Case closed.
2010	2010	Jacko v. WellCare Prescription Insurance, Inc.	County Court Monroe County, Florida	10-SC-000013-K	Claims Dispute	Plaintiff filed suit alleging incorrectly applied pharmacy claims.	Case settled pursuant to a confidential settlement agreement.
<b>WellCare Private Fee for Service</b>							
2009	2010	Simmons v. WellCare PFFS, et al.	Court of Common Pleas Butler County, Ohio	CV 2009 08 3793	Subrogation	Plaintiff filed suit listing WellCare as an interested party as to subrogation.	Case settled pursuant to a confidential settlement agreement.
2009	2009	Cress, et al. v. Niece, et al.	Court of Common Pleas Butler County, Ohio	CV 2009 03 1045	Subrogation	Plaintiff filed suit listing WellCare as an interested party as to subrogation.	Case settled pursuant to a confidential settlement agreement.

**B.5**

***Provide a statement of whether, in the last ten years, you or a predecessor company has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors. If so, provide an explanation providing relevant details including the date in which the Proposer emerged from bankruptcy or expects to emerge. If still in bankruptcy, provide a summary of the court-approved reorganization plan. Include your organization's parent organization, affiliates, and subsidiaries.***

Neither WellCare LA nor WellCare (or any of their predecessor companies) has, in the last ten years, filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors (any such action described in this sentence being a "**Bankruptcy Event**"). To the Company's knowledge, no member of the WellCare group of companies experienced a Bankruptcy Event prior to becoming a subsidiary of WellCare.

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**B.6**

***If your organization is a publicly-traded (stock-exchange-listed) corporation, submit the most recent United States Securities and Exchange Commission (SEC) Form 10K Annual Report, and the most-recent 10-Q Quarterly report.***

***Provide a statement whether there have been any Securities Exchange Commission (SEC) investigations, civil or criminal, involving your organization in the last ten (10) years. If there have been any such investigations, provide an explanation with relevant details and outcome. If the outcome is against the Proposer, provide the corrective action plan implemented to prevent such future offenses. Also provide a statement of whether there are any current or pending Securities Exchange Commission investigations, civil or criminal, involving the Proposer, and, if such investigations are pending or in progress, provide an explanation providing relevant details and provide an opinion of counsel as to whether the pending investigation(s) will impair the Proposer's performance in a contract/Agreement under this RFP. Include your organization's parent organization, affiliates, and subsidiaries.***

The Company has attached its most recent Form 10-K and Form 10-Q filings with the SEC (see Attachments B.6.a and B.6.b). As of the date of this submission, the Company is unaware of any current or pending SEC investigation involving the Proposer, its parent or any subsidiary.

In the past three years, there has been one SEC investigation of the Company. Following the public notice in 2007 of the government's investigation of the Company (see response to Section B.26), the SEC notified the Company that it was investigating the Company. The investigation centered on questions surrounding the accuracy of the Company's public financial filings in light of the conduct that gave rise to the government's investigation. In May 2009, the Company resolved this SEC investigation. Under the terms of a Consent and Final Judgment, without admitting or denying the allegations in the complaint filed by the SEC, the Company consented to the entry of a permanent injunction against any future violations of certain specified provisions of the federal securities law. The Consent and Final Judgment has been posted at the Company's website, [www.wellcare.com](http://www.wellcare.com). Additionally, the Company has remediated its internal financial structure and reporting requirements so as to ensure full compliance with all regulatory reporting requirements.

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**B.7**

***If another corporation or entity either substantially or wholly owns your organization, submit the most recent detailed financial reports for the parent organization. If there are one (1) or more intermediate owners between your organization and the ultimate owner, this additional requirement is applicable only to the ultimate owner.***

***Include a statement signed by the authorized representative of the parent organization that the parent organization will unconditionally guarantee performance by the proposing organization of each and every obligation, warranty, covenant, term and condition of the Contract.***

The financial reports for WellCare, the ultimate parent of WellCare LA, can be found in Attachments B.31.b and B.31.d.

Below is a signed statement that WellCare will unconditionally guarantee performance by WellCare LA.

**PARENTAL GUARANTEE**

This Guaranty is made on the 8<sup>th</sup> day of June 2011, by WellCare Health Plans, Inc. (“Guarantor”), a corporation formed under the laws of the State of Delaware.

**Whereas**, Guarantor is the ultimate parent of WellCare of Louisiana, Inc. (“WCLA”); and

**Whereas**, WCLA is submitting a response to the State of Louisiana RFP #305PUR-DHHRFP-CCN-P-MVA for Medicaid Prepaid Coordinated Care Networks (the “RFP”) in order to participate as a managed care organization in the Prepaid Coordinated Care Network Medicaid managed care program; and

**Whereas**, the RFP requires WCLA to include a signed statement from its parent organization which unconditionally guarantees performance by WCLA of each and every obligation, warranty, covenant, term and condition of any contract WCLA may be awarded pursuant to the RFP; and

**Whereas**, Guarantor desires to provide a guarantee required by the RFP;

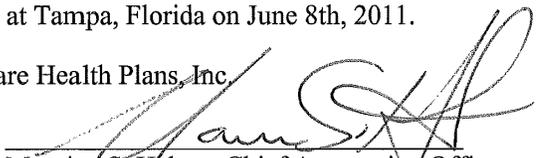
**Now, therefore**, Guarantor unconditionally guarantees:

1. The performance by WCLA of each and every obligation, warranty, covenant, term and condition of any contract WCLA may be awarded pursuant to the RFP.
2. That Guarantor warrants that it has the capacity and is authorized to make this Guarantee.

Signed at Tampa, Florida on June 8th, 2011.

WellCare Health Plans, Inc.

By:

  
Maurice S. Hebert, Chief Accounting Officer

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**B.8**

**Describe your organization's number of employees, client base, and location of offices. Submit an organizational chart (marked as Chart A of your response) showing the structure and lines of responsibility and authority in your company. Include your organization's parent organization, affiliates, and subsidiaries.**

**WellCare Workforce**

WellCare traces its roots to the founding of its primary Florida company in 1985. WellCare provides managed care services exclusively to government-sponsored health care programs, primarily to Medicaid and Medicare beneficiaries. Our corporate mission is to:

- Enhance our members' health and quality of life;
- Partner with providers and governments to provide quality, cost-effective health care solutions; and
- Create a rewarding and enriching environment for our associates.

Our current workforce of more than 3,000 associates nationwide contribute to performance of our organizational mission. Twenty of our employees are located in the State of Louisiana.

**Client Base**

WellCare has Medicaid health plans in seven states: Florida, Georgia, Hawai'i, Illinois, Missouri, New York, and Ohio. In three of these states (Florida, Hawai'i, and New York), we provide physical health, behavioral health and/or long-term care services to a combination of TANF and ABD/SSI enrollees (TANF not currently covered by WellCare in Hawai'i), including dual eligibles. WellCare also operates Medicare Advantage coordinated care plans in twelve states and a stand-alone Medicare prescription drug plan in forty-nine states, including Louisiana. The WellCare group of companies operates plans under the WellCare, Staywell, HealthEase, Harmony and 'Ohana brand names. We currently serve approximately 2.3 million Medicaid, Children's Health Insurance Program ("**CHIP**") and Medicare beneficiaries throughout the United States.

**Office Locations**

WellCare's corporate headquarters is located in Tampa, Florida. As illustrated in Exhibit B.8.a. In addition to this location, we maintain offices/workforces in the following locations:

**Exhibit B.8.a – Office Locations**

Market Main Office Location	Market Satellite Office(s)	Products Served	# of Employees
WellCare Health Plans, Inc. 8735 Henderson Road Tampa, Florida (Corporate Office)			2147

Market Main Office Location	Market Satellite Office(s)	Products Served	# of Employees
WellCare of Florida Tampa, Florida	Miami Lakes, Hialeah, West Palm Beach, Maitland, Kissimmee, Jacksonville, Springhill, Largo, Pinellas Park, Pensacola, Lakeland, Winter Haven, Melbourne, Tallahassee and Ocala.	Medicaid MA-Advantage D-SNP PDP	188
WellCare of Connecticut 127 Washington Ave 4 <sup>th</sup> Floor, East Building North Haven, CT 06473	New Haven, Southport	Medicare PDP	21
WellCare of Georgia 211 Perimeter Circle Atlanta, Georgia	Columbus, Macon, Gainesville, Albany, Savannah and Augusta	Medicaid MA-Advantage D-SNP PDP	188
WellCare of Hawai'i 94-450 Macula St Ste 106 Waipahu HI 96797	Hilo, Maui	Medicaid MA-Advantage D-SNP PDP	141
WellCare of Illinois 200 W Adams Ste 800 Chicago IL 60606	Hyde Park, Swansea	Medicaid MA-Advantage PDP	217
WellCare of Louisiana 11603 Southfork Drive Baton Rouge, LA	Metairie, Lafayette	MA-Advantage D-SNP PDP	20
WellCare of Missouri 133 S 11 <sup>th</sup> Street Ste 200 St. Louis MO 63102	Jefferson City	Medicaid MA-Advantage D-SNP PDP	19
WellCare of New Jersey 33 Washington St 1 <sup>st</sup> Floor Newark, NJ 07102		MA-Advantage PDP	14
WellCare of New York 110 5th Ave Floor 3 New York NY 10011	Brooklyn, Washington Heights, Chinatown, Flushing, Hempstead, Bronx, Poughkeepsie, Albany, Rochester, Buffalo, Newburgh and Syracuse	Medicaid MA-Advantage D-SNP PDP	386
WellCare of Texas 2211 Norfolk Street Ste 300 Houston TX 77098 as	Dallas, San Antonio	MA-Advantage D-SNP PDP	70

<b>Market Main Office Location</b>	<b>Market Satellite Office(s)</b>	<b>Products Served</b>	<b># of Employees</b>
WellCare of Ohio 6060 Rockside Woods Blvd. N. Suite 300 Independence, OH 44131	Cincinnati	Medicaid MA-Advantage D-SNP PDP	49

Attachment B.8.a – Chart A – WellCare Organizational Chart shows the structure and lines of responsibility and authority in the WellCare group of companies.

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## **B.9**

***Provide a narrative description of your proposed Louisiana Medicaid Coordinated Care Network project team, its members, and organizational structure including an organizational chart showing the Louisiana organizational structure, including staffing and functions performed at the local level. If proposing for more than one (1) GSA, include in your description and organizational chart if: 1) the team will be responsible for all GSAs or 2) if each GSA will differ provide details outlining the differences and how it will differ.***

WellCare has a proven approach for the effective implementation of government contracts, which includes local market business rule and compliance plan overall development, supported by centralized solutions and project management resources. We have implemented Medicaid contracts as well as Medicare Advantage, Special Needs Plans (SNPs) for dual eligibles, and Prescription Drug Plan (PDP) agreements over the past 17 years, with full consideration of the various complexities and product nuances unique to each.

We have done this successfully with a basic model that includes: Opportunity framing and market development by a single project executive, post-award project management and implementation activities led by the WellCare Solutions team, and development of a cross-functional steering committee with representation from business units involved in the implementation of the contract.

The WellCare Solutions team is tasked with providing global project management and implementation planning for all new market entries and will do so for Louisiana. This team works with the local market WellCare management staff to fully understand the state specific Medicaid contract, customer expectations, testing requirements and, ultimately, go-live testing for all of system compliance.

Project implementation work plans are developed to address all contractual requirements in accordance with the Medicaid contract and other regulatory requirements. WellCare, in anticipation of implementation of the Louisiana CCN-P program, has reviewed all state agency procurement documents, state Medicaid plan documents, and other program policy information to continue the implementation planning process we began for this market in August 2010.

### **Project Team**

#### Executive Steering Committee

An executive steering committee (ESC) is established for a new market representing all business units of WellCare involved in the implementation process to ensure that the project is a priority throughout the organization and is well-executed. Members of the ESC include a Division President, Market President, Project Executive (Vice President Business Development), Chief Information Officer, Senior Vice President of Health Care Delivery, Vice President Quality, Vice President Utilization Management, Vice President Actuarial Services, Vice President Contract Operations, Vice President Operations, Vice President Solutions, Vice President Field Human Resources, Associate General Counsel and the Senior Director Finance. This committee is tasked with reviewing the opportunity to consider how it fits into WellCare's overall product portfolio and the strategic approach required for market entry and implementation.

The ESC works to ensure the following is completed: appropriate regulatory agency contact; a complete assessment of the Medicaid environment including review of existing state Medicaid plan, amendments, waivers, health outcomes/improvement opportunities, and existing Medicaid program structure; review of provider network requirements/availability in state; assessment of service/network access gaps; identification of key stakeholders vital to the success of a newly introduced managed care approach; and internal opportunity review sessions and business assessments to ascertain WellCare's preparation requirements to support the proposed product. In addition, the ESC confirms all department of insurance requirements are met and initiates high-level planning with regard to pre-implementation considerations, potential resource requirements and funding, and assignment of departmental project implementation work plans and leaders for each WellCare functional area.

The ESC meets at least weekly and will do so more frequently as the project requires.

#### Project Executive (PE)

Our market operations planning activities for Louisiana CCN have been led by a project executive (PE), who functions as a chief administrator/plan leader and is tasked with market entry planning including all facets of operations development. The PE role can either be occupied by the permanent Market President or other identified executive within the organization best suited to develop the opportunity. In this instance, the PE develops the market and assumes chief administrator duties for a period of time, until a permanent Market President is identified. Lyle Luman has accepted WellCare's offer to be the Market President in Louisiana and will be starting on July 18. In the meantime, Teresa Smith, Vice President – Business Development, continues to serve as the PE for the Louisiana CCN-P opportunity, a role she has occupied over the past year. In this capacity she has actively worked on issues related to Medicaid managed care in Louisiana, including understanding the dynamics of the regulatory requirements, market (beneficiary) needs, provider landscape and operational planning for CCN-P implementation.

Ms. Smith has significant experience in the planning for new health plan start-ups, including work related to strategic planning, administration/operations design, regulatory and governmental affairs, and product compliance /brand management in the Medicaid managed care space. She will remain involved in the project throughout the implementation process, readiness review and go-live to ensure all client expectations are clearly addressed.

#### Implementation Project Manager (IPM)

A project implementation work plan is developed utilizing Microsoft Project software for each prospective new market or line of business WellCare enters, which is administered by our Solutions team based in Tampa, Florida. This function is led by an implementation project manager (IPM), who will be tasked with providing project management oversight from RFP submission to post go-live for up to ninety days. While the project implementation work plan is administered by the IPM, its development includes the input of all key organizational stakeholders to map the best approach for developing business protocols for the market. Cathy Powell-Voigt, Vice President Solutions, will serve as IPM for the Louisiana CCN implementation. Ms. Powell-Voigt has successfully led various implementation projects for WellCare including our Hawai'i Medicaid ABD contract implementation in 2008. She has extensive Medicaid

product knowledge and a keen awareness of process interdependencies that impact the success of a go-live.

### Provider Network Development Team Lead

A provider network development team lead is established for every new WellCare market entry. The provider network development team lead is tasked with building out the local WellCare provider panel in compliance with all Medicaid contract requirements for access, composition, and credentialing standards. John Crowley, Vice President Corporate Network Contracting, will serve as the provider network development team lead for Louisiana, a role he has filled since October 2010. He will lead the preliminary build efforts for Louisiana Medicaid and transition ongoing network develop activities to the local market for this product post implementation. Mr. Crowley will work with the existing WellCare of Louisiana contracting staff to further build upon our existing Medicare network currently in the market.

### Cross-Functional Project Steering Committee

WellCare has a team of professionals who are experienced in implementing Medicaid programs from contract award through implementation and onto go-live, representing all functional areas of the organization. The knowledge and expertise of this team has enabled us to develop “*WellCare’s Expansion Playbook Body of Knowledge*”. This book provides details on how to successfully implement a Medicaid program at WellCare. It provides the details and tasks on what must be completed as well as length of time to achieve certain milestones (e.g., configuration, testing, etc.). It provides the overall framework of project management, such as project implementation work plan templates, organization structure, communications plan, testing plan, go-live, and ongoing post go-live support. This model will be utilized in the cross-functional project meetings and tracking implementation progress.

The cross-functional project steering committee meets at least weekly, and sub-committees of this larger group meet on a regular basis to discuss implementation “departmental” issues (e.g., enrollment file exchanges comprised of IS, Enrollment, Solutions, Compliance, and Member Communications staff). Also, as the implementation progresses, the cross-functional project steering committee meets daily to review “flash reporting” of milestone progress, barriers, or immediate interventions required.

## **Project Team Member Composition**

### Implementation Team Members

WellCare’s cross-functional steering committee members represent the implementation team who will be responsible for bringing up all facets of our operations related to the CCN-P contract. Staff is expected to fully participate in implementation planning and execution to ensure a successful launch and that operations are structured in consideration of the best methods/approaches to meet program goals. The implementation project manager (IPM) chairs the cross-functional implementation committee which includes representatives from the following areas, in developing business protocols, testing schedules, and ultimately ensuring go-live functions are progressing as scheduled:

- Business Development
- Operations
- Solutions
- Information Services
- Legal
- Human Resources
- Care Management (Quality Improvement)
- Utilization Management
- Contract Operations (Claims)
- Case/Disease Management
- Grievance and Appeals
- Provider Relations
- Credentialing
- Claims Configuration
- Provider Resolution
- Actuary
- Medical Economics
- Claims
- Customer Service
- Enrollment
- Facilities
- Compliance
- Marketing
- Product (Benefits)
- Network Contracting
- Finance
- Provider Communications
- Public Relations/Community Outreach

#### Implementation Team Organizational Chart

Included in response to Section C.5 is the listing of staff identified as key members of the cross-functional steering committee tasked with implementation planning. Exhibit B.9.a is the Louisiana Medicaid Implementation Team Organizational Chart, which highlights the functional area leads for the project. Members on this chart represent every function across the WellCare enterprise critical to the implementation of a new state Medicaid contract. Some staff represented on the chart will also be permanent resources tied to the Louisiana Medicaid product, post go-live and are reflected appropriately as such on the Louisiana Market Organizational Chart (Exhibit B.9.b). As the project progresses, identification of any implementation barriers, gaps or other issues will result in the immediate deployment of additional corporate and market based staff resources or consultants for specific planning activities to ensure a timely go-live.

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## Market Organizational Structure

WellCare will utilize a single project team to implement all provisions of the CCN-P statewide. For certain functions that will benefit a specific GSA, such as provider relations and community outreach, these GSA specific planning resources are highlighted within the organizational chart in Exhibit B.9.b.

### **Local Organizational Structure Governing Project**

WellCare approaches each new market where it does business by placing staffing resources first and foremost in the local market, and then leveraging centralized transactional services to achieve cost efficient improvement outcomes. We intend to replicate this approach in Louisiana by placing key staff resources within our main Baton Rouge and State satellite offices for defined functions.

A Market President, who will be physically located in our main office in Baton Rouge, will be responsible for the overall operations in Louisiana, including strategic direction, administration of all existing programs and development of new programs. As previously stated, Lyle Luman has accepted our offer to be the Market President in Louisiana and will start on July 18. Teresa Smith will continue her role as Project Executive for the Louisiana market and will remain tied to the implementation of the CCN-P program for whatever period of time is necessary to ensure seamless transition and implementation continuity.

Other key functions that will be located within our Baton Rouge main office and satellite offices within the state include at this time:

- Administrative Oversight (Market President);
- Government/Regulatory Affairs;
- Contract Compliance;
- Provider Relations Team, in-house Provider Services staff;
- Community Relations staff;
- Network Development staff; and
- Regional Care Teams.

We have already made a number of staff appointments for Louisiana in relation to required positions in the RFP. These positions are denoted in the accompanying organizational chart. Current members of WellCare's leadership team assigned to Louisiana which include:

- Lyle Luman (President, Louisiana);
- Kyle Godfrey (Director of Regulatory Affairs and Contract Compliance Officer);
- Dr. Bernie Cohen (Vice President of Quality and Interim Quality Director);
- JoJo Young (Senior Director of Finance and Interim Finance Director-Louisiana);
- Jason Bollent (Director of Customer Service and Member Services Manager);
- Chuck Beeman (Senior Director of Encounters and IT and Information Management and Systems Director); and
- LaSheka Robinson (Claims Manager and Claims Administrator).

These staff members are reflected on the market organizational chart under the permanent role they will serve relative to administration of CCN-P requirements. We will update this grid to reflect additional hires made during the implementation process.

Our philosophy of member-centered care will be demonstrated through our organizational structure, which is locally-based and will be staffed with experienced and highly trained associates. As such, each GSA will have a case management team that will be managed by a case management manager who will oversee the day-to-day activities of our case managers. Under the supervision of a clinician, our case managers will assist in the clinical and socio-economic coordination and implementation of members' care to ensure that appropriate and timely primary, acute and long-term care services are provided, assist the interdisciplinary regional care team by monitoring care plans and provide assistance to members to promote self management of health care.

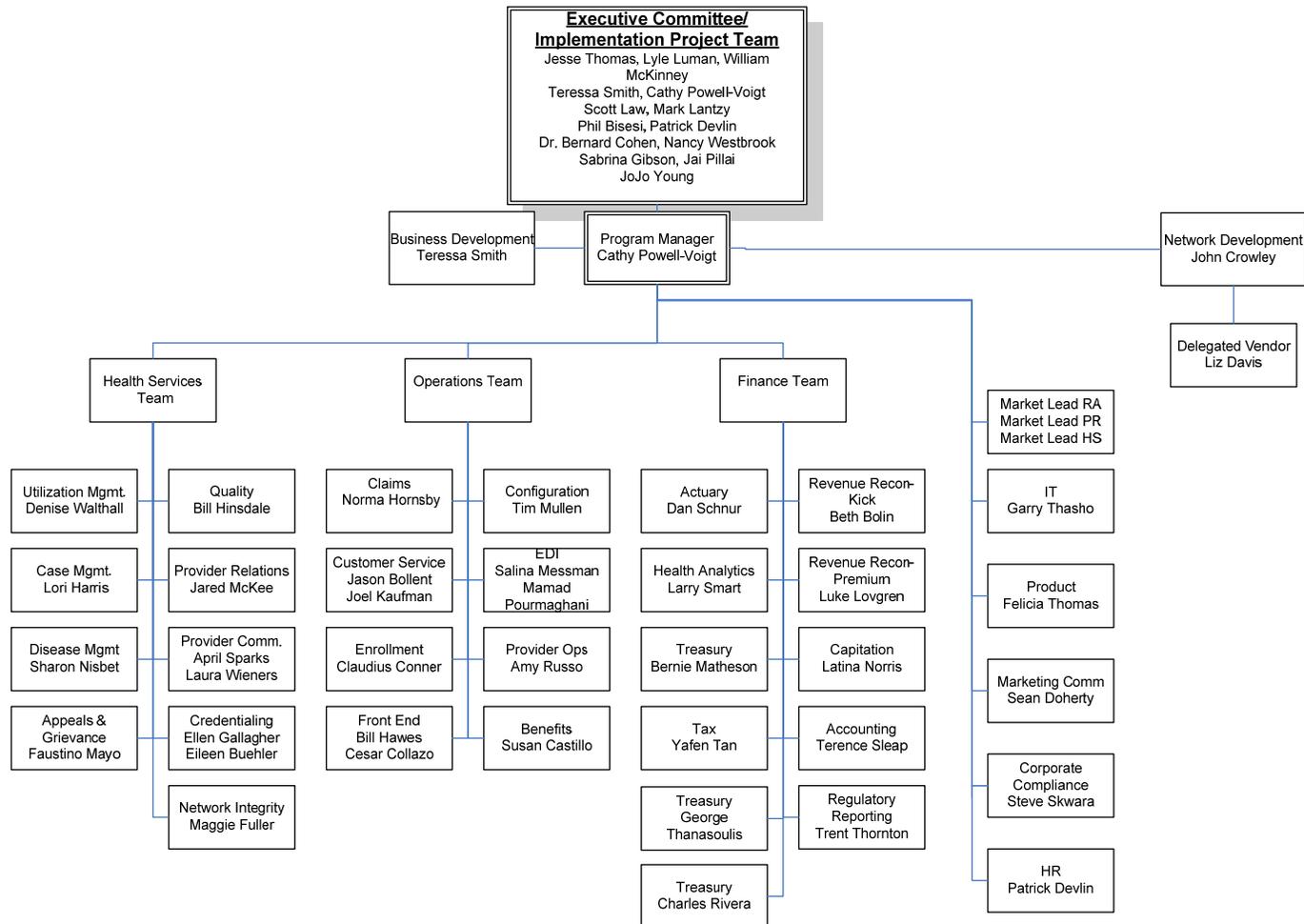
Exhibit B.9.b provided on the following page shows our organizational structure in Louisiana, including staffing and functions performed at the local level. Key personnel are shaded with their current WellCare titles.

#### Customer Interface During Implementation Process

Immediately upon contract award, WellCare will meet with DHH and other necessary contractors to define the required project management and reporting standards, affirm key activities/milestones, and obtain clarifications on expectations for content and format of all contract deliverables. WellCare will work with DHH to review, develop and finalize data transmission protocols and schedules for data files relating to membership information, provider listings, claims/encounter information, etc. WellCare will begin the provider credentialing and contracting process, load contracted providers into our core processing system, and conduct system testing. WellCare understands the overall responsibility of meeting the milestones, expectations, and achieving a successful implementation falls upon us.

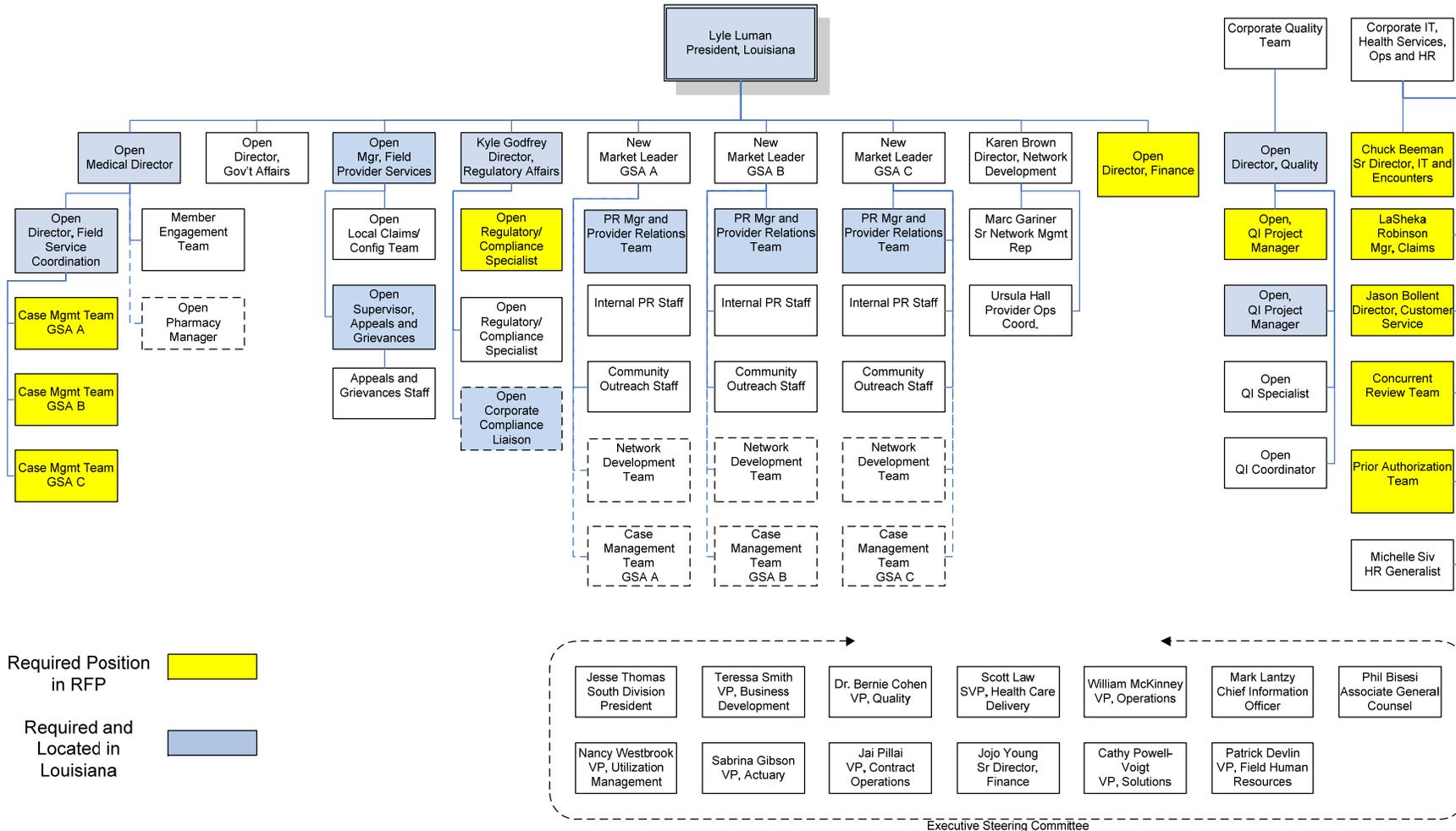
Exhibit B.9.a – Louisiana Medicaid Implementation Team Organizational Chart

Louisiana Medicaid Expansion Implementation Team



**NOTE:** The project team listed in this organizational chart will be responsible for the development of all operational protocols, functions and final implementation of related processes for all three GSAs for which WellCare of Louisiana is proposing.

### Exhibit B.9.b – Louisiana Organizational Chart



**NOTE:** The staff listed on this organizational chart will be responsible for the day to day operations and administration for all three GSAs; under the terms of a CCN-P contract awarded to WellCare by DHH. The Executive Implementation Project Team will serve as executive transition leaders to work with market staff to ensure successful pre launch planning and go-live implementation.

## **B.10**

***Attach a personnel roster and resumes of key people who shall be assigned to perform duties or services under the Contract, highlighting the key people who shall be assigned to accomplish the work required by this RFP and illustrate the lines of authority. Submit current resumes of key personnel documenting their educational and career history up to the current time. Include information on how long the personnel have been in these positions and whether the position included Medicaid managed care experience.***

***If any of your personnel named is a current or former Louisiana state employee, indicate the Agency where employed, position, title, termination date, and last four digits of the Social Security Number.***

***For key positions/employees which are not full time provide justification as to why the position is not full time. Include a description of their other duties and the amount of time allocated to each.***

### **Personnel Roster**

Attachment B.10.a is a personnel roster of key staff for the Contract. This roster includes a cross-walk of the position name as referenced in Section 4.1 of the RFP, the WellCare title, the position's reporting structure, and whether the position is full time for Louisiana.

### **Resumes and Job Descriptions**

Attachment B.10.b contains resumes of key personnel for positions that are currently filled. In consideration of DHH's preference (as expressed in response to an RFP question) "to see all open positions that would be recruited rather than interim employees who will not be actually be assigned to the Louisiana account," we have not included resumes for interim employees. However, we have included resumes for members of the executive steering committee. This team will be responsible for ensuring the successful implementation of this Contract.

Attachment B.10.b includes the following resumes for the executive steering committee:

- Jesse Thomas, President, South Division
- Lyle Luman, President, Louisiana (resume included with key personnel who will be assigned to perform duties under the Contract – see below)
- Teressa Smith, VP, Business Development
- Bernard ("Bernie") Cohen, M.D., VP, Quality
- Scott Law, SVP, Health Care Delivery
- William McKinney, VP, Operations
- Mark Lantzy, Chief Information Officer
- Phil Bisesi, Associate General Counsel
- Nancy Westbrook, VP, Utilization Management
- Sabrina Gibson, VP, Actuary
- Jai Pillai, VP, Contract Operations
- Jojo Young, Senior Director, Finance

- Cathy Powell-Voigt, VP, Solutions
- Patrick Devlin, VP, Field Human Resources

Following the resumes of the executive steering committee please find the resumes for the following key personnel who will be assigned to perform duties under the Contract:

- Lyle Luman, President, Louisiana
- Kyle Godfrey, Director, State Regulatory Affairs (corresponds to RFP position “Contract Compliance Officer”)
- Jason Bollent, Director, Customer Services (corresponds to RFP position “Member Services Manager”)
- LaSheka Robinson, Manager, Claims (corresponds to RFP position “Claims Administrator”)
- Chuck Beeman, Senior Director, IT (corresponds to RFP position “Information Management and Systems Director”)

In lieu of providing resumes for interim employees, Attachment B.10.c provides job descriptions for the key positions that are not currently filled.

#### **Former Louisiana State Employee**

Thomas Kyle Godfrey is a former Louisiana state employee. He was an attorney with the Department of Insurance (DOI). He left the State’s employ on May 20, 2011. The last 4 digits of his social security number are 9795.

#### **Positions that are Not Full Time**

All positions are full time, but not all positions are dedicated to Louisiana. The personnel roster in Attachment B.10.a identifies key positions/employees who are not full time to our Louisiana operations and provides a description of their other duties.

**B.11**

**Provide a statement of whether you intend to use major subcontractors (as defined in the RFP Glossary), and if so, the names and mailing addresses of the subcontractors and a description of the scope and portions of the work for each subcontractor with more than \$100,000 annually. Describe how you intend to monitor and evaluate subcontractor performance. Also specify whether the subcontractor is currently providing services for you in other states and where the subcontractor is located.**

**In addition, as part of the response to this item, for each major subcontractor that is not your organization’s parent organization, affiliate, or subsidiary, restate and respond to items B.1 through B.7, B.10 and, B.16 through B.27**

**If the major subcontractor is your organization’s parent organization, affiliate, or subsidiary, respond to items B.1, B.8 and B.9. You do not need to respond to the other items as part of the response to B11; note, however, responses to various other items in Section B must include information on your organization’s parent organization, affiliates, and subsidiaries, which would include any major subcontractors that are your organization’s parent organization, affiliate, or subsidiary.**

**Key Subcontractor Information**

WellCare LA intends to use several major subcontractors (as defined in the RFP Glossary) to implement the Louisiana CCN. The following table includes information about our major subcontractors that are not WellCare LA’s parent, affiliate, or subsidiary:

Subcontractor Name	Mailing Address	Scope of Work	Services Provided to WellCare in Other States
CareCentrix	323 Pitkin Street, 111 Founders Plaza East Hartford, CT 06108	Home Health, DME	FI, GA, OH, TX, HI
CareCore National, LLC	400 Buckwalter Place Blvd Bluffton, SC 29910	Utilization management for high dollar imaging services	NY, NJ, CT, FL, GA, TX, IL, IN, MO, OH.
Focus Health, Inc.	7301 Tamarind Circle Pinellas Park, FL 33782	Utilization and case management services for behavioral health	LA
Health Dialog Services Corporation	60 State Street, 11 <sup>th</sup> Floor Boston, MA 02109	Perform outbound calls to provide education and appointment setting on select HEDIS preventive care measures to address care gaps	FI, GA, HI, OH, TX NY, NJ, CT, LA, IL, MO, IN
IBM Daksh Business Process Services Pvt. Ltd.	Tech Park One, Tower A, Yerwada, Pune – INDIA	BPO services, manual claims processing	CT, OH, HI, GA, TX, IL, IN, MO, LA, FL, NY, NJ

Subcontractor Name	Mailing Address	Scope of Work	Services Provided to WellCare in Other States
Legacy Services, LLC	4965 Preston Park Blvd., Suite 600 Plano, TX 75093	Electronic Data Interchange (EDI) clearinghouse. Services for medical billing.	CT, OH, HI, GA, TX, IL, IN, MO, LA, FL, NY, NJ
LogistiCare Solutions, LLC	1275 Peachtree St NE, 6 <sup>th</sup> Floor Atlanta, GA 30309	Transportation services	CT, NY, NJ, FL
Outcomes Health Information Solutions, LLC	13010 Morris Road, Building Two Alpharetta, GA 30004	HEDIS reporting- Medical records extraction and review	FL, GA, HI, OH, TX NY, NJ, CT, LA, IL, MO, IN
Payformance Corporation	7751 Belfort Parkway, Suite 200 Jacksonville, FL 32256	They take our 835 payment file and facilitate the delivery of the payment and claims information to the vendors that are receiving payments	All states WellCare operates in
Ocular Benefits	111 Rockville Pike, Suite 735 Rockville, MD 20850	Hearing and vision services	FL
Relay Health, a Division of McKesson Technologies Inc.	1145 Sanctuary Parkway, Alpharetta, GA 30009	Electronic Data Interchange (EDI) clearinghouse services for medical billing	CT, OH, HI, GA, TX, IL, IN, MO, LA, FL, NY, NJ
The Results Companies, LLC	499 E. Sheridan Street, Suite 400 Dania, FL 33004	Provide customer service for inbound phone calls	FL, NY, MO, IL, CT, NJ, HI, LA, TX, GA, OH
The Myers Group (Patient Satisfaction Plus, LLC)	1965 Evergreen Blvd. Suite 100 Duluth, GA 30096	Customer service for outbound calls-welcome calls, member education, surveys	FL, NY, MO, GA
Verity HealthNet, LLC	PO Box 83578, Baton Rouge, LA 70884-3578	Provider Network-IPA	LA
Westport Insurance Companies	5200 Metcalf, P.O. Box 2991, Overland Park, KS 66201-1391	Reinsurance	FL, HI, NY, CT, IL, LA, GA, OH, TX, NJ, and AZ (Hawai'i Medicare only).

In addition WellCare uses two major subcontractors that are affiliates of WellCare LA:

Affiliate Subcontractor Name	Mailing Address	Scope of Work	Services Provided to WellCare in Other States
Comprehensive Health Management, Inc.	8735 Henderson Road Tampa, FL 33634	Management and administrative services	All states WellCare operates in
Comprehensive Reinsurance, Ltd.	PO Box 1051 Governors Square 23 Lime Bay Avenue KYI-1102 Grand Cayman Cayman Islands	Reinsurance	All states WellCare operates in

### Major Subcontractor Oversight Process

WellCare maintains a formal standardized vendor oversight process. We consistently monitor the administration of delegated functions to ensure vendors are performing in accordance with the terms of the delegated service agreement while maintaining compliance with federal, state, and contractual requirements.

- WellCare completes a comprehensive audit prior to formal delegation of any function to ensure each vendor has the ability to fulfill the delegated obligation;
- WellCare maintains ongoing annual audits to ensure compliance of all requirements of delegated functions;
- WellCare evaluates the vendor’s ability to fulfill delegation obligations through review of the vendor’s programs, policies, procedures and service delivery; and
- WellCare completes ongoing performance monitoring via review of submitted performance reports and ensures that corrective action is completed to address any identified opportunities for improvement.

Our vendor management process supports ongoing monitoring and holds vendors to high levels of accountability in order to improve overall member satisfaction and to ensure contractual, regulatory and accreditation standards are maintained. Each vendor requires a slightly different approach to monitoring based on the type of service that vendor provides.

#### Example 1 - IBM

As an illustrative example, WellCare routinely monitors IBM via the following processes:

##### *Daily Monitoring:*

- Claim inventory and age are monitored through WellCare reporting tools. The claims command center partners with regional claims managers to prioritize IBM’s work when appropriate.

- IBM sends a daily report to show targeted/actual production each day. Production counts are also logged on a WellCare Share point site for historical reporting.
- Conference calls with IBM/WellCare management are held daily to review inventory, aging and claims of concern (i.e., specific claims where additional guidance may be needed). Participants include the senior director of claims, manager of the claims command center, manager of claims quality and development and others as needed.
- Additional dialogue routinely occurs throughout the day via phone and email regarding any questions/concerns, system issues, etc.
- Any potential quality/training issues are discussed daily with the claims quality and development team.

#### *Weekly Monitoring:*

- IBM submits a weekly deck to summarize and trend concerns regarding production, inventory/aging and quality reviews for the previous week.
- Calls are held as needed to review quality concerns as a result of audit findings.

#### *Monthly Monitoring:*

- As part of the monthly user compliance and SOX compliance audits, the operational audit team reviews processed claims for payment, financial and procedural accuracy.
- Operational Audit will review and report the results of audits for 1,100 claims processed by IBM per month. Additionally, IBM quality is monitored through the SCA audits which are not focused specifically on IBM, but will bring to light any issues found with the 2,000 claims audited globally per month. The Claims Quality and Development team reviews all of these findings in detail with IBM and remediation plans are developed as needed.
- IBM WellCare Monthly Business Reviews are held by conference call each month. Participants include executive leadership and management from IBM.

#### Example 2 - RelayHealth

As an additional example, WellCare monitors RelayHealth on the basis of the following categories:

*Inbound Transaction Processing Speed (EDI)* – A daily report is monitored by the IT and the claims command center team to determine the length of time between the creation date and the process date. Most claims process within one day. Claims that are in process for more than one day immediately appear on this report. EDI claims received beyond one day generate an inquiry to the clearinghouse unless they notify us of an issue prior to sending the files.

*Inbound Transaction Processing Speed (Paper)* – A daily report is monitored by the IT and the claims command center team to determine the length of time between the scan date and the process date. Most claims process within three to four days. Claims that are in process for more than four days immediately appear on this report. Paper claims received beyond four days generate an inquiry to the clearinghouse unless they notify us of an issue prior to sending the files.

*Inbound Inventory Reconciliation* – File names and claims counts are logged by WellCare as the inventory passes through X-Engine (Edifecs Software). IT-ops and the claims command center monitor inbound and outbound counts to ensure inventory is not lost. They reconcile these values against reports generated by Relay Health and the X-engine output as well. The business rule vendor (Legacy Consulting) sends an hourly response file informing WellCare of the file names generated for WellCare to pick up/consume. Each file is reconciled on WellCare’s side of the FTP process to ensure it was received and loaded to the adjudication system appropriately. Daily and weekly reconciliation processes are in place to look for anomalies in claim volume or file receipts or file loads. Issues are reported via the claims command center reconciliation log and assigned to the appropriate person or department for resolution. Once remediation or reconciliation occurs, the resolution is recorded and the issue is closed.

*Outbound EDI transactions (997, 227U, etc.)* - WellCare will send response files to RelayHealth for each transaction received by WellCare. These transactions are passed to RelayHealth via FTP. We monitor the FTP logs to ensure the response files were sent to RelayHealth. The provider or clearing House with a reciprocal agreement with RelayHealth has a pre-determined set-up agreement with RelayHealth. They are responsible ensuring that our EDI response files are being filed appropriately with originator of the claim.

**Detailed Major Subcontractor Information (Response to Specified RFP Items)**

WellCare contacted each potential major subcontractor with a survey requesting the additional information requested as part of this response. Each subcontractor completed the survey providing information required by B.1 through B.7, B.10, and B.16 through B.26. These responses, including the completed survey, completed managed care contract chart (B.16) and performance guarantee commitment letter (if applicable per B.7) are included as Attachments B.11.a through B.11.o. (One attachment per subcontractor.) Please refer to the following chart to access the required information that was collected in the survey responses:

RFP Response Requirement	Survey Question	Notes
B.1	1-6	
B.2	7	
B.3	8	
B.4	9	
B.5	10	
B.6	11-12	As applicable, response may include 10-K and 10-Q separate from the completed survey
B.7	13	As applicable, response may include financial statements separate from the completed survey

RFP Response Requirement	Survey Question	Notes
		Parental guarantee submitted as separate letter (not part of completed survey)
B.10	14	Response may include resumes separate from the completed survey
B.16	15	Submitted as Excel spreadsheet
B.17	16	
B.18	16.a	
B.19	17	
B.20	18	
B.21	19	
B.22	20	
B.23	21	
B.24	22	
B.25	23	
B.26	24	

In addition reference letters for subcontractors, as required in B.27 will be submitted with this proposal (original version only).

WellCare's two affiliate major subcontractors Comprehensive Health Management, Inc. and Comprehensive Reinsurance, Ltd. submitted required information in items B.1, B.8 and B.9. This information is included as Attachments B.11.p and B.11.q.

## **B.12**

***Provide a description your Corporate Compliance Program including the Compliance Officer's levels of authority and reporting relationships. Include an organizational chart of staff (marked as Chart B in your response) involved in compliance along with staff levels of authority.***

### **Program Goals**

WellCare's Corporate Compliance Program, which applies to all of the Company's subsidiaries and affiliates, including WellCare LA, is intended to promote ethical conduct in all aspects of our operations and to ensure compliance with applicable federal and state laws and regulatory requirements by WellCare and its associates and business partners through:

- Written corporate policies and procedures, developed to provide guidance and internal controls on matters affecting legal and regulatory compliance issues;
- Compliance training programs, conducted to ensure that policies, procedures and related compliance concerns are clearly understood and followed by all WellCare associates;
- Open lines of communication for WellCare associates, members and others to easily and confidentially ask questions or report suspected violations of WellCare policies or of legal and regulatory requirements without fear of retaliation;
- Prompt investigation of reported concerns and the implementation of effective corrective action when required;
- Conducting periodic audits of business operations to measure and assess WellCare's compliance with its internal controls and with applicable federal and state laws, regulations and guidance; and
- Clear and specific disciplinary policies that address violations and promote accountability.

### **Code of Conduct and Business Ethics**

The Code of Conduct and Business Ethics (the "**Code**") is the foundation of the Compliance Program. It describes WellCare's commitment to operate in accordance with the laws and regulations governing our business and accepted standards of business integrity.

The Code must be adhered to throughout the organization and at all times. Associates are required to acknowledge that they have reviewed the Code and will carry out their responsibilities lawfully and according to WellCare policies.

Under the Code, WellCare associates have an obligation to report suspected compliance violations. Associates are required to play an active role in preventing and eliminating fraud, waste and abuse and other program violations, and must speak up when they become aware of a possible compliance violation. The Code contains a strong non-retaliation policy on behalf of associates to encourage them to come forward if they become aware of possible compliance violations.

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The Code of Conduct and Business Ethics is reviewed periodically and validated by senior management and WellCare's Board of Directors.

## **Policies and Procedures**

The Compliance Program is carried out through a comprehensive system of internal policies and procedures that address day-to-day legal risks and help reduce the prospect of fraudulent, wasteful and abusive activity by identifying and responding to specific risk areas. All departments are responsible for developing written policies and procedures that address areas of compliance risk in their business units.

## **Organization and Oversight**

### The Chief Compliance Officer

WellCare's Chief Compliance Officer (the "**CCO**") oversees and directs the Corporate Compliance Program throughout the organization and is responsible for ensuring that the Program's goals are achieved and maintained. The CCO also is responsible for the oversight and monitoring of compliance with Medicaid, Medicare Advantage and Medicare Part D program requirements, compliance training and education, privacy and data security compliance, and the detection and prevention of fraud, waste and abuse by members, providers and other business partners. The CCO reports to WellCare's Chief Executive Officer (CEO) and to the Regulatory Compliance Committee of WellCare's Board of Directors (the "**RCC**"). The CCO also serves as the point of contact for WellCare associates regarding compliance concerns or violations.

### The Corporate Compliance Committee

The Corporate Compliance Committee (the "**CCC**"), established by the RCC and chaired by the CCO, oversees the operations of WellCare's Compliance Program through an established charter and serves as a resource to the CCO. The CCC is comprised of senior executives throughout WellCare. The principal purpose of the CCC is to ensure the development and implementation of an effective corporate ethics and compliance program for all WellCare lines of business, including Medicaid, Medicare Advantage and Medicare Part D, and to oversee WellCare's Compliance Department.

### The Compliance Department

The Compliance Department has responsibility for the oversight of WellCare's regulatory compliance performance, including risk assessment, compliance policy development, education, investigations of alleged violations, and auditing. The department includes units concentrating on Special Investigations, Policy and Training, Compliance and Audit, and HIPAA Privacy and Security. See Exhibit B.12.a–Chart C on page 54 for a high-level organizational chart for the Compliance Department.

## The Board of Directors

The WellCare Board of Directors is responsible for the overall organization and performance of the Corporate Compliance Program through the RCC. The RCC is comprised of four Directors, three of which are independent, and generally meets on a quarterly basis. The RCC reviews and evaluates reports from the CCO and other sources and initiates actions as it deems necessary to promote the overall effectiveness of the Program.

## **Training and Education**

WellCare conducts mandatory compliance training on an annual basis for all associates. The program includes general compliance overview training, as well as mandatory courses on fraud, waste and abuse and on HIPAA privacy and security. WellCare's curriculum of general and specialized compliance training programs are reviewed and revised as needed to ensure continued compliance with federal and state laws, regulations and guidance.

## **Compliance Reporting and Investigations**

WellCare's compliance reporting and inquiry system strives to foster efficient communication between and among the Compliance Department, the CCO, associates, agents, members and other WellCare stakeholders.

The Compliance Hotline (866-364-1350) is a central component of WellCare's compliance reporting and inquiry system. By accessing the Compliance Hotline, associates and others can report compliance program violations any hour of the day or evening. Hotline calls are reviewed by Compliance Department staff and escalated with the assistance of other business managers as necessary (e.g., Legal, Human Resources, and Finance).

Associates are obligated to report actual or suspected violations of law, the Code of Conduct and Business Ethics, or other WellCare policies. Such violations may include matters affecting the accuracy of accounting practices and financial results.

The availability of the Hotline is publicized to the WellCare community through the Code, office posters and our intranet. Hotline activity is reviewed regularly by the CCC.

Callers who report violations may remain anonymous upon their request. In an effort to encourage appropriate reporting and use of the Compliance Hotline, WellCare policy strictly prohibits retaliation against anyone who reports a legal or compliance concern in good faith.

Associates also may raise compliance questions with or report a suspected violation to:

- Their immediate supervisors
- The Human Resources Department
- The Chief Compliance Officer
- The General Counsel
- The Chief Financial Officer

Matters reported through the Compliance Hotline or other communication sources that suggest violations of WellCare policies, federal or state program requirements or applicable laws are investigated promptly to determine their veracity and significance. Depending on the nature of the issue, an investigation may be conducted with the assistance of the Legal Department or outside counsel.

### **Monitoring and Auditing**

Compliance-related audits may be conducted as part of an investigation of a reported issue or as a proactive means of monitoring regulatory compliance in areas of actual or potential risk. WellCare has designated two independent audit teams: one to conduct audits of its Medicaid plans and the other to conduct audits of its Medicare plans. Both teams conduct a series of ongoing targeted and comprehensive audits through an annual work plan that is based on an assessment of compliance risk areas by the Compliance Department and the CCC. Areas subject to internal monitoring and audit include enrollment, disenrollment, marketing, provider relations, member claims, data collection, data submission, utilization of quality care, and anti-kickback law compliance.

The results of Medicaid compliance audits are shared with affected business units, leadership and the Corporate Compliance and Regulatory Compliance Committees. The timely remediation of gaps identified from the audits is managed via the corrective action plan (CAP) and internal action plan (IAP) processes detailed below.

### **Corrective Action**

If an investigation or audit confirms the existence of a compliance issue, the Compliance Department works closely with the affected department/area to promptly resolve the issue and take necessary corrective action, including timely and appropriate disciplinary action. Overpayments are returned to the appropriate federal or state programs, and significant issues are disclosed to the Centers for Medicare & Medicaid Services or other federal or state officials.

### **Corrective Actions Plans and Internal Action Plans**

Corrective action plans (“**CAPs**”) and internal action plans (“**IAPs**”) are designed to address underlying problems that result in deficiencies or compliance violations. They are also intended to prevent defects or misconduct from recurring in the future.

When an investigation or audit result indicates that a particular department is deficient or does not comply with Medicare or Medicaid program requirements, such department/area is directed to take all actions necessary to come into compliance with the applicable requirements. This directive generally is contained in a CAP. CAPs are remedial measures tailored to address the particular misconduct or deficiency that has been identified, with specific timeframes for resolution.

CAPs may be implemented either internally within WellCare or externally to delegated entities, such as providers, agents and contractors who are involved with delivering services to WellCare members. Persons or entities subject to CAPs are required to adhere to the remedial measures to ensure that the deficiencies that have been identified are eliminated. Periodic monitoring of

future performance measures seeks to ensure that remedial steps have been taken to correct deficiencies.

Corrective actions also may take the form of IAPs. IAPs are tools to monitor and measure identified deficiencies in services, work flows, policies, procedures or processes in an effort to improve performance and meet compliance standards. IAPs focus on identifying specific, measurable steps or actions to be taken by associates to conform to compliance requirements within a designated timeframe. IAPs play an integral role in correcting performance discrepancies.

## **Discipline**

WellCare has a zero-tolerance disciplinary policy that includes automatic suspension for any associate who violates compliance policies or laws. Individuals who have violated laws, regulations, CMS guidance, or WellCare policies are subject to further disciplinary action, up to and including termination of employment and, where appropriate, potential referral for criminal prosecution. Likewise, such violations by subcontractors may result in the termination of their contractual relationship with WellCare.

## **Screening for Excluded Parties**

WellCare screens current and new associates, contractors, and agents against the List of Excluded Individuals/Entities (LEIE) maintained by the Office of Inspector General of the Department of Health and Human Services and the Excluded Parties List System (EPLS). As required by DHH, we will also search the Health Care Integrity and Protection Data Bank (HIPDB). WellCare will not hire or retain an associate, contractor, or agent who has been excluded, debarred or suspended from participating in federal programs.

## **Detecting and Preventing Fraud, Waste and Abuse by Members, Providers and Business Partners**

WellCare has created and fully supports a Special Investigation Unit (the “**SIU**”), and has given this unit primary responsibility for the detection, prevention, investigation, reporting, correction and deterrence of fraud, waste and abuse by members or providers and for implementing WellCare’s Fraud, Waste and Abuse (“**FWA**”) Plan. Suspicions of fraud, waste or abuse can be reported to the SIU anonymously. See our response to Section O.1 for information about our FWA plan.

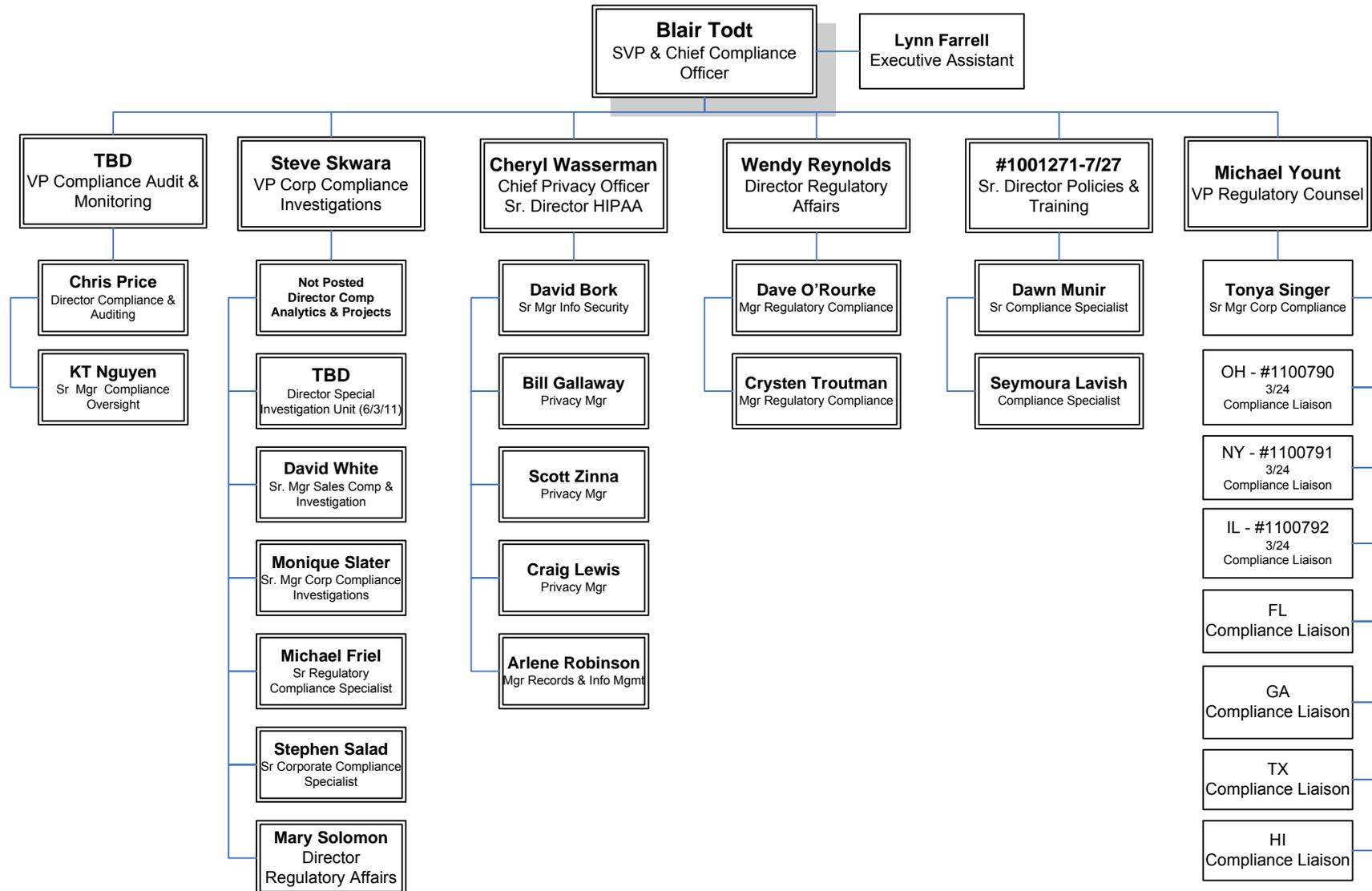
## **HIPAA Program Management Office**

The purpose of the WellCare HIPAA Program Management Office is to manage WellCare’s privacy and security compliance requirements in accordance with the federal standards established pursuant to the Health Insurance Portability and Accountability Act of 1996 and its associated regulations (collectively, “**HIPAA**”). This compliance effort covers all HIPAA compliance requirements, including privacy, security and WellCare’s business associates.

## Delegated Entities

WellCare's compliance responsibilities extend to entities that perform functions or services on behalf of WellCare (commonly called delegated entities). Oversight of delegated entities is managed internally at WellCare by the Delegation Oversight Committee (the "**DOC**"). The DOC meets on a monthly basis to review audits of delegated entities, address remediation of identified issues and discuss pending delegated services agreements. While certain activities may be delegated, WellCare is ultimately responsible for all services performed by its delegated entities.

Exhibit B.12.a – Chart C – Corporate Compliance Organizational Chart



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**B.13**

***Provide copies of any press releases in the twelve (12) months prior to the Deadline for Proposals, wherein the press release mentions or discusses financial results, acquisitions, divestitures, new facilities, closures, layoffs, significant contract awards or losses, penalties/fines/ sanctions, expansion, new or departing officers or directors, litigation, change of ownership, or other very similar issues. Do not include press releases that are primarily promotional in nature.***

Please refer to Attachment B.13.a for WellCare's press releases over the last 12 months regarding the above referenced subject matters.

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## **B.14**

***Describe your plan for meeting the Performance Bond, other bonds, and insurance requirements set forth in this RFP requirement including the type of bond to be posted and source of funding.***

### **Bonds**

#### Performance Bond

WellCare LA plans to obtain a performance bond in the amount of \$10 million from Liberty Mutual Insurance Company, which is an agent on the United States Department of Treasury's list of approved sureties. The bond will comply with the requirements in Section 2.6.1.2 of the RFP. WellCare LA will maintain the performance bond as required by Section 2.6.1.1 of the RFP and will comply with the other requirements in Section 2.6.1 of the RFP.

#### Fidelity Bond

WellCare LA will secure and maintain during the life of the Contract a fidelity bond that complies with the requirements in Section 2.6.2 of the RFP. WellCare LA currently has a fidelity bond with Great American Insurance Company with aggregate liability coverage of \$5 million including forgery or alteration, securities, and computer systems.

### **Insurance Requirements**

WellCare LA will maintain during the life of the Contract all insurance as required in Section 2.5 of the RFP. This includes Workers' Compensation Insurance, Commercial Liability Insurance, Errors and Omissions Insurance, Special Hazards Insurance, Automobile Liability Insurance, and Reinsurance.

WellCare LA currently has a General Liability policy with Hartford Insurance Group with a \$1 million each occurrence limit and an aggregate limit of \$2 million; Automobile Liability with a combined single limit of \$1 million; and Workers' Compensation including Employer's Liability Insurance with a \$1 million limit. In addition, WellCare LA has a \$20 million Umbrella policy that is excess over these three lines of coverage.

WellCare LA has Errors and Omissions (E&O) Insurance from Darwin Select Insurance Company with an aggregate limit of \$10 million and from Illinois Union Insurance Company with an aggregate limit of \$5 million, in excess of primary coverage (\$15 million total aggregate).

WellCare maintains two reinsurance programs that are used in similar Medicaid programs: (1) an internal reinsurance program among WellCare's different MCOs and programs with a \$50,000 annual per member specific deductible level; and (2) a catastrophic reinsurance policy with an unaffiliated, highly-rated (A) reinsurance company with a higher annual deductible, typically around \$1 million per member.

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**B.15**

***Provide the following information (in Excel format) based on each of the financial statements provided in response to item B:31: (1) Working capital; (2) Current ratio; (3) Quick ratio; (4) Net worth; and (5) Debt-to-worth ratio.***

Please see Exhibit B.15.a on the following page.

**Exhibit B.15.a – WellCare of Louisiana, Inc. Financial Ratios**
**WellCare Health Plans, Inc.**

<b>Ratios</b>	<b>December 31, 2009</b>	<b>March 31, 2010</b>	<b>June 30, 2010</b>	<b>September 31, 2010</b>	<b>December 31, 2010</b>	<b>March 31, 2011</b>
1 <b>Working Capital</b> = Current Assets - Current Liabilities	\$ 537,395	\$ 550,040	\$ 562,563	\$ 598,959	\$ 629,470	\$ 641,875
2 <b>Current Ratio</b> = Current Assets/Current Liabilities	1.46	1.56	1.59	1.54	1.53	1.55
3 <b>Quick Ratio</b> =(Cash + Marketable Securities + AR)/Current Liabilities	1.34	1.43	1.45	1.38	1.37	1.40
4 <b>Net Worth</b> = Total Assets - Total Liabilities	\$ 880,900	\$ 883,606	\$ 755,884	\$ 802,036	\$ 832,046	\$ 857,654
5 <b>Debt-to-Worth</b> = Total Liabilities/Net Worth	1.40	1.17	1.60	1.67	1.70	1.62

**WellCare of Louisiana, Inc.**

<b>Ratios</b>	<b>December 31, 2009</b>	<b>March 31, 2010</b>	<b>June 30, 2010</b>	<b>September 31, 2010</b>	<b>December 31, 2010</b>	<b>March 31, 2011</b>
1 <b>Working Capital</b> = Current Assets - Current Liabilities	\$ 4,398,272	\$ 3,749,662	\$ 3,250,577	\$ 3,511,328	\$ 3,945,070	\$ 3,517,526
2 <b>Current Ratio</b> = Current Assets/Current Liabilities	1.50	1.39	1.34	1.44	1.45	1.33
3 <b>Quick Ratio</b> =(Cash + Marketable Securities + AR)/Current Liabilities	1.49	1.34	1.26	1.36	1.42	1.28
4 <b>Net Worth</b> = Total Assets - Total Liabilities	\$ 4,398,272	\$ 3,749,662	\$ 3,250,577	\$ 3,511,328	\$ 3,945,070	\$ 3,517,526
5 <b>Debt-to-Worth</b> = Total Liabilities/Net Worth	1.99	2.59	2.91	2.27	2.24	3.08

## **B.16**

**Identify, in Excel format, all of your organization’s publicly-funded managed care contracts for Medicaid/CHIP and/or other low-income individuals within the last five (5) years. In addition, identify, in Excel format your organization’s ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP and/or other low-income individuals within the last five (5) years. For each prior experience identified, provide the trade name, a brief description of the scope of work, the duration of the contract, the contact name and phone number, the number of members and the population types (e.g., TANF, ABD, duals, CHIP), the annual contract payments, whether payment was capitated or other, and the role of subcontractors, if any. If your organization has not had any publicly-funded managed care contracts for Medicaid/SCHIP individuals within the last five (5) years, identify the Proposer’s ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP individuals within the last five (5) years and provide the information requested in the previous sentence. Include your organization’s parent organization, affiliates, and subsidiaries.**

Exhibit B.16.a – Summary of State Medicaid/CHIP Contracts provides the required information for each of our publicly-funded managed care contractors for Medicaid/CHIP and/or other low-income individuals within the past five years.

Exhibit B.16.b – Summary of 10 Largest Non-Medicaid/CHIP Contracts provides the required information for each of our ten largest managed care contractors in the past five years for populations other than those specified in Exhibit B.16.a. Note that all of these contracts are for Medicare beneficiaries.

**Exhibit B.16.a – Summary of State Medicaid/CHIP Contracts**

State, Trade Name, Client and Contact Information	Scope of Services	Contract/Payment Information	Membership Information (2010 Data Unless Otherwise Indicated)
<p><b>Connecticut</b> <i>WellCare of Connecticut, Inc.</i></p> <p><b>Client:</b> Department of Social Services 25 Sigourney Street Hartford, CT 06106-5033</p> <p><b>Contact:</b> Michael Starkowski Commissioner, Department of Social Services (860) 424-5053 michael.starkowski@po.state.ct.us</p>	<p><b>Benefits:</b> Full medical and behavioral</p> <p><b>Carve-Outs:</b> Dental, 24-hour nurse hotline</p>	<p><b>Initial Contract Date:</b> September 1995</p> <p><b>Contract End Date:</b> March 31, 2008</p> <p><b>2007 Annual Contract Payments:</b> \$81 million</p> <p><b>Payment Type:</b> Capitated</p>	<p><b>2007 Average Monthly Enrollment:</b> 36,008</p> <p><b>Covered Population:</b> TANF, CHIP</p>

State, Trade Name, Client and Contact Information	Scope of Services	Contract/Payment Information	Membership Information (2010 Data Unless Otherwise Indicated)
<p><b>Florida</b> <i>HealthEase of Florida, Inc.</i></p> <p><b>Client:</b> Agency for Health Care Administration (AHCA) 2727 Mahan Drive Tallahassee, FL 32308</p> <p><b>Contact:</b> <u>Medicaid:</u> Suzanne Gjevukaj Bureau of Medicaid Health Systems Development Agency for Health Care Administration (850) 412-4067 Suzanne.Gjevukaj@ahca.myflorida.com</p> <p><u>CHIP:</u> Jennifer Lloyd Chief External Affairs Officer Florida Healthy Kids Corporation 661 E Jefferson St # 200 Tallahassee, FL 32301-2788 (850) 701-6108 lloydj@healthykids.org</p>	<p><b><u>Non-Reform:</u></b></p> <p><b><u>Benefits:</u></b> Full medical and behavioral</p> <p><b><u>Subcontracted:</u></b> Behavioral Health, Transportation</p>	<p><b><u>Initial Contract Date:</u></b> May 2000 (Medicaid) October 2003 (CHIP)</p> <p><b><u>Current Contract:</u></b> September 1, 2009 – August 31, 2012 (non-reform) October 1, 2010 – September 30, 2011 (CHIP)</p> <p><b><u>2010 Annual Contract Payments:</u></b> \$381 million</p> <p><b><u>Payment Type:</u></b> Capitated</p>	<p><b><u>Average Monthly Enrollment:</u></b> 172,688</p> <p><b><u>Covered Population:</u></b> TANF, SSI, Dual Eligible, CHIP</p>

State, Trade Name, Client and Contact Information	Scope of Services	Contract/Payment Information	Membership Information (2010 Data Unless Otherwise Indicated)
<p><b>Florida</b> <i>HealthEase of Florida, Inc.</i></p> <p><b>Client:</b> Agency for Health Care Administration (AHCA) 2727 Mahan Drive Tallahassee, FL 32308</p> <p><b>Contact:</b> Suzanne Gjevukaj Bureau of Medicaid Health Systems Development Agency for Health Care Administration (850) 412-4067 Suzanne.Gjevukaj@ahca.myflorida.com</p>	<p><b>Reform:</b></p> <p><b>Benefits:</b> Full medical and behavioral</p> <p><b>Carve-Outs:</b> Dental, NEMT, pharmacy, vision, 24-hour nurse hotline</p>	<p><b>Initial Contract Date:</b> September 1, 2006</p> <p><b>Contract End Date:</b> August 31, 2009 (reform)</p> <p><b>2008 Annual Contract Payments:</b> \$112 million</p> <p><b>2009 Annual Contract Payments:</b> \$43 million</p> <p><b>Payment Type:</b> Capitated</p>	<p><b>2008 Average Monthly Enrollment:</b> 49,795</p> <p><b>2009 Average Monthly Enrollment:</b> 39,415</p> <p><b>Covered Population:</b> TANF, CHIP, ABD, long-term care, dual eligibles</p>

State, Trade Name, Client and Contact Information	Scope of Services	Contract/Payment Information	Membership Information (2010 Data Unless Otherwise Indicated)
<p><b>Florida</b> WellCare of Florida, Inc. dba Staywell Health Plans of Florida</p> <p><b>Client:</b> Agency for Health Care Administration 2727 Mahan Drive Tallahassee, FL 32308</p> <p><b>Contact:</b> Suzanne Gjevukaj Bureau of Medicaid Health Systems Development Agency for Health Care Administration (850) 412-4067 Suzanne.Gjevukaj@ahca.myflorida.com</p> <p><b>CHIP:</b> Jennifer Lloyd Chief External Affairs Officer Florida Healthy Kids Corporation 661 E Jefferson St # 200 Tallahassee, FL 32301-2788 (850) 701-6108 lloydj@healthykids.org</p>	<p><b>Non-Reform:</b></p> <p><b>Benefits:</b> Full medical and behavioral</p> <p><b>Subcontracted:</b> Behavioral Health, Transportation</p>	<p><b>Initial Contract Date:</b> July 1994 (Medicaid) October 2001 (CHIP)</p> <p><b>Current Contract:</b> September 1, 2009 – August 31, 2012 (non-reform) October 1, 2010 – September 30, 2011 (CHIP)</p> <p><b>2010 Annual Contract Payments:</b> \$511 million</p> <p><b>Payment Type:</b> Capitated</p>	<p><b>Average Monthly Enrollment:</b> 246,185</p> <p><b>Covered Population:</b> TANF, SSI, Dual Eligible, CHIP</p>

State, Trade Name, Client and Contact Information	Scope of Services	Contract/Payment Information	Membership Information (2010 Data Unless Otherwise Indicated)
<p><b>Florida</b> WellCare of Florida, Inc. dba Staywell Health Plans of Florida</p> <p><b>Client:</b> Agency for Health Care Administration (AHCA)</p> <p><b>Contact:</b> Suzanne Gjevukaj Bureau of Medicaid Health Systems Development Agency for Health Care Administration (850) 412-4067 Suzanne.Gjevukaj@ahca.myflorida.com</p>	<p><b>Reform:</b></p> <p><b>Benefits:</b> Full medical and behavioral</p> <p><b>Carve-Outs:</b> Dental, NEMT, pharmacy, vision, 24-hour nurse hotline</p>	<p><b>Initial Contract Date:</b> September 1, 2006 September 1, 2007 (LTC)</p> <p><b>Contract End Date:</b> August 31, 2009 (reform) August 31, 2008 (long-term care)</p> <p><b>2008 Annual Contract Payments:</b> \$72 million</p> <p><b>2009 Annual Contract Payments:</b> \$25 million</p> <p><b>Payment Type:</b> Capitated</p>	<p><b>2008 Average Monthly Enrollment:</b> 31,907</p> <p><b>2009 Average Monthly Enrollment:</b> 28,070</p> <p><b>Covered Population:</b> TANF, CHIP, ABD, long-term care, dual eligibles</p>

State, Trade Name, Client and Contact Information	Scope of Services	Contract/Payment Information	Membership Information (2010 Data Unless Otherwise Indicated)
<p><b>Georgia</b> <i>WellCare of Georgia, Inc.</i></p> <p><b>Client:</b> Georgia Department of Community Health 2 Peachtree St., NW Atlanta, Georgia 30303</p> <p><b>Contact:</b> Becky Thatcher <i>Program Auditor, Contract Compliance and Resolution</i> Georgia Department of Community Health Division of Medicaid 2 Peachtree St., NW Atlanta, Georgia 30303 404.657.9945 bthatcher@dch.ga.gov</p>	<p><b>Benefits:</b> Full medical and behavioral including Rx, Dental, Vision (dental and vision - children only)</p> <p><b>Carve-Outs:</b> NEMT, Long Term Care</p> <p><b>Subcontracted:</b> Dental, Vision, Behavioral Health, Pharmacy</p>	<p><b>Initial Contract Date:</b> July 18, 2005</p> <p><b>Current Contract:</b> July 1, 2010 – June 30, 2011 <i>(recently extended to June 30, 2012)</i></p> <p><b>2010 Annual Contract Payments:</b> \$1.375 billion</p> <p><b>Payment Type:</b> Capitated</p>	<p><b>Average Monthly Enrollment:</b> 543,565</p> <p><b>Covered Population:</b> TANF, CHIP, Pregnant Women, Breast and Cervical Cancer Waiver (BCC)</p>

State, Trade Name, Client and Contact Information	Scope of Services	Contract/Payment Information	Membership Information (2010 Data Unless Otherwise Indicated)
<p><b>Hawai'i</b> WellCare Health Insurance of Arizona, Inc. dba 'Ohana Health Plan</p> <p><b>Client:</b> Department of Human Services 1390 Miller Street Honolulu, Hawai'i 96813</p> <p><b>Contact:</b> Patricia Bazin Health Care Services Branch Administrator State of Hawai'i Department of Human Services MedQuest Division (808) 692-8083 pbazin@medicaid.dhs.state.hi.us</p>	<p><b>Benefits:</b> Full medical, behavioral and home and community based services (HCBS)</p> <p><b>Carve-Outs:</b> DD/MR, Chronic Behavioral Health, Dental</p> <p><b>Subcontracted:</b> Transportation</p>	<p><b>Initial Contract Date:</b> February 4, 2008</p> <p><b>Current Contract:</b> February 4, 2008 – June 30, 2011</p> <p><b>2010 Annual Contract Payments:</b> \$340 million</p> <p><b>Payment Type:</b> Capitated</p>	<p><b>Average Monthly Enrollment:</b> 22,068</p> <p><b>Covered Population:</b> ABD</p>

State, Trade Name, Client and Contact Information	Scope of Services	Contract/Payment Information	Membership Information (2010 Data Unless Otherwise Indicated)
<p><b>Illinois</b> <i>Harmony Health Plan of Illinois, Inc.</i></p> <p><b>Client:</b> Illinois Department of Healthcare and Family Services 201 South Grand Avenue East Springfield, IL 62763-0001</p> <p><b>Contact:</b> Ms. Michelle Maher Chief, Bureau of Managed Care Illinois Department of Healthcare and Family Services 201 South Grand Avenue East Springfield, IL 62763-0001 (217) 524-7478 Michelle.Maher@Illinois.gov</p>	<p><b>Benefits:</b> Full medical and behavioral</p> <p><b>Carve-Outs:</b> Dental, Vision, Pharmacy</p> <p><b>Subcontracted:</b> 24-hour nurse hotline</p>	<p><b>Initial Contract Date:</b> December 1997</p> <p><b>Current Contract:</b> October 1, 2009 – September 30, 2012</p> <p><b>2010 Annual Contract Payments:</b> \$180 million</p> <p><b>Payment Type:</b> Capitated</p>	<p><b>Average Monthly Enrollment:</b> 144,131</p> <p><b>Covered Population:</b> TANF, CHIP</p>

State, Trade Name, Client and Contact Information	Scope of Services	Contract/Payment Information	Membership Information (2010 Data Unless Otherwise Indicated)
<p><b>Missouri</b> Harmony Health Plan of Illinois, Inc. d/b/a Harmony Health Plan of Missouri</p> <p><b>Client:</b> Missouri Department of Social Services MO HealthNet Division (MHD) P.O. Box 6500 Jefferson City, MO 65102-6500</p> <p><b>Contact:</b> Susan M. Eggen Assistant Deputy Director, Managed Care MO HealthNet Division (MHD) P.O. Box 6500 Jefferson City, MO 65102-6500 (573) 751-3277</p>	<p><b>Benefits:</b> Full medical and behavioral Medicaid benefits (limited dental and optical, NEMT covered for majority of recipients)</p> <p><b>Carve-Outs:</b> Pharmacy</p> <p><b>Subcontracted:</b> Behavioral Health, Dental, Hearing, Transportation, 24-hour nurse hotline</p>	<p><b>Initial Contract Date:</b> July 1, 2006</p> <p><b>Current Contract:</b> July 1, 2010 – June 30, 2011 (<i>recently extended to June 30, 2012</i>).</p> <p><b>2010 Annual Contract Payments:</b> \$41 million</p> <p><b>Payment Type:</b> Capitated</p>	<p><b>Average Monthly Enrollment:</b> 17,000</p> <p><b>Covered Population:</b> TANF, CHIP</p>
<p><b>New York</b> WellCare of New York, Inc.</p> <p><b>Client:</b> New York State Department of Health</p> <p><b>Contact:</b> <u>FHP/MMC:</u> Mary Jane Vogel Project Manager NYS Department of Health Empire State Plaza Corning Tower Room 1911 Albany, NY 12237</p>	<p><b>Benefits:</b> Full medical and behavioral</p> <p><b>Carve-Outs:</b> Dental, NEMT, Pharmacy</p>	<p><b>Initial Contract Date:</b> October 2001 (Child Health Plus) October 2001 (Family Health Plus) July 1, 2007 (long-term care)</p> <p><b>Current Contract:</b> January 1, 2008 – December 31, 2012 (Child Health Plus) March 1, 2011- February 28, 2013 (Family Health Plus/Medicaid Managed Care) January 1, 2011 – December 31, 2011 (Medicaid Advantage Plus) January 1, 2011 – December 31, 2011 (Managed Long Term Care Partial)</p>	<p><b>Average Monthly Enrollment:</b> 83,000</p> <p><b>Covered Population:</b> TANF and MA-ADC or MA-HR, SSI, CHIP, Eligible for Nursing Home Admission (for MLTC).</p>

State, Trade Name, Client and Contact Information	Scope of Services	Contract/Payment Information	Membership Information (2010 Data Unless Otherwise Indicated)
<p>(518) 474-5515</p> <p><u>MLTC/Medicaid Advantage:</u> Linda Gowdy Director, Bureau of Continuing Care Initiatives NYS Department of Health Empire State Plaza Corning Tower Room 2084 Albany, NY 12237 (518)-408-1245 llg07@health.state.ny.us</p> <p><u>CHP:</u> Muhammad A Shahab Health Program Administrator II NYS Department of Health Division of Coverage &amp; Enrollments Room 1629, Corning Tower Empire State Plaza Albany, New York 12237 (518) 473-4708 mas32@health.state.ny.us</p>		<p>Capitation Contract) January 1, 2011 – December 31, 2011 (Coordination of Benefits Agreement [Medicaid Advantage])</p> <p><b><u>2010 Annual Contract Payments:</u></b> \$250 million</p> <p><b><u>Payment Type:</u></b> Capitated</p>	

State, Trade Name, Client and Contact Information	Scope of Services	Contract/Payment Information	Membership Information (2010 Data Unless Otherwise Indicated)
<p><b>Ohio</b> <i>WellCare of Ohio, Inc.</i></p> <p><b>Client:</b> State of Ohio, Department of Jobs and Family Services 50 W Town Street Columbus, OH 43215</p> <p><b>Contact:</b> Jon Barley Chief, Bureau of Health Services Research Office of Ohio Health Plans Ohio Department of Job and Family Services 50 W Town Street Columbus, OH 43215 614 466-4693 Jon.Barley@jfs.ohio.gov</p>	<p><b>Benefits:</b> Full medical including Dental, Vision, Chiropractic (children only), HCBS</p> <p><b>Carve-Outs:</b> Partial Behavioral; Pharmacy</p> <p>Potential Pharmacy Carve-in eff. 10-1-11</p> <p><b>Subcontracted:</b> 24-hour nurse hotline</p>	<p><b>Initial Contract Date:</b> November 1, 2006 (Medicaid/CHIP) December 1, 2006 (ABD)</p> <p><b>Current Contract:</b> July 1, 2010 – June 30, 2011 (Medicaid/CHIP)</p> <p><b>Contract End Date:</b> June 30, 2008 (ABD)</p> <p><b>2010 Annual Contract Payments:</b> \$234 million</p> <p><b>Payment Type:</b> Capitated</p>	<p><b>Average Monthly Enrollment:</b> 101,211</p> <p><b>Covered Population:</b> TANF, CHIP</p>

State, Trade Name, Client and Contact Information	Scope of Services	Contract/Payment Information	Membership Information (2010 Data Unless Otherwise Indicated)
<p><b>Indiana</b>  <i>Harmony Health Plan of Illinois, Inc.</i>  <i>d/b/a Harmony Health Plan of Indiana</i></p> <p><b>Contact:</b>            Family and Social Services Administration            P.O. Box 7083            402 W. Washington Street            Indianapolis, IN 46207-7083</p> <p><b>Contact:</b>            Ginger Brophy            Manager, Office of Medicaid            (317) 232-4345            ginger.brophy@fssa.in.gov</p>	<p><b>Benefits:</b>            Full medical and behavioral Medicaid benefits (except dental)</p> <p><b>Subcontracted:</b>            NEMT, pharmacy co-pay, 24-hour nurse hotline</p>	<p><b>Initial Contract Date:</b>            September 1995</p> <p><b>Contract End Date:</b>            December 31, 2006</p> <p><b>2006 Annual Contract Payments:</b>            \$129 million</p> <p><b>Payment Type:</b>            Capitated</p>	<p><b>2006 Average Monthly Enrollment:</b>            75,670</p> <p><b>Covered Population:</b>            TANF, CHIP</p>

**Exhibit B.16.b – Summary of 10 Largest Non-Medicaid/CHIP Contracts**

Medicare Plan, Trade Name, Client and Contact Information	Scope of Services	Contract/Payment Information	Membership Information (2010 Data Unless Otherwise Indicated)
<p><b>Nationwide Prescription Drug Plan</b>  <i>WellCare Prescription Insurance, Inc.</i></p> <p><b>Client:</b>            Centers for Medicare and Medicaid Services (CMS)            7500 Security Boulevard            Baltimore, MD 21244</p> <p><b>Contact:</b>            Estavan Carter            CMS            61 Forsyth Street SW            Suite 4T20            Atlanta, GA 30303            (404) 562-7344            Estavan.Carter@cms.hhs.gov</p>	<p><b>Benefits:</b>            Medicare Part D</p> <p><b>Subcontracted:</b>            Prescription Drugs</p>	<p><b>Initial Contract Date:</b>            January 1, 2006</p> <p><b>Contract End Date:</b>            January 1, 2011 – December 31, 2011</p> <p><b>2010 Annual Contract Payments:</b>            \$785 million</p> <p><b>Payment Type:</b>            Capitated</p>	<p><b>Average Monthly Enrollment:</b>            747,788</p> <p><b>Covered Population:</b>            Medicare Eligible, Dual Eligible</p>

Medicare Plan, Trade Name, Client and Contact Information	Scope of Services	Contract/Payment Information	Membership Information (2010 Data Unless Otherwise Indicated)
<p><b>Florida Medicare HMO</b> <i>WellCare of Florida, Inc.</i></p> <p><b>Client:</b> Centers for Medicare and Medicaid Services (CMS) 7500 Security Boulevard Baltimore, MD 21244</p> <p><b>Contact:</b> Estavan Carter CMS 61 Forsyth Street SW Suite 4T20 Atlanta, GA 30303 (404) 562-7344 Estavan.Carter@cms.hhs.gov</p>	<p><b>Benefits:</b> Medicare Parts A, B, and D; routine dental, vision, and hearing; medically necessary transportation; and home delivered meals</p> <p><b>Subcontracted:</b> Chiropractic, podiatry, durable medical equipment, home health, physical/ outpatient/speech therapy, outpatient prescription drugs, dental, vision, hearing, medically necessary transportation, home delivered meals</p>	<p><b>Initial Contract Date:</b> January 1, 2000</p> <p><b>Current Contract:</b> January 1, 2011 – December 31, 2011</p> <p><b>2010 Annual Contract Payments:</b> \$737 million</p> <p><b>Payment Type:</b> Capitated</p>	<p><b>Average Monthly Enrollment:</b> 61,945</p> <p><b>Covered Population:</b> Medicare Eligible, Dual Eligible</p>

Medicare Plan, Trade Name, Client and Contact Information	Scope of Services	Contract/Payment Information	Membership Information (2010 Data Unless Otherwise Indicated)
<p><b>Medicare Advantage – Private Fee For Service Plan</b>  <i>WellCare Health Insurance of Arizona, Inc.</i></p> <p><b>Client:</b>            Centers for Medicare and Medicaid Services (CMS)            7500 Security Boulevard            Baltimore, MD 21244</p> <p><b>Contact:</b>            Estavan Carter            CMS            61 Forsyth Street SW            Suite 4T20            Atlanta, GA 30303            (404) 562-7344            Estavan.Carter@cms.hhs.gov</p>	<p><b>Benefits:</b>            Medicare Parts A, B, and D; routine dental, vision, and hearing</p> <p><b>Subcontracted:</b> PFFS            Non-Network Model</p> <p>No longer providing services effective 1/1/2010</p>	<p><b>Initial Contract Date:</b>            January 1, 2007</p> <p><b>Contract End Date:</b>            December 31, 2009</p> <p><b>2009 Annual Contract Payments:</b>            \$605 million</p> <p><b>Payment Type:</b>            Capitated</p>	<p><b>2009 Average Monthly Enrollment:</b>            56,507</p> <p><b>Covered Population:</b>            Medicare Eligible, Dual Eligible</p>

Medicare Plan, Trade Name, Client and Contact Information	Scope of Services	Contract/Payment Information	Membership Information (2010 Data Unless Otherwise Indicated)
<p><b>Medicare Advantage – Private Fee For Service Plan</b>  <i>WellCare Health Insurance of Illinois, Inc.</i></p> <p><b>Client:</b>            Centers for Medicare and Medicaid Services (CMS)            7500 Security Boulevard            Baltimore, MD 21244</p> <p><b>Contact:</b>            Estavan Carter            CMS            61 Forsyth Street SW            Suite 4T20            Atlanta, GA 30303            (404) 562-7344            Estavan.Carter@cms.hhs.gov</p>	<p><b>Benefits:</b>            Medicare Parts A, B, and D; routine dental, vision, and hearing</p> <p><b>Subcontracted:</b> PFFS            Non-Network Model</p> <p>No longer providing services effective 1/1/2010</p>	<p><b>Initial Contract Date:</b>            January 1, 2007</p> <p><b>Contract End Date:</b>            December 31, 2009</p> <p><b>2009 Annual Revenue:</b>            \$465 million</p> <p><b>Payment Type:</b>            Capitated</p>	<p><b>2009 Average Monthly Enrollment:</b>            41,998</p> <p><b>Covered Population:</b>            Medicare Eligible, Dual Eligible</p>

Medicare Plan, Trade Name, Client and Contact Information	Scope of Services	Contract/Payment Information	Membership Information (2010 Data Unless Otherwise Indicated)
<p><b>New York Medicare HMO</b> <i>WellCare of New York, Inc.</i></p> <p><b>Client:</b> Centers for Medicare and Medicaid Services (CMS) 7500 Security Boulevard Baltimore, MD 21244</p> <p><b>Contact:</b> Estavan Carter CMS 61 Forsyth Street SW Suite 4T20 Atlanta, GA 30303 (404) 562-7344 Estavan.Carter@cms.hhs.gov</p>	<p><b>Benefits:</b> Medicare Parts A, B, and D; routine dental, vision, and hearing;</p> <p><b>Subcontracted:</b> Chiropractic, outpatient prescription drugs, dental, vision, hearing</p>	<p><b>Initial Contract Date:</b> September 1, 1995</p> <p><b>Current Contract:</b> January 1, 2011 – December 31, 2011</p> <p><b>2010 Annual Contract Payments:</b> \$210 million</p> <p><b>Payment Type:</b> Capitated</p>	<p><b>Average Monthly Enrollment:</b> 19,489</p> <p><b>Covered Population:</b> Medicare Eligible, Dual Eligible</p>

Medicare Plan, Trade Name, Client and Contact Information	Scope of Services	Contract/Payment Information	Membership Information (2010 Data Unless Otherwise Indicated)
<p><b>Illinois Medicare HMO</b> <i>Harmony Health Plan of Illinois, Inc.</i></p> <p><b>Client:</b> Centers for Medicare and Medicaid Services (CMS) 7500 Security Boulevard Baltimore, MD 21244</p> <p><b>Contact:</b> Estavan Carter CMS 61 Forsyth Street SW Suite 4T20 Atlanta, GA 30303 (404) 562-7344 Estavan.Carter@cms.hhs.gov</p>	<p><b>Benefits:</b> Medicare Parts A, B, and D; routine dental, vision, and hearing; medically necessary transportation</p> <p><b>Subcontracted:</b> Outpatient prescription drugs, dental, vision, hearing, medically necessary transportation</p>	<p><b>Initial Contract Date:</b> May 1, 2005</p> <p><b>Current Contract:</b> January 1, 2011 – December 31, 2011</p> <p><b>2010 Annual Contract Payments:</b> \$113 million</p> <p><b>Payment Type:</b> Capitated</p>	<p><b>Average Monthly Enrollment:</b> 10,722</p> <p><b>Covered Population:</b> Medicare Eligible, Dual Eligible</p>

Medicare Plan, Trade Name, Client and Contact Information	Scope of Services	Contract/Payment Information	Membership Information (2010 Data Unless Otherwise Indicated)
<p><b>Georgia Medicare HMO</b> <i>WellCare of Georgia, Inc.</i></p> <p><b>Client:</b> Centers for Medicare and Medicaid Services (CMS) 7500 Security Boulevard Baltimore, MD 21244</p> <p><b>Contact:</b> Estavan Carter CMS 61 Forsyth Street SW Suite 4T20 Atlanta, GA 30303 (404) 562-7344 Estavan.Carter@cms.hhs.gov</p>	<p><b>Benefits:</b> Medicare Parts A, B, and D; routine dental, vision, and hearing</p> <p><b>Subcontracted:</b> Outpatient prescription drugs, dental, vision, hearing</p>	<p><b>Initial Contract Date:</b> July 1, 2005</p> <p><b>Current Contract:</b> January 1, 2011 – December 31, 2011</p> <p><b>2010 Annual Contract Payments:</b> \$60 million</p> <p><b>Payment Type:</b> Capitated</p>	<p><b>Average Monthly Enrollment:</b> 5,990</p> <p><b>Covered Population:</b> Medicare Eligible, Dual Eligible</p>

Medicare Plan, Trade Name, Client and Contact Information	Scope of Services	Contract/Payment Information	Membership Information (2010 Data Unless Otherwise Indicated)
<p><b>Texas HMO</b> <i>WellCare of Texas, Inc.</i></p> <p><b>Client:</b> Centers for Medicare and Medicaid Services (CMS) 7500 Security Boulevard Baltimore, MD 21244</p> <p><b>Contact:</b> Estavan Carter CMS 61 Forsyth Street SW Suite 4T20 Atlanta, GA 30303 (404) 562-7344 Estavan.Carter@cms.hhs.gov</p>	<p><b>Benefits:</b> Medicare Parts A, B, and D; routine dental, vision, and hearing</p> <p><b>Subcontracted:</b> Outpatient prescription drugs, dental, vision, hearing</p>	<p><b>Initial Contract Date:</b> January 2, 2008</p> <p><b>Current Contract:</b> January 1, 2011 – December 31, 2011</p> <p><b>2010 Annual Contract Payments:</b> \$68 million</p> <p><b>Payment Type:</b> Capitated</p>	<p><b>Average Monthly Enrollment:</b> 5,533</p> <p><b>Covered Population:</b> Medicare Eligible, Dual Eligible</p>

Medicare Plan, Trade Name, Client and Contact Information	Scope of Services	Contract/Payment Information	Membership Information (2010 Data Unless Otherwise Indicated)
<p><b>Medicare Advantage – Private Fee For Service Plan</b>  <i>WellCare Health Insurance of New York, Inc.</i></p> <p><b>Client:</b>            Centers for Medicare and Medicaid Services (CMS)            7500 Security Boulevard            Baltimore, MD 21244</p> <p><b>Contact:</b>            Estavan Carter            CMS            61 Forsyth Street SW            Suite 4T20            Atlanta, GA 30303            (404) 562-7344            Estavan.Carter@cms.hhs.gov</p>	<p><b>Benefits:</b>            Medicare Parts A, B, and D; routine dental, vision, and hearing</p> <p><b>Subcontracted:</b> PFFS            Non-Network Model</p> <p>No longer providing services effective 1/1/2010</p>	<p><b>Initial Contract Date:</b>            January 1, 2007</p> <p><b>Contract End Date:</b>            December 31, 2009</p> <p><b>2009 Annual Contract Payments:</b>            \$54 million</p> <p><b>Payment Type:</b>            Capitated</p>	<p><b>2009 Average Monthly Enrollment:</b>            5,462</p> <p><b>Covered Population:</b>            Medicare Eligible, Dual Eligible</p>

Medicare Plan, Trade Name, Client and Contact Information	Scope of Services	Contract/Payment Information	Membership Information (2010 Data Unless Otherwise Indicated)
<p><b>Louisiana Medicare HMO</b> <i>WellCare of Louisiana, Inc.</i></p> <p><b>Client:</b> Centers for Medicare and Medicaid Services (CMS) 7500 Security Boulevard Baltimore, MD 21244</p> <p><b>Contact:</b> Estavan Carter CMS 61 Forsyth Street SW Suite 4T20 Atlanta, GA 30303 (404) 562-7344 Estavan.Carter@cms.hhs.gov</p>	<p><b>Benefits:</b> Medicare Parts A, B, and D; routine dental, vision, and hearing</p> <p><b>Subcontracted:</b> Outpatient prescription drugs, dental, vision, hearing</p>	<p><b>Initial Contract Date:</b> September 1, 2004</p> <p><b>Current Contract:</b> January 1, 2011 – December 31, 2011</p> <p><b>2010 Annual Contract Payments:</b> \$40 million</p> <p><b>Payment Type:</b> Capitated</p>	<p><b>Average Monthly Enrollment:</b> 3,343</p> <p><b>Covered Population:</b> Medicare Eligible, Dual Eligible</p>

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**B.17**

**Identify whether your organization has had any contract terminated or not renewed within the past five (5) years. If so, describe the reason(s) for the termination/non-renewal, the parties involved, and provide the address and telephone number of the client. Include your organization's parent organization, affiliates, and subsidiaries.**

WellCare LA has not had a contract terminated or not renewed within the past five years. However, certain WellCare LA affiliates have terminated contracts. We do not believe these constitute terminations or non-renewals as intended in the question, but we are nevertheless including this information in the interest of transparency. Details follow:

1. In March 2008 WellCare of Connecticut, Inc. ("**WellCare CT**") terminated Purchase of Service Contract Number 093-MED-FCHP-1 and Purchase of Service Contract Number 093-HUS-WCC-2 (collectively, the "**Husky Contracts**"), pursuant to which WellCare CT participated as a managed care organization in Connecticut's Husky A and Husky B Medicaid programs. WellCare CT's decision to terminate the Husky Contracts was prompted by a November 20, 2007 letter from the Connecticut Department of Social Services ("**CT DSS**") notifying WellCare CT that it intended to amend all risk-based contracts with the MCOs that participated in the Husky A and Husky B Medicaid programs effective December 31, 2007. CT DSS announced that such risk-based contracts would be amended to require the MCOs to provide administrative services only in return for a fixed fee. Upon receiving this notice, WellCare CT evaluated its ability to operate such an administrative services only Medicaid plan in Connecticut and determined that doing so was not feasible under its then-current business model.

The client's address and phone number are:

Michael Starkowski  
Commissioner, Connecticut Department of Social Services  
25 Sigourney Street  
Hartford, CT 06106-5033  
(860) 424-5016  
[michael.starkowski@po.state.ct.us](mailto:michael.starkowski@po.state.ct.us)

2. WellCare of Ohio, Inc. ("**WellCare OH**") had an Ohio Medical Assistance Provider Agreement for Managed Care Plan ABD Eligible Population dated as of 7/1/2007 with the Ohio Department of Jobs and Family Services. Due to higher than expected medical costs for the Ohio Medicaid program, particularly for WellCare OH's Medicaid aged, blind and disabled members, WellCare OH withdrew from the ABD program effective August 31, 2008. WellCare OH continues to participate in the Ohio Covered Families and Children program.

The client's address and phone number are:

Jon Barley  
Chief, Bureau of Health Services Research  
Office of Ohio Health Plans  
Ohio Department of Job and Family Services  
50 W Town Street  
Columbus, OH 43215  
614 466-4693  
[Jon.Barley@jfs.ohio.gov](mailto:Jon.Barley@jfs.ohio.gov)

3. Harmony Health Plan of Illinois, Inc. (d/b/a Harmony Health Plan of Indiana) ("**Harmony**") had a Contract dated 12/21/2000 with the Indiana Office of Medicaid Policy and Planning ("**IN OMPP**") and the Office of Children's Health Insurance Program of the Indiana Family and Social Services Administration pursuant to which Harmony offered managed care plans to beneficiaries of Indiana's Medicaid program. Harmony's contract expired on December 31, 2006. In 2006, the State of Indiana held a competitive bidding process to award new contracts to provide managed care benefits to Indiana Medicaid recipients in 2007. Harmony responded to the request for proposal (the "**RFP**") but was not one of the successful bidders. Harmony's contract expired on December 31, 2006. Because Harmony did not receive a new contract in 2007 based on a competitive bidding process, we do not believe this is a "nonrenewal" of a contract.

The client's address and phone number are:

Ginger Brophy  
Manager, Office of Medicaid  
Indiana Family and Social Services Administration  
402 W. Washington St.  
Indianapolis, IN 46204  
(317) 232-4345  
[ginger.brophy@fssa.in.gov](mailto:ginger.brophy@fssa.in.gov)

4. Harmony currently has a contract with the Centers for Medicare & Medicaid Services ("**CMS**") pursuant to which it offers Medicare Advantage coordinated care plans (as defined in 42 CFR 422.4(a)(1)(iii)) to eligible Medicare beneficiaries in Indiana. Harmony has recently notified CMS that it intends not to renew this contract when it expires on December 31, 2011. The decision not to renew was based generally on an evaluation of how this contract related to the enterprise's overall business plan, and specifically based in part on the small geographic area currently covered by Harmony's plans in Indiana.

The client's address and phone number are:

CMS Contact:  
Estavan Carter  
61 Forsyth Street SW  
Suite 4T20

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Atlanta, GA 30303  
(404) 562-7344  
[Estavan.Carter@cms.hhs.gov](mailto:Estavan.Carter@cms.hhs.gov)

5. WellCare Health Insurance of Arizona, Inc. (“**WHI Arizona**”) and WellCare Health Insurance of Illinois, Inc. (“**WHI Illinois**”) and, together with WHI Arizona, the “**PPO Companies**”), each previously had a contract with CMS pursuant to which it offered preferred provider organization (“**PPO**”) plans to eligible Medicare beneficiaries. WHI Arizona elected not to apply for renewal of its contract for 2009 and WHI Illinois elected not to apply for renewal of its contract for 2010; these PPO contracts therefore expired as of December 31, 2008 and December 31, 2009 respectively. In each case, the decision not to renew was based on a determination by the PPO Company that continued participation in the PPO program was not in the best interests of the enterprise due in part to the low number of members enrolled in these pilot PPO plans.

The client’s address and phone number are:

CMS Contact:  
Estavan Carter  
61 Forsyth Street SW  
Suite 4T20  
Atlanta, GA 30303  
(404) 562-7344  
[Estavan.Carter@cms.hhs.gov](mailto:Estavan.Carter@cms.hhs.gov)

6. WHI Arizona, WHI Illinois and WellCare Health Insurance of New York, Inc. (collectively, the “**PFFS Companies**”), each previously had a contract with CMS pursuant to which it offered private fee-for-service (“**PFFS**”) plans (as defined in 42 CFR 422.4(a)(3)) to eligible Medicare beneficiaries. The PFFS Companies elected not to apply for renewals of their contracts for 2010; these contracts therefore expired as of December 31, 2009. The decision not to renew was based on a determination by the PFFS Companies that continued participation in the PFFS plans was not in the best interests of the enterprise due to future provider network requirements and potential reductions in premium rates and benefits.

The client’s address and phone number are:

CMS Contact:  
Estavan Carter  
61 Forsyth Street SW  
Suite 4T20  
Atlanta, GA 30303  
(404) 562-7344  
[Estavan.Carter@cms.hhs.gov](mailto:Estavan.Carter@cms.hhs.gov)

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**B.18**

***If the contract was terminated/non-renewed in B.17 above, based on your organization's performance, describe any corrective action taken to prevent any future occurrence of the problem leading to the termination/non-renewal. Include your organization's parent organization, affiliates, and subsidiaries.***

For item 1 in the response to B.17 (WellCare CT), because this termination was based on a business decision, no corrective action was necessary.

For item 2 in the response to B.17 (WellCare OH), because this termination was based on a business decision, no corrective action was necessary.

For item 3 in the response to B.17 (Harmony and IN OMPP), because the awarding of 2007 Indiana Medicaid contracts was based on a competitive bidding process, awards were based on multiple factors and corrective action was not necessary.

For item 4 in the response to B.17 (Harmony and CMS), because this termination was based on a business decision, no corrective action is necessary.

For item 5 in the response to B.17 (PPO Companies), because these terminations were based on a business decision, no corrective action was necessary.

For item 6 in the response to B.17 (PFFS Companies), because these terminations were based on a business decision, no corrective action was necessary.

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**B.19**

**As applicable, provide (in table format) the Proposer’s current ratings as well as ratings for each of the past three years from each of the following:**

- **AM Best Company (financial strengths ratings);**
- **TheStreet.com, Inc. (safety ratings); and**
- **Standard & Poor’s (long-term insurer financial strength).**

In July of 2009, A.M. Best withdrew its public data rating assignments of U.S. health insurers. Thus, these ratings are not applicable.

We are not familiar with TheStreet.com, Inc. safety ratings. Based on internet research we performed, we understand that Weiss Ratings re-introduced safety ratings in 2010 (after Weiss had been purchased by TheStreet.com). We are not familiar with Weiss Ratings but did a search on <http://www.weissratings.com/> and found a rating for WellCare LA of C+. We could not find any historical ratings information.

We are familiar with and have a relationship with Standard & Poor’s (S&P). Exhibit B.19.a below provides the current and historical ratings (for each of the past three years) for WellCare. S&P rates the Company as a whole; thus there is no separate S&P rating for WellCare LA.

Exhibit B.19.a – S&P Ratings for WellCare

Current (as of 3/16/11)	2010	2009	2008
B	B – (through 3/17/10) B (upgraded 3/17/10)	B-	B (through 12/17/2008) B – (downgraded 12/17/2008)

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## B.20

***For any of your organization's contracts to provide physical health services within the past five years, has the other contracting party notified the Proposer that it has found your organization to be in breach of the contract? If yes: (1) provide a description of the events concerning the breach, specifically addressing the issue of whether or not the breach was due to factors beyond the Proposer's control. (2) Was a corrective action plan (CAP) imposed? If so, describe the steps and timeframes in the CAP and whether the CAP was completed. (3) Was a sanction imposed? If so, describe the sanction, including the amount of any monetary sanction (e.g., penalty or liquidated damage) (4) Was the breach the subject of an administrative proceeding or litigation? If so, what was the result of the proceeding/litigation? Include your organization's parent organization, affiliates, and subsidiaries.***

The Company incorporates by reference, as if set forth fully herein, the Company's response to Section B.25 and is providing the following additional information.

### **Centers for Medicare & Medicaid Services ("CMS")**

In February 2009, CMS notified the Company that it was being sanctioned through a suspension of marketing of, and enrollment into, all lines of the Company's Medicare business. CMS' determination was based on findings of deficiencies in the Company's compliance with Medicare regulations related to marketing activities, enrollment and disenrollment operations, appeals and grievances, timely and proper responses to beneficiary complaints and requests for assistance and marketing and agent/broker oversight activities.

In response to the CMS suspension, the Company launched an enterprise-wide initiative to analyze the processes and procedures for each of the issues identified by CMS in an effort to comply fully with all requirements going forward. The primary result of these efforts was the development of a significantly more robust compliance program. Since early 2009, the Company's Compliance Department has completed significant initiatives, including the adoption of a fulsome Code of Conduct and Business Ethics, a major review and consolidation of policies and procedures, enhanced compliance training initiatives – with special emphasis on the reporting of fraud, waste, and abuse issues by the Company's associates - HIPAA program management, Medicaid contractual requirements assessments, the implementation of an enterprise-wide compliance management system and a new contractual reporting certification policy. Additionally, and in response to CMS' sanctions, the Company significantly enhanced the oversight and monitoring of sales and marketing activities through numerous mechanisms, including a new Sales Compliance Investigations unit focusing on identification of potential misconduct by sales agents, a completely revamped internal "secret shopper" program and a new sales agent disciplinary policy.

After identifying many of the root causes of CMS-observed deficiencies, the Company also made a series of approximately 70 specific extra-regulatory operational commitments to CMS, designed to address the root cause issues in various operational areas, including sales and marketing, enrollment and appeals and grievances. For example, one of the root cause issues was a historic failure to confirm Medicare beneficiary enrollment; in response, the Company created a paperless "tele-application" and an outbound verification calling system, designed to ensure that enrollees had a complete understanding of their terms of enrollment. These paperless processes – which went above and beyond CMS' actual requirements – reduced

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enrollment-related compliance issues upon implementation. These commitments also included additional, and extensive, internal compliance auditing requirements and deliverables. The Company successfully met these commitments in 2009 and continues to execute upon them.

On November 3, 2009, the Company received written notification from CMS that it had determined that the Company had satisfactorily addressed the deficiencies that formed the basis for the CMS sanction and that CMS had released the Company from its marketing and enrollment sanction.

### **South Carolina Department of Health and Human Services**

On December 17, 2007, WellCare LA's affiliate, WellCare of South Carolina, Inc., ("WCSC") entered into a Settlement Agreement and General Release ("Settlement Agreement") whereby it agreed to withdraw an application for a contract with the South Carolina Department of Health and Human Services ("DHHS"), and agreed that neither it nor its affiliates would apply to participate as a Medicaid managed care organization in the South Carolina Medicaid program for a period of three years.

The facts that led to this Settlement Agreement are that a subcontractor of WCSC that was attempting to build a provider network for WCSC sent allegedly erroneous information to health care providers. DHHS sought to fine WCSC as a result of that communication by WCSC's subcontractor. WCSC denied liability. WCSC entered into the Settlement Agreement with DHHS dated December 17, 2007. Under the Settlement Agreement WSCS denied liability but agreed to withdraw its application for participation and to not reapply for three years.

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**B.21**

***Indicate whether your organization has ever sought, or is currently seeking, National Committee for Quality Assurance (NCQA) or American Accreditation HealthCare Commission (URAC) accreditation status. If it has or is, indicate current NCQA or URAC accreditation status and accreditation term effective dates if applicable.***

WellCare Health Plans, Inc. currently has three health plans that are accredited for Medicaid operations by NCQA or URAC. Two additional active applications are in process for NCQA accreditation - Harmony Health Plan of Missouri (NCQA Health Plan) and 'Ohana Health Plan in Hawai'i (New Health Plan). WellCare is committed to quality and has set an organization goal of all states having NCQA accreditation by 2013.

The following WellCare plans currently hold accreditation status:

- WellCare of Georgia Medicaid/CHIP line of business
  - NCQA New Health Plan Accreditation
  - Next review date scheduled for 07/11/2011 for Health Plan Accreditation
- WellCare of Florida, Inc. Medicaid, Medicare and CHIP lines of business
  - URAC Health Plan with Health Utilization Management Accreditation
  - Effective Dates: May 1, 2010 – May 1, 2013
- HealthEase of Florida, Inc. Medicaid and CHIP lines of business
  - URAC Health Plan with Health Utilization Management Accreditation
  - Effective Dates: May 1, 2010 – May 1, 2013

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**B.22**

***Have you ever had your accreditation status (e.g., NCQA, URAC,) in any state for any product line adjusted down, suspended, or revoked? If so, identify the state and product line and provide an explanation. Include your organization's parent organization, affiliates, and subsidiaries.***

The accreditation status of a WellCare plan has never been suspended, revoked or adjusted down.

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**B.23**

**If you are NCQA accredited in any state for any product line, include a copy of the applicable NCQA health plan report cards for your organization. Include your organization's parent organization, affiliates, and subsidiaries.**

As noted in our response to Section B.21, WellCare of Georgia has NCQA New Health Plan (NHP) Accreditation for its Medicaid/CHIP line of business.

The following is the NCQA health plan report card for WellCare of Georgia copied from NCQA's website:

**WellCare of Georgia, Inc.**

[Print](#) [Close this window](#)

**General Information**

**Plan Type:** Medicaid  
**Accredited Product:** HMO  
**Address:** 211 Perimeter Center Parkway NW, Suite 800, Atlanta, GA, 30346  
**Number of members enrolled:** 565,700  
**Website:** [www.wellcare.com](http://www.wellcare.com)  
**Other Names:** Medicaid, Peachcare Kids  
**This health plan serves members in the following state(s):**  
Georgia

For specific areas covered, please contact the plan directly.

**Accreditation Details**

This Plan has achieved [New Health Plan Accreditation](#)  
**Accreditation Type:** Health Plan Accreditation  
**Date of Next Review:** 07/11/2011

**Performance Results**

**Accreditation Status:** Scheduled

**Accreditation Star Ratings**

**Access and Service:**

**Qualified Providers:**

**Staying Healthy:**

**Getting Better:**

**Living with Illness:**

**Other**

For cost of benefits information, please contact this plan directly or speak with the benefits manager at your place of work.

[\[Close this window\]](#)

The following is the NHP Status List copied from NCQA's website:

## New Health Plan Report Card

The New Health Plan (NHP) Accreditation Status List, updated on the 15th of each month, catalogs all NHPs that have an accreditation status with NCQA, all NHPs with pending accreditation decisions and all NHPs scheduled to be surveyed. NHP accreditation is available to health plans that have been in existence less than three years and is awarded for a three year period. It evaluates how well a plan manages its clinical and administrative systems to deliver value to purchasers and improve health care for its members. An organization that achieves NHP accreditation is scheduled for a Health Plan Accreditation (HPA) survey for its subsequent review. NCQA's HPA standards evaluate an organization's core systems and process, as well as performance results that the plan achieves on key dimensions of care, service and efficiency.

### New Health Plan Accreditation

<a href="#">Plan Name</a>	<a href="#">Plan Office Location</a>	<a href="#">Expiration Date</a>	<a href="#">Next Review Date</a>	<a href="#">Accreditation Status</a>
<a href="#">Absolute Total Care</a>	Columbia, SC	09/09/2013	06/19/2013	Accredited
<a href="#">AMERIGROUP Community Care of New Mexico, Inc.</a>	Albuquerque, NM	04/04/2014	01/08/2014	Accredited
<a href="#">AMERIGROUP Community Care Ohio</a>	Cincinnati, OH	11/24/2011	08/30/2011	Accredited
<a href="#">Anthem Insurance Companies, Inc. dba Anthem Blue Cross and Blue Shield in Indiana</a>	Indiana	12/21/2012	09/16/2012	Accredited
<a href="#">MDwise, Inc.</a>	Indianapolis, IN	11/09/2012	08/14/2012	Accredited
<a href="#">Molina Healthcare of Florida</a>	Doral, FL	12/06/2013	09/10/2013	Accredited
<a href="#">Molina Healthcare of Ohio, Inc.</a>	Columbus, OH	01/26/2012	11/02/2011	Accredited
<a href="#">Molina Healthcare of Texas, Inc.</a>	San Antonio, TX	07/15/2012	04/24/2012	Accredited
<a href="#">Peach State Health Plan</a>	Smyrna, GA	12/12/2011	09/21/2011	Accredited
<a href="#">Sunshine State Health Plan</a>	Florida	03/11/2013	12/12/2012	Accredited
<a href="#">Unison Health Plan of the Capital Area</a>	Pittsburgh, PA	11/18/2012	08/27/2012	Accredited

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<u>Plan Name</u>	<u>Plan Office Location</u>	<u>Expiration Date</u>	<u>Next Review Date</u>	<u>Accreditation Status</u>
UnitedHealthcare Community Plan of Ohio, Inc.	Pittsburgh, PA	12/19/2011	10/03/2011	Accredited
<a href="#"><u>UnitedHealthCare of Delaware, Inc.</u></a>	Pittsburgh, PA	07/07/2013	04/17/2013	Accredited
<a href="#"><u>Wellcare of Georgia, Inc.</u></a>	Atlanta, GA	07/28/2011	05/03/2011	Accredited

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**B.24**

***Provide (as an attachment) a copy of the most recent external quality review report (pursuant to Section 1932(c)(2) of the Social Security Act) for the Medicaid contract identified in response to item B.16 that had the largest number of enrollees as of January 1, 2011. Provide the entire report. In addition, provide a copy of any corrective action plan(s) requested of your organization (including your organization's parent organization, affiliates, and subsidiaries) in response to the report.***

Please see Attachment B.24.a for a copy of the most recent EQRO report for our Georgia Medicaid contract, which is our largest Medicaid contract, as measured by the number of members, as of January 1, 2011.

The Attachment includes the following three reports prepared by the EQRO as part of its external quality review of WellCare of Georgia, Inc.:

- Validation of Performance Measures
- Performance Improvement Projects (PIPs) Report
- External Quality Review of Compliance with Standards

No corrective action plan was requested in response to any of these reports. WellCare of Georgia was fully compliant on the performance measures validated by the EQRO. WellCare of Georgia received “Met” score for each of its PIPs. The EQRO identified opportunities for improvement but did not request a corrective action plan. WellCare of Georgia met all standards in the compliance with standards review, so the EQRO did not request a corrective action plan.

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**B.25**

***Identify and describe any regulatory action, or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity against your organization within the last five (5) years. In addition, identify and describe any letter of deficiency issued by as well as any corrective actions requested or required by any federal or state regulatory entity within the last five (5) years that relate to Medicaid or CHIP contracts. Include your organization's parent organization, affiliates, and subsidiaries.***

The Company incorporates by reference, as if set forth fully herein, the Company's response to Section B.20 and is providing the following additional information.

Exhibit B.25.a – Summary of Medicaid Regulatory Actions, Sanctions and/or Fines and Exhibit B.25.b – Summary of Medicare Regulatory Actions, Sanctions and/or Fines, together include any regulatory actions, sanctions, letters of deficiency or corrective actions that have been imposed upon Proposer, its parent organization, affiliates and subsidiaries by any state or federal agencies within the last five (5) years. The list is complete and accurate to the best of our knowledge, information and belief at the time of submission based upon internal record keeping systems and due investigation.

**Exhibit B.25.a – Summary of Medicaid Regulatory Actions, Sanctions and/or Fines**

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
FL	AHCA	Fine	Members were not notified of change in Plan.	May 2006	NA	Actions were not the result of any conscious company policy to evade the requirements of the Insurance Law HealthEase consented to the imposition of a civil penalty in the sum of Twenty Thousand Dollars (\$20,000.00).
FL	AHCA	Fine	Members were not notified of change in Plan.	June 2006	NA	Actions were not the result of any conscious company policy to evade the requirements of the Insurance Law HealthEase consented to the imposition of a civil penalty in the sum of Twenty One Thousand Dollars (\$21,000.00).
FL	AHCA	Fine	Members were not notified of change in Plan.	July 2006	NA	Actions were not the result of any conscious company policy to evade the requirements of the Insurance Law HealthEase consented to the imposition of a civil penalty in the sum of Seven Thousand, Five Hundred Dollars (\$7,500.00).
FL	AHCA	Fine	Several marketing rules violations committed by benefit consultants.	7/10/2006	NA	Fine amount \$36,000.
FL	AHCA	Fine	Untimely filing of regulatory reporting requirement by Staywell.	8/28/2006	NA	Fine amount \$400
FL	AHCA	Fine	Several marketing violations committed by a sales agent. Violations identified as activities in provider offices, engaging in misleading practices or misrepresentation of benefits, agent licensure, etc.	9/13/2006	NA	Fine amount \$2,000

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
FL	AHCA	Fine	Several marketing violations committed by a sales agent. Violations identified as over aggressively marketing practices, cold calling, etc.	9/14/2006	NA	Fine amount \$25,000
FL	AHCA	Fine	Marketing violations	10/5/2006	NA	Fine amount \$75,000
FL	AHCA	Fine	Marketing violations	10/6/2006	NA	Fine amount \$20,000
FL	AHCA	Fine	Several marketing violations committed by a sales agent. Violations identified as marketing at non-approved marketing events, plan changes without beneficiary consent, etc.	10/23/2006	NA	Fine amount \$31,500
FL	AHCA	Fine	Several marketing violations committed by a sales agent. Violations identified as providing misleading information, overly aggressive marketing practice, activities in provider offices, etc.	10/23/2006	NA	Fine amount \$71,000
FL	AHCA	Fine	Unapproved marketing materials	10/30/2006	NA	Actions were not the result of any conscious company policy to evade the requirements of the Insurance Law WCFL consented to the imposition of a civil penalty in the sum of Seven Thousand, Dollars (\$7,000.00)
FL	AHCA	Fine	Marketing violations	10/23/2006	NA	Fine amount \$21,000
FL	AHCA	Fine	Marketing violations	3/7/2007	NA	Fine amount \$152,000

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
FL	AHCA	Fine	Several marketing violations committed by several sales agents. Violations identified as changing recipient's plans without beneficiary consent.	3/14/2007	NA	Fine amount \$358,700
FL	AHCA	Fine	Case #: 21060042 and 21060043. On March 22, 2007 notification received that HealthEase and Staywell were using forms whose approval had been rescinded by the Agency in Sept 2006. The Plan was instructed at that time that the RBI forms were to have been discontinued by HealthEase and Staywell when the inventory of forms ran out or by December 31, 2006, whichever came first. Agency has been provided a total count of non-approved forms that were used by HealthEase and Staywell from January 1 through march 31, 2007. As a result of these actions and under Section XIV.B of the Contracts, HealthEase and Staywell are fined a sum total of \$5K each.	4/26/2007	NA	Fine amount \$10,000
FL	AHCA	Fine	Subcontract non-compliance	4/11/2007	NA	Fine amount \$17,600 (\$8,800 for each Company)

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
FL	AHCA	Fine	The Agency for Health Care Administration received the 2006 audited financial report and annual financial report on 04/04/2007. Therefore, as specified in Section XIV of the Contract, the Agency is fining HealthEase and Staywell the sum total of \$800. This amount is a result of the audited financial statement being filed two day late, April 2- 3. The fine is calculated at \$200 a day times the number of days not received.	4/28/2007	NA	Fine amount \$800
FL	AHCA	Fine	Several marketing violations committed by sales agents. Violations include agents identified without a valid license, inaccurate applications, etc.	5/24/2007	NA	Fine amount \$44,000
FL	AHCA	Fine	Marketing violations	9/20/2007	NA	Fine amount \$331,000
FL	AHCA	Fine	Several marketing violations	9/27/2007	NA	Fine amount \$103,000
FL	AHCA	Fine	Several marketing violations	9/27/2007	NA	Fine amount \$94,000
FL	AHCA	Fine	Several marketing violations, including use of misleading information, overly aggressive solicitation, cold call marketing, etc.	8/10/2007	NA	Fine amount \$56,000
FL	AHCA	Fine	Untimely filing of the grievances and appeals report.	12/12/2007	NA	Fine amount \$5,200 (\$2,600 for each Company)
FL	AHCA	Fine	Several marketing violations	January 2008	NA	Fine amount \$55,500

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
FL	AHCA	Fine	Each Disease Management program shall have policies and procedures that follow the National Committee for Quality Assurance's (NCQA's). In addition to policies and procedures, the Health Plan shall have a Disease Management program description for each disease state that describes how the program fulfills the principles and functions of each of the NCQA Disease Management Standards and Guidelines categories. Each program description should also describe how Enrollees are identified for eligibility and stratified by severity and risk level. The Health Plan shall submit a copy of its policies and procedures and program description for each of its Disease Management programs to the Agency by April 1st of each year.	July 2008	NA	Fine amount \$2,200
FL	AHCA	Sanction	Suspension of marketing activities in Miami-Dade County.	July 2008	NA	Suspension of marketing activities

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
FL	AHCA	Fine	Amendment No. 7, Page 17 of 66, #58.b Each Disease Management program shall have policies and procedures that follow the National Committee for Quality Assurance's (NCQA). In addition to policies and procedures, the Health Plan shall have a Disease Management program description for each disease state that describes how the program fulfills the principles and functions of each of the NCQA Disease Management Standards and Guidelines categories. Each program description should also describe how Enrollees are identified for eligibility and stratified by severity and risk level. The Health Plan shall submit a copy of its policies and procedures and program description for each of its Disease Management programs to the Agency by April 1st of each year.	July 2008	NA	Fine amount \$2,200
FL	AHCA	Fine	Marketing violations	July 2008	NA	Fine amount \$1,000
FL	AHCA	Sanction	Suspension of marketing activities in Hillsborough County.	July 2008	NA	Sanction effective September 1 through October, 31 2008.

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
FL	AHCA	Fine	The Reform and Non-Reform Reports are due to the Agency of Health Care Administration no later than August 15, 2008. On August 15, the plan filed a combined Reform and Non-Reform report and was notified by the Agency that a combined report was not in compliance with the claims aging filing instructions. The plan was given an extension to file the Reform and Non-Reform reports by September 4. The reports were received on September 11th. The Agency considers this a violation of Section XII.1.a and 6, health Plan Reporting Requirements, of the Reform and Non-Reform 1006-2009 Medicaid HMO Contracts.	Sept. 2008	NA	As specified in Section XIV of the Contract, the Agency is fining HealthEase the sum total of \$2,800 as a result of the 2nd Qtr Reform Claims Aging Report and the 2nd Qtr Non-Reform Claims Aging Report being filed 7 days late from the extended due date, September 4. The fine is calculated at \$200 a Day per contract times the number of days not received.

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
FL	AHCA	Fine	The Agency for Health Care Administration received the 2008 2nd Qtr Reform and Non-Reform Claims Aging Reports on September 11, 2008. The Reform and Non-Reform Reports were due to the Agency no later than August 15. On August 15, the Plan filed a combined Reform and Non-Reform report and was notified by the Agency that a combined report was not in compliance with the claims aging filing instructions. Staywell was then given an extension to file the Reform and Non-Reform Reports by Sept 4. The Reports were received on Sept 11. The Agency considers this a violation of Section XII 1.a and 6, Health Plan Reporting Requirements, of the Reform and Non-Reform 2006-2009 Medicaid HMO Contracts. As specified in Section XIV of the contract, the Agency is fining Staywell the sum total of \$2,800. as a result of the 2nd Qtr Reform Claims Aging Rpt and the 2nd Qtr Non-Reform Claims Aging Rpt being filed 7 days late form the extended due date, September 4. The fine is calculated at \$200 a day per contract times the number of days not received.	Sept 2008	NA	As specified in Section XIV of the Contract, the Agency is fining HealthEase the sum total of \$2,800 as a result of the 2nd Qtr Reform Claims Aging Report and the 2nd Qtr Non-Reform Claims Aging Report being filed 7 days late from the extended due date, September 4. The fine is calculated at \$200 a Day per contract times the number of days not received.
FL	AHCA	Fine	Untimely filing of the Reform CHCUP Report.	10/10/2008	NA	Fine amount \$2,400 (\$1,200 for each Company)

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
FL	AHCA	Fine	Under Section XII, titled "Reporting Requirements", of the 2006 - 2009 Reform and Non-Reform HMO Medicaid Contracts, WellCare of Florida is required to File an Audited Financial Statement no later than April 1. The Agency for Health Care Administration received and granted a request from WellCare of Florida for an extension to file the 2007 Audited Financial Statement until August 29, 2008. The Agency received the 2007 Audited Financial Statement for WellCare of Florida on December 30, 2008. As specified in Section XIV of the Contracts, the Agency is fining HealthEase of Florida the sum total of \$24,400.	January 2009	NA	The amount is a result of the 2007 Audited Financial Statement being filed 122 days late, August 30 - December 30. The fine is calculated at \$200 a day times the number of days not received.

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
FL	AHCA	Fine	Under Section XII, titled "Reporting Requirements", of the 2006 - 2009 Reform and Non-Reform HMO Medicaid Contracts, WellCare of Florida is required to File an Audited Financial Statement no later than April 1. The Agency for Health Care Administration received and granted a request from WellCare of Florida for an extension to file the 2007 Audited Financial Statement until August 29, 2008. The Agency received the 2007 Audited Financial Statement for WellCare of Florida on December 30, 2008. As specified in Section XIV of the Contracts, the Agency is fining WellCare of Florida the sum total of \$24,400.	January 2009	NA	The amount is a result of the 2007 Audited Financial Statement being filed 122 days late, August 30 - December 30. The fine is calculated at \$200 a day times the number of days not received.
FL	FL AHCA	CAP	Onsite Behavioral Health Audit - Cooperative agreements with state mental facilities, jails, and ALF did not meet contract requirements. TCM records noted several deficiencies.	12/14/09	12/30/2009	Company submitted and implemented a corrective action plan to address the deficiencies.
FL	FL AHCA	CAP	Internal Risk Management Survey - Risk management training materials needed update as well as P&P to ensure submission of member incident reports.	04/01/10	5/14/2010	Company submitted and implemented a corrective action plan to address the deficiencies. The agency accepted the CAP.
FL	FL AHCA	CAP	Comprehensive Desk Onsite Review - Several contract sections were audited. As a result, the Agency requested updated to some policies and procedures.	10/18/10	10/27/2010	Company submitted and implemented a corrective action plan to address the deficiencies.

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
FL	FL AHCA	CAP	HealthEase Submission of Model Provider Agreements, Amendments and Subcontracts - The Agency requested a CAP to ensure submission of vendor subcontracts for approval prior to execution.	10/29/10	11/11/2010	Company submitted and implemented a corrective action plan to address the deficiencies and paid a fine of \$10,000.
FL	FL AHCA	CAP	ATA Corrective Action Plan Request - Use of clinical guidelines not consistent with FL Medicaid Clinical Guidelines.	12/10/10	1/25/2011	Company submitted and implemented a corrective action plan to address the deficiencies.
FL	FL AHCA	CAP	2010 Contract Compliance Survey (FWA) - The state requested updates to several Policies and Procedures and training materials. Also one instance of an untimely submission of FWA Report was noted.	12/30/10	1/25/2010	Company submitted and implemented a corrective action plan to address the deficiencies. The CAP was accepted and released.
FL	AHCA	Fine	Untimely submission of the claims aging report for Q2 2010.	5/2/2011	NA	Fine amount \$5,000. Under appeal and review by the Agency. Pending final determination.
GA	GA DCH	CAP	HIPAA website incident - PHI was exposed, via the internet, during the deployment of reports through WellCare Production Ports.	04/25/08	5/23/2008	WellCare notified all members impacted, offered one year of credit counseling to those affected members, and paid liquidated damages to DCH in the sum of \$725,000.00.
GA	GA DCH	CAP	March 2008 PCP Assignment Report lists PhDs that do not participate as PCPs.	5/7/08	5/9/08	Company submitted and implemented a corrective action plan to address the deficiencies.
GA	GA DCH	CAP	FQHC/RHC Corrective Action Plan - Inadequate data submissions for FQHC/RHC files.	09/03/08	9/5/2008	Data submissions were corrected and CAP resolved.

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
GA	GA DCH	CAP	Doral Telephone Report - Service level of dental calls answered within 30 seconds, fell below threshold.	09/18/08	10/17/2008	Service levels were achieved and CAP was resolved.
GA	GA DCH	CAP	Doral phone agents giving incorrect information regarding the open status of the network.	10/03/08	10/8/2008	Incorrect information was corrected and CAP resolved.
GA	GA DCH	CAP	Doral network access in Whitfield - DCH identified a potential discrepancy in the provider listing for Whitfield County dental providers.	10/07/08	10/20/2008	Provider listing was corrected and CAP resolved.
GA	GA DCH	CAP	Encounter Summary Report & Submissions CAPA.	11/25/08	12/1/2008	Large volume of encounters that need to be submitted in the next cycle.
GA	GA DCH	CAP	Telephone & Internet Activity Report CAPA - Service level of provider calls answered within 30 seconds, fell below threshold.	12/05/08	12/12/2008	Service levels were achieved and CAP was resolved.
GA	GA DCH	CAP	EQRO CAP related to member communication (ER and PA).	12/16/08	1/14/2009	Corrective actions were completed and CAP resolved.
GA	GA DCH	CAP	Telephone Internet Cap Pharmacy - Service level of pharmacy calls answered within 30 seconds fell below threshold.	12/22/08	1/5/2009	Service levels were achieved and CAP was resolved.
GA	GA DCH	CAP	GeoAccess CAPA Q3 2009 - Quarterly review of GeoAccess reporting by DCH, revealed several data errors and network vulnerabilities.	01/07/09	2/25/2009	These data errors were corrected and network vulnerabilities were remediated through Provider Network Development staff.
GA	GA DCH	CAP	Dental Data not submitted to DCH by due date.	03/09/09	4/9/2009	Original liquidated damages assessment of \$110,000.00 was reduced, upon appeal, to \$10,000.00.

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
GA	GA DCH	CAP	CAP - CMS Finding of CMO Vulnerability (see C090205-006) - Upon completion of a CMS audit of DCH's Program Integrity (PI) oversight procedures, DCH identified vulnerabilities within each CMO's PI operations.	02/03/09	2/24/2009	WellCare implemented the program changes requested by DCH.
GA	GA DCH	CAP	Unlabeled reports CAPA - WellCare implemented a new Secure Web Portal for submitting regulatory reports to DCH The historical reporting data from 2006 and 2007 were not labeled in a manner that could be easily identifiable.	02/04/09	3/4/2009	DCH requested WellCare re-label all of these reports.
GA	GA DCH	CAP	CAPA - Claims Reprocessing - WellCare identified a system failure that impacted the correct processing of 18,716 claims and reported this occurrence to DCH on 12/19/08.	03/17/09	3/30/2009	All claims were reprocessed, with interest on or before 3/25/09 as requested by DCH through this CAPA.
GA	GA DCH	CAP	Third Party Liability (TPL), CAPA - DCH mandated WellCare discontinue the recovery of overpayments when TPL is identified citing OCGA 49-4-148.	03/31/09	4/30/2009	WellCare complied with this mandate and published an article explaining these recoveries would be discontinued.
GA	GA DCH	CAP	Hospital access requirements in Laurens County fell below threshold.	06/01/09	6/26/2009	DCH assessed Liquidated Damages of \$100,000.00 WellCare contracted with additional facilities through single case agreements, which brought us back in line with network adequacy requirements.
GA	GA DCH	CAP	WellCare failed to meet submission requirements of the CAPA during the month of April 2009.	06/24/09	07/16/09	DCH assessed total Liquidated Damages of \$150,000.00 for month of April 2009.

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
GA	GA DCH	CAP	CAPA - Provider Terminations (PPG) Physician's Practice Group.	07/24/09	7/31/2009	DCH interpreted WellCare's Provider Termination Report to show a large number of terms for one IPA group. Upon further clarification, only 1/4 of these were unique provider terms and the rest accounted for multiple locations.
GA	GA DCH	CAP	Myers & Stauffer Audit Findings CAPA - M&S was retained by DCH to conduct an on-site review at WellCare's headquarters in addition to on-sites at the headquarters for each of WellCare's Subcontractors.	07/31/09	9/30/2009	Vulnerabilities identified by M&S were remediated through the CAPA process.
GA	GA DCH	CAP	WellCare failed to meet submission requirements of the CAPA during the months of May – July 2009.	10/05/09	10/13/2009	DCH assessed total Liquidated Damages of \$460,000.00 for May, June and July 2009.
GA	GA DCH	CAP	WellCare failed to achieve a 95% submission requirement for encounter data.	10/05/09	6/2/2010	DCH assessed total Liquidated Damages of \$460,000.00 for three Recon Periods (10/2009, 11/2009, 12/2009).
GA	GA DCH	CAP	GeoAccess CAPA Q3 2009 - Quarterly review of GeoAccess reporting by DCH, revealed several data errors and network vulnerabilities.	01/21/10	2/16/2010	These data errors were corrected and network vulnerabilities were remediated through Provider Network Development staff.
GA	GA DCH	CAP	EQRO Findings 2009 CAPA - HSAG was hired by DCH to conduct WellCare's EQRO Audit.	02/17/10	8/18/2010	Several findings were identified and all were remediated by WellCare.
GA	GA DCH	CAP	Timely Access CAPA Q2 and Q3 2009 - Network adequacy for Pediatric Routine visits fell below the 90% benchmark for appointment wait time standard of 21 calendar days.	03/22/10	3/26/2010	Individual Provider Education was targeted to all providers who failed to meet this standard.

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
GA	GA DCH	CAP	Pharmacy Telephone reports CAPA April 2010 - A group of WellCare Pharmacy Call Center staff engaged in performing "test" calls to their call center in an attempt to improve speed of handling scores.	04/28/10	4/30/2010	Upon investigation by a third party law firm, all employees found to be directly and indirectly involved were terminated Focused education with remaining staff took place.
GA	GA DCH	CAP	GeoAccess CAPA Q4 2009 - Quarterly review of GeoAccess reporting by the Department of Audits & Accounts, revealed several data errors and network vulnerabilities.	05/12/10	6/10/2010	These data errors were corrected and network vulnerabilities were remediated through Provider Network Development staff.
GA	GA DCH	CAP	NICU payment CAPA - DCH's review of WellCare's self-reported NICU cases revealed there to be three NICU baby cases that did not qualify for kick payment.	06/17/10	8/17/2010	WellCare recalculated the NICU report and refunded the overpayment.
GA	GA DCH	CAP	GeoAccess CAPA Q1 2010 - Quarterly review of GeoAccess reporting by the Department of Audits & Accounts, revealed several data errors and network vulnerabilities.	07/21/10	8/16/2010	These data errors were corrected and network vulnerabilities were remediated through Provider Network Development staff.
GA	GA DCH	CAP	Timely access CAPA Q2 2010 - Network adequacy for Adult Sick visits, Pediatric Sick visits, and Pediatric Routine visits fell below the 90% benchmark for appointment wait time standards.	08/05/10	8/13/2010	Individual Provider Education was targeted at all providers who failed to meet this standard Widespread education was distributed through a provider newsletter.
GA	GA DCH	CAP	Provider newsletter was published prior to DCH approval.	8/16/10	8/18/10	WellCare removed the unapproved materials from the website and created internal procedures to safeguard against a re-occurrence.

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
GA	GA DCH	CAP	GeoAccess CAPA Q2 2010 - Quarterly review of GeoAccess reporting by the Department of Audits & Accounts, revealed several data errors and network vulnerabilities.	10/14/10	11/19/2010	These data errors were corrected and network vulnerabilities were remediated through Provider Network Development staff.
GA	GA DCH	CAP	ER PIP Performance Concerns	10/26/10	12/29/2010	DCH requested minor changes/updates to the annual ER PIP Report.
GA	GA DCH	CAP	PCP Assignment Report CAPA Q3 2010 - When this report was submitted to DCH, it was identified that new data elements, recently added by DCH, were missing.	11/10/10	11/19/2010	Report was corrected and resubmitted.
GA	GA DCH	CAP	GeoAccess CAPA Q3 2010 - Quarterly review of GeoAccess reporting by the Department of Audits & Accounts, revealed several data errors and network vulnerabilities.	01/24/11	2/21/2011	These data errors were corrected and network vulnerabilities were remediated through Provider Network Development staff.
GA	GA DCH	CAP	Pharmacy Rebate CAPA - Pharmacy Rebate data could not be reconciled prior to the deadline originally imposed by DCH.	02/03/11	2/11/2011	DCH granted a two day extension and WellCare was able to meet this updated target.
GA	GA DCH	CAP	Timely Access CAPA Q4 2010 - Network adequacy for Adult Sick visits (24 hours) and Adult Routine visits (14 days) fell below the 90% benchmark for appointment wait time standards.	02/04/11	2/18/2011	Individual Provider Education was targeted at all providers who failed to meet this standard Face-to-face education with each "failed provider" took place.

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
GA	GA DCH	CAP	GeoAccess CAPA Q4 2010 - Quarterly review of GeoAccess reporting by the Department of Audits & Accounts, revealed several data errors and network vulnerabilities.	3/14/2011	4/15/2011	These data errors were corrected and network vulnerabilities were remediated through Provider Network Development staff.
HI	HI MedQuest	CAP	<p>HI HSAG EQRO Findings from 2010 review:</p> <p>1 Ensure that the cultural competency plan summary that it gives its providers (in the provider manual) includes a statement that the provider may obtain a full copy of the plan at no charge, and how to do so.</p> <p>2 Ensure that the provider Notice of Action (NOA) letters clearly articulate the required written information to the provider related to the kind of action being taken.</p> <p>3 Ensure that the information provided to members in the NOAs meets the requirement to ensure ease of understanding by the member.</p>	06/10/10	8/11/2010	<p>1. Revised Provider Manual to include notice to providers that they may request and obtain a copy of the full Cultural Competency Plan by calling the Plan's toll-free customer service number.</p> <p>2. A new provider NOA letter was created to clearly articulate the required information to the provider related to the kind of action being taken.</p> <p>3. 'Ohana instituted a monitoring program of NOA to ensure the communication to the member met grade level requirements and was clear and concise to ensure member understanding. Monitoring to be conducted monthly with direct feedback to the medical director.</p>
IL	HFS	Fine/\$4,000	Door-to-door marketing and providing misleading network information.	12/2007	12/2007	Training was strengthened with regard to all violations, and procedures were put in place to eliminate recurrence.

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
IL	HFS	Fine/\$4,000	Door-to-door marketing and providing misleading network information.	12/2007	12/2007	Training was strengthened with regard to all violations, and procedures were put in place to eliminate recurrence.
IL	HFS	Fine/\$2,000	Providing misleading information and an incomplete application.	12/2007	12/2007	Training was strengthened with regard to all violations, and procedures were put in place to eliminate recurrence.
IL	DOI	Fine/\$1,000	Failure to respond and comply with 3 orders from 2006 financial audit.	1/2008	1/2008	Fine paid.
IL	DOI	Fine/\$1,800	Failure to submit annual financial statement.	3/2008	3/2008	Fine paid.
IL	DOI	Fine/\$1,800	Failure to submit Risk-Based Capital Report.	3/2008	3/2008	Fine paid.
IL	DOI	Fine/\$9,600	Failure to submit audited financial statement.	9/2008	9/2008	Fine paid.
IL	DOI	Fine/\$300	Failure to submit audited financial statement.	9/2008	9/2008	Fine paid.
IL	DOI	Fine/\$37,200	Failure to submit audited financial statement.	9/2008	9/2008	Fine paid.
IL	DOI	Fine/\$1,000	Failure to receive permission to file an amendment to financial statements.	3/2009	3/2009	Fine paid.

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
MO	MO HealthNet	CAP	Back to School Flyer/Herbert Hoover Boys & Girls Club event with approval date 6/28/07, was distributed with unapproved language, specifically the word "prizes". This is in violation of contract cite 2.6.1 a. (14) dot point which prohibits MC+ Managed Care health plans from advertising gifts.	07/27/2007	07/27/2007	Upon receipt of the faxed letter from the state on July 27, 2007, Harmony's regulatory affairs contact informed the Director of Community Relations of the violation. All Community relations representatives were mobilized to pull all flyers from the market. The approved flyers were then printed and distributed. Harmony has a process for obtaining state approval on marketing materials. This process flow was interrupted resulting in miscommunication of the final state approved flyer. All parties involved in the process flow have been reeducated on the process and an additional step requiring regulatory review prior to distribution has been implemented to ensure there is not a reoccurrence of this contract violation.
MO	DSS/MO HealthNet	CAP	PCP Assignment - Monthly reports run by the State did not reflect PCP assignments for Harmony members. The state requested the health plan relay how it will ensure that every member is linked to a PCP.	01/25/10	2/25/2010	Harmony demonstrated compliance with linking every member to a PCP through submission of appropriate policy and procedures, and work flows. Harmony worked with the state's IT vendor to identify the disconnect between the State's data system, the IT vendor and Harmony.
MO	MO HealthNet	CAP	Provider Termination Notification - allegations that Harmony failed to provide notification to the state of a par hospital's intent to terminate their contract with the health plan.	10/26/2009	11/4/2009	Harmony demonstrated contractual compliance with notification requirements. The response letter was accepted by the MHD as submitted.

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
MO	MO HealthNet	CAP	Self-disclosed PHI Breach through third party vendor - Member periodicity letters were sent to 139 Harmony members with incorrect member information.	12/18/2009	12/23/2009	It was determined that the breach was a result of programming changes. The third party vendor immediately corrected the programming of the Missouri Periodicity file processing. The vendor committed to include Harmony/WellCare in any future programming changes prior to their occurrence. Quality processes were implemented to include verification of member data on all print/mail jobs on a sample basis across all lines of business.
MO	MO HealthNet	CAP	Failure to issue provider/member notifications within contractual timeframes - Specific to Notice of Action letters; Harmony failed to send notice of action letters to members for administrative denials (based upon determination that benefit was not covered) Harmony did send notifications to requesting providers and PCP only.	05/05/10	6/11/2010	Upon an adverse determination, Harmony now issues notice of action letters to members impacted by these decisions for any denial reason. This process is an automated process through the prior-auth department and was implemented on March 2, 2010.
MO	MO HealthNet	CAP	Marketing Flyer Violation - A par clinic distributed a marketing flyer which did not comply with the contractual guidelines.	8/3/2010	8/10/2010	Harmony immediately obtained a copy of the flyer at which time the clinic confirmed they had not communicated to Harmony their intent to produce a flyer, nor had they obtained prior written approval to use the Harmony logo. Harmony re-educated the clinic on contractual requirements concerning marketing guidelines and had all flyer removed from distribution.
MO	MO HealthNet	Sanction	MO Harmony Behavioral Health Review - intermediate sanction of 0.47% of one month of capitation payments resulting from repeat audit findings from 2009 to 2010 Behavioral Health Audit.	03/01/11	5/1/2011	Terminated former Behavioral Health vendor relationship on 8/30/2010.

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
MO	MO HealthNet	CAP	Fraud and Abuse Reporting - the state indicated that Harmony had not included two potential cases allegedly referred to the Plan by the state in 2009 and 2010 in subsequent quarterly F&A reports.	3/8/2011	3/31/2011	Harmony provided the state with documentation indicating that one of the referred cases had been termed from the Plan four months prior to the referral. The Plan has no record of receiving the 2009 referral. The state will consider the CAP closed when the Plan includes the case notes in the June 2011 quarterly report.
NY	SDOH	CAP	SDOH conducted a focused audit of WCNY's claims, utilization review, and grievance processes. SDOH identified deficiencies related to denials of emergency services claims, inappropriate denials of claims from non-participating providers, and incorrect denial letter language. SDOH issued a Statement of Deficiencies on August 9, 2005.	5/26/2005	9/07/2005	WCNY submitted a plan of correction ("POC") on September 7, 2005. SDOH approved the POC on September 16, 2005. The corrective actions have been implemented.

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
NY	SDOH	CAP	SDOH conducted follow-up focus survey to assess WCNY's compliance with Articles 44 and 49 of the Public Health Law and Title 10 of the New York Codes, Rules and Regulations (NYCRR). SDOH issued a Statement of Deficiencies on August 23, 2006 that addressed deficiencies related to WCNY's notices of adverse determination issued to enrollees that contained information which is inaccurate and/or misleading to the consumer public with regard to appeal rights. SDOH also determined that WCNY failed to demonstrate that its management information system (MIS) was capable of accurate data collection for analysis.	5/19/2006	9/11/2006	WCNY submitted a POC to SDOH on September 11, 2006 and implemented the necessary corrective actions. SDOH approved the POC in January of 2007. The corrective actions have been implemented.
NY	SDOH	CAP	SDOH conducted a focused audit of WCNY's Health Provider Network. SDOH issued a Statement of Deficiency that addressed WCNY's failure to identify and terminate contracts with physicians who appeared on the New York Office of Professional Medical Conduct (OPMC) sanctioned file. SDOH issued a Statement of Deficiency on October 24, 2006.	1/1/2006	11/2006	WCNY submitted a POC in November 2006. The SDOH approved the POC and the corrective actions have been implemented.

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
NY	SDOH	CAP	SDOH conducted a focused audit of WCNY's provider directory. SDOH issued a Statement of Deficiencies that addressed WCNY's failure to ensure that its provider directory is strictly factual in nature. SDOH also identified that three out of seventeen inaccurate provider listings from the prior survey remained uncorrected. SDOH issued a Statement of Deficiencies on January 29, 2007.	1/29/2007	3/9/2007	WCNY submitted a POC on March 9, 2007. SDOH approved the POC on April 5, 2007. The corrective actions have been implemented.
NY	SDOH	CAP	SDOH conducted a focused survey to assess WCNY's compliance with Articles 44 and 49 of the Public Health Law and Title 10 of the NYCRR. SDOH issued a Statement of Deficiencies on April 6, 2007 that addressed deficiencies related to WCNY's failure to accurately report its health provider network based on the inclusion of non-participating providers in WCNY's 4th Quarter 2006 Network Submission. SDOH also identified WCNY failed to remove such providers subsequent to the identification and sufficient notification of such by the SDOH.	4/6/2007	5/1/2007	WCNY submitted a Plan of Correction (POC) to SDOH on May 1, 2007 and implemented the necessary corrective actions. The POC was approved on May, 22, 2007.

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
NY	NY DOI	Fine	Review of the plan's prompt pay violations based on files reviewed by DOI which were closed between April 1, 2006 and March 31, 2007. The fine is based on a ratio of the number of files found in violation vs. the quantity of claims processed during the same timeframe. The claims processed exclude ASO contracts, Medicare HMO, Federally employee coverage and contracts issued outside of New York.	4/2/07	5/9/07	Plan was fined \$1800.00. Stipulation # 2007-0256-S.
NY	NYC DOHM	Fine	The New York City Department of Health and Mental Hygiene (" <u>NYC DOHMH</u> ") notified WCNY that it had conducted an investigation of allegations that WCNY marketing representatives were initiating cold calls to members enrolled in other plans with the intent of persuading them to transfer to WCNY. In addition, NYC DOHMH examined allegations that during face to face encounters, WCNY misled consumers into believing that they were enrolling into a plan that provided non-covered services.	9/26/2007		WCNY was directed to pay a civil penalty of Thirty Four Thousand Dollars (\$34,000), and institute a plan of correction including retraining of marketing personnel.

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
NY	NY DOI	Fine	Review of the plan's prompt pay violations based on files reviewed by DOI which were closed between April 1, 2007 and September 30, 2007. The fine is based on a ratio of the number of files found in violation vs. the quantity of claims processed during the same timeframe. The claims processed exclude ASO contracts, Medicare HMO, Federally employee coverage and contracts issued outside of New York.	11/5/07	11/15/07	Plan was fined \$5400.00. Stipulation # 2008-0080-S.
NY	NYS DOH	CAP	Statement of Deficiencies for Article 44/49 Site Survey - WellCare was issued eighteen (18) deficiencies based on Utilization Review letters, Grievance Letters, Credentialing and contract management.	06/11/08	2/3/2009	A Plan of Correction was submitted on July 10, 2008 and accepted by SDOH on March 3, 2009.
NY	NYS DOH	CAP	SDOH IPRO Statement of Deficiency - The 2007 IPRO Routine and Urgent Dental Appointment Availability Survey concluded that outside the NYC region WCNY scored below average results in routine and urgent care in New Rochelle and the North Eastern Region of New York. WCNY was required to provide a response to SDOH by August 6, 2008.	07/22/08	8/6/2008	The POC was approved on Sept 30, 2008.

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
NY	NYS DOH	CAP	Credentialing SOD - SDOH alleged that WCNY failed to process provider credentialing application within 90 days of receiving said application. The completed application was received by Plan August 2007; provider was credentialed July 17, 2008.	07/30/08	8/5/2008	A plan of correction was submitted on August 5, 2008 and approved by SDOH in September 2008.
NY	NYS DOH	CAP	Member Services Calls Q2 2008 - WellCare was in receipt of a letter that detailed issues that arose from SDOH efforts monitoring WellCare's Customer Services and Utilization Review departments. During the period of 7/22/08 to 7/25/08, SDOH made 9 calls; six responses were answered correctly and three incorrectly. Of the three incorrect responses, WC was asked to complete a Plan of Correction (POC) for only one incorrect response. The question, "Is Depo-Provera covered?" was answered incorrectly on a previous survey, therefore a plan of correction (POC) related to this incorrect response was submitted on August 25, 2008.	07/31/08	8/22/2008	The POC was approved by SDOH.

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
NY	NYS DOH	CAP	<p>Provider Directory Verification Study (1st Half 2008) - SDOH identified two (2) deficiencies regarding WCNY's Provider Directory.</p> <p>1. WCNY failed to ensure that our Printed Provider Directory contained accurate information. Twenty (20) out of 52 Providers sampled were inaccurate in content. This is a repeat Deficiency.</p> <p>2. There were two (2) out of 19 providers from the 2nd half 2007 Web-based Provider Directory Verification Study whose information has not been appropriately corrected in the Updated Web-based Provider Directory Verification Survey. This is a repeat Deficiency.</p>	08/21/08	9/17/2008	Correction of these deficiencies was required in order to bring WCNY into compliance. WCNY's response was submitted on Sept 17, 2008 and approved by SDOH.
NY	NYS DOH	CAP	<p>Fair Hearings Statement of Findings - SDOH found WCNY non-compliant in a fair hearings response regarding [name redacted]. A plan was required to send written notice to the enrollee and provider of all determinations. WCNY did not inform the provider and enrollee within 14 days of the receipt of the request.</p>	11/19/08	12/9/2008	A plan of correction that included the measure to correct this issue and any future issues, the actual or expected date of implementation and the party or parties responsible was submitted to SDOH on 12/9/2008 The POC was approved.

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
NY	NYS DOH	CAP	2007 MMCOR Statement of Deficiency - WCNY received a statement of deficiency (SOD) for failure to submit an acceptable annual 2007 MMCOR. SDOH alleged that the submission contained significant errors and inconsistencies.	11/21/08	12/1/2008	WCNY was required to submit a Plan of Correction by December 1, 2008 for each of the listed issues. The POC was accepted by SDOH.
NY	NYS DOH	CAP	Misdirected Calls SOD - SDOH issued a statement of deficiency for misdirected phone calls where WCNY Medicare members were instructed to call or were transferred to the SDOH complaint hotline during the period of 12/9/2008 – 12/15/2008. SDOH alleged that WCNY was in violation of 10 NYCRR 98.1.11(h): The governing authority of the MCO shall be responsible for the establishment and oversight of the MCO's policies, management and overall operation, regardless of the existence of any management contract.	12/17/08	1/7/2009	A plan of correction was submitted on January 7, 2009 and accepted by SDOH.
NY	NYS DOH	CAP	MLTC Audit and Cited Deficiencies - SDOH found five deficiencies: 1. Insufficient oversight by governing authority—review of the board meeting minutes revealed minimal discussions on activities pertinent to WellCare Advocate and WellCare Advocate Complete. Information was sparse and inadequate to satisfactorily demonstrate that the governing body was meeting its	01/05/09	1/20/2009	A Plan of Correction was submitted on January 20, 2009 and accepted by SDOH.

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
			<p>statutory and regulatory requirements pertaining to oversight of the program.</p> <p>2. The response letters for grievances lack documentation of the findings and whether the allegation was substantiated or not substantiated. In two instances, the response letter indicated that the issue raised by the complainant had been forwarded to the vendor for further investigation.</p> <p>3. Reassessment SAAM's were not always done in the required time frame.</p> <p>4. Failure to process as a service authorization request any services or item requested by a member. 5. There were no comprehensive care plans that showed current services authorized. There was a plan of care that was developed on enrollment, but there was no indication if it was implemented or changed and the reasons for the changes. It was difficult to determine if services, particularly evaluations (PT, OT, Social Work, etc) were authorized, if authorized were performed or if performed what the recommendations were.</p>			

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
NY	OMIG	Action	OMIG completed a final review of newborn and maternity supplemental capitation payments made to WCNY with no corresponding encounter data for service dates January 1, 2003 through December 31, 2005. The audit found that \$219,249.66 was inappropriately billed by WCNY to Medicaid for services rendered to newborns and mothers during a period where it appears the hospital was not paid.	2/2009	5/22/2009	In response to the draft report, WCNY submitted documentation on \$192,382.38 of the overpayments to support that WCNY was in fact entitled to the payments After reviewing the documentation, OMIG agreed with the WCNY response and reduced the findings to \$26,867.28 in the final report During the course of the audit WCNY repaid the \$26,867.28 overpayment through the submission of claim void transactions. In a revised final report, OMIG determined that accrued interest of \$5,700.57 was owed and due to SDOH. On May 22, 2009 WCNY submitted a check to SDOH in the amount of \$5,700.57.
NY	NYS DOH	CAP	Provider Directory Verification Study and Statement of Deficiency - SDOH has placed telephone calls to network providers to verify their participation with WCNY. SDOH outreached the providers with information from the Fall 2008 printed provider directory and the web-based provider directory.	02/18/09	3/11/2009	A Plan of Correction was submitted on March 11, 2009 and approved by SDOH.
NY	NYS DOH	CAP	Member Assignment Deficiency - SDOH issued WCNY a statement of deficiency for reassigning a PCP's enrollees to another PCP without verifying that the 2nd PCP did not practice at the three locations where his members were assigned.	02/25/09	3/18/2009	A Plan of Correction was submitted on March 18, 2009 and accepted by SDOH.

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
NY	NYS DOH	CAP	IPA Contracts Deficiency - WCNY received a Statement of Deficiency from SDOH regarding the response to a September 2008 letter. In the September 2008 letter, WellCare was required to bring our IPA contracts into compliance with the provider contract guidelines as well as submit a copy of each Medicaid contract that we have with FQHCs. WCNY completed the first requirement but failed to submit by December 31, 2008 all of our FQHC contracts SDOH required WCNY to submit each Medicaid FQHC contract with a contract statement and certification in accordance with the provider contract guidelines in a standard searchable PDF format on a closed session CD-R with copy/read permissions.	03/10/09	5/25/2009	The contracts were submitted on May 25, 2009 and approved by SDOH.

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<b>MEDICAID</b>						
NY	NYS DOH	CAP	Credentialing SOD - WCNY received a Statement of Deficiency from SDOH because: 1. In the 2nd QTR 2008 HPN review, WCNY said that Dr. [name redacted] (Thoracic Surgeon) will be reflected in the 4th QTR 2008 HPN submission. In the 4th QTR 2008 HPN submission, Dr. [name redacted] was not reflected. 2. In our 2nd QTR 2008 HPN review, we said that we have an existing agreement with the Queens/LI Medical Group and we are credentialing Dr. [name redacted]. In our 3rd QTR 2008 HPN Review, WCNY said that we are completing a credentialing audit and Dr. [name redacted] is expected to be credentialed by the end of January 2009. SDOH alleged that we failed to process the provider's credentialing application within 90 days.	03/23/09	4/7/2009	A Plan of Correction was submitted on April 7, 2009 and approved by SDOH.

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
NY	OMIG	Action	OMIG identified individuals who were enrolled in WCNY's Medicaid managed care plan at the time of their incarceration where the monthly capitation payments continued after the members were incarcerated and the Local Department of Social Services (LDSS) failed to facilitate the recovery. The audit identified \$21,292.60 in capitation payments where WCNY inappropriately re-billed monthly capitation payments for incarcerated enrollees.	4/2009	9/2009	In May 2009, WCNY submitted additional documentation and written arguments objecting to this determination and proposed action. In August 2009, WCNY voided the identified claims in the amount of \$21,305.80. In September 2009, WCNY received from OMIG a final audit report for Audit 09-2524. The final report confirmed that there are no further amounts due with respect to this audit.
NY	NYS DOH	CAP	Continuum Hospital Termination Deficiency - WCNY received a statement of deficiency for not providing SDOH with sufficient notice of the Continuum Hospital Termination. WCNY notified SDOH by telephone on 4/03/09 of the 04/06/09 termination, subject to a cooling off period. WCNY are required to provide written notice to SDOH 45 days prior to the termination date.	04/06/09	4/21/2009	A Plan of Correction was submitted to SDOH on April 21, 2009 and approved by SDOH.

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
NY	OMIG	Action	OMIG completed an audit of capitated payments made to WCNY after the date of death of recipients (the "Death Match 2009 Audit"). The audit included all dates of death through June 2008 that have been reported to NYS and NYC Vital Statistics. The audit found that \$183,099.94 was inappropriately billed by WCNY to Medicaid for capitation payments with respect to enrollees following their month of death.	5/2009	7/2009	In June 2009, WCNY submitted supporting documentation for a portion of the claims identified in the draft report in the amount of \$26,627.89. Additionally, OMIG found documentation identifying a portion of the claims identified in the draft report as having been identified and resolved prior to the Death Match 2009 Audit. These claims, totaling \$3,339.56, were previously voided by WCNY and are being removed from the findings of the Death Match 2009 Audit, reducing the total amount of inappropriately billed claims to \$154,132.49 In July 2009, WCNY voided the identified claims in the amount of \$154,132.49 to conclude the audit.
NY	OMIG	Action	OMIG conducted an audit of WCNY's claims with respect to incarcerated members. OMIG notified WCNY that it had identified capitation payments in the amount of \$39,553.15 made to WCNY with respect to incarcerated members following the month of incarceration over the period of the audit. OMIG requested that WCNY either void the claims or provide documentation supporting their right to the capitation payment. OMIG issued a final report on May 11, 2009 identifying an overpayment to WCNY of \$39,553.15. Subsequent to the issuance of this report, one claim was determined to have been paid appropriately, reducing the amount of the overpayment by \$192.44 to \$39,360.71.	5/11/2009	6/6/2009	WCNY submitted voids for all other claims and concluded the audit.

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
NY	NYS DOH	CAP	Psychiatry Based Deficiency re: 4th QTR HPN and Fall 2008 Provider Directory - WCNY received a statement of deficiency (SOD) from SDOH resulting from a complaint from a clinician seeking psychiatric services for a WCNY member in Albany County. According to the clinician, WCNY distributed a list of participating psychiatric providers in Albany County who upon outreach, claimed that they were no longer accepting WNCY or Harmony Behavioral Health. Subsequently, SDOH conducted a focus survey and found that out of the 29 psychiatric providers listed in the 4th QTR 2008 HPN, only 10 confirmed participation. These providers must be removed from the Provider Directory and the HPN.	04/08/09	4/29/2009	WCNY's plan of correction, included a review of WCNY's entire behavioral health network, was submitted to SDOH on April 29, 2009 and approved.
NY	NYS DOH	CAP	Provider Directory Verification Study (1st Half 2009) - A sample of 100 providers were called from June 29, to July 10, 2009 to verify participation in the network. A provider participation rate of 90% for Medicaid/FHP and 78% for CHP was confirmed. For the Web-based directory, a participation rate of 92% was confirmed.	08/20/09	9/11/2009	A Plan of Correction was submitted on September 11, 2009 and approved by SDOH.

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
NY	OMIG	Action	OMIG issued WCNY a draft report for an audit regarding capitation payments prior to birth. The purpose of the audit was to ensure that WCNY did not receive capitation payments for dates of service prior to the newborn's month of birth. The audit period included claims with dates of payment beginning February 1, 2004 and ending October 10, 2008. The audit found that \$4,641.50 was inappropriately paid to WCNY. Additionally, the audit identified one member with two (2) client identification numbers (CINs) with overlapping payments. The total of duplicate payments is \$649.90 The total finding was \$5,731.57 (including \$440.17 of interest).	10/2009	12/28/2009	On October 5, 2009, WCNY voided capitation payments for the identified members in the amount of \$5291.40 OMIG issued a final Audit Report in December 2009 requiring WCNY to make payment on the interest WCNY submitted payment of \$440.17 to OMIG on December 28, 2009.
NY	NYS DOH	CAP	2nd QTR 2009 HPN Review and SOD - WCNY received SDOH's review of its 2nd QTR 2009 HPN submission. In addition to providing an explanation for each identified network inadequacy, we also must respond to a statement of deficiencies (SOD). We were issued an SOD because we failed to ensure that the 2nd QTR 2009 HPN submission contained complete and adequate information about providers participating in the network.	09/22/09	10/6/2009	A Plan of Correction was submitted on October 6, 2009 and accepted by SDOH.

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
NY	NYS DOH	CAP	MLTC 2008 Nursing Home Report Submission Deficiency - SDOH rendered a SOD to the MLTC program for failing to submit complete, accurate and timely nursing home encounter data in 2008.	11/30/09	12/21/2009	A plan of correction was submitted on December 1, 2009 and approved by SDOH.
NY	NYS DOH	CAP	Statement of Deficiency--Healthplex Management Agreement Expiration - SDOH rendered a Statement of Deficiency (SOD) to WellCare because: WellCare failed to renew its management contract with Healthplex and permitted it to expire without written notice to the commissioner and WellCare continued to utilize Healthplex to perform management functions without an approved management contract.	12/16/09	1/4/2010	A Plan of Correction was submitted on Jan 4, 2010 and approved by SDOH.

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
NY	NYS DOI	Fine	New York State Department of Insurance (“DOI”) sent WCNY a list of ninety (90) DOI complaints between October 1, 2008 and September 30, 2009, where DOI determined that a prompt pay violation occurred. WCNY reviewed each case to determine whether the allegations of prompt pay violations were true and confirmed with DOI in February 2010 that prompt pay violations occurred in these 90 cases. In June 2009, WCNY received a stipulation from DOI assessing a fine in the amount of nine thousand dollars (\$9,000) which was paid in June 2010.	1/5/2010	6/1/2010	In June 2009, WCNY received a stipulation from DOI assessing a fine in the amount of nine thousand dollars (\$9,000) which was paid in June 2010.

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
NY	NYS DOH	CAP	Stipulation and Order from SDOH - SDOH mailed a Stipulation and Order to WellCare of New York as a result of WellCare's violation of Article 44 of the Public Health Law on October 10, 2007, April 15, 2008, August 20, 2008 and February 17, 2009. The cited violation dates reference the issuance date of statement of deficiencies resulting from site surveys conducted on August 23 – 28, 2007; December 26-27, 2007; July 7, 2008-August 12, 2008 and December 15 – 30, 2008. Pursuant to Public Health Law, WellCare was liable for penalties of \$2,000 for each cited violation [which according to SDOH, there were 10]. SDOH offered WellCare an opportunity to resolve these issues through a settlement agreement The stipulation assessed a civil penalty of twenty-thousand (\$20,000) to be paid by January 12, 2010 via certified mail.	12/29/09	1/12/2010	WCNY made payment to SDOH on January 12, 2010.

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
NY	OMIG	Action	WCNY received an OMIG draft audit report of locator codes related to capitation and supplemental payments made to WCNY for the year ended December 31, 2005. Based on its audit, OMIG has determined, on a preliminary basis, that due to the incorrect designations of the recipient's locator code, WCNY was overpaid \$4,742,887.	1/1/2010	5/1/2010	WCNY submitted written responses to OMIG in February 2010, April 2010 and May 2010 ultimately agreeing with the draft report findings. In addition, during WCNY's review of claims associated with the overpayments in the Draft Report, WCNY identified an additional \$2,475,727 in overpayments and \$835,966 in underpayments related to incorrect designations of recipients' locator codes. As a result, the findings increased to \$6,382,648 in the final report. Additionally, OMIG assessed interest in the amount of \$1,306,108. Based on this determination, the total amount of overpayment is \$7,688,756 WCNY is in the process of repaying this overpayment to OMIG.
NY	NYS DOH	CAP	Provider Directory Verification Study 2nd Half 2009 - SDOH has issued a Statement of Deficiencies (SOD) which is the result of SDOH's 2nd Half 2009 Provider and Web-based Directory Verification Studies. A sample of 100 providers was called during the period from December 28, 2009 to February 11, 2010 to verify participation in the network. A provider participation rate of 63% for Medicaid/FHP and 60% for CHP providers was confirmed. Since the accuracy rate was below 75%, two deficiencies were issued based on product line.	03/19/10	5/4/2010	A Plan of correction was submitted to SDOH on May 4, 2010 and approved.

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
NY	OMIG	Action	OMIG completed a draft audit of Managed Long Term Care capitation payments made to WCNY after the member's date of death. The audit included all dates of death through October 2009 that have been reported to Vital Statistics. The audit found that \$7,216.35 was inappropriately billed by WCNY to SDOH for capitation payments made following the enrollees' month of death. As a result, OMIG found that \$7,216.35 is due to NYS DOH.	4/1/2010	4/25/2010	In that same month, WCNY informed OMIG that it submitted claim voids in the amount of \$7,216.35 for the two members identified in the draft report. OMIG issued a final report in June 2010 stating that nothing further is owed.
NY	OMIG	Action	The New York State Office of the Medicaid Inspector General ("OMIG") completed a draft audit of Medicaid and Family Health Plus capitation payments made to WCNY after the member's date of death. The audit included all dates of death through October 2009 that had been reported to Vital Statistics. The audit found that \$62,850.72 in capitation was inappropriately paid to WCNY for Medicaid recipients following an enrollee's month of death. During the course of the audit there were claim rate adjustments in the amount of \$852.67, increasing the inappropriately paid total to \$63,703.39.	4/1/2010	5/1/2010	In April 2010, WCNY repaid the overpayment via the submission of claim void transactions in the amount of \$63,703.39 reducing the overpayment to \$0.00 in the final audit report of May 2010.

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
NY	OMIG	Action	OMIG issued a draft report for an audit which reviewed claims paid to WellCare for dates of service from January 1, 2006 through December 31, 2008. The review identified instances where Supplemental Maternity or Newborn Capitation payments were made to the plan and no corresponding encounter data was reported supporting the payment. WellCare was instructed to submit encounter data where appropriate to support the supplemental payments. According to the audit, WellCare was overpaid \$996,052.22.	5/2010	5/23/2011	In response to the draft report, WellCare submitted supporting documentation for a portion of the claims identified in the draft report in the amount of \$984,749.12. Subsequently, OMIG reduced the findings by \$984,749.12 therefore resulting in WellCare owing \$11,303.10. During the course of the audit, WellCare repaid \$11,303.10 via the submission of claim void transactions. The remaining overpayment was reduced to \$0. However, in February 2011, per NY regulation, OMIG requested an interest payment in the amount of \$2,636.14. On March 4, 2011 WellCare submitted a payment for the remaining interest via check, however, on March 10, 2011; OMIG issued a Notice of Withholding Form because, at the time of notice, OMIG was not in receipt of \$2,636.14. OMIG informed WellCare that it is withholding 50% payments for all current and future claims to recover the monies owed. On March 23, 2011, OMIG informed WellCare that it did receive the interest payment via check and subsequently will refund the withholding via a check to WellCare for \$2,636.14 by April 1, 2011.

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
NY	OMIG	Action	OMIG completed an audit of Healthy Choice and Family Health Plus capitation payments made to WellCare for incarcerated enrollees for the period beginning January 1, 2008 through June 30, 2009. The purpose of the audit was for OMIG to identify instances where WellCare received a capitation payment from SDOH when the enrollee was incarcerated for the entire payment month. The audit found \$37,899.83 in capitation payments were inappropriately paid to WellCare.	5/2010	6/2010	In June 2010 WellCare informed OMIG that, of the \$37,899.83 in capitation payments allegedly paid inappropriately to WellCare, \$11,881.13 were paid correctly for the member months of two members and therefore only \$26,018.70 was inappropriately paid. OMIG agreed with this assessment and in June 2010, WellCare submitted claim voids in the amount of \$26,018.70.
NY	NYS DOH	CAP	Complaint Determination Letters - SDOH issued a statement of deficiency and statement of findings resulting from a non-compliant Complaint Determination Notice triggered on January 14, 2010. According to SDOH, the notice was missing required information including detailed reasons for the determination and clinical rationale.	03/29/10	5/3/2010	A Plan of Correction was submitted to SDOH on May 3, 2010 and approved.

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
NY	NYS DOH	CAP	<p>Article 44/49 Statement of Deficiencies - During the 2010 SDOH Site Survey, WCNY was cited for the following:</p> <ul style="list-style-type: none"> <li>• Governing Authority of WCNY</li> <li>• Board of Directors Minutes</li> <li>• Delegation Oversight</li> <li>• Health Services Determination letters (Initial and Final)</li> <li>• Ownership of Corporate Management Agreements</li> <li>• Provider Manual</li> <li>• The POC was successfully entered into C360 (WellCare's Internal Compliance Tracking System) by Corporate Compliance</li> <li>• Business Owners are required to submit documentation into C360 confirming step-action plans are completed</li> <li>• C360 Reports demonstrate that POC implementation is being adhered to within mandated time frames</li> </ul>	08/26/10	9/17/2010	A Plan of Correction was submitted on September 17, 2010 and approved by SDOH.

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
NY	OMIG	Action	OMIG completed an audit of Healthy Choice and Family Health Plus capitation payments made to WellCare that were inappropriately paid for retroactively disenrolled members that presented no risk for the managed care organization. According to OMIG, WellCare was previously notified of the inappropriate payments and instructed to void the payments. OMIG identified retro disenrollment capitation payments that did not have a subsequent claim void submitted by WellCare. The audit found \$2,832.87 in capitation payments were inappropriately paid to the plan.	7/2010	10/2010	In August 2010, WellCare submitted void files to OMIG for \$2,832.87 for eight members. Interest payment of \$137 was paid by WellCare via check in September 2010.
NY	NYS DOH	CAP	IPRO 2009 Primary Care Access & Availability Survey - WCNY has received a Statement of Deficiency from SDOH regarding the results of the 2009 Primary Care Access & Availability Survey. A SOD is issued when call type categories fall below the 75% threshold.	10/12/10	11/2/2010	A Plan of Correction was submitted on November 2, 2010 and approved by SDOH.

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
NY	NYS DOH	CAP	Provider Directory Verification Study (1st Half 2010) - WCNY received the results of the SDOH Printed Provider Directory Verification Study, 1st Half 2010 and the Web-Based Provider Directory Verification Study, 1st Half 2010. Four (4) deficiencies were cited. As three (3) are repeat deficiencies, a governing authority deficiency was also issued. The focus of the verification study was Behavioral Health and Dental Providers in the Web-Directory and the Spring 2010 Printed Provider Directory (issued January 2010).	11/05/10	12/1/2010	A Plan of Correction was submitted on December 1, 2010 and approved by SDOH.
NY	NYS DOH	CAP	Member Services Calls Q4 2010 - SDOH completed its 3rd QTR 2010 telephone survey of WCNY. The Survey is designed to obtain information from Member Services and the Utilization Review department and to monitor correct responses to questions. Because WCNY provided an incorrect response for two (2) consecutive surveys, SDOH issued WCNY a Statement of Finding (SOF).	12/22/10	1/14/2010	A Plan of Correction (POC) was submitted to SDOH on January 14, 2010 and approved.

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
NY	OMIG	Action	WellCare received the Draft Report for OMIG Audit 10-7195 which alleged that WellCare was overpaid \$74,521.04 in monthly capitation payments for members who were retroactively disenrolled from the plan and placed into a Residential/Skilled Nursing Health Care Facility.	1/2011	3/2011	In February 2011, WellCare contested \$37,868.20 in charges by providing documentation that supported WellCare's payments of claims for enrollees listed in Draft Report for Audit 10-7195. The payments were submitted to OMIG to serve as evidence that identified members had not been placed in a Residential/Skilled Nursing Health Care Facility as OMIG suggests. In March 2011, OMIG provided a Final Audit report indicating that it accepted the supporting documentation and agreed that the total amount of the overpayment that WellCare must return is \$36,979.66 and not \$74,521.04 In March 2011, WellCare completed claim void for 111 member months, and 46 members for the amount of \$36,979.66
NY	NYS DOH	CAP	Encounter Data - WellCare received a Statement of Deficiency from SDOH regarding its 2010 Newborn/Maternity Encounter Data Reporting. SDOH alleges that in 2010, WellCare failed to submit complete and accurate newborn and maternity encounter data. No further information is provided WellCare submitted a plan of correction (POC) indicating the measure taken to correct the deficiency, the timetable for implementation, the responsible parties and methods.	03/14/11	4/29/2011	A plan of correction was submitted and is under review.

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
NY	NYS DOH	CAP	Provider Directory Verification Study 1st Half 2010 - WellCare of New York, Inc (WCNY) received the results of the 1st Half, 2010 Provider Directory Verification Study. The focus of the study was Dental and Behavioral Health Providers. Four (4) deficiencies were issued.	03/30/11	4/20/2011	A plan of correction was submitted and is under review.
NY	NYS DOH	CAP	Complaint Statement of Findings - WCNY received a Statement of Findings from SDOH. In a complaint investigation, SDOH alleged that WellCare violated its Medicaid contract by not allowing the Enrollee's spouse to file a complaint on the member's behalf in regards to a bill received by Albany Memorial Hospital for services rendered on November 22, 2010.	03/30/11	4/20/2011	A plan of correction was submitted and is under review.
OH	OH DJFS	CAP/Fine \$10,000	Provider Panel Requirements	04/23/07	5/8/2007	Provider file showed deficiencies in required specialties within certain contracted counties. These deficiencies were rectified by the next file submission.
OH	OH DJFS	Response to ODMH/O DADAS Provider	Provider Directory	07/02/07	7/9/2007	A provider's information was not listed correctly in the print directories and online. The issue was remediated within one week by updating online and print directories.

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
OH	OH DJFS	Fine	Appeal File	07/24/07	7/27/2007	The Appeals file is due on the 15th of each month. The file was placed to the outbound folder on July 13 <sup>th</sup> . However, on July 19th we learned that ODJFS did not receive the file. We found that unforeseen circumstances affected our ability to successfully transmit the file to ODJFS' ftp site. We added an additional verification step, instructed by ODJFS, which allows us to connect to the ODJFS server and confirm ODJFS' receipt of electronic submissions.
OH	OH DJFS	CAP/Points	Call Center Standards	04/14/08	4/23/2008	Average Speed of answer exceeded 30 seconds for member services line (40 seconds). This happened one month only from 2006-current.
OH	OH DJFS	CAP/Points	Phone Log Audit/Grievance Process – Potential grievances not indicated as such in the call record	08/28/08	9/5/2008	Issue was remediated by the June 22, 2009 audit (8 call records out of compliance (out of 800 submitted))
OH	OH DJFS	CAP	Delegation Requirements - Failed to submit proper documentation for delegation of a subcontract within the proper timeframe.	02/27/09	3/2/2009	Proper documentation sent on 3/2/09
OH	OH DJFS	CAP	McKesson 24 hour Nurse Line - vendor had an ASA of 31 and 32 seconds in September and October, exceeding the ASA requirement of 30 seconds ASA of 46 seconds in January 2011.	10/12/09 2/17/2011	10/12/2009 3-1-2011	McKesson modified process to correct overall issue.
OH	OH DJFS	CAP	Encounter Data Volume Lower than Expected - This was a timing issue based on program changes in submission.	04/13/10	4/13/2010	The issue was already remediated by the time the CAP was issued.

State	Agency	Category	Audit/CAP Detail	CAP Issue Date	CAP Status Date (Date CAP Response sent to Agency)	Description of Resolution
<b>MEDICAID</b>						
OH	OH DJFS	CAP	2010 HSAG Audit - Required consent forms from providers were all present, but some did not have all required fields populated.	07/16/10	8/10/2010	ODJFS provided clarification e-mails to all plans on required fields as a result of the audit WellCare paid fine of \$15,000.
OH	OH DJFS	CAP	Case Management Risk Stratification consent/delegation - Changes by the State mid-year in the CM program tiering caused a discrepancy in the risk stratification tier	8/4/2010	8/20/2010	Issue was corrected by the submission of the next CAMS file. Results found as part of an HSAG full Audit, in which WellCare scored 95percent.
OH	OH DJFS	CAP	Provider Panel Requirements - Provider file showed 1 dental deficiency in Medina county.	08/10/10	9/7/2010	Issue was a file issue and not an issue with the panel Remediated the next day with the daily submission of the file WellCare paid fine of \$1,000.
OH	OH DJFS	CAP	Phone Log Audit - narratives did not capture specific reason for call (lost vs. stolen card).	09/01/10	9/10/2010	Process was updated to include lost or stolen in the narrative.
OH	OH DJFS	CAP/Points	McKesson 24 hour Nurse Line - Average speed of answer exceeded 30 seconds.	02/17/11	2/28/2011	Vendor failed to meet the 30 second ASA because they failed to keep WellCare on the priority status Priority status was re-instituted in February and will be standard going forward.
OH	OH DJFS	CAP	Clinical Performance Measures - CAP on 3 of 15 Clinical performance measures - failure to meet standard on 3.	03/21/11	4/28/2011	Met the overall requirements which were 12 of 15.
OH	OH DJFS	CAP	Overall Expense Ratio	04/11/11	due 5-13-2011	Overall expense ratio exceeded 100% (102%)
OH	OH DJFS	CAP	Emergency Department Diversion	04/26/11	5/24/11	Standards not met for SFY 2011 CFC EDD, report period Jan through December 2009 Result equals 5.50% and difference from baseline is 0.57% increase.

**Exhibit B.25.b – Summary of Medicare Regulatory Actions, Sanctions and/or Fines**

Agency	Category	Audit/ CAP Title	CAP Status (Open/ Closed)	CAP Issue Date	CAP Status Date (Date CAP response sent to Regulatory Agency)	CMP	Description of Resolution
<b>MEDICARE</b>							
CMS	CMP	CY2010 ANOC/EOC mailers: timeliness & accuracy with submissions.	Closed	11/10/2009	1/11/2011	\$16,750	A source of truth material process was implemented to ensure accurate information is pulled into our membership communications.
CMS	CAP	Routine Part D audit	Closed	10/16/07	10/31/07	NA	Policies were not clear on processing of formulary changes, exception notifications and handling of IRE reversals Policies were revised and notification letters enhanced to ensure clear communication to members and third parties (as appropriate).
CMS	CAP	Enrollment, Marketing, Appeals, Grievances – post sanction audit.	Closed	9/15/2008	11/30/2009	NA	WellCare conducted internal audits and submissions to CMS Conducted final parallel audit with CMS January 2011 The audit findings lead to process remediation to make us compliant with CMS requirements.
CMS	Audit	Targeted Pharmacy Audit – Network, August 6, 2007	No CAP	NA	NA	NA	None, no findings
CMS	NONC	OOSA (Out of Service Area) Notice of Non Compliance (NONC).	Closed	06/22/10	NA	NA	WellCare conducts address look ups in CMS MARx to send Out of Service Area notification letters to members.
CMS	CAP	CMS Financial Audit WellCare Prescription Service, Inc. S5967 CY 2006.	Closed	05/10/10	7/1/2010	NA	WellCare enhanced its controls and processes around DIR calculations and retention of EOB documentation.

Agency	Category	Audit/ CAP Title	CAP Status (Open/ Closed)	CAP Issue Date	CAP Status Date (Date CAP response sent to Regulatory Agency)	CMP	Description of Resolution
<b>MEDICARE</b>							
CMS	CAP	CMS Financial Audit H1903 CY 2006	Closed	08/05/10	10/5/2010	NA	WellCare enhanced its controls around claims pricing, DIR calculation, MSP, and duplicate claims processing In addition, implemented processes to compliment new processes implemented by CMS to track/ report TrOOP dollars and accumulations.
CMS	CAP	CMS Financial Audit WellCare of New York H3361 CY 2006	Closed	08/05/10	10/5/2010	NA	WellCare enhanced its controls around claims pricing, DIR calculation, MSP, and duplicate claims processing In addition, implemented processes to compliment new processes implemented by CMS to track/ report TrOOP dollars and accumulations.
CMS	CAP	CMS Financial Audit WellCare of Florida H1032 CY 2006	Closed	08/05/10	10/5/2010	NA	WellCare enhanced its controls around claims pricing, DIR calculation, MSP, and duplicate claims processing In addition, implemented processes to compliment new processes implemented by CMS to track/ report TrOOP dollars and accumulations.
CMS	CAP	CMS Financial Audit WellCare of Connecticut H0712 CY 2007	Open	09/17/10	11/16/2010	NA	WellCare enhanced its controls around claims pricing, DIR calculation, MSP, and duplicate claims processing In addition, implemented processes to compliment new processes implemented by CMS to track/ report TrOOP dollars and accumulations.
CMS	CAP	CMS Financial Audit WellCare of Georgia H1112 CY 2007	Open	09/17/10	11/16/2010	NA	WellCare enhanced its controls around claims pricing, DIR calculation, MSP, and duplicate claims processing In addition, implemented processes to compliment new processes implemented by CMS to track/ report TrOOP dollars and accumulations.

Agency	Category	Audit/ CAP Title	CAP Status (Open/ Closed)	CAP Issue Date	CAP Status Date (Date CAP response sent to Regulatory Agency)	CMP	Description of Resolution
<b>MEDICARE</b>							
CMS	CAP	CMS Financial Audit WellCare of New York H3361 CY 2007	Open	10/06/10	12/3/2010	NA	WellCare enhanced its controls around claims pricing, DIR calculation, MSP, and duplicate claims processing In addition, implemented processes to compliment new processes implemented by CMS to track/ report TrOOP dollars and accumulations.
CMS	CAP	CMS Financial Audit WellCare of Florida H1032 CY 2007	Open	10/06/10	12/3/2010	NA	WellCare enhanced its controls around claims pricing, DIR calculation, MSP, and duplicate claims processing In addition, implemented processes to compliment new processes implemented by CMS to track/ report TrOOP dollars and accumulations.
CMS	Warning letter	Quality Improvement (QIP) warning letter (NY, FL, LA)	Closed	08/11/10	NA	NA	Corporate wide Quality program was initiated to target key HEDIS measures.
CMS	Warning letter	Best Available Evidence reporting - Failure to submit file on 12/24/2010	Closed	04/11/11	NA	NA	Enrollment team added an additional check to ensure all CMS vendor (Acumen) submissions are accepted.
CMS	Outlier Notice	CTM Outlier Notice - WellCare received a high number of complaints in July	Closed	08/25/10	9/8/2010	NA	Root cause analysis was conducted by functional business area to determine how to fix "controllable" member complaints.
CMS	NONC	Noncompliant Risk Adjustment Data File Submission	Closed	11/04/10	11/16/2010	NA	Instituted a better data scrubbing process to prevent submission of duplicate records.
CMS	CAP	CMS Compliance Audit	Open	1/5/2011	3/5/2011	NA	WCG prepared comprehensive response of current and future processes to address minor gaps in the Compliance program with respect to HPMS memo distribution, specific operational FWA training, and additional non-retaliation language in compliance materials.
CMS	NONC	PDE January submission failure	Closed	4/27/2011	NA	NA	Submitted January data in February once PBM obtained PDE certification.

Agency	Category	Audit/ CAP Title	CAP Status (Open/ Closed)	CAP Issue Date	CAP Status Date (Date CAP response sent to Regulatory Agency)	CMP	Description of Resolution
<b>MEDICARE</b>							
CMS	Warning letter	Rx Bin PCN invalid data submissions	Closed	11/2/2009	11/10/2009	NA	Submitted corrected information to CMS 11/10/2009
CMS	Warning letter	Customer Service availability after hours	Closed	3/24/2008	NA	NA	Verified CSR routing and availability. Conducted testing to ensure service levels were meeting guidelines.
CMS	Warning letter	Disconnect rates exceed 5% HI - 5.56% PDP 7.2%	Closed	4/24/2009	NA	NA	Verified CSR routing and availability. Conducted testing to ensure service levels were meeting guidelines.

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## B.26

***Provide a statement of whether your organization is currently the subject or has recently (within the past five (5) years) been the subject of a criminal or civil investigation by a state or federal agency other than investigations described in response to item B.6. If your organization has recently been the subject of such an investigation, provide an explanation with relevant details and the outcome. If the outcome is against your organization, provide the corrective action plan implemented to prevent such future offenses. Include your organization's parent company, affiliates and subsidiaries.***

The Company incorporates by reference as if set forth fully herein the Company's response to Sections B.4 and B.6. As has been widely reported, the Company was investigated by federal and state authorities beginning in 2007. These investigations already have been resolved or are pending final settlement. The following is a description and current status of the legal matters that flowed from the events that transpired in 2007. Since 2007, the Company has transformed its leadership and internal processes so as to avoid the problems that led to these investigations.

On October 24, 2007, government agents executed a search warrant at the headquarters of the Company in Tampa, Florida. As a result, the Company learned that it was the subject of an investigation by certain federal and state agencies, regulatory bodies and organizations. During the investigation, the Company cooperated fully and took extensive actions to remediate itself.

In May 2009, the Company entered into a Deferred Prosecution Agreement (the "**DPA**") to resolve the investigation. A copy of the DPA and the accompanying documents can be found on the Company's website at [www.wellcare.com](http://www.wellcare.com). The term of the DPA is thirty-six months, but such term may be reduced by the USAO Florida to twenty-four months upon consideration of certain factors set forth in the DPA, including the Company's continued remedial actions and compliance with all federal and state health care laws and regulations. As a part of the DPA, the Company retained an independent monitor (the "**Monitor**") for a period of 18 months from August 19, 2009 to February 18, 2011. The Monitor was selected by the USAO Florida after consultation with the Company and was retained at the Company's expense. In addition, the Company agreed to continue undertaking remedial measures to ensure full compliance with all federal and state health care laws. Among other things, the Monitor reviewed and evaluated the Company's compliance with the DPA and all applicable federal and state health care laws, regulations and programs. The Monitor also reviewed, evaluated and, as necessary, made written recommendations concerning certain of WellCare's policies and procedures. The Company agreed with and has implemented, or is in the process of implementing, those recommendations.

In October 2008, the Civil Division of the United States Department of Justice (the "**Civil Division**") informed the Company that as part of the government's investigation described above, the Civil Division was investigating four *qui tam* complaints filed by relators against the Company under the whistleblower provisions of the False Claims Act, 31 U.S.C. sections 3729-3733.

The Company also learned from a docket search that a former employee filed a *qui tam* action on October 25, 2007 in state court for Leon County, Florida against several defendants, including the Company and one of its subsidiaries (the "**Leon County qui tam Action**").

On June 24, 2010, (i) the United States government filed its Notice of Election to Intervene in three of the *qui tam* matters, and (ii) the Company announced that it had reached a preliminary agreement with the Civil Division, the United States Attorneys' Offices for the Middle District of Florida (the "**USAO Florida**"), and the Civil Division of the United States Attorney's Office for the District of Connecticut (the "**USAO Connecticut**") to settle their pending inquiries.

On April 26, 2011, the Company entered into certain settlement agreements which resolved these pending *qui tam* cases and related civil investigations. These settlements resolved the following *qui tam* cases: *U.S. et al. ex rel. Hellein v. WellCare Health Plans, Inc., et al.*, Case No. 8:06-cv-01079-T-30-TGW (M.D. Fla. June 21, 2010); *U.S. ex rel. Bolton v. WellCare Health Plans, Inc., et al.*, Case No. 8:07-cv-01909-T-30-TGW (M.D. Fla. Oct. 19, 2007); *U.S. et al. ex rel. Gonzalez v. WellCare Health Plans, Inc.*; Case No. 8:08-cv-1691-T-30-TGW (M.D. Fla. May 22, 2008); and *U.S. et al. ex rel. SF United Partners v. WellCare Health Plans, Inc., et al.*, Case No. 3:07cv1688 (SRU) (D. Conn. Nov. 15, 2007) and the Leon County *qui tam* Action.

These settlement agreements are with (a) the United States, with signatories from the Civil Division, the Office of Inspector General of the Department of Health and Human Services ("**OIG-HHS**") and the Civil Divisions of the USAO Florida and the USAO Connecticut (the "**Federal Settlement Agreement**") and (b) the following states (collectively the "**Settling States**"): Connecticut, Florida, Georgia, Hawai'i, Illinois, Indiana, Missouri, New York and Ohio (collectively, the "**State Settlement Agreements**"). The material terms of the Federal Settlement Agreement and the State Settlement Agreements are, collectively, substantively the same as the terms of the preliminary settlement with the Civil Division, the USAO Florida and the USAO Connecticut.

The terms of these settlement agreements are as follows: In exchange for the payment of the settlement amount, the United States and the Settling States agree to release WellCare from any civil or administrative monetary claim under the False Claims Act and certain other legal theories for certain conduct that was at issue in their inquiries and the *qui tam* complaints. Likewise, in consideration of the obligations in the Federal Settlement Agreement and the Corporate Integrity Agreement (see below), OIG-HHS agreed to release and refrain from instituting, directing or maintaining any administrative action seeking to exclude the Company from Medicare, Medicaid and other federal health care programs.

The Federal Settlement Agreement has not been executed by one of the relators. Under its terms, this failure to timely execute is deemed to be an objection to the Federal Settlement Agreement. In the case of an objection, the United States District Court for the Middle District of Florida (the "**Federal Court**") is required to conduct a hearing (a "**Fairness Hearing**") to determine whether the proposed settlement is fair, adequate and reasonable under all the circumstances. The Federal Settlement Agreement and the State Settlement Agreements will not be effective until the earlier of (a) the execution of the Federal Settlement Agreement by the objecting relator or (b) entry by the Federal Court of a final order determining that the settlement is fair, adequate and reasonable under all the circumstances.

As part of the Federal and State settlement agreements, on April 26, 2011, the Company also entered into a Corporate Integrity Agreement (the "**CIA**") with the OIG-HHS. The CIA has a term of five years.

The CIA formalizes various aspects of the Company's ethics and compliance program and contains other requirements designed to help ensure the Company's ongoing compliance with

federal health care program requirements. The terms of the CIA include certain organizational structure requirements, internal monitoring requirements, compliance training, screening processes for new employees, reporting requirements to OIG-HHS, and the engagement of an independent review organization to review and prepare written reports regarding, among other things, the Company's reporting practices and bid submissions to federal health care programs.

Since the events of 2007, the Company has been transformed, with new leadership in the Board of Directors and a new executive leadership team. Highlights of this transformation include:

- Board of Directors. Charles G. Berg was appointed Chairman in January 2008 and since then, several outside directors with stellar credentials have joined the board, including: (i) David J. Gallitano (March 2009); (ii) Glenn D. Steele, M.D. (November 2010); (iii) Paul E. Weaver (February 2010); (iv) William L. Trubeck (February 2010); and (v) Carol J. Burt (June 2010).
- Senior Management Team. The business has been reorganized, new positions have been created and a new senior management team has been appointed, including: (i) Alec Cunningham, Chief Executive Officer; (ii) Thomas L. Tran, Chief Financial Officer; (iii) Timothy S. Susanin, Senior Vice President and General Counsel; (iv) Walter W. Cooper, Chief Administrative Officer; (v) Maurice S. Hebert, Chief Accounting Officer; (vi) Blair W. Todt, Senior Vice President and Chief Compliance Officer; (vii) Ann O. Wehr, M.D., Chief Medical Officer; (viii) Scott D. Law, Senior Vice President, Health Care Delivery; (ix) Jesse L. Thomas, President, South Division; (x) Marc Russo, President, North Division; and (xi) Larry D. Anderson, Senior Vice President and Chief Human Resources Officer.
- WellCare has set a new and exemplary “tone at the top” and has created a new culture that emphasizes integrity, personal accountability, ethical business practices, regulatory compliance and transparency with federal and state agencies, government clients and investors.
- WellCare commitments and values are enunciated in its new Code of Conduct and Business Ethics and in a broad array of new policies and procedures. They are reflected in the daily work of the thousands of associates who are dedicated to serving the beneficiaries of the Medicare and Medicaid programs.
- Since January 2008, the Board of Directors of WellCare and senior management have transformed the culture and operations of WellCare through a series of comprehensive corporate compliance and governance initiatives. Among other things, they have:
  - (i) Established two new board committees with separate charters focusing on, respectively, Regulatory Compliance and Health Care Quality and Access;
  - (ii) Separated the general counsel and chief compliance officer functions, and named a total of five new vice presidents in those two departments;
  - (iii) Separated the chief financial officer and chief accounting officer functions;
  - (iv) Added a chief auditor function that reports directly to the Audit Committee of the Board of Directors;
  - (v) Developed, and invested in, a new robust compliance organization to meet the evolving needs of WellCare; and

- (vi) Launched a new enhanced company-wide compliance program, which includes mandatory training in critical areas, clear reporting and channels for anonymous alerts, including a telephonic hotline and web-based system.

**B.27**

**Submit client references (minimum of three, maximum of five) for your organization for major contracts; with at least one reference for a major contract you have had with a state Medicaid agency or other large similar government or large private industry contract. Each reference must be from contracts within the last five (5) years. References for your organization shall be submitted to the State using the questionnaire contained in RFP Appendix PP. You are solely responsible for obtaining the fully completed reference check questionnaires, and for submitting them sealed by the client providing the reference, with your Proposal, as described herein. You should complete the following steps:**

- a. Make a duplicate (hard copy or electronic document) of the appropriate form, as it appears in RFP Appendix PP (for your organization or for subcontractors, adding the following customized information:**
  - **Your/Subcontractor’s name;**
  - **Geographic Service Area(s) for which the reference is being submitted;**
  - **Reference organization’s name; and**
  - **Reference contact’s name, title, telephone number, and email address.**
- b. Send the form to each reference contact along with a new, sealable standard #10 envelope;**
- c. Give the contact a deadline that allows for collection of all completed questionnaires in time to submit them with your sealed Proposal;**
- d. Instruct the reference contact to:**
  - **Complete the form in its entirety, in either hard copy or electronic format (if completed electronically, an original should be printed for submission);**
  - **Sign and date it;**
  - **Seal it in the provided envelope;**
  - **Sign the back of the envelope across the seal; and**
  - **Return it directly to you.**
- e. Enclose the unopened envelopes in easily identifiable and labeled larger envelopes and include these envelopes as a part of the Proposal. When DHH the opens your Proposal, it should find clearly labeled envelope(s) containing the sealed references.**

WellCare is providing the following client references in accordance with the RFP requirements:

State Medicaid Agency	Agency Contact	Scope of Service
1. Florida Agency for Health Care Administration	Melanie Brown-Woofter Acting Assistant Deputy Secretary, Managed Care Operations	Medicaid managed care services for approximately 420,000 members; TANF, SCHIP core population served.
2. Georgia Department of Community Health	Dr. Jerry Dubberly Chief, Medicaid Division	Medicaid managed Medicaid managed care services for approximately 560,000 members; TANF, SCHIP core population served.

State Medicaid Agency	Agency Contact	Scope of Service
3. Hawai'i Department of Human Services	Dr. Kenneth Fink Administrator MedQuest Division	Medicaid managed care services for approximately 22,000 members; ABD core population served.
4. Illinois Department of Healthcare and Family Services	Michelle Maher Chief, Bureau of Managed Care	Medicaid managed care services for approximately 144,000 members; TANF, SCHIP core population served.
5. Ohio Department of Jobs and Family Services	Dale Lehmann Assistant Bureau Chief Policy & Health Plan Services	Medicaid managed care services for approximately 100,000 members; TANF, SCHIP core population served.

**B.28**

**Indicate the website address (URL) for the homepage(s) of any website(s) operated, owned, or controlled by your organization, including any that the Proposer has contracted to be run by another entity as well as details of any social media presence ( e.g., Facebook, Twitter). If your organization has a parent, then also provide the same for the parent, and any parent(s) of the parent. If no websites and/or social media presence, so state.**

Exhibit B.28.a and Exhibit B.28.b beginning on the following page, provide a listing of the website addresses (URLs) for the homepages of websites operated, owned or controlled by WellCare and its subsidiaries.

WellCare's Corporate Communications Department maintains policies and procedures for social media. Any WellCare employee who plans to engage in social media on behalf of the company must notify the Corporate Communications Department of his or her intentions in order to ensure compliance with established policies and procedures. At this time, WellCare has social media accounts with Twitter and LinkedIn, as listed below.

- Twitter: WellCare currently has three accounts.
  - WCGHealthPlans: intended for company announcements;
  - WellCare\_Health: intended for information articles and health-related information;  
and
  - WCGWellCare: intended for community/volunteering information.
- LinkedIn
  - <http://www.linkedin.com/company/wellcare>: intended for networking and recruitment purposes.

**Exhibit B.28.a – WellCare Managed Sites**

Destination Site Name	Destination Site URL	URL Used	How URL Is Displayed
WellCare	wellcare.com	wellcare.com	http://www.wellcare.com/
		wellcarehmo.com	http://www.wellcare.com/
		wellcareny.com	http://www.wellcare.com/
Harmony	harmonybehavioralhealth.com	harmonybehavioralhealth.com	Please note that Harmony Behavioral Health is currently in the process of transitioning to Magellan Behavioral Health.
Harmony Health Plans of Illinois	harmonyhpi.com	harmonyhpi.com	http://www.harmonyhpi.com/
Harmony Health Plans of Missouri	harmonyhpm.com	harmonyhpm.com	http://www.harmonyhpm.com/
Ohana	ohanahealthplan.com	ohanacares.com	http://www.ohanacares.com/
		ohanacares.org	http://www.ohanacares.org/
		ohanahealthplan.com	http://www.ohanahealthplan.com/
PDP	wellcarepdp.com	pdpwellcare.com	http://www.wellcarepdp.com/
		pdpwellcare.net	http://www.wellcarepdp.com/
		pdpwellcare.org	http://www.wellcarepdp.com/
		welcarepdp.com	http://www.wellcarepdp.com/
		wellcarepdd.net	http://www.wellcarepdp.com/
		wellcarepdp.com	http://www.wellcarepdp.com/
		wellcarepdp.net	http://www.wellcarepdp.net/
		wellcarepdp.org	http://www.wellcarepdp.org/
		wellcareppd.info	http://www.wellcarepdp.info/
		wellcarerx.net	http://www.wellcarepdp.com/
wellcarerx.org	http://www.wellcarepdp.com/		
PFFS	wellcarepffs.com	wellcarepffs.com	http://www.wellcarepffs.com/

**Exhibit B.28.b – Vendor Managed Sites**

Destination Site Name	Destination Site URL	URL Used	How URL Is Displayed
WellCare University	wellcareuniversity.com	wellcareu.com	www.wellcareu.com
		wellcareuniversity.com	www.wellcareuniversity.com
Producers	wellcareproducer.com	wellcareproducer.com	www.wellcareproducer.com
Better Medicare-WellCare	bettermedicareplan.com	bettermedicareplan.com	www.bettermedicareplan.com
		bettermedicareplans.com	www.bettermedicareplans.com
		enrollwellcare.com	www.enrollwellcare.com
		enrollwellcareplans.com	www.enrollwellcareplans.com
		getmorewellcare.com	www.getmorewellcare.com
		iwantwellcare.com	www.iwantwellcare.com
		1877mywellcare.com	www.1877mywellcare.com
		1888miwellcare.com	www.1888miwellcare.com
		cogicwellcare.com	www.cogicwellcare.com
		getwellcaregift.com	www.getwellcaregift.com
		joinwellcare.com	www.joinwellcare.com
		miwellcareahorro.com	www.miwellcareahorro.com
		mywellcaregift.com	www.mywellcaregift.com
		mywellcaresavings.com	www.mywellcaresavings.com
		obtenerwellcareregalo.com	www.obtenerwellcareregalo.com
		switchwellCareplans.com	http://www.switchwellcareplans.com/
		thewelcomeroom.com	www.thewelcomeroom.com
		thewellcarehealthplanslounge.com	www.thewellcarehealthplanslounge.com
		thewellcarelounge.com	www.thewellcarelounge.com
		thewellcarewelcomeroom.com	www.thewellcarewelcomeroom.com
		welcomeroom.com	www.welcomeroom.com
wellcareahorro.com	www.wellcareahorro.com		
wellcarecogic.com	www.wellcarecogic.com		
wellcarehealthplanslounge.com	www.wellcarehealthplanslounge.com		
wellcarelounge.com	www.wellcarelounge.com		
wellcaremiregalo.com	www.wellcaremiregalo.com		

Destination Site Name	Destination Site URL	URL Used	How URL Is Displayed
Better Medicare-WellCare (cont.)	bettermedicareplan.com	wellcarenow.com	www.wellcarenow.com
		wellcareregalo.com	www.wellcareregalo.com
		wellcaresavings.com	www.wellcaresavings.com
		wellcarewelcomeroom.com	www.wellcarewelcomeroom.com
Better Medicare-Ohana	hawaiiicareplans.com	enrollohana.com	www.enrollohana.com/
		hawaiiicareplans.com	www.hawaiiicareplans.com
		1877ourohana.com	www.1877ourohana.com
		getohanagift.com	www.getohanagift.com
		getohanasavings.com	www.getohanasavings.com
		joinohana.com	www.joinohana.com
		myohanagift.com	www.myohanagift.com
		myohanasavings.com	www.myohanasavings.com
		getohana.com	www.getohana.com
iwantohana.com	www.iwantohana.com		
switchohanaplans.com	www.switchohanaplans.com		
Better Medicare-WellCare	bettermedicareplan.com	wellcarerep.com	www.wellcarerep.com
		wellcarereps.com	www.wellcarereps.com
Better Medicare-Ohana	hawaiiicareplans.com	ohanarep.com	www.ohanarep.com
		ohanareps.com	www.ohanareps.com
Better Medicare-PDP	bettermedicarepartdplan.com	bettermedicarepartdplan.com	www.bettermedicarepartdplan.com
		extramedicarehelp.com	www.extramedicarehelp.com
		lowcostmedicareplans.com	www.lowcostmedicareplans.com
		wellcarerxplan.com	www.wellcarerxplan.com
Better Medicare-Extras (vision, dental, hearing)	extrahealthbenefits.com	extrahealthbenefits.com	www.extrahealthbenefits.com
DestinationRX	wellcare.destinationrx.com	wellcare.destinationrx.com	www.wellcare.destinationrx.com

**B.29**

***Provide evidence that the Proposer has applied to Louisiana Department of Insurance for a certificate of authority (COA) to establish and operate a prepaid entity as defined in RS 22:1016 and in accordance with rules and regulations as defined by the Department of Health and Hospitals.***

Attachment B.29.a is a copy of WellCare LA's certificate of authority to establish and operate an HMO in the State of Louisiana.

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**B.30**

**Provide the following as documentation of financial responsibility and stability:**

- **a current written bank reference, in the form of a letter, indicating that the Proposer's business relationship with the financial institution is in positive standing;**
- **two current written, positive credit references, in the form of a letters, from vendors with which the Proposer has done business or, documentation of a positive credit rating determined by a accredited credit bureau within the last 6 months;**
- **a copy of a valid certificate of insurance indicating liability insurance in the amount of at least one million dollars (\$1,000,000) per occurrence and three million dollars (\$3,000,000) in the aggregate; and**
- **a letter of commitment from a financial institution (signed by an authorized agent of the financial institution and detailing the Proposer's name) for a general line of credit in the amount of five-hundred thousand dollars (\$500,000.00).**

**Current Bank Reference**

A current bank reference is included on the following page.



April 29, 2011

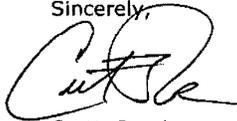
Wellcare Inc.  
Attention Treasury Department  
8735 Henderson Road  
Renaissance One Floor Two  
Tampa, Florida 33634-1143

To whom it may concern:

At the request of Wellcare Inc. the following information has been verified by JPMorgan Chase Bank. The checking account listed below is open, active and maintained in the Commercial Bank Line of Business.

Bank Name	JPMorgan Chase Bank
Bank Account Name	Wellcare of Louisiana, Inc.
Address	8735 Henderson Rd. Ren 1 2 <sup>nd</sup> Floor, Attn: Treasury Tampa, Florida 33634
Tax ID	90-0247713
Bank Account Number	660577461
ABA	065400137
Type of Account	Checking

Sincerely,



Curtis Reed  
Division Manager  
Chase Commercial Banking

### **Credit References from Vendors**

Two current written, positive credit references, from vendors are included on the following pages. These references list Comprehensive Health Management, Inc. and WellCare Health Plans, Inc., as those entities pay vendors and subcontractors on behalf of WellCare. In addition, Attachment B.30.a includes documentation of a positive credit rating from Moody's.



8514 Sunstate Street  
Tampa, FL 33634  
T 813-855-4274  
F 813-855-0969  
[www.genesisdirect.com](http://www.genesisdirect.com)

May 4, 2011

Judy Hooper  
Senior Manager AP and Capitation  
Wellcare Health Plans, Inc.  
8735 Henderson Road  
Tampa, Florida 33634

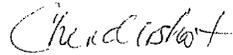
Dear Judy,

During the four years that Comprehensive Health Management has been a client of ours, the payment history has been more than satisfactory.

For the most part, early-pay discounts were taken and payments have been within terms, although from time to time there have been some straggling invoices.

Over the past twelve months, the maximum account balance was \$1.1 million. At this time, the account balance is \$181,000 and is in good standing.

Best regards,



Chris Hendershot  
Accounting Manager



The Results Companies  
499 Sheridan Street  
Dania, Florida 33004

May 2, 2011

Ms. Judy Hooper  
WellCare Health Plans, Inc.  
8725 Henderson Road, Renaissance Four  
Tampa, FL 33634

Re. Reference of credit worthiness.

Dear Ms. Hooper,

WellCare Health Plans, Inc. (WellCare) has been a customer of The Results Companies since August 2006. We have billed WellCare in excess of 32 million annually and have had open accounts receivable balances, all current, in excess of 6 million dollars. As a customer, they have consistently maintained an excellent payment record with an average of a 27 days collection cycle on net 30 days terms. WellCare continues to be a business leading partner for Results. WellCare's commitment to business terms has enabled our company to grow and provide additional services to our clients. If you need any additional information, please feel free to call or email me.

Sincerely,



Edward Matera



Controller  
The Results Companies LLC  
499 Sheridan Street, Suite 400  
Dania Beach FL, 33004  
(954) 926-4113  
[edward.matera@resultstel.com](mailto:edward.matera@resultstel.com)

Phone: 954-921-2400 | Fax: 954-927-4709 | [www.resultscompanies.com](http://www.resultscompanies.com)

**Certificate of Insurance**

A copy of a valid certificate of insurance indicating General Liability insurance in the amount of \$1 million per occurrence/\$2 million aggregate and an additional \$5 million through umbrella liability is included on the following page.



**Letter of Commitment**

See Attachment B.30.b for a copy of a credit agreement for an amount in excess of \$500,000.

### **B.31**

**Provide the following as documentation of the Proposer's sufficient financial strength and resources to provide the scope of services as required:**

- **The two most recent independently audited financial statements and associated enrollment figures from the Proposer. Compiled or reviewed financial statements will not be accepted. The audited financial statements must be:**
  - **Prepared with all monetary amounts detailed in U.S. currency;**
  - **Prepared under U.S. generally accepted accounting principles; and**
  - **Audited under U.S. generally accepted auditing standards. The audited financial statements must include the auditor's opinion letter, financial statements, and the notes to the financial statements.**
- **The Proposer's four (4) most recent internally prepared unaudited quarterly financial statements (and Year-to- Date), with preparation dates indicated. The statements must include documentation disclosing the amount of cash flows from operating activities. This documentation must indicate whether the cash flows are positive or negative, and if the cash flows are negative for the quarters, the documentation must include a detailed explanation of the factors contributing to the negative cash flows.**
- **Verification of any contributions made to the Proposer to improve its financial position after its most recent audit (e.g., copies of bank statements and deposit slips), if applicable**

**Proposer shall include the Proposer's parent organization.**

#### **Audited Financial Statements**

##### WellCare LA

Attachment B.31.a provides the most recent independently audited financial statements (2009 and 2010) for WellCare LA. WellCare LA's financial statements are prepared in conformity with the accounting practices prescribed by the Louisiana Department of Insurance, so they are prepared in accordance with statutory accounting principles rather than GAAP.

##### WellCare Health Plans, Inc.

Attachment B.31.b includes WellCare's annual report on Form 10-K for 2009 and 2010 (excluding non-financial Exhibits), which provides WellCare's most recent independently audited financial statements (2009 and 2010).

#### **Unaudited Quarterly Financial Statements**

##### WellCare LA

Attachment B.31.c provides the four most recent internally prepared unaudited quarterly financial statements (Q1 2010, Q2 2010, Q3 2010, and Q1 2011) for WellCare LA. WellCare LA had negative operating cash flows in 2009 and 2010. Total 2010 cash flows were positive because of a \$1 million capital contribution from WellCare (WellCare LA's ultimate parent). The

negative operating cash flows resulted primarily from the net losses incurred. WellCare is committed to funding the operations of WellCare LA, as demonstrated by the 2010 capital contribution.

WellCare Health Plans, Inc.

Attachment B.31.d includes WellCare's four most recent quarterly reports on Form 10-Q (excluding non-financial Exhibits), which provides WellCare's four most recent unaudited quarterly financial statements (Q1 2010, Q2 2010, Q3 2010, and Q1 2011).

**Contributions to WellCare LA**

On June 16, 2011, The WellCare Management Group, Inc. made a \$2 million capital contribution to WellCare of Louisiana. Below is the wire confirmation relating to this transaction.

**DOMESTIC WIRE TRANSFER DETAIL**

Initiated By: ..... CW089235 On Jun 16 2011 At 9:12:26 AM ET  
Last Modified By: ..... CW071155 On Jun 16 2011 At 10:00:52 AM ET  
Status: ..... Completed  
Approved By: ..... CW071155 On Jun 16 2011 At 10:00:52 AM ET  
Processed: ..... On Jun 16 2011 At 10:05:04 AM ET  
Template Name: .....  
Transaction ID: ..... 20008434  
Entry Method: ..... User Entry  
MTS Advice #: ..... 2011061600015544  
  
Amount: ..... \$ 2,000,000.00  
Value Date: ..... 06/16/2011  
Debit Account: ..... WBFL [REDACTED]

**Receiving Financial Institution**

ABA #: ..... 065400137  
Name: ..... JPMORGAN CHASE BANK, NA  
City/State/Zip: ..... BATON ROUGE, LA

**Beneficiary**

Account #: ..... [REDACTED]  
Account Name: ..... WellCare of Louisiana  
Address Line 1: .....  
Address Line 2: .....

Address Line 3: .....

Reference: .....

**Originator to Beneficiary Information**

Orig/Ben Info: ..... Capital Contribution

**Beneficiary Financial Institution**

Account Name: ..... WellCare of Louisiana

Address Line 1: .....

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INSERT TAB HERE  
Section C  
Planned Approach to Project

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Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		<b>Section C: Planned Approach to Project</b>	<b>100</b>		
<b>Section C Page 1</b>	<b>All</b>	<p>Describe how you will launch a network and set up operations capable of supporting its membership and meeting the requirements of the RFP by January 1, 2012 for GSA "A", March 1 of 2012 for GSA "B", and May 1 of 2012 for GSA "C".</p> <p><b>C.1</b></p> <p>Discuss your approach for meeting the implementation requirements and include:</p> <ul style="list-style-type: none"> <li>• A detailed description of your project management methodology. The methodology should address, at a minimum, the following: <ul style="list-style-type: none"> <li>○ Issue identification, assessment, alternatives analysis and resolution;</li> <li>○ Resource allocation and deployment;</li> <li>○ Reporting of status and other regular communications with DHH, including a description of your proposed method for ensuring adequate and timely reporting of information to DHH project personnel and executive management; and</li> <li>○ Automated tools, including use of specific software applications.</li> </ul> </li> </ul>	<b>20</b>		
<b>Section C Page 11</b>	<b>All</b>	<p><b>C.2</b></p> <p>Provide a work plan for the implementation of the Louisiana Medicaid CCN Program. At a minimum the work plan should include the following:</p>	<b>25</b>		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		<ul style="list-style-type: none"> <li>• Tasks associated with your establishment of a “project office” or similar organization by which you will manage the implementation of the CCN Program;</li> <li>• An itemization of activities that you will undertake during the period between the awarding of this procurement and the start date of the CCN Program. These activities shall have established deadlines and timeframes and as needed conform to the timelines established under this RFP for deliverables.               <ul style="list-style-type: none"> <li>○ All activities to prepare for and participate in the Readiness Review Process; and</li> <li>○ All activities necessary to obtain required contracts for mandatory health care providers as specified in this RFP.</li> </ul> </li> <li>• An estimate of person-hours associated with each activity in the Work Plan;</li> <li>• Identification of interdependencies between activities in the Work Plan; and</li> <li>• Identification of your expectations regarding participation by DHH and/or its agents in the activities in the Work Plan and dependencies between these activities and implementation activities for which DHH will be responsible. (In responding the CCN shall understand DHH shall not be obligated to meet the CCN’s expectation.)</li> </ul>			
<b>Section C Page</b>	<b>All</b>	<b>C.3</b>	<b>25</b>		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
17		<p>Describe your Risk Management Plan.</p> <ul style="list-style-type: none"> <li>• At a minimum address the following contingency scenarios that could be encountered during implementation of the program:               <ul style="list-style-type: none"> <li>○ Delays in building the appropriate Provider Network as stipulated in this RFP;</li> <li>○ Delays in building and/or configuring and testing the information systems within your organization's Span of Control required to implement the CCN program;</li> <li>○ Delays in hiring and training of the staff required to operate program functions;</li> <li>○ Delays in the construction and/or acquisition of office space and the delivery of office equipment for staff required to operate program functions;</li> <li>○ Delays in enrollment processing during the implementation of CCN; and</li> <li>○ Delays in the publication of marketing and related materials and/or the delivery of these materials to DHH and/or its agents.</li> </ul> </li> <li>• For each contingency scenario identified in the Proposal, at a minimum the Risk Management Plan must include the following:               <ul style="list-style-type: none"> <li>○ Risk identification and mitigation strategies;</li> <li>○ Risk management implementation plans; and</li> <li>○ Proposed or recommended monitoring and tracking tools.</li> </ul> </li> </ul>			

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
Section C Page 28	All	<b>C.4</b> Provide a copy of the Work Plan, generated in Microsoft Project or similar software product that includes the aforementioned implementation activities along with the timeframes, person-hours, and dependencies associated with these activities.	20		
Section C Page 29	All	<b>C.5</b> Provide a roster of the members of the proposed implementation team including the group that will be responsible for finalizing the Provider network.	5		
Section C Page 33	All	<b>C.6</b> Provide the resume of the Implementation Manager (the primary person responsible for coordinating implementation activities and for allocating implementation team resources).	5		

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## Section C: Planned Approach to Project

### C.1

***Discuss your approach for meeting the implementation requirements and include:***

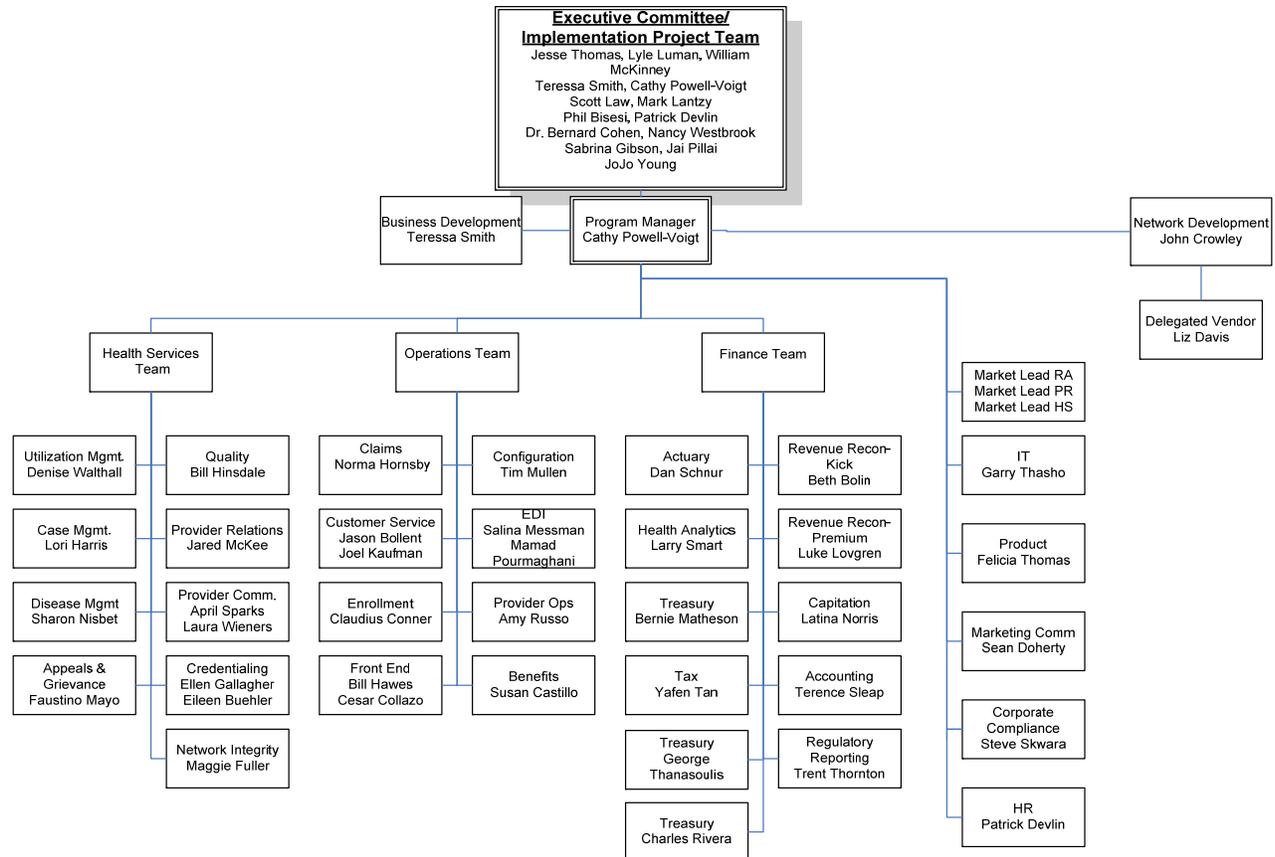
- ***A detailed description of your project management methodology. The methodology should address, at a minimum, the following:***
  - ***Issue identification, assessment, alternatives analysis and resolution;***
  - ***Resource allocation and deployment;***
  - ***Reporting of status and other regular communications with DHH, including a description of your proposed method for ensuring adequate and timely reporting of information to DHH project personnel and executive management; and***
  - ***Automated tools, including use of specific software applications.***

WellCare is committed to working with DHH to meet the all of the GSA go live dates. Considering WellCare's previous experience with successful, large scale implementations, WellCare would like the opportunity to schedule regular recurring collaborative planning meetings with DHH staff as soon as possible after the RFP award date. We believe the sooner we can begin preliminary joint planning and technical requirement discussions with DHH, the sooner we can refine our draft project implementation work plan to align with DHH's expectations. WellCare is confident that our experience in partnering with states to carefully plan these types of implementations, combined with our current familiarity and experience in Louisiana, will lend itself to a seamless implementation within the required timeframe, while addressing the needs of the CCN population.

WellCare has the advantage of being able to leverage an experienced strong cross-functional project management team to work with DHH staff during these initial planning meetings. The proposed implementation team organizational chart illustrates the varied and multiple levels of corporate involvement in the start-up of this program to ensure full integration into current process and systems (Exhibit C.1.a).

**Exhibit C.1.a – Medicaid Expansion Implementation Team**

**Louisiana Medicaid Expansion Implementation Team**



Through the initial and ongoing planning meetings, WellCare will partner with DHH staff to schedule recurring meetings to ensure frequent and timely communication of progress and any issues. We will collaborate with DHH to design an appropriate agenda to include planning and scheduling details, status updates, issue discussions and assignment of action items to ensure clear communication and satisfaction of DHH expectations.

**Issue Management**

WellCare maintains an issue and action log that is a compendium to the global project implementation work plan. This document is reviewed during all implementation meetings and becomes a standing component of the meetings to ensure immediate attention is given to items that pose a risk of delaying go-live. This same approach will be utilized for the implementation of the Louisiana CCN program. “WellCare’s Expansion Playbook Body of Knowledge,” which details our overall methodology and approach to implementation of new markets, is contained in the body of this response.

## **Resource Allocation and Deployment**

We will assemble a cross-functional team comprised of representatives for all departments with responsibility for the implementation of some component of the CCN-P contract. The implementation project manager (IPM) is responsible for identifying and confirming various segments of the organization are included in the planning process to support key business functions of the CCN-P contract. As the project scope and associated tasks are defined, assessments are made as to the number and intensity of resources required to develop the applicable business processes. The need for deployment of additional resources is monitored throughout the project implementation by functional area, and tracked to ensure deliverables are not delayed due to resource limitations. The attached project implementation work plan (Attachment C.4.a) defines all resources, interdependencies, duration and start date for each functional area/task associated with the implementation of the CCN-P contract.

## **Communication and Reporting on Implementation Status**

Through the initial and ongoing planning meetings, WellCare will partner with DHH staff to schedule recurring meetings to ensure frequent and timely communication of progress and any issues. We will collaborate with DHH to design an appropriate agenda to include planning and scheduling details, status updates, issue discussions and assignment of action items to ensure clear communication and satisfaction of DHH expectations. We will provide updated versions of our project implementation work plan as requested, and suggest the use of various workgroups with CCNs and DHH representatives to track and address project issues (see our response to Section C.2 for more information on suggested DHH Workgroups).

## **Use of Automated Project Management Tools**

WellCare utilizes Microsoft Project (version 10) as the primary tool to develop and track all project implementation work plan related data elements including, tasks, resources interdependencies, duration/due date for tasks and deliverable milestones. We supplement the use of this tool with Microsoft Visio as needed to document process flows developed for any component of the implementation. For customer communication, we also can convert our project implementation work plan into Microsoft Excel for the purpose of providing project updates; as well as Microsoft Word and Power Point summary updates for use within DHH.

Below is a summary description of WellCare's overall project management methodology which includes all of the above concepts discussed in more activity-driven formats.

## **Project Management Methodology for Expansion Activities**

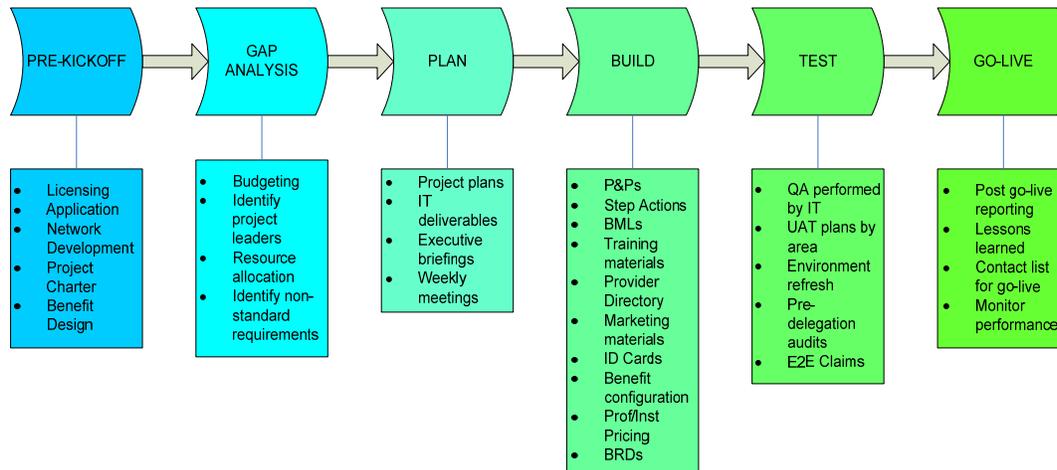
### **1.0 Expansion**

In this context, "Expansion" refers to offering plans in new counties/states where previously WellCare has not conducted business for that product. All of the functional areas of the company are involved at some level in "Expansion".

## 2.0 Implementation Approach

For the purposes of this document we approach Market Expansion as a chronology of activities divided into the following six high-level phases: Pre-Kickoff, Gap Analysis, Plan, Build, Test, Go-Live (Exhibit C.1.b).

Exhibit C.1.b – Market Expansion Implementation Phases



## 3.0 Pre-Kickoff

### 3.1 Application

WellCare will complete an application which shows the plan's preparedness to offer this product in the designated areas.

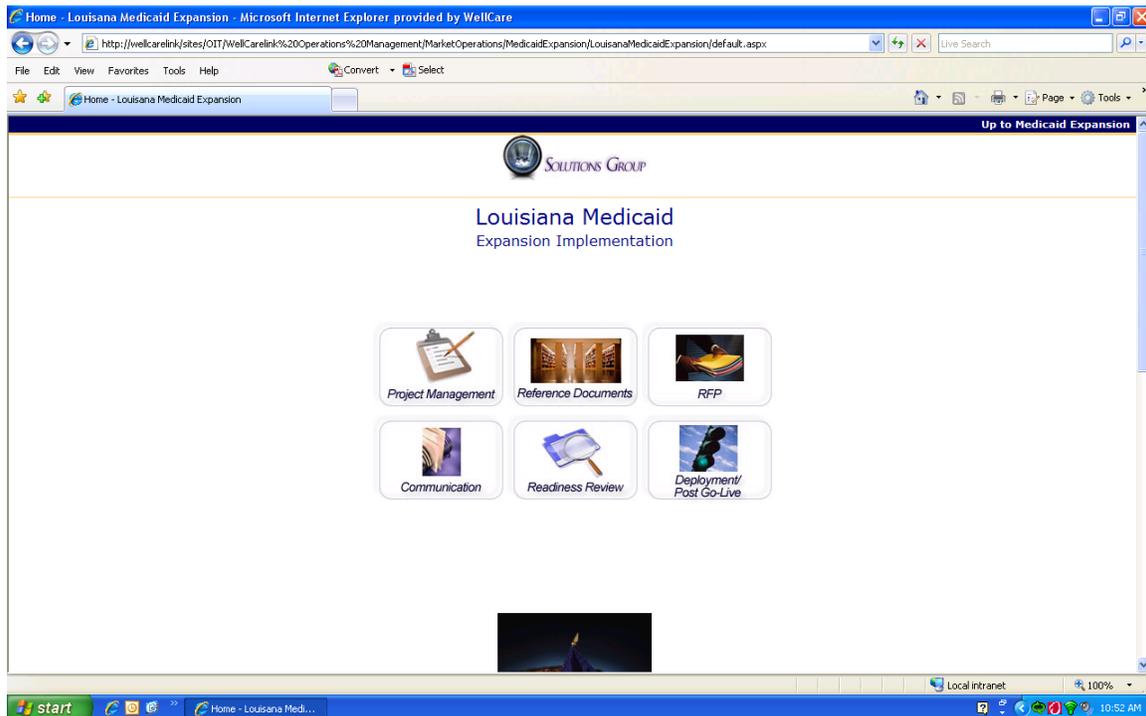
### 3.2 Network Development

WellCare will demonstrate adequate network coverage in order to provide services in a given area. This includes meeting requirements as to the mix of specialists, primary care providers, hospitals, and specific ancillary and community providers as well as meeting accessibility requirements for members, i.e., enrollees must be able to reach their providers in a reasonable amount of time/effort. Additionally, there may be services that are provided through delegated vendors.

### 3.3 Project Documentation

The following documents are typically produced during the course of an Expansion Implementation. They will reside in a custom central project SharePoint site to enable cross-functional access and sharing of documents. See Exhibit C.1.c:

## Exhibit C.1.c – SharePoint Site Example



- Project Charter – Provides high level scoping of the project. The project charter outlines the scope of the implementation project, potential risks, benefits, and methodology for management, communication, assumptions, and business reason for the effort.
- Project Implementation Work Plan – This document shows the key dates in the implementation process across all areas of the business. This allows for a high-level view of the interdependency of activities as dates may change.
- Status Reports – Each functional area mentioned completes a weekly status report (some roll-up under others, e.g., mailroom is reported under EDI). The status report includes the key (not all) milestones for that area during the implementation. The report also indicates weekly task completion, current issues and the status of the milestones (e.g., green, yellow).
- Process flows – Expansion implementation may require new process documentation. These documents are created by all areas.
- Test Plans – Each functional area creates a test plan to ensure that new business (as well as existing) will operate as expected after system changes have been put in place. The test plan describes what must be tested, how it will be tested and the criteria for passing the test. Each area is responsible for the creation and execution of their test plan.
- Testing documentation - Testing documentation is the result of the functional area's execution of their test plan. This document provides evidence that all test cases in the test plan were executed as well as the results of each case.

### **3.4 Benefit Design**

This step of the process is completed by our Product team in association with the Actuarial Services department. The type and level of benefits offered is discussed and determined based on State requirements. Determination is also made if additional benefits will achieve desired results.

## **4.0 Gap Analysis**

### **4.1 Budgeting**

Finance works in conjunction with the Operations Analytics and other departments to determine the budget levels. This step helps to ensure readiness from an operational standpoint.

### **4.2 Identify project and team leaders**

The implementation effort is broad reaching and impacts nearly all areas of the company. Project leaders from each area are identified in order to contribute to group discussions as to how the proposed business decisions will impact their area. They also serve to coordinate activities within their area. Lastly, they are responsible for disseminating project information to the rest of their area. Each area is responsible for designating a resource to lead the effort for their area, to act as the single point of contact (SPOC).

### **4.3 Resource allocation**

As the scope of the implementation takes shape it is necessary to identify the resources available for implementation activities. Based on the expected effort it may come to light that additional resources will be necessary. The need for additional resources becomes apparent once the budgeting of additional benefits/processes is complete. Resource allocation is completed by the individual areas based on the anticipated level of effort. If it is determined that there is a resource constraint, this is communicated to the project lead and escalated as necessary.

### **4.4 Identify non-standard requirements**

The information provided by the functional teams may identify non-standard requirements which need to be met. The potential solutions for these requirements will be evaluated through investigation of current systems and process capabilities, and the feasibility and level of effort required for the various alternatives.

## **5.0 Plan**

### **5.1 Project implementation work plans**

Each key functional area completes a project implementation work plan. It is the responsibility of each area to maintain their work plan. The implementation project manager (IPM) is responsible for maintaining a milestone-based comprehensive project implementation work plan that allows identification of cross-departmental dependencies and better management of potential constraints.

## **5.2 IT deliverables**

With the development of the product offering and scope of the expansion effort it is necessary to identify the systems and reports which will need to be created and/or modified for successful implementation. IT is responsible for delivery of the solutions. Each business area is responsible for identifying additional system needs specific to their area. Some issues may be cross functional in which case it is a collaborative effort to identify necessary system changes. The overall IT deliverables are typically managed by a single project manager for IT.

## **5.3 Executive briefings**

A dashboard is completed and reported to an executive steering committee on a weekly or bi-weekly basis, depending on the need. The steering committee meetings are used for reporting on progress and making high level business decisions.

## **5.4 Weekly cross-functional meetings**

The weekly meeting is used to disseminate information to all areas, report on progress, development of cross functional processes and tracking of issues. Minutes are taken and posted on the project SharePoint site for viewing.

## **6.0 Build**

### **6.1 Policy and Procedures**

The Policy & Procedure documents will be created and updated depending on the impact of the Expansion. These documents are required as formal documentation of how the business is run. The P&P's are the responsibility of the area in which the process or policy is in place. These documents require executive level sign-off and are required for auditing purposes.

### **6.2 Step Action Tables (SAT)**

The functional area that has the new/updated process is responsible for the creation/modification of the SAT.

### **6.3 Benefit Master Lists (BMLs)**

The BML is created and owned by Benefits Configuration. The BML is created based on the benefits required by the State.

### **6.4 Training Materials**

Training materials are created by the individual areas in conjunction with the instructional designers within the department. Associates will need to be aware of the plan and benefits offered. They may also need to be made aware of new processes that are implemented with the new plan. The source of the materials will be documentation from discussions during the "Gap Analysis" stage in the process.

## **6.5 Provider Directories**

A critical aspect of any Expansion is the creation of provider directories. Provider directories are market-specific guides which list providers that are part of the WellCare network, their specialties and additional demographic information. The provider directories must be completed pre-enrollment as potential members will want to know if their physician is in WellCare's network.

## **6.6 Marketing Plan and Materials**

All member materials must comply with DHH guidelines. Consequently, materials must be submitted to DHH for approval on language, design, and/or layout, before they may be used. As a result it is necessary to allow for adequate lead time when producing materials.

## **6.7 Enrollment Materials**

Enrollment materials consist of most member correspondence which occurs after the member has been enrolled in a plan. As with marketing materials, all Enrollment materials must comply with DHH guidelines. Enrollment materials (and ID Cards) are managed through the Correspondence Tracking System (CTS). This system utilizes bar coding of materials to track issued and returned correspondence. This allows WellCare to better ensure members receive all necessary mailings.

## **6.8 ID Cards**

Creation and fulfillment of ID Cards is a critical aspect of any implementation as ID Cards are the means by which members may access services.

## **6.9 Benefit Configuration**

Benefits Configuration occurs when benefits are translated into system specific business rules. These business rules ultimately determine how claims are paid in the system. The configuration of the system ultimately matches what is shown on the BMLs. Benefit Configuration is a prerequisite for claims testing.

## **6.10 Professional / Institutional Pricing**

Professional / Institutional pricing consist of loading fee schedules and contracts into the system. This step is necessary to ensure that each provider is compensated on claims according to their contract.

## **6.11 Authorizations**

Authorizations are created by Health Services and required for some services. Without an authorization in the system, a claim will be denied. Health Services finalizes the authorizations and then communicates with Configuration (for claims payment) and Provider Communications (for creation of the provider Quick Reference Guide (QRG)).

## **6.12 Authorization Match Rules**

Authorization match rules determine how a claim locates an authorization in the system.

## **6.13 Quick Reference Guides (QRGs)**

Quick Reference Guides are developed by the Provider Communications area to inform providers about which services require authorization for payment as well as all important contact phone and FAX numbers. The QRGs require input from multiple areas for completion.

## **6.14 Business Requirements (BRDs)**

The functional areas are responsible for producing the requirements which drive the deliverables for IT. Each area is responsible for requirements that exist within their department. The BRDs must receive sign-off and approval from all involved parties. The BRD document serves as guide for quality assurance and user acceptance testing.

## **7.0 Test**

### **7.1 Quality Assurance**

Quality assurance testing is conducted by the Information Technology (IT) department. IT will test all of the IT deliverables for which a BRD has been completed. The deliverables will be tested according to the BRDs submitted. IT has the responsibility to complete testing and notify the affected functional area point person of any issues.

### **7.2 User Acceptance Testing**

User acceptance testing (UAT) is performed by a subject matter expert in the area which originated the request. Each area is responsible for the testing of their IT deliverables. The items for testing will be those outlined in the BRD submitted.

### **7.3 Environment Refresh**

Performing a refresh of the testing environment ensures that the most current production environment (i.e., configuration) is available for testing.

### **7.4 Pre-delegation Audits**

When benefits are administered through delegated vendors, WellCare performs an audit of the processes which are being delegated. Pre-delegation audits consist of reviewing items such as policies and procedures, and turnaround times for delegated services prior to contract implementation. Once the audit is complete the vendor is recommended for delegation or not. The audit must be completed before go-live to allow for the Delegation Oversight Committee to meet and either approve or deny the delegation.

### **7.5 End to End Claims Testing**

End to end claims testing is one of the final steps prior to go-live. This combines the testing efforts of multiple areas as they relate to the lifecycle of a claim. The test claims

are submitted through the various intake channels and then tracked through each area until reaching the end of the process. Successful completion of all end to end scenarios provides assurance that the system will adjudicate claims correctly once live.

## **8.0 Go-Live**

### **8.1 Transition Activities**

Each area is individually responsible for transitioning the implementation activities/processes to their production team. Each area has production team members engaged in the implementation process. This will allow for them to absorb the material over a longer time period and a smooth transition to production.

### **8.2 Post Go-Live Project Reporting**

A frequent cross-departmental meeting is held (daily or multiple times a week) to monitor the first 90 days of the new business in production. The meeting acts as a forum for identifying issues and quickly resolving them.

### **8.3 Lessons Learned**

Lessons learned during the expansion effort are documented for reference in future implementations.

### **8.4 Monitor Performance**

All markets are subject to performance monitoring after go-live. Claims for Expansion markets are audited at 100% for the first 60 days and ongoing audits are performed. New benefits are also monitored in terms of volume and WellCare's own performance in their administration. Customer service calls are monitored closely as leading indicators of expansion issues.

## C.2

**Provide a work plan for the implementation of the Louisiana Medicaid CCN Program. At a minimum the work plan should include the following:**

- **Tasks associated with your establishment of a “project office” or similar organization by which you will manage the implementation of the CCN Program;**
- **An itemization of activities that you will undertake during the period between the awarding of this procurement and the start date of the CCN Program. These activities shall have established deadlines and timeframes and as needed conform to the timelines established under this RFP for deliverables.**
  - **All activities to prepare for and participate in the Readiness Review Process; and**
  - **All activities necessary to obtain required contracts for mandatory health care providers as specified in this RFP.**
- **An estimate of person-hours associated with each activity in the Work Plan;**
- **Identification of interdependencies between activities in the Work Plan; and**
- **Identification of your expectations regarding participation by DHH and/or its agents in the activities in the Work Plan and dependencies between these activities and implementation activities for which DHH will be responsible. (In responding the CCN shall understand DHH shall not be obligated to meet the CCN’s expectation.)**

### **Project Office Establishment**

As mentioned under our B.9 response earlier, WellCare Solutions Team is tasked with providing global project management and implementation planning for all new market entries and will do so for the CCN-P contract. This team works with the local WellCare management staff within the market to fully understand the state specific Medicaid contract, customer expectations, testing requirements and ultimately go-live confirmations for all system compliance. Project implementation work plans are developed to address all contractual requirements in accordance with the Medicaid contract and other regulatory requirements. WellCare utilizes Microsoft Project (version 10) as the primary tool to develop and track all work plan related data elements including, tasks, resources, interdependencies, duration/due date for tasks and deliverable milestones.

An implementation project manager (IMP) is assigned from the Solutions Team, to provide leadership oversight, development of a comprehensive work plan, and ultimately successful implementation of that plan with monitoring 90 days post go-live of any contract. Cathy Powell-Voigt is the assigned IMP for the Louisiana Medicaid opportunity. In this role, Ms. Powell-Voigt is tasked with the following core responsibilities in establishing our “project office” for the CCN-P contract implementation:

- *Project Charter Development* – This document serves as the starting point of defining the opportunity, expected benefits, required compliance activities, implementation key milestones, desired outcomes, and process for post evaluation.
- *Cross-Functional Team Assignment* – This activity requires the IPM to identify and confirm participants that represent various segments of the organization necessary for inclusion in the planning process to support key business functions of the CCN-P

contract. The IPM establishes the high level expectations/tasks the participants will be expected to own through go-live. Team meetings are scheduled as well as required sub-work groups necessary to develop and implement business rules germane to the CCN-P contract (e.g., capitation reconciliation sub-workgroup could have team members representing Enrollment, Information Systems, and Finance departments while the overall responsibility for the accuracy of eligibility records maintained on the core processing system is held by the Enrollment department).

- *Global Project Implementation Work Plan Development and Tracking* – The global project implementation work plan is developed to build the key phases of the implementation (readiness review preparation, pre-implementation planning, post implementation); and then refined as the individual functional area work plans are developed for inclusion. Each task associated with this implementation will be clearly defined in the project implementation work plan, with resources, interdependencies, and duration for planning and start date of a key function. Protocols for tracking deliverables within the work plan and the process for identifying potential risks are identified as well under this task and communicated to all members of the cross functional implementation team. A single point of contact is established for each functional area.
- *Line of Business Establishment* – This activity is the formal financing and development of a platform within our existing core processing system that will house all data specifically associated with the CCN-P contract which includes however is not limited to: enrollment/eligibility files, benefits, utilization management authorization portals, information system-related applications (e.g., business rules, website, reporting, etc.), provider contracts/credentialing, etc.
- *Executive Steering Committee (ESC) Project Updates/Approvals* – The IPM will provide comprehensive project updates to the ESC for the purpose of communicating progress, risks, gaps or other pertinent issues for the group to consider as it relates to the functional areas they represent. This body will also be responsible for approving any newly created processes, approaches, or applications that are material modifications to our core processing system, which could impact other existing lines of business.

### **Implementation Planning: Readiness Review through 90 Days Post Go-live**

Under the guidance of the implementation project manager (IPM), simultaneously during the RFP response development phase work begins on the global project implementation work plan for the organization, which includes planning specifically tied to the readiness review. WellCare established its project team well in advance of the RFP submission. This team has looked at all aspects of the RFP and provided input to all responses reflected in the document as to the procedural approaches we will employ to bring up the CCN-P product by January 1, 2012.

Our cross-functional implementation team has started the process of reviewing the attached project implementation work plan (Attachment C.4.a) and actively working on the development of business rules, resource recruitment, and other technical aspects of the proposal that we can address at this stage. A component of the work plan is the preparation for the readiness review, which defines all necessary planning activities/tasks to ensure WellCare can fully demonstrate to DHH our overall preparedness should we be awarded a CCN-P contract.

WellCare will complete the following key tasks between the contract award and the go-live date of the CCN program, if not already defined within the current project implementation work plan:

- Identify and complete all planning activities for the Readiness Review Process;
- Confirm all necessary follow-up activities in order to obtain the required Provider contracts;
- Document Duration/Work (hours) for each task; and
- Link all Predecessors/dependencies.

Each task/activity contained within the project implementation work plan as previously mentioned has established deadlines and timeframes. For additional details, please see the work plan contained under Attachment C.4.a.

### Readiness Review Preparation

WellCare staff are currently planning implementation activities to ensure we are fully capable of demonstrating readiness for the first GSA no later than September 30, 2011; and for each subsequent GSA in line with DHH expectations. The IPM will drive readiness review preparation activities, utilizing the global project implementation work plan as the primary tool to define and track deliverables for this activity. Key activities that will take place between contract award and readiness review assessment for the first GSA go-live include, however are not limited to:

- Implementing global staff recruitment plan; which includes identifying critical staff that need to be on board prior to go-live;
- Confirming expansion plans for satellite offices, if necessary based on award;
- Gathering updated financial, regulatory action, insurance, and affiliate information for submission to DHH;
- Submission of all member/provider marketing plans/materials for DHH approval; and
- Preparing operations, systems, and compliance proofing to all elements under Readiness Review, defined in the tool to be used by Quality Improvement Organization on behalf of DHH.

All activities tied to readiness review preparation are denoted on the attached global project implementation work plan (Attachment C.4.a). WellCare will finalize this work plan and provide an updated final version to DHH within 30 days of contract signing.

### Provider Network Preparation

WellCare has high confidence it has the technology, resources and infrastructure to launch a provider network and set up operations to support the membership in GSA A, B, and C within the enrollment go-live dates established by DHH (1/1/12, 3/1/12, and 5/1/12 respectively). We will draw from a combination of corporate, Louisiana-based field associates and experienced consultant resources to meet these deadlines. WellCare already has a current Medicare presence that represents over 2600 physicians and also has active Louisiana Medicaid contracts with several organizations that represent over 1200 physicians and nearly 20 hospitals. Nearly all of these relationships exist in GSA A and B. We plan to move forward immediately (prior to award by DHH) with the credentialing and as applicable loading of providers. Furthermore, we plan to begin network contracting efforts in GSA A and B immediately given the timelines outlined above. We plan to expand our Medicare presence in Louisiana and we believe that we can engage many large institutional providers in contract discussions in July even prior to award by DHH.

All activities necessary to obtain required contracts for mandatory health care providers as specified in this RFP will be completed in accordance with DHH timelines, ensuring that WellCare will be able to pass the first network adequacy test on October 7, 2011 for GSA A; and subsequent GSAs according to schedule.

Key activities that will take place between contract award and readiness review assessment for the first GSA network include, however are not limited to:

- Completion of contracting activities to address any identified network deficiencies by specialty/volume;
- Conversion of executed LOIs to contracts;
- Completion of credentialing for all GSA A providers; and
- System load and contract configuration by October 7, 2011 to ensure files can be transmitted to DHH for enrollment broker/fiscal intermediary use.

The same activities will be done for the remaining GSAs and are delineated in the global project implementation work plan to coincide with the DHH network adequacy testing for each.

### **Estimated Staff Implementation Hours**

WellCare is committed to working with DHH to meet the all the GSA go live dates. The attached project implementation work plan (Attachment C.4.a) defines the estimated staff implementation hours to be devoted to this project for all functional areas, and specific tasks. Freestanding of the individual man hours required for each task, WellCare defines the project implementation period globally as July 2011 – August 2012. Staff that are participants of the cross functional implementation team are expected to complete and track deliverables for their respective functional areas up to ninety days after the last GSA go-live on May 1, 2012. Project hours within the work plan are delineated to reflect post go-live monitoring activities. Should there be a specific need to monitor select functions for an extended period the post-90 day go-live, the work plan will be updated to reflect as such.

### **Project Interdependencies within the Work Plan**

Identification of project interdependencies is key within our project implementation work plan to ensure complete and accurate implementation planning to reflect all CCN-P contract requirements. The global project implementation work plan is developed to encapsulate overlapping processes/functions that may impact various departments. As mentioned earlier in the response, the global project implementation work plans is developed with the inclusion of individual functional area work plans. All work plans are then reviewed to identify interdependencies so that these are then linked within the global work plan. Sub-work groups are also formed to cover planning for core processes and business rules for specific functions that parallel the interdependencies identified in the work plan. Examples of sub-work groups that will be formed to address specific implementation issues for Louisiana Medicaid include but are not limited to:

- *LA Medicaid Network Development* – This team has been meeting for the past four months in consideration of the network requirements for the CCN-P program. Staff

representatives included market regulatory affairs, network management, credentialing, provider education, claims configuration, network reporting. Additional members will be added to reflect any issues identified during implementation.

- *LA Medicaid Customer Service* – Typically represented by staff from customer service, claims, network management, finance and benefits.
- *LA Medicaid Claims Configuration* – Typically represented by staff from claims, network management, finance and benefits.
- *LA Medicaid Eligibility* – Typically represented by staff from enrollment, finance, customer service, network management.
- *LA Medicaid Quality Assurance* – Typically represented by staff from health services, quality improvement, customer service, and network management.

### **DHH Implementation Planning Assistance/Collaboration**

Our previous experience in the implementation of Medicaid managed care contracts with states has allowed valuable insight into the required level, frequency and early interaction with state customers to plan for a successful implementation; which we define “Success” as going “live” on the customer defined date, with little to no provider abrasion and members’ ability to access services immediately without limitation. In order for us to accomplish this, WellCare wants to schedule regular recurring collaborative planning meetings with DHH staff as soon as possible post the July 25<sup>th</sup> award date. Key areas of focus for collaboration between WellCare and DHH we believe can contribute to implementation success include, however are not limited to:

- *Information Systems/Fiscal Intermediary Agent Activities* – Under the previous application process DHH had instituted weekly CCN systems planning meetings so that “peer to peer” discussions could take place on all implementation activities related to data file exchanges and other technology based issues. Issues that we would look to cover in these forums include: enrollment file exchange planning, encounter data planning, confirmation of critical file test schedules, and other interface related activities.
- *Member Material and Education Outreach* – DHH will have contracts with at least three new entities that will be tasked with providing some form of member education, the Enrollment Broker, Outreach and Education Vendor, and the CCNs. Collaboration on common member materials and education that will be delivered through each will aid in ensuring prospective enrollees are receiving consistent messages and understand how to access services.
- *Benefits and Services Planning Activities* – Under the previous application process DHH had proposed the implementation of weekly benefits and services meetings so that “peer to peer” discussions could take place on all implementation activities in similar fashion described above for information systems. Other work groups DHH proposed last fall that we think should be revisited as vehicles for plans to communicate with DHH on CCN implementation issues include:
  - Provider and Member Services
  - Marketing
  - Financial
- *Routine Bi-Weekly/Monthly Contractor Meetings* – Within each new market where we currently conduct business, state Medicaid customers have established routine ongoing monthly meetings with all health plans to discuss any issues, program changes, and or

initiatives adopted by the state. Initially the frequency is once a week or twice a month as implementation is in progress, and then reduces to a monthly forum.

We will collaborate with DHH to design an appropriate agenda to include planning and scheduling details, status updates, issue discussions and assignment of action items to ensure clear communication and we are meeting DHH expectations. We believe the sooner we can begin preliminary joint planning and technical requirement discussions with DHH, the more likely we can refine our project implementation work plan to align with DHH's expectations. WellCare is confident that our experience in partnering with the State's to carefully plan these types of implementations, combined with our current familiarity and experience in implementations, will lend itself to support the timeframe while addressing the needs of the population.

In addition to routine meetings, the receipt of any final system, policy and procedure or other governing DHH guides will enable us to program all aspects of our core processing system more efficiently and track to interface testing immediately.

### **WellCare Project Implementation Work Plan**

Please see Attachment C.4.a for a copy of WellCare's project implementation work plan for the Louisiana Medicaid CCN program. This work plan will continue to be refined by project management and functional area representatives, as we transition from RFP response to preparation for readiness review and implementation.

### C.3

#### **Describe your Risk Management Plan.**

- **At a minimum address the following contingency scenarios that could be encountered during implementation of the program:**
  - **Delays in building the appropriate Provider Network as stipulated in this RFP;**
  - **Delays in building and/or configuring and testing the information systems within your organization's Span of Control required to implement the CCN program;**
  - **Delays in hiring and training of the staff required to operate program functions;**
  - **Delays in the construction and/or acquisition of office space and the delivery of office equipment for staff required to operate program functions;**
  - **Delays in enrollment processing during the implementation of CCN; and**
  - **Delays in the publication of marketing and related materials and/or the delivery of these materials to DHH and/or its agents.**
- **For each contingency scenario identified in the Proposal, at a minimum the Risk Management Plan must include the following:**
  - **Risk identification and mitigation strategies;**
  - **Risk management implementation plans; and**
  - **Proposed or recommended monitoring and tracking tools.**

Through our scheduled recurring internal meetings with the cross-functional implementation team, risks will be gathered and closely monitored from identification to resolution. Our project management team will conduct the following support initiatives to ensure timely and accurate identification, monitoring, and resolution of risks.

- Routine meetings with a cross-functional implementation team and other enterprise leaders to review overall project progress, identify risks and mitigation strategies, resolve issues, and maintain the direction of targeted deliverables (see our response to Section C.2 regarding Project Office Establishment). The cross functional team will meet at least weekly and as the project progresses, move to daily meetings if required to address open issues/gaps impacting the project. Documents utilized for review and tracking will include:
  - Risk/Issue Log; and
  - Milestone Tracking Document.
- Regular executive steering committee meetings, comprised of enterprise leaders tied to the project, will occur weekly. More frequent meetings will be scheduled to ensure timely resolution of issues/risks that may impact the project. During these meetings, the group leaders will obtain general status, percentage complete and actual work completed on each task as well as performing a revalidation of original level of effort and active risk identification and mitigation. All gathered elements are entered into the project implementation work plan and re-evaluated against baseline. Based on results, corrective action and mitigation strategies are executed to maintain targeted direction. Documents utilized for review and tracking will include:
  - Risk/Issue Log – Individual Department & Project Wide; and

- Milestone Tracking – Individual Department & Project Wide.
- Once a week meeting with the executive steering committee (ESC) to review current deliverables, at-risk items/mitigation plans and escalated issues for decision. Documents utilized for review and tracking will include:
  - Risk/Issue Log;
  - Risk Elements;
  - Milestone Tracking Document;
  - Dependencies; and
  - Assumptions.
- Status Reports: Each main area will complete a weekly status report. The status report will include the key milestones for that area during the implementation. The report will also indicate weekly task completion, current risks/issues and the status of the milestones (e.g., green, yellow).

### Risk Identification Activities

All project staff members are responsible for being aware of potential risks to the project and are held accountable to communicate the risks via the various avenues available to them (ex: recurring meetings, upper management, Risk Log, etc.) to ensure the risk is captured and monitored to resolution. Risk descriptions need to be clear and concise and need to identify those project implementation work plan activities that are affected and/or will trigger a risk event.

The risks will be constantly reviewed via the risk log described below on a weekly basis during the ongoing implementation meetings.

### Tools and Techniques

The risk log is used to:

- Assist in the assessment of risks, to ensure that risk assessments address all pertinent aspects of the project and to provide specific means of overcoming the underlying basis for the risks;
- Track and monitor risks;
- Assign responsibility for the risk.

The items listed below are what will be tracked via the risk log:

## Risk Management Log

Risk ID	Probability of Occurrence Value	Criticality Value	Risk Factor Value	Risk Owner	Brief Description	Status	Avoidance/Mitigation Plan	Trigger Event (Threshold)	Contingency Plan	Tools & Techniques for Monitoring
001	Low	High	Low	Network Development	Delays in receiving fully executed and compliant provider contracts that reflect an adequate provider network in applicable parishes associated with the CCN program.	Active	<ol style="list-style-type: none"> <li>WellCare will send a statewide mailing of recruitment information, contracts and credentialing information to all providers who are currently accepting Medicaid or who have executed a letter of intent. We will have a telephonic team dedicated to frequent follow up in order to recruit, educate, and track the status of providers' willingness to execute the WellCare contract and complete the credentialing materials.</li> <li>Simultaneously, WellCare will deploy contracting personnel within Louisiana to directly engage with hospitals, large independent practitioner associations, larger provider groups and other large STPs to directly contract for Medicare (in most parishes) and Medicaid services. This process is likely to begin pre-award in early July for GSA A and B due to short time frame associated between award and readiness reviews.</li> <li>In correlation with efforts in item (2) our national contracting team will work directly with HCA, IASIS, Quorum, LabCorp, Quest, Logisticare, Fresenius, and other national providers to contract with providers and / or locations in Louisiana.</li> <li>Lastly, we will directly engage field contracting personnel with other STPs or with providers in specialties where network inadequacies persist even after telephonic follow up. WellCare has tools that will allow contracting personnel to easily identify providers by specialty and parish, enabling WellCare to most efficiently address all network adequacy needs.</li> </ol>	<ul style="list-style-type: none"> <li>Any area with a network deficiency that is lingering 45 days prior to "readiness review".</li> <li>Any network deficiency that is still active 15 days prior to the effective date of the GSA.</li> </ul>	<ul style="list-style-type: none"> <li>If trigger event #1 occurs then providers will immediately move to stage 4 in risk mitigation plan. If triggering event # 2 occurs they will remain in stage 4 but health services will be alerted and will be prepared to refer medically necessary referrals to OON providers.</li> </ul>	<ul style="list-style-type: none"> <li>Create weekly validation reports to make sure recruitment is progressing</li> <li>Run GeoAccess reports bi-weekly to ensure progress in closing gaps in progress</li> <li>Create targeted recruitment plans with provider groups that will address any network deficiency</li> <li>Create daily validation reports to make sure the system is configured correctly</li> </ul>

Risk ID	Probability of Occurrence Value	Criticality Value	Risk Factor Value	Risk Owner	Brief Description	Status	Avoidance/Mitigation Plan	Trigger Event (Threshold)	Contingency Plan	Tools & Techniques for Monitoring
002	Low	Low	Low	Configuration	Delays in building and/or configuring and testing the information systems within your organization's Span of Control required to implement the CCN program	Active	<ol style="list-style-type: none"> <li>1. Identifies Unit Testing - Initially WellCare creates adjudication interpretation sheets that are originated from the RFP, state and federal guidelines. Once the interpretation sheets are created the Configuration Department meets on a regular basis to create and build the configuration rules. Once the rules are created unit testing begins where test scenarios are created for each component of configuration. Once each test scenario passes and is approved by the Director of Configuration then end-to-end testing can be implemented.</li> <li>2. Configuration Testing – Once the unit testing is completed, Configuration will perform end-to-end unit testing which includes all components of the Configuration Department. These components include institutional pricing, professional pricing, benefits adjudication, and fee schedules. Claim test scenarios will be completed to validate that each Configuration component is working appropriately in conjunction with each other. Any item that fails in the test environment is logged and tracked to make sure that each error is corrected 100%. If an item passes in the final testing stage, the Configuration Department will approve the configuration and end-to-end testing including all areas of Operations will start. At this time the production environment is populated with the configuration rules. When the rules have been added reports are created to identify any configuration rule that does not match the testing environment to the production environment. These reports continue to run until after post go live.</li> <li>3. Prior to Go-Live - A testing team is derived from each department within Operations to perform volume testing of all systems including claims; WellCare utilization of test claims from other like markets to validate each component are configured correctly; from benefit adjudication to pricing to identify any issues before go live. If any items are identified during this testing, the situation is brought to the appropriate</li> </ol>	<ul style="list-style-type: none"> <li>• A large volume of providers that have not been configured and loaded within the claim/provider system. We will be able to identify these providers by monitoring the daily inventory report within our contract load tool (Omniflow).</li> <li>• Information is not included for benefits or pricing from the State of Louisiana.</li> </ul>	<ul style="list-style-type: none"> <li>• If the providers are not configured claims are held until the provider records can be loaded. State payment policies and claims penalty rules are applied when appropriate.</li> </ul>	<ul style="list-style-type: none"> <li>• Create daily validation reports to make sure the system is configured correctly.</li> <li>• Create comparison reports between testing environment and production environment.</li> <li>• Create daily claims reports to ensure that claims entered into the system are pricing correctly.</li> </ul>

Risk ID	Probability of Occurrence Value	Criticality Value	Risk Factor Value	Risk Owner	Brief Description	Status	Avoidance/Mitigation Plan	Trigger Event (Threshold)	Contingency Plan	Tools & Techniques for Monitoring
							<p>department for immediate correction. Each item is logged into a system for tracking purposes. The team will review open items daily until the issue is resolved. If for some reason an item cannot be corrected before go live, those claims will be held for manual review.</p> <p>4. Post Go-Live - Claims monitoring reports are created to capture any claims received and they are forwarded to the Configuration and Claims departments for 100 % review. This includes claims that are manually and systematically processed. If any issues arise, they are immediately identified and corrected prior to any payment posting process. However, if a provider is not configured we have pricing packages and standardized contracts that allow providers to be configured in a timely manner. For any provider that has significant denials, the WellCare Configuration Department will directly reach out to the provider to explain the current situation and work with the provider to address issue(s).</p>			

Risk ID	Probability of Occurrence Value	Criticality Value	Risk Factor Value	Risk Owner	Brief Description	Status	Avoidance/Mitigation Plan	Trigger Event (Threshold)	Contingency Plan	Tools & Techniques for Monitoring
003	Low	Very High	Low	Patrick Devlin	Delay in hiring of staff	Active	<ol style="list-style-type: none"> <li>1. Create a staged hiring plan with specific hire dates for all positions in Louisiana.</li> <li>2. Assign a Green, Yellow or Red status to each requisition which will be based on recruiting metrics such as total applicants, qualified applicants, candidate to position ratio, hire date, etc.</li> <li>3. On a weekly basis, we will be reviewing our progress versus the stated goal.</li> <li>4. When a requisition becomes Yellow, we will provide additional recruiting resources to identify a higher volume of candidates and also identify an interim candidate for a business critical role from either within WellCare or a contract/temporary resource.</li> <li>5. In the case of a Red status, business criticality will be assessed and additional resources and possibly an outside search agency will be used and the interim resource will be put on notice they will need to be available to service in an interim capacity until the right candidate is identified or the particular business need is met.</li> </ol>	<ul style="list-style-type: none"> <li>• Red and Yellow Status resulting from the weekly tracking of progress versus stated goals.</li> </ul>	<ul style="list-style-type: none"> <li>• When a business critical role becomes Yellow through our weekly tracking process, WellCare of Louisiana will identify either an internal WellCare resource or external contract/temporary resource to serve in the role to meet the requirements in the contract. In the case of a Red status, the company will put the identified resource on notice they need to be available to serve in an interim role while we continue to source candidates through normal and enhanced recruiting strategies.</li> </ul>	<ul style="list-style-type: none"> <li>• WellCare Health Plans uses an Applicant Tracking Tool called Taleo to manage all requisition activity across the enterprise. This tool provides a comprehensive overview of all open requisitions across the company as to the progress we are making toward filling specific roles. This tool allows us to not only review applicants for the role, but also the total number of applicants, which applicants are qualified based on an initial electronic screening and where each candidate is in the recruiting process.</li> <li>• In addition to Taleo, WellCare will use existing database tools to monitor our openings in Louisiana on a weekly basis that will be shared with local and enterprise leadership</li> </ul>

Risk ID	Probability of Occurrence Value	Criticality Value	Risk Factor Value	Risk Owner	Brief Description	Status	Avoidance/Mitigation Plan	Trigger Event (Threshold)	Contingency Plan	Tools & Techniques for Monitoring
004	Low	High	Low	Training Directors	Staff training is delayed	Active	<ol style="list-style-type: none"> <li>1. We will secure training materials</li> <li>2. Develop training curriculum, schedule and calendar.</li> <li>3. Train associates in new curriculum.</li> <li>4. We will outsource training materials/manual production and assembly if time does not allow for in-house production</li> <li>5. To bring delays to the required training back on schedule, we will utilize weekend and after-hours sessions to catch up, as needed.</li> <li>6. Supervisors and other staff knowledgeable of the program will be assigned to assist in the delivery of the training modules.</li> </ol>	<ul style="list-style-type: none"> <li>• Limited staffing; lack of access to systems and business documentation; limited manager engagement; no resource facility for training</li> </ul>	<ul style="list-style-type: none"> <li>• Work directly with supervisors and training lead on re-tooling the schedule and building business documentation</li> <li>• Determine leveraging needs with existing staff supporting other states and ensure state confidentiality is maintained.</li> <li>• Secure appropriate facility to meet needs of larger training class.</li> </ul>	<ul style="list-style-type: none"> <li>• Weekly workgroup meetings to review project plan status and remediate any issues</li> </ul>
005	Very Low	Very Low	Very Low	Patrick Devlin	Delays in the construction and/or acquisition of office space and the delivery of office equipment for staff required to operate program functions		<ol style="list-style-type: none"> <li>1. WellCare Health Plans has an entire Facilities Management team that manages all of our real estate across the enterprise. In addition to this team, WellCare contracts with local commercial real estate experts to identify proper space for our employees. On a regular basis, and no less frequent than weekly, the Facilities team reviews all current and new facilities requests and new build-outs of space in order to ensure space is ready to meet the business needs.</li> <li>2. In addition to constant monitoring in Step 1, the Facilities team will also pro-actively identify temporary, move-in ready, office space that can be used for a short duration until the regular office is completed.</li> <li>3. WellCare Health Plan's employees are equipped with the appropriate technology that would allow nearly all Louisiana associates to work out of a home office while still protecting PHI and honoring our HIPAA obligations. This technology is used in many other states and it will be available if the office space is not available.</li> </ol>	<ul style="list-style-type: none"> <li>• Results of the weekly review of the real estate needs across the organization.</li> </ul>	<ul style="list-style-type: none"> <li>• As outlined above, the Facilities Management team meets no less than weekly to review current and future space needs for the entire organization. Because of this consistent review, the team is able to identify risks early so additional resources or alternate space can be identified to mitigate the risk of not being ready at the appropriate time.</li> </ul>	<ul style="list-style-type: none"> <li>• The Facilities Management team uses a combination of Space Planning software and reports to consistently monitor current and future space needs for the organization. As outlined above, the entire review process takes place no less than weekly.</li> </ul>

Risk ID	Probability of Occurrence Value	Criticality Value	Risk Factor Value	Risk Owner	Brief Description	Status	Avoidance/Mitigation Plan	Trigger Event (Threshold)	Contingency Plan	Tools & Techniques for Monitoring
006	Very Low	High	Medium	IT Lead	WellCare receives an 834 enrollment file but the Louisiana enrollment channel is not fully operational	Active	<ol style="list-style-type: none"> <li>WellCare will leverage its existing enrollment processing technology to build what we refer to as an "enrollment channel" for Louisiana members based on the generic implementation guide.</li> <li>We will then leverage the Louisiana specific requirements based on the state companion guide once the guide is published. This will allow us to ability to process membership well before the December 23, 2011 deadline for member enrollment for GSA A.</li> </ol>	<ul style="list-style-type: none"> <li>Enrollment and Eligibility processing system is not complete by readiness review on 10/15/11</li> </ul>	<ul style="list-style-type: none"> <li>In the unlikely event that the WellCare enrollment and eligibility system is not fully operational, WellCare has the ability to parse an 834 file and separate the file by transaction type (add, update, retro enroll, reinstate, terminate).</li> <li>Once the file is parsed WellCare can apply each transaction separately to our core processing system either via manual data entry, in which the enrollment department will ensure staffing for this process or by normalizing data and processing transaction types separately leveraging the standard implementation guide specification and making updates as required based on the state specific companion guide.</li> </ul>	<ul style="list-style-type: none"> <li>Members normalized and processed through the enrollment channel are subject to transaction and validation processes contained with the application.</li> </ul>

Risk ID	Probability of Occurrence Value	Criticality Value	Risk Factor Value	Risk Owner	Brief Description	Status	Avoidance/Mitigation Plan	Trigger Event (Threshold)	Contingency Plan	Tools & Techniques for Monitoring
007	Very Low	Medium	Medium	IT Lead	WellCare receives a proprietary file instead of an 834 enrollment file	Active	1. Preliminary testing of the file and frequent Communication with DHH on expected enrollment format and date expectations.	<ul style="list-style-type: none"> <li>Notification from DHH</li> </ul>	<ul style="list-style-type: none"> <li>In the event that WellCare receives a proprietary enrollment file instead of an 834 file, WellCare has the ability to normalize the file and remap the demographic and eligibility components within the file to be consistent with the 834 file.</li> <li>Once this effort is completed WellCare will be able to process the file through the Louisiana enrollment channel consistent with the expected normal processing procedure.</li> </ul>	<ul style="list-style-type: none"> <li>Members normalized and processed through the enrollment channel are subject to transaction and validation processes contained with the application.</li> </ul>

Risk ID	Probability of Occurrence Value	Criticality Value	Risk Factor Value	Risk Owner	Brief Description	Status	Avoidance/Mitigation Plan	Trigger Event (Threshold)	Contingency Plan	Tools & Techniques for Monitoring
008	Medium	Medium	Medium	Marketing Communications	Delays in the publication of marketing and related materials and/or the delivery of these materials to DHH and/or its agents.		<ol style="list-style-type: none"> <li>1. Develop detailed project plans to manage the development, review, and production of materials.</li> <li>2. Institute regular status meetings to monitor progress against plans; identify potential risks</li> </ol>	<ul style="list-style-type: none"> <li>• If project milestones are not met, there is potential risk in being unable to compensate for time in downstream production steps.</li> </ul>	<ul style="list-style-type: none"> <li>• Leverage depth &amp; breadth of the print network to ensure materials are produced timely.</li> <li>• Deploy cycle printing strategies and leverage 3rd shift to create added capacity.</li> <li>• Prepare alternative mailing methods to ensure timely receipt (including first class and priority mail).</li> <li>• Evaluate dropping mail directly into LA postal system (vs. shipping from plant).</li> </ul>	<ul style="list-style-type: none"> <li>• Project plans</li> <li>• Production schedules</li> <li>• ProSight Database</li> <li>• Status meetings</li> </ul>

Risk ID	Probability of Occurrence Value	Criticality Value	Risk Factor Value	Risk Owner	Brief Description	Status	Avoidance/Mitigation Plan	Trigger Event (Threshold)	Contingency Plan	Tools & Techniques for Monitoring
009	Low	High	Low	Network Development	Delays in receiving complete and process able credentialing applications for providers in applicable parishes associated with the CCN program; may result in last minute influx of applications in need or processing in advance of final configuration.		1. WellCare will leverage FTEs, temporary staff and the services of presently contracted credentials verifications organization (CVO) in order to maximize production.	<ul style="list-style-type: none"> <li>Providers who have not been submitted by Provider Relations into WellCare systems for processing and loading &gt;60 days prior to final cut-off date</li> </ul>	<ul style="list-style-type: none"> <li>If trigger event occurs, local PR staff must work with corporate resources and possible temporary staff in order to submit providers into the workflow and system for processing.</li> <li>Credentialing staff will be prepared to absorb higher volumes of work based on mitigation plan previously mentioned.</li> </ul>	<ul style="list-style-type: none"> <li>Create dashboards reflecting providers submitted for network build and their complete credentialing and configuration status.</li> </ul>

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**C.4**

***Provide a copy of the Work Plan, generated in Microsoft Project or similar software product that includes the aforementioned implementation activities along with the timeframes, person-hours, and dependencies associated with these activities.***

Please see Attachment C.4.a for a copy of WellCare's project implementation work plan for the CCN program.

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**C.5**

***Provide a roster of the members of the proposed implementation team including the group that will be responsible for finalizing the Provider network.***

**Implementation Team Roster**

Name	Position Title	Implementation Team Role
Jesse Thomas	President, South Division	Executive Steering Committee
Lyle Luman	Market President	Executive Steering Committee
Teresa Smith	VP, Business Development	Executive Steering Committee
William McKinney	VP, Operations	Executive Steering Committee
Cathy Powell-Voigt	VP, Solutions	Executive Steering Committee - IPM
Scott Law	SVP, Health Care Delivery	Executive Steering Committee
Mark Lantzy	CIO	Executive Steering Committee
Phil Bisesi	Associate General Counsel	Executive Steering Committee
Patrick Devlin	VP, Field Human Resources	Executive Steering Committee
Dr. Bernard Cohen	VP, Care Management	Executive Steering Committee
Nancy Westbrook	VP, Utilization Management	Executive Steering Committee
Sabrina Gibson	VP, Actuary	Executive Steering Committee
Jai Pillai	VP, Contract Operations	Executive Steering Committee
JoJo Young	Sr. Director, Finance	Executive Steering Committee
John Oleksyn	Director, Market Operations	Solutions Project Manager
Denise Walthall	Project Manager	Utilization Management Team Lead
Lori Harris	Sr. Director, Case/Disease Mgmt.	Case Management Team Lead
Sharon Nisbet	Sr. Director, Medical Informatics	Disease Management Team Lead
Faustino Mayo	Sr. Director, Grievances and Appeals	Grievances and Appeals Team Lead
Jared McKee	Sr. Manager, Corporate Network Svcs	Provider Relations Team Lead

Name	Position Title	Implementation Team Role
April Sparks	Manager, Provider Relations Training	Provider Communications Team Lead
Laura Wieners	Provider Communications Specialist	Provider Communications
Ellen Gallagher	Sr. Director, Corporate Network Svcs	Credentialing Team Lead
Eileen Buehler	Sr. Manager, Credentialing	Credentialing Co-Team Lead
Maggie Fuller	Director, Corporate Network Integrity	Network Integrity Team Lead
Norma Hornsby	Claims Supervisor	Claims Team Lead
Claudius Conner	Director, Medicaid Enrollment	Enrollment Team Lead
Jason Bollent	Director, Customer Service	Customer Service Team Lead
Bill Hawes	Sr. Manager, EDI and Operations	Front End Claims Co-Team Lead
Cesar Collazo	Manager, Front End	Front End Claims Team Co-Team Lead
Tim Mullen	Sr. Director, Configuration	Configuration Team Lead
Amy Russo	Director, Provider Resolution	Provider Operations Team Lead
Salina Messman	EDI Analyst	EDI Team Co-Team Lead
Mamad Pourmaghani	QA Business Analyst Sr.	EDI Team Co-Team Lead
Susan Castillo	Manager, Configuration	Benefits Team Lead
Dan Schnur	Director, Actuary	Actuary Team Lead
Larry Smart	VP, Medical Economics	Health Analytics Team Lead
Bernie Matheson	Sr. Manager, Cash Management	Treasury Team Lead
Yafen Tan	Sr. Manager, Tax	Tax Team Lead
Luke Lovgren	Sr. Manager, Revenue Reconciliation	Revenue Reconciliation Co-Team Lead
Beth Bolin	Sr. Manager, Revenue Reconciliation	Revenue Reconciliation Co-Team Lead
Latina Norris	Manager, Finance – Capitation	Capitation Team Lead
Terrence Sleaf	Director, Accounting and SEC Rpt.	Accounting Team Lead

Name	Position Title	Implementation Team Role
Trent Thornton	Sr. Mgr., Regulatory Cost Reporting	Regulatory Reporting Team Lead
Garry Thasho	Manager, Technical Project Delivery	Information Systems Team Lead
Felicia Thomas	Director, Product	Product Team Lead
Sean Doherty	Manager, Marketing Communications	Marketing and Comm. Team Lead
Steve Skwara	VP, Corporate Compliance	Corporate Compliance Team Lead
Liz Davis	Sr. Manager, Ancillary Provider Services	Delegated Vendor Team Lead
John Crowley	VP, Corp. Network Contracting	Provider Net. Development Team Lead
Karen Brown	Director, Network Development	Provider Network Development Team
Marc Garnier	Sr. Network Management Rep.	Provider Network Development Team
Anna Pinera	Director, Network Development	Provider Network Development Team
Amy Knapp	VP, Corporate Communications	Public Relations/Community Outreach Lead
Ken Van Stedum	Real Estate Director	Facilities Team Lead

### **Provider Network Build Team**

Name	Position Title	Implementation Team Role
John Crowley	VP, Corp. Network Contracting	Provider Net. Development Team Lead
Karen Brown	Director, Network Development	Provider Network Development Team
Marc Garnier	Sr. Network Management Rep.	Provider Network Development Team
Anna Pinera	Director, Network Development	Provider Network Development Team
Jay Howell	National Ancillary Net. Dev. Spc.	Provider Network Development Team
Jim Puckett	National Ancillary Net. Dev. Spc.	Provider Network Development Team
Nancy Everitt**	Project Manager and Reporting	Provider Network Development Team
Penny L Marshall**	Project Manager and Provider Recruitment	Provider Network Development Team

Name	Position Title	Implementation Team Role
Irby C Simpkins III**	Project Lead and Provider Recruitment	Provider Network Development Team
Corey Sippola**	Project Lead and Provider Recruitment	Provider Network Development Team
Michael Hart**	Provider Recruitment	Provider Network Development Team
Justin Forte**	Data Research and Provider Recruitment	Provider Network Development Team
Michael Pozzebon**	Provider Recruitment	Provider Network Development Team
Meela Dixon**	Provider Recruitment	Provider Network Development Team
Sarah L Combs**	Provider Recruitment	Provider Network Development Team
Jessica Grondin**	Contract Administration Lead	Provider Network Development Team
Jamenise Wilson**	Contract Administration	Provider Network Development Team
Norah Al-Hussaini**	Contract Administration	Provider Network Development Team

\*\* Indicates consulting resources.

**C.6**

***Provide the resume of the Implementation Manager (the primary person responsible for coordinating implementation activities and for allocating implementation team resources).***

Please see the following page which contains the resume of WellCare's implementation project manager (IPM) for the CCN-P product, Cathy Powell-Voigt.

# CATHY POWELL-VOIGT

8735 Henderson Road

Tampa, FL 33634

(813)290-6200

Email: [Cathy.Powell-Voigt@WellCare.com](mailto:Cathy.Powell-Voigt@WellCare.com)

## Professional Experience

<b>WellCare Health Plans, Inc.</b>	<b>2010 – Present</b>
Vice President, Solutions	
<p>Executive level accountability for enterprise functions of Corporate Procurement, Corporate PMO and Operations Training. Responsibilities include Medicare market implementation and readiness including regulatory changes and expansion efforts, Medicaid new market design and program implementation. Direction of projects including: health reform tracking and implementation, dual special needs plan (D-SNP) state contracting and implementation such as WellCare’s New York Liberty plan which is an integrated D-SNP providing Medicare benefits, Medicaid cost-share coverage and wrap around benefits, HIPAA 5010 (electronic data interchange) and ICD-10 remediation, and Operations and IT capex/opex planning.</p>	
Senior Director, Ops Business Planning	2009 - 2010
<p>Management of Operations and IT budget, procurement and program management of multiple expansion, regulatory and compliance cross-functional projects and medical expense initiatives including WellCare’s entrance into the State of Hawai’i in 2009 with the O’hana plan with plan supporting both Medicare membership and the Medicaid ABD population including long-term care services and dual member coordination of benefits. Direction of \$5 Million in SG&amp;A savings within Operations and IT to stream-line the organization.</p>	
Director, Market Operations	2007 – 2009
<p>Successful Medicare expansion into 5 additional states and 3 new product implementations. Program management of yearly Medicare regulatory changes and annual preparedness across the organization. Implementation of Medicare dual coordination contracts in states allowing for improved care for dual members with complex needs. Performed financial impact analysis which demonstrating potential savings of \$6.5 Million for in-sourcing of operational functions.</p>	
<b>AMS Services/Vertafore Benefits</b>	<b>2005 - 2007</b>
Director, Operations	
<p>Management of all areas of operations including multiple tiered teams located throughout the United States. Responsibilities included management of operational budget, strategic planning and forecasting for future development and growth within the organization. Direction of all QA Testing, Release Management, Documentation, Implementation, Data Conversion, Training, Service and Support of 2000+ user community. Performed onsite and web trainings and developed training certification protocol.</p>	

Manager, Operations	2003 - 2005
Management of operations for growing software development organization providing agency management and benefits administration software. Maintained customer retention rates of 96.5% for 2005 and 97.7% in 2006.	
<b>USAA</b>	<b>1993 - 2003</b>
Senior Business Analyst	
Support of regional 2,500+ client community. Lead Claims troubleshooter for the Eastern region of the United States, involving training, mentoring and quality management. Support of agents in all line of property and casualty insurance, rate analysis and accounting. Facilitated software testing and implementation for technology customers.	
Educational Credentials/Professional Development	
<b>Education</b>	
University of South Florida, Bachelor of Science in International Studies	
Saint Leo University, Masters in Business Administration	

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Section D

Member Enrollment and Disenrollment

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Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		<b>Section D: Member Enrollment and Disenrollment</b>	25		
<b>Section D Page 1</b>	All	<b>D.1</b> Describe your enrollment procedure requirements, including how you will ensure that you will coordinate with DHH and its Agent.	5		
<b>Section D Page 3</b>	All	<b>D.2</b> Describe your enrollment procedure requirements, including how you will ensure that you will coordinate with DHH and its Agent.\	5		
<b>Section D Page 5</b>	All	<b>D.3</b> Describe your enrollment procedure requirements, including how you will ensure that you will coordinate with DHH and its Agent.	10		
<b>Section D Page 7</b>	All	<b>D.4</b> Describe your enrollment procedure requirements, including how you will ensure that you will coordinate with DHH and its Agent.	5		

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## Section D: Member Enrollment and Disenrollment

### D.1

***Describe your enrollment procedure requirements, including how you will ensure that you will coordinate with DHH and its Agent.***

#### **Coordinating with DHH and its Agent**

WellCare has extensive experience providing information systems technology for Medicaid managed care programs, including creating all necessary interfaces with state information systems to facilitate member enrollment. WellCare has seven state Medicaid contracts in which information systems technology interfaces with multiple vendors. Our information systems are flexible and can be adapted to changes in business practices and policies within the timelines established by DHH. WellCare's system and data infrastructures support interfacing capabilities using standard protocols and specifications and mutually defined custom specifications.

WellCare will interface with DHH and its agent for the transmission and receipt of enrollment transaction data for processing. We are able to receive and process all standard HIPAA-compliant transaction types including the 834 enrollment file. In cooperation with DHH, we will modify our system to meet specific state requirements for interfaces by developing a joint interface plan with DHH and its agent. We will also participate in readiness review prior to implementation, which may include joint testing and validation exercises.

WellCare is also aware of the CMS mandate to move to the HIPAA compliant 5010 transaction code set. WellCare will work closely with DHH to ensure that this transition is successful.

#### **Enrollment Procedures**

WellCare maintains a corporate policy and has implemented procedures to update the enrollment database within 24 hours of receipt of the enrollment roster. We have the capability to process segment updates based on DHH requests and to make the record active as required by DHH. Our member enrollment system performs the following functions:

- Electronic receipt of enrollment rosters;
- Strategic national implementation process (SNIP) edits;
- Validation and reconciliation of enrollment records;
- Generation of error reports;
- Transfer of enrollment data to our core processing system; and
- Capitation validation

WellCare will obtain daily enrollment/disenrollment rosters and third party liability data electronically. Immediately after we receive an enrollment file, we scrub it to strip erroneous data that may cause the file to fail. The scrubbing process removes characters such as apostrophes and extra spaces. The electronic data interchange (EDI) team monitors the process to determine if the file is or is not compliant. When a file is indicated as non-compliant, WellCare will inform DHH/the enrollment broker. If the file is compliant, the raw enrollment data is loaded into our system.

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WellCare uses the enrollment transaction types (add, update, terminate, reinstate, retroactively enroll) sent by DHH to update members, which is consistent with the expectations of DHH.

A new enrollment record will be assigned an enrollment transaction code that will route it to the primary care provider (PCP) assignment process. Once a PCP is assigned, whether selected by the member or through our DHH-approved algorithm, the file is sent for validation. Validation includes a series of edits to confirm the completeness and accuracy of enrollment records. Edits include: confirmation of permissible values within each field (including null); and comparison of identifying and demographic data to previously-loaded enrollee records (e.g., birth date, address).

If during the validation process a member level error is identified, an error report is generated for manual review. Member enrollment staff review every record contained in the error report to reconcile and correct any discrepancies. Upon completion of the manual review, an error report including any member records that are incomplete or contain inaccurate information is generated. This report will be forwarded to DHH via the specified file transfer protocols.

After all errors have been addressed, we update our system and create a member correspondence extract for printing member materials. The extract is checked for errors and then uploaded to our vendor's FTP site for printing and delivery of member materials and ID cards.

As part of our enrollment procedures, enrollment rosters are also reconciled with capitation reports to ensure that payments, by rate cell, tie to enrollment. Any discrepancies between capitation payment amounts and enrollment rosters will be reported to DHH.

## D.2

**Describe your approach to meeting the newborn enrollment requirements, including how you will:**

- **Encourage Members who are expectant mothers to select a CCN and PCP for their newborns; and**
- **Ensure that newborn notification information is submitted, either by you or the hospital, to DHH or its Agent within twenty-four (24) hours of the birth of the newborn.**

WellCare understands the importance of prenatal care and access to primary care services. We have a newborn coordination team within the Enrollment department whose responsibility is to oversee enrollment and outreach for expectant mothers and newborns. When WellCare learns that a member is pregnant, the newborn coordination team will notify DHH of the pregnancy and any additional relevant information (such as due date) known to the team.

The expected date of delivery is provided to the newborn coordination team based on the member enrollment file from the enrollment broker or from authorization data obtained through the Utilization Management department, whichever is known first.

### **Encouraging Expectant Mothers to Make a Choice**

During the member's second trimester, or at least 60 calendar days prior to the expected date of delivery, WellCare will contact the expectant mother and encourage her to choose a CCN and a primary care provider (PCP) for her unborn baby. The letter will provide information regarding:

- The mother's right to choose a CCN other than WellCare;
- The process for selecting a CCN and PCP and what will happen if one or either is not chosen;
- The importance of continuing to receive prenatal treatment;
- The importance of scheduling an appointment with the baby's doctor after the baby is born;
- The importance of scheduling a postpartum visit after the baby is born;
- Access and use of the CMS initiative, *Text 4 Baby*; and
- The availability of transportation for appointments.

In addition to the information listed above, the letter will include the name of a PCP who will be assigned to the unborn baby in the event that the mother declines to choose a CCN or a PCP. The assigned PCP's address and phone number will be provided so the member has the information she needs to make appointments if she chooses to keep the pre-assigned PCP. A provider directory will also be included to assist the member in selecting a PCP for her baby should she choose not to use the assigned PCP.

Once the baby is enrolled in WellCare, we will send the member a confirmation letter including our contact information and a list of actions the mother will need to complete in order to finalize enrollment, including verifying the baby's name on the Medicaid ID card and notifying DHH of any changes in her address or telephone number.

As part of our prenatal care program, all expectant mothers receive a maternity education booklet that includes information regarding the importance of selecting a PCP for their newborn. Additionally, all new members receive a new member handbook that contains information about PCP selection.

### **Newborn Notification**

WellCare will ensure that hospital providers adhere to the protocols and time frames established by DHH for:

- Reporting births to DHH to facilitate the issue of a Medicaid ID number for the newborn; and
- Registering births in the state through the Louisiana Electronic Event Registration System (LEERS) operated by the Office of Public Health/Vital Records.

The Provider Relations (PR) department oversees training and education regarding the newborn reporting and registration process and is charged with ensuring that hospital providers understand all these requirements. Information will be included in the provider handbook as well as in a quick reference guide, a tool that highlights important information regarding state-specific policies and protocols.

Provider Relations is available to assist providers in obtaining log-in information for both systems and to ensure that providers know where to find training materials for DHH's web-based Request for Newborn Manual System and LEERS.

WellCare's hospital provider contracts will include the requirements specified in Sections 11.10.4.3 and 11.10.4.4 of the RFP regarding newborn reporting and registration. The requirements will also be included as part of our provider site visit monitoring checklist and presented as part of our ongoing provider training.

Upon learning that the member has given birth, the Utilization Management department sends a newborn authorization delivery fax. Contained within the fax, is a notification to the hospital to record the newborn's birth with DHH. If WellCare learns that a hospital has failed to follow established protocols, the provider will be contacted by Provider Relations to determine why reporting or registration was not completed and to provide additional training and support as needed.

### D.3

**Describe the types of interventions you will use prior to seeking to disenroll a Member as described in CCN Initiated Member Disenrollment, Section § 11 of this RFP. If applicable, provide an example of a case in which you have successfully intervened to avert requesting the disenrollment of a member.**

When the member's behavior is disruptive, uncooperative, abusive, or unruly to the extent that WellCare or our providers cannot effectively manage the member's care, WellCare will request an involuntary disenrollment action from DHH using the CCN request for member disenrollment form.

WellCare will not request disenrollment because of a member's health diagnosis; adverse change in health status; utilization of medical services; diminished medical capacity; pre-existing medical condition; refusal of medical care or diagnostic testing; attempts to exercise his or her rights under our grievance system; attempts to exercise his or her right to change, for cause, the primary care provider that he or she has chosen or been assigned; or, uncooperative or disruptive behavior resulting from special needs, unless the behavior seriously impairs our ability to furnish services to the member or other WellCare members.

If a provider or a provider's staff calls WellCare to file a complaint against a member for disruptive, unruly, abusive or uncooperative behavior that seriously impairs our ability to furnish services to the member or other members, we will work with the member and multiple departments that may be involved with the member's case, including:

- Provider Relations: to assist with repairing the member and provider relationship;
- Member Services: in an attempt to educate the member regarding his or her rights and responsibilities as a member of WellCare;
- Case Management: to determine if the member requires case management services or behavioral health assessment;
- Quality: to determine if changes are required to policies and procedures;
- Utilization Management: to provide information regarding service utilization; and
- Grievance: to assist the member with filing a grievance.

WellCare will first determine whether the relationship with the discharging provider can be restored and, if possible, attempt to resolve the issue. We will educate the member regarding his or her rights and responsibilities as a member of WellCare, provide a verbal warning to the member, and offer assistance through a referral to case management.

Case management will review member's medical history to determine if the behavior is attributable to a behavioral health issue. If so, a referral for behavioral health services is made to ensure member is offered appropriate behavioral health services. The verbal warning, our efforts to educate the member, and any referral to case management and/or behavioral health services will be documented.

If the issue cannot be resolved and all interventions are unsuccessful, WellCare will obtain documentation from our system and all providers who have interacted with the member. Data regarding the member's behavior is reviewed for possible involuntary disenrollment. If the review determines that there are no additional actions to take, or that WellCare is unable to

resolve or facilitate health care for the member, the case is evaluated for involuntary disenrollment. Member services will send a written notice to the member using a template letter pre-approved by DHH listing the implications of the behavior that caused WellCare to seek the member's disenrollment. The letter will also notify the member regarding the right to appeal the involuntary disenrollment. All requests for involuntary disenrollment and supporting documentation are submitted to DHH for a final decision.

#### **D.4**

#### ***Describe the steps you will take to assign a member to a different Provider in the event a PCP requests the Member be assigned elsewhere.***

WellCare maintains a uniform policy, consistent with specific State and/or Federal contractual requirements, to ensure the proper evaluation and processing of primary care provider (PCP) requests to transfer or reassign members from his or her patient panel. PCPs may request that a member be removed from their patient panel if:

- The physician feels that the member is non-compliant with the treatment plan or plan of care;
- There is evidence of abusive or inappropriate behavior; or
- The physician is unable to adequately address the member's needs.

Upon the PCP's request, the customer service representative (CSR) will send the PCP a transfer/reassignment request form or refer the provider to our website where the form can be downloaded and printed. The PCP will complete the form, stating the reason for requesting a change and providing all supporting documentation.

The PCP will return the completed form and supporting documentation to WellCare. If the member is under a care plan, the CSR will refer the request to the Case Management department to ensure proper transition of care. The member's case manager will assist with the selection of a new PCP.

If the PCP's reason for requesting a re-assignment is chronically missed appointments, disruptive behavior or non-compliance with treatment on the part of the member, the CSR will attempt to contact the member or member's caregiver at least three times to:

- Inform the member or caregiver that their PCP has requested that the member change to a different PCP (if the member wants the specific reasons for the change, they will be referred back to the requesting PCP for explanation); and
- Assist the member or caregiver in selecting a new PCP.

If the CSR is not able to reach the member by phone, a letter will be mailed to the member explaining the need for change and providing additional instructions on how the member should proceed in the event that he or she disagrees with the decision.

The requesting physician's name and the reason for the reassignment request, including dates of missed appointments if applicable, will be documented in our system. The CSR will also document dates and times of the telephone contact attempts and that a contact letter was sent to the member or caregiver, and the name of the new physician to whom the member is being reassigned. Once the member is transferred to a new physician a new ID card will be printed and mailed to the member.

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INSERT TAB HERE  
Section E  
Chronic Care/Disease Management

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Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		<b>Section E: Chronic Care/Disease Management (Section § 6 of RFP)</b>	<b>100</b>		
<b>Section E Page 1</b>	<b>All</b>	<b>E.1</b> Describe existing (other state Medicaid or CHIP contracts) and planned Chronic Care/Disease Management programs for the Louisiana CCN Program that are designed to improve health care outcomes for members with one or more chronic illnesses. Describe how the Chronic Care/Disease Management programs' data are analyzed and the results utilized by your organization to improve member outcomes.	<b>50</b>		
<b>Section E Page 10</b>	<b>All</b>	<b>E.2</b> Describe how recipients will be identified for inclusion into the Chronic Care/Disease Management program. Identify which disease states/ recipient types will be targeted for the Chronic Care/Disease Management program. Describe how the Chronic Care/Disease Management program will coordinate information and services with the PCP.	<b>50</b>		

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## Section E: Chronic Care Disease Management

### E.1

***Describe existing (other state Medicaid or CHIP contracts) and planned Chronic Care/Chronic care management programs for the Louisiana CCN Program that are designed to improve health care outcomes for members with one or more chronic illnesses. Describe how the Chronic Care/Chronic care management programs data are analyzed and the results utilized by your organization to improve member outcomes.***

WellCare provides chronic care management programs in all of our markets. WellCare has served more than 160,000 Medicaid members in chronic care management in the past 12 months. The following model has been designed to serve the Louisiana population and meet the State's specific needs.

### **Disease Management Programs for Louisiana**

The following disease management programs that focus on managing the disease state and improving health outcomes will be available to our members upon contract implementation:

- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes
- Congestive Heart Failure (CHF)
- Hypertension (HTN)
- HIV/AIDS
- Coronary Artery Disease (CAD)

In addition, WellCare is in the process of developing a Child and Adolescent Obesity program for Louisiana.

Chronic care management programs will meet goals through implementation of the following activities:

- Identifying members at risk;
- Stratification of risk for each member with intervention strategies designed for each level of stratification;
- Assessment and planned interventional strategies;
- Referrals to appropriate health care professional services such as behavioral health, pharmacy and other specialized practitioners when needed;
- Development, monitoring and adjustment of care plans as needed to optimize outcomes for members and to meet established goals;
- Monitoring contractual arrangements and resource allocation to ensure that appropriate services are available to meet members' health needs;
- Identifying opportunities for improvement in the chronic care management process and implementing as needed;
- Maintaining cultural sensitivity;

- Reviewing overall services provided to the member to ensure those services are medically necessary, appropriate and consistent with the member diagnosis and level of care required by the chronic care management plan; and
- Consulting when needed with appropriate specialized health care personnel such as medical directors, pharmacists, social workers, behavioral health professionals, and health coaches and medical homes.

### Asthma Chronic Care Management Description

Asthma is a serious health concern for citizens of Louisiana. According to DHH's Asthma Management and Prevention Program:

- Asthmatics in Louisiana face a higher risk of death from asthma than asthmatics nationwide;
- Louisiana falls within the top 25 percent of states for asthma related deaths;
- An estimated 200,000 adults in Louisiana currently suffer from asthma;
- One-in-ten Louisiana households with children have at least one child with asthma; and
- Over two percent of Medicaid enrollees have asthma (see Exhibit E.1.a below).

**Exhibit E.1.a – Asthma Prevalence among Medicaid Enrollees in Louisiana**

Age Group	# of Enrollees	# with Asthma	Prevalence
0-10	453,614	14,435	3.18%
11-17	228,430	5,805	2.54%
18-64	413,917	6,359	1.54%
65+	111,286	240	0.22%
Total	1,207,247	26,839	2.22%

Source: 2008 Louisiana Asthma Surveillance Report

Note: Results were based on 2008 enrollment data. Also, # of enrollees and # with Asthma were calculated from recipients eligible at least one month during 2008.

WellCare's asthma chronic care management program focuses on improving each participating member's ability to understand and manage his or her condition. Chronic care managers (care managers) will provide members with materials such as the *Asthma Quick Reference Guide* and the *Living with Asthma* workbook (see Exhibit E.1.b below). The workbook provides in-depth information to members on a variety of topics related to asthma. As necessary, care managers will review this information with the member to improve understanding and to assess the member's increased awareness about his or her condition. In addition, programs such as DHH's Asthma Management and Prevention Program and Head-off Environmental Asthma in Louisiana (HEAL) raise concerns on their respective websites about increases in asthma rates and asthma related illness due to an increase in mold and other indoor allergens after Hurricane Katrina. WellCare will partner with local experts to provide targeted education to residents in New Orleans who have special environmental concerns.

## Exhibit E.1.b – Asthma Quick Reference Guide and the Living with Asthma Workbook

### Your Diagnosis and Evaluation

You've probably already had an evaluation. Most likely this included questions about your symptoms, triggers, and any family history of asthma or allergies. You may also have had a physical exam and lung function tests. This information helps your healthcare provider learn more about your health and design a treatment plan.

#### Lung Function Tests

Lung function tests help measure how well your lungs are working. One common test involves blowing into a **spirometer**. This device measures the amount of air you breathe out (exhale). It also measures how long it takes for you to exhale completely. To diagnose asthma, spirometry and other tests are done before and after you take certain medications. If your lung function improves with medication, this indicates asthma. These tests are also used to find out whether your asthma gets worse with exercise, allergens, lung function tests can help you and your healthcare provider see how well your treatment is working.



#### Words You May Hear

Lung function tests measure how much air you can exhale, and how quickly. There are several types of lung function graphs that show data from the tests. Some of the things that tests measure include:

- **FVC** (forced vital capacity). This is the total amount of air you can exhale in a single, prolonged breath.
- **FEV<sub>1</sub>** (forced expiratory volume in one second). This is the amount of air you exhale in the first second. FEV<sub>1</sub> is often expressed as a percentage of FVC.
- **FEV<sub>1</sub>/FVC**. This is the amount of air exhaled in the first second compared to the total amount of air exhaled. It's given as a ratio (fraction) or a percentage. In general, the higher the FEV<sub>1</sub>/FVC, the better.
- **PEF** (peak expiratory flow). This is a measure of how fast you can exhale. It can be tested with spirometry or a peak flow meter.

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This workbook is not intended as a substitute for professional medical care. Only your doctor can diagnose and treat a medical problem.  
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### Specific Goals

The care manager will set goals with the member, the member's medical home and other providers. Examples of individualized goals include:

- Develop an asthma action plan and identify potential health problems associated with non-treatment, including flare-ups and emergency procedures;
- Understand signs and symptoms of asthma and learn how to properly use a peak flow meter;
- Identify asthma triggers, and environmental and lifestyle modifications to reduce severity of asthma; and
- Understand the difference between quick relief and steroid inhaled medications, and the proper technique for administering medications.

## Congestive Heart Failure (CHF) Chronic Care Management Description

WellCare's CHF chronic care management program focuses on improving each participating member's ability to understand and manage CHF. Care managers will send materials to members such as the *CHF Quick Reference Guide* (Exhibit E.1.c below).

### Exhibit E.1.c – CHF Quick Reference Guide

**Understanding Heart Failure**  
 Heart body needs a steady supply of oxygen-rich blood to do its work. Your heart is the pumping force behind the system that supplies your body with the oxygen it needs.

**How the System Works**  
 1 Oxygen-poor blood travels from your body to your heart.  
 2 Your heart pumps the oxygen-poor blood to your lungs where it picks up oxygen. The oxygen-rich blood then returns to your heart.  
 3 Your heart pumps the oxygen-rich blood to your body through "pipes" called blood vessels.

**What is Heart Failure?**  
 When you have heart failure, it does not mean that your heart has stopped working. It just means that your heart is not pumping as well as it should. There are two main types of heart failure.

**Systolic Heart Failure**  
 This type of heart failure occurs when the heart pumps with less force.

**Diastolic Heart Failure**  
 This type of heart failure occurs when the heart becomes stiff and can't fill with blood.

**The Causes of Heart Failure**  
 When your heart does not pump as well as it should, it's usually due to some other condition. Conditions that can lead to heart failure include:  
 - Narrowing of the blood vessels that supply blood to the heart (called coronary artery disease)  
 - Past heart attack  
 - High blood pressure  
 - Heart valve disease  
 - Primary disease of the heart muscle (called cardiomyopathy)  
 - Defects in the heart present at birth (called congenital heart disease)  
 - Infection of the heart muscle and/or the heart muscle

**Learning About Heart Failure**  
 Understanding how heart failure occurs will help you manage your condition. To keep better about heart failure:  
 - Ask your doctor to help you understand your condition, including what questions to ask when you have a doctor's appointment.  
 - Get in touch with help for support groups.  
 - Search the Internet if you have access to a computer.  
 - Check your local library for books and other resources.

**Lung Congestion**  
 When your heart is not pumping well, blood can back up to your lungs and force fluid into the breathing spaces. The fluid then builds up, causing congestion in the lungs.  
**Symptoms**  
 - Shortness of breath, wheezing, or coughing when you exert yourself.  
 - Nighttime coughing when lying flat.  
 - Waking up at night coughing or short of breath.  
 - Bringing up sputum (a thick liquid) colored with blood.

**Fluid Buildup**  
 When your heart is not pumping well, blood can back up through blood vessels and force fluid into your body tissue. The fluid then builds up, causing congestion throughout the body.  
**Symptoms**  
 - Rapid weight gain.  
 - Swelling (called edema) of the feet, ankles, and legs, as well as other parts of your body.  
 - The need to urinate more often during the night.

**Decreased Blood Flow**  
 When your heart is not pumping well, less blood moves through your body. That means your tissues and organs don't get the oxygen they need.  
**Symptoms**  
 - Trouble exerting yourself.  
 - Blue disc.  
 - Feeling weak, tired, and dizzy.  
 - Confusion and trouble thinking clearly (usually only in older people).

**Kidney Problems**  
 Your kidneys help rid your body of salt (sodium) and excess water. When your heart is not pumping well, your kidneys do not get the blood they need to do their work. Salt and excess water build up, and make your body even more congested.

**Heart Changes**  
 When your heart is not pumping well, it can't pump up for its full power. Your heart may:  
 - Get bigger so it can hold on to plenty more blood.  
 - Build more muscle mass to include its pumping power.  
 - Beat faster.  
 At first, these changes help your heart work normally. In the end, however, they only make your heart more tired.

**Physical Exam**  
 A medical evaluation helps your doctor diagnose your condition and come up with the best treatment plan for you. During your physical exam your doctor may:  
 - Ask about your medical history.  
 - Look for signs of heart failure, such as shortness of breath, weakness, and swollen ankles and feet.  
 - Check for possible causes such as high blood pressure.  
 - Listen to your heart's rhythm to make sure it's normal.  
**Medical Tests**  
 Your doctor may use other information about your condition, he or she may recommend medical testing. Common medical tests include:  
 - Echocardiogram (which uses sound waves to produce an image of your heart on a screen).  
 - Electrocardiogram (which uses a recording device to measure the electrical activity of your heartbeat).  
 - Chest x-ray.

### Specific Goals

The care manager will set goals with the member, the member's medical home and other providers. Examples of individualized goals include:

- Make specific dietary changes;
- Monitor daily weight as an early indicator of worsening condition;
- Adherence to medications;
- Attend education classes or support groups;
- Cholesterol management and LDL-C screening; and
- Reduce preventable hospital admissions.

## Chronic Obstructive Pulmonary Disease (COPD) Chronic Care Management Description

Chronic obstructive pulmonary disease (COPD) refers to a group of diseases that cause airflow blockage and breathing-related problems. COPD, also referred to as emphysema and chronic bronchitis, is one of the most significant public health issues in the United States today. It is a preventable, treatable disease that is currently the fourth leading cause of death, and is projected to be the third leading cause of death by 2020. It is estimated that 12 million people in the United States have been diagnosed with COPD, and an additional 12 million are believed to have the disease and are unaware that they have it.

## Specific Goals

The care manager will set goals with the member, the member's medical home, and other providers. Examples of individualized goals include:

- Pharmacotherapy management of COPD including:
  - Systemic corticosteroid use
  - Bronchodilator use
- Use of spirometry testing in the assessment and diagnosis of COPD;
- Increase patient knowledge about COPD (cause, treatment, prognosis, and strategies to live with the disease) through delivery of education for patients and their caregivers, and dissemination of patient materials such as newsletters for COPD patients and their caregivers;
- Smoking cessation; and
- Ensure access to non-pharmacologic therapy, including pulmonary rehabilitation, home medical equipment and oxygen, by collaborating with community fitness resources and establishing a standardized menu of home oxygen equipment options.

### **Diabetes Chronic Care Management Description**

Diabetes is a serious, common, and costly disease, which if left unmanaged can lead to an array of complications such as end-stage renal disease. WellCare's chronic care management program is structured to educate and assist members in obtaining information necessary to better self-manage their diabetes through primary prevention, behavior modification programs, and compliance/surveillance. We use nationally recognized materials, tailored as necessary to be culturally appropriate.

### **WellCare Case Example**

A case manager contacted a member in the COPD chronic care management program and conducted an initial evaluation with the member. The member is a former smoker who was diagnosed with COPD (Chronic Obstructive Pulmonary Disease) in 2008, and was said to be very healthy until an acute hospital stay in February of 2009. After returning home, the member was experiencing shortness of breath and wheezing with activity; and became easily stressed due to business related matters. The member was referred to pulmonary rehabilitation. The care manager educated the member and his wife on COPD and techniques for pacing activity, energy conservation, pursed lip breathing and relaxation to help control symptoms, and also ordered a COPD workbook for the member. During a return call in April of 2009, the wife stated that both she and the member read the COPD workbook. The member does the strengthening exercises in the book daily and uses the pursed lip breathing techniques with all activities. The member noticed a significant improvement in his strength and endurance and during a doctor's visit in March was told that his pulmonary status has improved greatly.

The burden of diabetes in Louisiana and in the nation is large and growing. According to the 2008 Louisiana Behavioral Risk Factor Surveillance System (BRFSS) Report, about 10.7 percent of Louisiana residents age 18 and older have been diagnosed with diabetes. This compares to 8.1 percent of adults nationwide. Over the last 10 years, the prevalence of diabetes among Louisiana adults has risen almost half a percentage point each year, from 6.4 percent in 1998 to 10.7 percent in 2008.

WellCare's diabetes chronic care management program focuses on improving each diabetic member's ability to understand and manage his or her diabetes. Care managers will send and/or deliver materials to members such as the *Comprehensive Guide to Living with Diabetes*.

### Specific Goals

The care manager will set goals with the member, the member's medical home and other providers. Examples of individualized goals include:

- Annual HbA1c testing;
- Annual lipid profiles;
- Annual retinal exams;
- Annual screening for renal disease;
- Specific dietary changes;
- Weight loss; and
- Attend education classes or support groups.

### **HIV Chronic Care Management Description**

Because of the need for ongoing treatment and the potential for acquiring co-occurring illnesses, HIV patients are appropriate for targeted intervention through chronic care management to prevent complications associated with the disease. HIV infection disproportionately affects individuals of lower socioeconomic status, and many with the disease have other special needs like substance abuse treatment or behavioral health services.

Anti-retroviral treatment has extended the lifespan of people with HIV infection, and more people become infected with HIV than die from the disease each year. Since the mid-1990s, the age-adjusted HIV death rate has declined by more than 70 percent (Kaiser Family Foundation, 2009). As more people with HIV infection live longer, the demand for HIV care and treatment will continue to grow. For HIV, medication compliance is especially important to help prevent the virus' resistance to therapy. This is one reason that chronic care management programs offering treatment adherence support may be a particularly useful approach for HIV patients.

### Specific Goals

The care manager will set goals with the member, the member's medical home and other providers. Examples of individualized goals include:

- Decreased hospitalizations related to opportunistic infections;
- Compliance with anti-retroviral medications;

- Member receives ongoing education and social support;
- Member receives treatment for opportunistic infections;
- Member understands importance of CD4 count and what viral load lab results mean; and
- Member understands importance of treatment and medication compliance.

### **Hypertension Chronic Care Management Description**

High blood pressure increases the workload on the heart and blood vessels and can lead to heart disease, stroke, kidney problems and even blindness. Many Americans tend to develop high blood pressure as they get older; however hypertension is not a healthy part of aging. Others at high risk of developing hypertension are persons who are overweight, those with a family history of high blood pressure, and those with a high-normal blood pressure. Chronic care management for hypertension (HTN) will aid both members and care managers in recognizing early signs of HTN and reducing the risk of negative health effects.

#### Specific Goals

The care manager will set goals with the member, the member's medical home and other providers. Examples of individualized goals include:

- Improve blood pressure control;
- Decrease rate of preventable hospital admissions;
- Make specific dietary changes;
- Learn stress management techniques; and
- Attend education classes or support groups.

### **CAD Chronic Care Management Program**

Coronary artery disease (CAD) is the most common type of heart disease. About 13 million people in the U.S. have CAD and it is the leading cause of death in the U.S. for both men and women. Each year, more than half a million Americans die from CAD. The CAD chronic care management program provides members information related to the risks associated with CAD. The chronic care manager will also address other factors such as obesity and smoking. The goal of these interventions is to slow the progression of CAD and reduce the incidence of heart attacks and strokes.

#### Specific Goals

The chronic care manager will set goals with the member, the member's medical home and other providers. Examples of individualized goals include:

- Use of Beta blocker after acute myocardial infarction;
- Member understands that heart attacks and angina (chest pain) can be caused by blood flowing through unhealthy arteries;
- Member recognizes signs and symptoms of heart attack and stroke; and

- Member understands lifestyle changes necessary to improve his or her health and reduce risk of heart attack or stroke, such as weight management, smoking cessation, exercise.

### **Corporate Support for Chronic Care Management**

All of our chronic care management programs will be supported by the WellCare Disease Management department. Disease Management also contributes to external market audits by organizations such as the National Committee for Quality Assurance (NCQA), external quality review organizations (EQROs), and state and federal governments. It provides strategic direction and leadership in designing chronic care initiatives, collaborates with market-based leadership in program development and designs consistent policies, procedures and processes for implementing and maintaining chronic condition management programs.

WellCare utilizes a dedicated staff for area compliance. The compliance team is comprised of the manager of clinical compliance and audit, a clinical compliance specialist, a compliance nurse specialist and a clinical quality auditor. The compliance team is responsible for creating, maintaining, and updating policies and procedures; preparing for and attending department audits; tracking regulatory requirements relating to chronic care management and implementing actions necessary to comply with them; conducting staff audits in cooperation with the chronic care management manager and/or supervisor; and conducting other compliance functions as needed.

### **Measuring Program Outcomes and Improving Member Outcomes**

Member progress is measured through WellCare's care planning process. If a member requires a Health Risk Assessment (HRA), he or she will receive a detailed care plan that identifies service needs. The care plan is not a document for compliance; it is a living document that describes each member's care. Once the care plan is created it will continuously evolve and reflect the level of care for members. WellCare will monitor the results of our chronic care management programs using three types of measures:

- Process Measures – common managerial measurements for productivity and timeliness of services, e.g., numbers of members, completed cases, nurse to patient ratios, etc.
- Clinical Outcomes – disease specific measures are updated quarterly and annually (depending on the measure); most are derived from evidence-based practice guidelines, e.g., two HbA1c tests annually, lipid profiles annually, flu vaccine annually, etc.
- Financial Outcomes – measures derived from claims data, e.g., the reduction of certain services and costs once members are empowered with greater understanding of their disease process as a result of chronic care management.

Members who require a Health Risk Assessment will have individualized goals for chronic care management that are tracked and monitored by the member's care manager and included in the care plan. Care managers will track improvements in the member's understanding of the disease state using tools available in WellCare's Enterprise Medical Management Application (EMMA).

In addition, WellCare uses HEDIS measures and member satisfaction surveys to evaluate clinical outcomes. Exhibit E.1.d and Exhibit E.1.e are examples of HEDIS measures reported in Florida.

**Exhibit E.1.d - 2010 Diabetes HEDIS Clinical Compliance Outcomes – Florida**

Measures	2009 Rate	2010 Rate	Diff 2009-2010
HbA1c Testing	71.35%	78.35%	↑ 9.8%
Diabetic Retinal Eye Exam	41.10%	52.80%	↑ 28.4%
LDL-C Screening	75.18%	75.91%	↑ .97%

**Exhibit E.1.e – 2010 Asthma HEDIS Outcomes – Florida**

Measures	2009 Rate	2010 Rate	Diff 2009-2010
Asthma ED visits (per 1,000 members per year)	1,387	1,210	↓ 12.76%

Annual results are presented to the Utilization Management Medical Advisory Committee (UMAC) for discussion and external physician recommendations. Physician input and feedback is evaluated by corporate staff, interventions are identified, and programmatic changes are presented to the market Quality Improvement Committee (QIC) for approval. To continue to improve chronic care management performance measures in 2010 WellCare also implemented: (1) a member incentive to those members who get HbA1c, LDL-C, eye exam and nephropathy screening (\$10 Walgreens gift card); (2) HEDIS education and screening calls for members who are noncompliant with appointment scheduling; and (3) targeted member letters with the participating eye care providers in the area of the member’s home and a magnet reminder.

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## E.2

**Describe how recipients will be identified for inclusion into the Chronic Care/Disease Management program. Identify which disease states/recipient types will be targeted for the Chronic Care/Disease Management program. Describe how the Chronic Care Disease Management program will coordinate information and services with the PCP.**

WellCare will operate an integrated case management/chronic care management model that addresses medical and behavioral health needs within a single care plan. Each member identified as having a chronic condition will receive targeted chronic care management based on specific needs. Members whose circumstances require face-to-face case management will be assigned a local case manager who will facilitate the chronic care management services as part of the integrated case plan.

The mission of the chronic care management programs is to educate members regarding chronic diseases, recommended interventions and necessary lifestyle adjustments that help members to maintain the highest quality of life possible. Through specially developed chronic care management programs, WellCare will offer individualized services that provide education, identify resources in the member's community, and promote good health.

Chronic care management programs will meet goals through implementation of the following activities:

- Identification of members at risk;
- Stratification of risk for each member with intervention strategies designed for each level of stratification;
- Assessment and planned interventional strategies;
- Referrals to appropriate health care professional services such as behavioral health, pharmacy, and other specialized practitioners when needed;
- Monitoring and adjustment of care plans as needed to optimize outcomes for members and to meet established goals;
- Monitoring contractual arrangements and resource allocation to ensure that appropriate services are available to meet members' health needs;
- Identifying opportunities for improvement in the process and implementing as needed;
- Maintaining cultural sensitivity;
- Reviewing overall services provided to the member to ensure those services are medically necessary, appropriate, and consistent with the member's diagnosis and level of care required by the chronic care management plan; and
- Consulting when needed with appropriate specialized health care personnel such as medical directors, pharmacists, social workers, behavioral health professionals, health coaches and medical homes.

Medical homes and providers are our partners in managing the health care needs of members. They play a critical role in the management of members' chronic conditions. WellCare's care managers collaborate with the primary care provider and/or specialist to encourage member participation and referrals. We educate providers about the services offered by the program via a provider introduction letter, office visits and monthly lists of members with chronic conditions, in-service educational sessions, provider newsletters, and clinical practice guidelines. We

understand that providers have limited time and resources and so we assist them with member-related tasks such as appointment reminders, intensified member education, referrals to community support and by acting as additional eyes and ears for the provider between scheduled visits.

## **Member Identification and Enrollment in Chronic Care Management**

WellCare will identify chronic care management candidates at time of enrollment through the initial health screening questionnaire (see below) and thereafter through all of the following methods: application of a monthly proprietary algorithm that analyzes institutional, professional and pharmaceutical claims; self-referrals by members and families; referrals from providers, case managers, hospital discharge planners and the medical advice line. Providers and members will be educated about the chronic care management program as part of our broader educational activities at the time of enrollment/inclusion in the network.

### Assessment

New members will receive a welcome call, during which a brief intake screen will be conducted. The screening will be used to trigger a referral, as appropriate, to case management or chronic care management. Members with multiple chronic care conditions, or a single chronic condition and risk of another or serious mental illness will receive a chronic care management referral. Members identified for both chronic care management and case management will be referred initially to a case manager, who will perform a comprehensive Health Risk Assessment (HRA) and refer the member to chronic care management, as appropriate. Other members, who meet the criteria for chronic care management or are referred after enrollment, will be assigned to a chronic care manager for performance of a chronic condition-specific HRA. The chronic care managers also will review the comprehensive HRA for those members who are referred by a case manager, along with any existing care plan.

### Stratification and Provision

Members newly enrolled into chronic care management will be stratified into one of three levels based on the results of their chronic condition-specific HRA. Levels are determined based on a scoring system that considers severity, utilization and cost. Each of the three components is given a score from 0-100, for a maximum possible member score of 300. The score tiers are:

- Level 1 (1 – 75 points): member is relatively stable. Services are often psychosocial in nature; member is stable in self-care and understands the disease process; may benefit from reinforcement education.
- Level 2 (76 – 150 points): member may be newly diagnosed or newly discharged. There may be co-morbid disease states and extra assistance needed or member may not be managing his or her disease well and could benefit from extra education and adherence monitoring.
- Level 3 (151 or higher): member requires more intensive disease management and education. These members are either not adherent, not managing their disease well, or unstable because of co-morbid conditions.

Members will be screened for chronic care management each time a Health Risk Assessment (HRA) is performed by a case manager. In addition, members may receive chronic care

management based on prior participation in chronic care management, referral by the member's medical home, routine reviews of utilization and encounter data, review of pharmacy data, the 24/7 medical advice line, a provider's recommendation or upon a self-referral.

### **The Chronic Care Management Process**

The following process is applied to members who are referred to chronic care management:

- **Assessment:**
  - Identifies a member's health status and condition specific issues
  - Includes historical medical and psychosocial information
  - Identifies needs, barriers and cultural diversity information
- Risk stratification tool applied, member interventional strategy schedule is set up;
- Development of the care plan with the member; goals and interventions are identified in accordance with nationally recognized standards of care and evidence based guidelines;
- Monitoring the member throughout the process of education;
- Regular contact with member based on acuity and needs;
- Monitoring all activities and report as needed; and
- Obtaining feedback from the member and providers on the chronic care management program.

These activities occur between the member and the chronic care managers located at WellCare's Tampa, FL corporate headquarters. Chronic care managers provide educational materials, clinical best practice updates, and support to the local case managers as needed. Listed below are the key functions of the chronic care manager and case manager in chronic care management:

- Identification of the member at risk;
- Risk stratification of each member within each disease state;
- Assessment and development of member directed goals through care planning;
- Implementation of chronic care management care plans within interventional strategy guidelines depending on the risk level of the member, including education of the member and adherence monitoring;
- Monitoring of the member throughout all transitions of care;
- Education of the member;
- Documentation of all interactions; and
- Optimizing outcome and goal attainment.

When a member requires both chronic care management and face-to-face case management services; the referral will go first to case management so that the member receives chronic care management services including in-person health coaching if needed. These members are provided information about the available chronic care management programs for which they qualify by the case manager. When a member qualifies for a care management program, the chronic care management interventions and goals are included in the overall case plan.

## **Coordination with Primary Care Providers**

Primary care providers (PCPs) receive information and education about WellCare chronic condition management programs. The PCP is an important referral source for members and a critical player in the chronic care management process.

The chronic care manager will provide the PCP with a copy of the member's chronic care plan (with the member's consent) and seek input regarding additional goals or services. The chronic care manager will include recommendations for goals and services from the PCP and any ancillary providers who deliver health services to the member. The member's compliance with care and services provided by the PCP are an important part of monitoring compliance progress, behavior and lifestyle changes, and the efficacy of treatment. WellCare encourages providers to use the care plan during appointments with the member, as a tool to ensure coordination of efforts, to improve the member's health.

INSERT TAB HERE  
Section F  
Service Coordination

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Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		<b>Section F: Service Coordination (Section § 14 of RFP)</b>	<b>170</b>		
<b>Section F Page 1</b>	<b>All</b>	<p><b>F.1</b></p> <p>DHH intends to provide CCNs with two years of historic claims data for members enrolled in the CCN effective the start date of operations. Describe how you will ensure the continuation of medically necessary services for members with special health needs who are enrolled in your CCN effective the start date of operations. The description should include:</p> <ul style="list-style-type: none"> <li>• How you will identify these enrollees, and how you will use this information to identify these enrollees, including enrollees who are receiving regular ongoing services;</li> <li>• What additional information you will request from DHH, if any, to assist you in ensuring continuation of services;</li> <li>• How you will ensure continuation of services, including prior authorization requirements, use of non-contract providers, and transportation;</li> <li>• What information, education, and training you will provide to your providers to ensure continuation of services; and</li> <li>• What information you will provide your members to assist with the transition of care.</li> </ul>	<b>10</b>		
<b>Section F Page 7</b>	<b>All</b>	<p><b>F.2</b></p> <p>Describe your approach to CCN case management. In particular, describe the following:</p>	<b>85</b>		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		<ul style="list-style-type: none"> <li>• Characteristics of members that you will target for CCN case management services;</li> <li>• How you identify these members;</li> <li>• How you encourage member participation;</li> <li>• How you assess member needs;</li> <li>•</li> <li>• How you develop and implement individualized plans of care, including coordination with providers and support services;</li> <li>• How you coordinate your disease management and CCN case management programs;</li> <li>• How you will coordinate your case management services with the PCP; and</li> <li>• How you will incorporate provider input into strategies to influence behavior of members.</li> </ul>			
Section F Page 17	All	<p><b>F.3</b></p> <p>Describe your approach for coordinating the following carved out services which will continue to be provided by the Medicaid fee-for-service program:</p> <ul style="list-style-type: none"> <li>• Dental</li> <li>• Specialized Behavioral Health</li> <li>• Personal Care Services</li> <li>• Targeted Case Management</li> </ul>	5		
Section F Page 21	All	<p><b>F.4</b></p> <p>For members who need home health services upon discharge from an acute care hospital, explain how you will coordinate service planning and</p>	10		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		delivery among the hospital's discharge planner(s), your case manager(s), your disease management staff member(s), and the home health agency. Further, explain how you will monitor the post-discharge care of enrollees receiving home health services in remote areas.			
Section F Page 23	All	<b>F.5</b> Aside from transportation, what specific measures will you take to ensure that members in rural parishes are able to access specialty care? Also address specifically how will you ensure members with disabilities have access?	10		
Section F Page 25	All	<b>F.6</b> Detail the strategies you will use to influence the behavior of members to access health care resources appropriately and adapt healthier lifestyles. Include examples from your other Medicaid/CHIP managed care contracts as well as your plan for Louisiana Medicaid CCN members.	40		
Section F Page 32	All	<b>F.7</b> Many faith based, social and civic groups, resident associations, and other community-based organizations now feature health education and outreach activities, incorporate health education in their events, and provide direct medical services (e.g., through visiting nurses, etc.). Describe what specific ways would you leverage these resources to support the health and wellness of your members.	10		
Section F Page	All	<b>F.8</b> Submit a statement of any moral and	Included/Not Included		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
36		religious objections to providing any services covered under Section §6 of RFP. If moral and religious objections are identified describe, in as much detail as possible, all direct and related services that are objectionable. Provide a listing of the codes impacted including but not limited to CPT codes, HCPCS codes, diagnosis codes, revenue codes, modifier codes, etc. If none, so state. Describe your plans to provide these services (e.g., birth control) to members who are entitled to such services.			

## Section F: Service Coordination

### F.1

***DHH intends to provide CCNs with two years of historic claims data for members enrolled in the CCN effective the start date of operations. Describe how you will ensure the continuation of medically necessary services for members with special health needs who are enrolled in your CCN effective the start date of operations. The description should include:***

- ***How you will identify these enrollees, and how you will use this information to identify these enrollees, including enrollees who are receiving regular ongoing services;***
- ***What additional information you will request from DHH, if any, to assist you in ensuring continuation of services;***
- ***How you will ensure continuation of services, including prior authorization requirements, use of non-contract providers, and transportation;***
- ***What information, education, and training you will provide to your providers to ensure continuation of services; and***
- ***What information you will provide your members to assist with the transition of care.***

WellCare has extensive experience managing the transition of populations with complex needs from fee-for-service to managed care. We have transitioned over 2.3 million Medicaid and Medicare beneficiaries into managed care and have effectively managed transitions for enrollees on an on-going basis. We know that members with special health needs require special care to experience as little disruption as possible. Accordingly, minimizing disruption to ensure continuity of care will be our primary objective during transition and beyond.

Members with special health care needs who are receiving services upon transition will be identified through review of (1) current treatment plans provided by the state (if available); (2) DHH claims data; (3) information received from our current vendors; and (4) completion of our initial health screening questionnaire. Our review of existing treatment plans will be essential to ensuring continuation of current services; existing plans will also be used to provide a basis for developing updated plans when needed.

### **Identification of Members with Special Health Care Needs**

#### Claims Data Analysis

WellCare will review available claims data both upon program implementation and on an on-going basis to identify members who have special health care needs. The review will focus on diagnoses, utilization, hospitalizations, emergency department visits, and service locations. WellCare will utilize pharmacy data received both real time and via the refreshed claims data from DHH for utilization patterns that may indicate that a member has special health care needs. WellCare will work with DHH to obtain pharmacy data in accordance with DHH-defined file transfer and format protocols. Assuming availability in a standard NCPDP or similar format, WellCare will populate the enterprise data warehouse to review utilization patterns, incorporate the data into predictive modeling tools, and make results available to care managers in EMMA.

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## Intake Screen

The initial health screening questionnaire is designed to confirm demographic and health information, identify urgent needs, and identify members who will need case management and/or disease management. This essential part of the welcome call, which is performed by an NCQA CAHPS certified vendor, is used to help identify potential candidates for coordination through case management. Members who are identified as having a mental or physical disability and members who demonstrate any other special health care need will be automatically referred to case management for further evaluation and a comprehensive Health Risk Assessment (HRA).

## Health Risk Assessments (HRA) and Education for Members

Members with special health care needs will receive case management, as is the current practice in many existing WellCare Medicaid markets. The case manager has primary responsibility for providing education, coordination and support to the member. The HRA is conducted on a face-to-face basis with the member, and any other professionals or individuals that the member requests also participate when possible. The assigned case manager will review the member's current treatment plan (if available) and focus on the following as it relates to the member's physical, behavioral and social health needs:

- Evaluate the appropriateness of the enrollee's existing care plan, if applicable;
- Identify potential risks to the enrollee's health, safety and welfare;
- Determine what changes, if any, are necessary to appropriately address the enrollee's needs; and
- Facilitate any necessary service authorizations.

The HRA captures information about physical health, behavioral health and substance abuse issues/challenges and includes questions that will help case managers determine what services are needed by the member. In addition, the HRA allows the case manager to collect information regarding providers the member is currently seeing (including providers that perform services related to carve out benefits such as behavioral health and pharmacy) so that the case manager can proactively engage them in the care management process.

If the comprehensive assessment reveals that the current course of treatment remains necessary for the member, the member will continue to receive services from any network providers he or she is currently seeing. When services are provided by an out-of-network provider, provider relations representatives will contact that provider and encourage him or her to participate in the network (subject to credentialing). Case managers will provide any necessary updates to providers concerning changes or significant developments in the enrollee's health status, and will assist in scheduling follow-up appointments if necessary. Based upon the comprehensive assessment, the case manager may determine that it is necessary to make adjustments to the service frequency, units of service and/or duration. Case managers will consult with the member's primary medical home, and other current provider(s), to determine the efficacy of the existing course of treatment and next steps before making any changes to the member's care plan.

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## **Additional DHH Information Required**

Historical claims data provided by DHH on an ongoing basis would allow for a strong start to the transition care planning process. To fully prepare for the transition requirements of the target CCN population, DHH can further ensure successful care coordination for newly enrolled CCN members by providing the following additional information to participating health plans:

- **Alternative Member Contact Information:** We understand that address information will be provided via the HIPAA EDI 834 transaction files for upload into our core processing system. Typically most enrollment systems can transact up to two contact files (address/telephone) to health plans. We think it would be valuable to receive alternative cell phone, e-mail or relocation addresses (i.e., in case of storm evacuation etc.) if such information is available.
- **Case Information Related to Benefit Limit Removals:** Under the existing Community Care/Fee-for-Service program, benefits such as adult office visits have annual limits. For cases in which an exception has been approved to waive the annual limit, it would be helpful to receive case notes or other related information to the extent available.
- **Pharmacy Lock-in Members:** DHH has indicated that pharmacy data shall be made available to health plans on a real time basis to allow for inclusion in the care planning process. Data regarding members in pharmacy lock-in programs for over-utilization or inappropriate utilization (i.e., ED visits for pain medication) would help enable health plans to quickly identify members who may be candidates for additional counseling regarding appropriate care settings. The data could also help plans begin monitoring for appropriate opportunities to refer members for behavioral health/substance abuse counseling.
- **Coordination Protocols for Interaction with DHH Clinical Staff:** DHH has provided information in both the CCN-P policy and procedure manual and the RFP regarding its expectations with respect to transition of care coordination. We suggest that, during the implementation planning period, joint sessions be held with WellCare and DHH clinical staff to foster a proactive dialogue on cases and consideration of carve-out benefits and services.

## **Continuing Current Services During Transitions**

Through the transition period members will be able to retain their existing services and providers until an appropriate transition can be arranged (if necessary). Transition periods will be defined by individual care needs and will comply with DHH requirements to help ensure patients remain stable and progress to a positive outcome. WellCare intends to enter into provider arrangements with all providers currently serving Medicaid patients within the state as well as achieve substantial expansion of the provider network. WellCare provider relations representatives will contact enrollees' out-of-network providers and offer to enroll them in the network (subject to credentialing).

If an enrollee needs to be transferred to a different provider, WellCare will facilitate communications between the member's existing provider and the new provider if both are willing, and the member signs a release form. In addition to the ability to retain existing services and providers through the care planning process, members currently under treatment with out-of-network providers for one or more acute or chronic conditions may request to continue their existing courses of treatment from those providers for a ninety (90) day transition period.

On a case by case basis, WellCare may allow a member to continue to receive a course of treatment from an out-of-network provider beyond the transition period. The member must be willing to continue receiving care from the provider and the case manager, in consultation with the medical home, must determine that the member's health and treatment would be better served if the member were to continue receiving services from the out-of-network provider. In addition, the provider must agree to WellCare's rates and sign a single case agreement. Providers allowed to continue providing care under such circumstances must be in good standing with state licensure requirements and not listed on any debarment list to ensure patient safety.

If WellCare denies a member's request to extend his or her use of an out-of-network provider beyond the ninety day transition period and the member's out-of-network provider declines to join the network, the case manager will work with the member to transition to an alternative network provider as soon as practical. The case manager's goal will be a seamless transition to the new provider.

During the transition period for new members, our continuity of care policies will be implemented using the following procedures:

- If a service authorized by Medicaid or the previous plan in which a member was enrolled also requires authorization under WellCare's guidelines, Utilization Management will enter the authorization into the system at the request of the provider. If no authorization is requested, the claims system is configured to waive authorization requirements for most outpatient procedures during the transition of care period;
- WellCare also will seek to contact all new members by telephone within 30 days of enrollment, to conduct an intake screen (or request a call back). The screen will inquire about pregnancy status (if applicable); existing health services, including from out-of-network providers; any special health care needs; and whether the member may require case management;
- A case manager will be assigned to a new member based on the member's geographic location if the results of the intake screen indicate a need for further follow-up or if the member requests one. The assigned case manager will contact the member to schedule a health risk assessment. The HRA will be used to determine the degree of case management needed, and to develop a comprehensive case plan covering both capitated and non-capitated services;
- During the HRA process, case managers will secure releases from members in order to: contact existing out-of-network providers and agencies to obtain service plans (if applicable), member records and other clinical information; identify previously authorized services; and assist members in selecting a WellCare network PCP as part of the care planning process. If records are transferred before the 90-day transition period ends, calls will be made to the member to arrange alternative network services and to authorize new services. The plan will ensure that any services being delivered by out-of-network providers are transitioned to network providers. The case manager may include out-of-network providers within the ongoing care management plan, if doing so is determined to be in the best interest of the member while the member completes a course of care;
- If the results of the intake screen do not indicate a need for case management, WellCare will continue to adjudicate clean claims from out-of-network providers for payment until the member's initial visit with his or her WellCare PCP, as determined through receipt of

a claim for a new patient visit, or for dates of service through the 90th day following enrollment;

- WellCare will allow continuation of existing treatment plans by participating and out-of-network providers during the transition period. Providers should notify WellCare to receive an authorization number to assure payment for services that are medically necessary and covered by the benefit package. The claims system will be configured to process payments for certain outpatient services even if no authorization is in the system. However, WellCare encourages providers to notify us to help us identify members that may have care coordination needs.
- The member's record will be flagged in our system so that clean claims from out-of-network providers will be adjudicated for payment for dates of service within the 90 day time period following enrollment, unless the record is modified to indicate the transition to a network provider has occurred;
- If services are being furnished by an out-of-network provider, WellCare's Network Development department will contact the provider and offer to add the provider to our network (subject to credentialing); we also will provide instructions to the provider for claims submission during the transition period. Should an out-of-network provider be found to not be eligible to provide services to members (for example, the provider's license has expired), WellCare case managers will proactively work with members to identify appropriate providers to continue their care;
- The same procedures will be followed for new members past their 24th week of pregnancy. Additionally, these members will be flagged in the authorization system so that all claims from their identified prenatal providers are processed for payment from the effective date of enrollment through delivery and postpartum;
- Members with out-of-network claims who do not visit their network PCPs within the first 75 days will be contacted and encouraged to schedule an initial appointment. WellCare call center associates will be available to assist with appointment scheduling when requested.

### **Educating Providers on Continuation of Service Protocols**

WellCare will conduct provider orientation activities with our Louisiana network at least sixty (60) days prior to the first member enrollments. Multiple outreach attempts will be made to maximize provider participation and awareness. Outreach methods will include telephone calls, mailings, fax blasts, e-mails, and visits from Provider Relations representatives. In addition WellCare staff will attend Medicaid stakeholder meetings and other public forums where we may meet and engage providers directly.

Provider participation will be logged and tracked during the 60-day period. Approximately 30 days prior to go-live, we will re-contact all providers who have not yet undergone training and direct them to online training resources or schedule a live session. Going forward, as new providers are placed on active status, our policy will be to conduct training prior to their joining the network but never later than 30 days after they become active.

Core training materials utilized for provider orientations and ongoing education include but are not limited to:

- Provider Contracts

- Provider Handbooks
- Provider Bulletins
- Provider Newsletters

During the orientation session, provider relations representatives review the provider contract and handbook with the newly enrolled provider. The provider contract details the contractual requirements relating to care coordination, including transition planning for patients and timeframes within which care should be provided. Provider handbooks will be issued no later than five business days after the provider's inclusion in the network. These will be supplemented with quick reference guides, which are step-by-step instruction guides for requesting authorizations, making referrals, filing claims, and other administrative matters.

Providers will be able to offer feedback and evaluation of training programs through surveys offered in conjunction with the sessions, or at any time via our online provider portal. The information will be used to identify additional areas that need to be addressed and to otherwise improve our training materials and activities.

### **Member Information on Transition of Care**

Members will receive education about the transition of services by phone during the initial intake screen by phone and during the comprehensive assessment, if applicable. Members who have special health care needs will be assigned case managers who will be responsible for face-to-face interaction with their members and with coordinating the transition of services for those members. Members will also receive information about which of their providers are in WellCare's network and about their options with respect to selecting different providers. The process described above assumes that the contact information we will receive will be correct on the date of receipt and that we are able to contact the members. WellCare will work with DHH and providers to quickly locate members we believe require transition care planning and/or assistance. WellCare will also make member education materials available in provider offices and other appropriate venues that members can access. Concurrently, we will train providers on how and when to redirect members to WellCare for assistance in accessing benefits, which may include transition services.

## F.2

**Describe your approach to CCN case management. In particular, describe the following:**

- **Characteristics of members that you will target for CCN case management services;**
- **How you identify these members;**
- **How you encourage member participation;**
- **How you assess member needs;**
- **How you develop and implement individualized plans of care, including coordination with providers and support services;**
- **How you coordinate your disease management and CCN case management programs;**
- **How you will coordinate your case management services with the PCP; and**
- **How you will incorporate provider input into strategies to influence behavior of members.**

### **Case Management Approach Overview**

The foundation of WellCare's case management model is ensuring that each individual receives appropriate care and attention in a culturally sensitive manner. Members who require specialized assistance managing their health care needs will be referred for case management. In addition, members with special health care needs, high risk or complex conditions and high cost conditions will automatically be enrolled in case management.

### **The MCC Team**

Members who receive case management are supported by WellCare's member-centric care management (MCC) team, a group of WellCare professionals who work together to support a comprehensive approach to case management. The team includes the case manager, PCP, chronic care manager, behavioral health providers, social support providers, and others who can contribute to the improved health and well-being of the member. The MCC team works in an inter-disciplinary manner to coordinate and carry forward the member's care plan. The case manager is responsible for leading this team and incorporates all services provided in the comprehensive care plan.

### **Key Components of Case Management**

Members who are identified for case management and enrolled in the program are assigned an individual case manager who takes the lead role in ensuring the following key components of the care management program are delivered:

#### Member-centered care

The member and his or her family are integral parts of the case management team beginning with the service planning process, identification of care plan goals and continuing thereafter. Member-centered care is the foundation of all case management activities. All professionals involved in the case management team must focus on the needs of the member, the member's

understanding of his or her own health care needs and satisfaction with care received, and the member's ability to be an advocate for himself or herself and the member's family.

Integral role for physicians and behavioral health practitioners

Members' providers will participate in the care planning process and be kept informed of ongoing case management activities. A member who has a special health condition that requires a specialist may select a specialist physician to serve as his or her PCP and will have direct access to specialist physicians identified in the care plan.

Multidisciplinary teams

Members will be matched with case managers with the credentials to best meet their needs. In addition to the case manager, other team members will be available to provide expertise and support throughout the case management process. The team may include, for example: behavioral support; social work; community outreach professionals, and/or additional providers such as a pharmacist; and/or family members and caregivers.

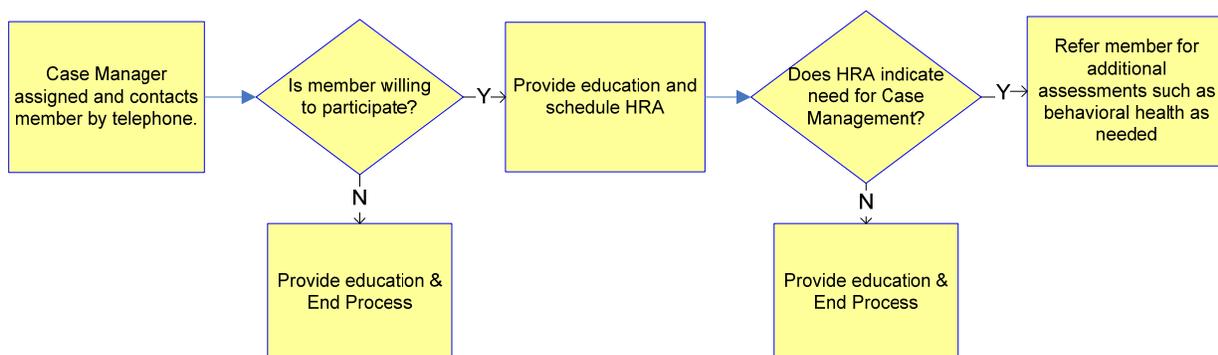
Local presence

Case management teams will be located throughout Louisiana's geographic service areas, as is done currently in our Hawai'i and Florida markets. This local presence allows case managers to have face-to-face visits with members as needed. In addition, the case managers will become familiar with community resources that may benefit members beyond services covered by WellCare.

Service integration

Case management is integrated and covers a member's, physical, behavioral and social needs as they relate to the members health, well-being and safety. The care plan is designed to integrate all needed services and address both capitated and non-capitated services.

Once a member is referred by any source for case management the assessment and care planning process is initiated. The assigned case manager will contact the member by telephone to schedule a time convenient for the member to conduct an in-home health risk assessment (HRA) and to begin developing the member's care plan.



The case manager will use this information, in concert with relevant findings from the functional and medical components of the HRA, to devise a care plan that is responsive to the member's needs including medical, behavioral health, social and/or transportation needs.

### **Members Targeted for Case Management**

Through WellCare's experience in the coordination of Medicaid managed care benefits in other states, we have identified some core populations that should be targeted for case management. Children or adults who have serious medical or chronic conditions, or who are identified with special health care needs, have previously been discussed. This includes individuals who face daily physical, mental, or environmental challenges that place at risk their health and/or ability to fully function in society. This includes severe chronic illnesses as well as physical, mental, and developmental disabilities.

Members with more than one chronic condition (or multiple co-morbid conditions) and a recent exacerbation of one or more conditions require extensive coordination. Examples include COPD, CHF, CAD, diabetes, and HIV/AIDS. Also targeted are members with multiple inpatient admissions over the preceding six months with the most recent being within the preceding 30 days. Re-admissions may be related to lack of follow through on discharge plans or acute exacerbation of chronic condition(s).

Members discharged home from acute inpatient or SNF facility with multiple service and coordination needs such as durable medical equipment (DME), physical, occupational or speech therapy, and home health may have complex discharge needs. These may include members with complicated, non-healing wounds, oncology patients, or members recovering from significant traumatic injuries such as amputations, blunt trauma, spinal cord injuries, head injuries, burns, or multiple traumas. Any member that is being referred for transplant related services and any member in any phase of transplantation will receive case management services.

In Medicaid markets with a similar Medicaid population mix and volume as Louisiana we have found that 10-15% of pregnancies may be classified as high risk, many of which can potentially result in pre-term deliveries and consequently higher neonatal intensive care unit utilization. WellCare therefore also targets for case management pregnant members having the following conditions: gestational diabetes; hyperemesis gravidarum; multiple gestation, oligohydramnios; placenta previa; placental abruption; polydraminios; pregnancy induced hypertension (PIH); history of PIH; preterm labor; history of preterm delivery; ruptured membranes, domestic abuse; Rh-negative mother; recreational drugs or alcohol use during pregnancy; history of low birth weight baby not related to preterm delivery; teenage pregnancy (maternal age <18 years); and advanced maternal age (maternal age >35 years).

### **Intake Screen and Identification for Case Management**

Every WellCare member receives an initial health screening questionnaire as part of the initial welcome call. Information collected during the brief assessment, together with any available claims data and prior or existing care plans, is considered to determine if a member has a potential need for case management. This assessment allows WellCare to provide early intervention based on the following goals:

- Identify any emergent need requiring immediate attention;

- Determine if the member has complex medical needs;
- Determine if the member is potentially eligible for a disease management program; and
- Determine if the member has behavioral health needs that need to be addressed.



Information gathered by the intake screener is entered into the member’s case file in WellCare’s Enterprise Medical Management Application (EMMA), a component of our core processing system. Any emergent needs are flagged in EMMA for immediate attention by a case manager.

WellCare promotes a “no wrong door” approach to identifying members for case management. WellCare employees who interact with members and network providers receive training regarding when and how to make a referral to case management. WellCare will work with community agencies who may serve as referral sources as well. In addition, members may self-refer and request an assessment at any time. Members are identified through a variety of proactive methods including paid claims data, the member accessing disease management, and/or the member having utilized emergency department services. Each member identified with a need for coordination is screened, assessed and mentored as needed.

### Women with High Risk Pregnancies

We understand that high-risk pregnancies are among the leading health concerns in Louisiana. The March of Dimes 2010 Premature Birth Report Card for Louisiana showed a premature birth rate of 15.4 percent, almost twice the national objective of 7.6 percent. A majority of poor birth outcomes are related to lack of prenatal care. Our prenatal case management employs multiple methods to reach women and improve the health of both the mother and infant. Its specific objectives include: increasing the number of pregnant women, including teens, identified in the first trimester (or earliest possible time from enrollment); increasing the frequency and amount of prenatal care provided by physicians; decreasing the percentage of babies with birth weights less than <1500g; increasing the gestational age at birth; and enhancing member safety, productivity, satisfaction and quality of life.

Core elements of our program were initially developed for our Georgia Medicaid health plan. In 2010, approximately 32,000 women, including a significant number of teenagers, were referred for a comprehensive OB assessment and over 5,000 were enrolled in the high-risk program. The program is operated on an opt-out basis, with case management initiated and provided unless the member asks to be excluded. An example of the program’s impact is illustrated by a case involving a teen member (see inset):

New members who are pregnant or think they may be pregnant at time of enrollment will be identified through initial intake screening. Members who become pregnant after enrollment will be identified through a combination of paid claims data, hospital discharge planners, medical advice line alerts and home health, physician and member self-referrals. In addition, handbooks and educational materials will encourage members to contact WellCare as soon as they learn of their pregnancy.

When a pregnant member is identified, case management will contact her to conduct a comprehensive pregnancy risk assessment. If the member already has been assessed and consents, we will obtain and review the results. In our experience, this can be a useful source of information for pregnant teens that may have been to Planned Parenthood or another similar provider, but may be reluctant to share information directly with a WellCare case manager at the start of their relationship.

The case management team will include nurses and social workers with expertise in high-risk prenatal care management. Assessment results will be used to categorize members into low and high risk based on the number and severity of identified risk factors. Low risk members will be enrolled in our HUGS well pregnancy program. WellCare makes targeted outreach telephone calls to each member identified as being pregnant urging her to enroll in HUGS. Upon enrollment, HUGS assists members with scheduling and completing all recommended prenatal visits and connects them with other available social and community resources, such as WIC, that may help improve the health of both mother and baby. HUGS members also receive prenatal care outreach letters and booklets about prenatal care and what to expect during pregnancy as well as information about the post-partum visit and a copy of the schedules for childhood immunizations and well-child visits.

**WellCare Case Example of Program  
Impact: High Risk Pregnancy**

We enrolled a 16-year old member who was referred to the program in the middle of her second trimester. She lived with her elderly grandmother and had been estranged from her mother since age 12. Upon initial case management interview, the grandmother voiced concern related to prenatal care, truancy issues, and financial concerns that resulted in limited food and utility resources. The nurse case manager, in conjunction with a social worker, engaged the member in developing a plan of care. The member was encouraged to participate in goal setting, which included a personal commitment to attending school, obtaining life skills for independent living, completing all scheduled OB appointments, and communicating regularly with her care management team. Ongoing efforts to maintain member contact were extended to the involvement of the school counselor for coordination of conference calls during school hours. This effort served a twofold benefit: to decrease truancy issues and to establish a scheduled time for communication of prenatal education teaching objectives. The member was well engaged during the teleconferences, asked thoughtful and appropriate questions with an overall demonstrated growth of maturity and readiness by the time of delivery. The success of this member hinged on the collaborative efforts of the case management team (including the school counselor and provider). The pregnancy course was unremarkable for complications until 36 weeks, when the member experienced signs and symptoms of pregnancy induced hypertension and was placed on bed rest. The case manager monitored her compliance through regular home visits. The member delivered at 37.5 weeks via elective Cesarean birth due to an estimated fetal weight > 8 lbs and increasing elevations in blood pressure.

## **Encouraging Member Participation**

A number of strategies are employed to encourage member participation in case management. The initial welcome call and health screening is used to inform members of available programs and, based on the screening results, encourage the member to participate in the identified program opportunity. HUGS, described above, is another example of a targeted outreach member engagement strategy used by WellCare. This type of outreach is used for both high risk pregnancy and chronic condition disease management. Our chronic care managers and case managers have been trained in motivational interviewing techniques; this improves the engagement rate for targeted members. Member incentives are often used to enhance participation and/or compliance in our high risk HUGS program. Sixty percent of members in HUGS were compliant with the recommended prenatal visits, compared with 42 percent of members not in HUGS; sixty-eight percent of members in HUGS were compliant with the recommended postpartum visits as compared to 47 percent of members not in the HUGS program. WellCare will evaluate the use of member incentives post implementation after we have a base of experience upon which to assess needed interventions.

It is important not to reduce the impact of case manager encouragement in the relationship with a member and family or caregiver. A case manager involves the member and/or caregiver in the process of developing and implementing an individualized case management plan of care. They ensure and facilitate access to quality health care; offer education and information regarding topics such as available resources, clinical topics and access to services; empower informed members to be independent advocates for self management; provide members with ongoing access to qualified health care professionals; monitor members throughout the process of case management activities and goal achievement; and assess progress against case management plans for members.

## **Assessment of Member Needs**

### Health Risk Assessment (HRA)

The assigned case manager contacts the member by telephone to schedule a time convenient for the member to conduct an in-home HRA and comprehensive assessment and develop the member's care plan. The case manager will establish a meeting date and time that is convenient for the member and other participants. Prior to the visit, the case manager will request that the member provide the names of any providers, caregivers, or others that the member wishes to have present during the HRA.

Information to be collected will include demographic information, current health and behavioral health status to determine the member's need for care management, disease management, behavioral health services and/or any other health or community services. The case manager will observe the member's living environment, non-verbal indicators of health and safety, and initiate a personal relationship with the member. During the completion of the HRA, the case manager may learn about other individuals who should be consulted by the care planning team such as specialists, representatives, family or friends.

Members will be offered assistance in arranging an initial visit with his or her PCP for a baseline medical assessment, including assistance with obtaining non-emergency transportation if needed, and other preventive services. The completed HRA (including behavioral health

assessment), care plan, disease management program referral, and all other information obtained during the in-home visit) will be captured in EMMA.

Case managers will regularly interact with members to monitor their health, safety and welfare. Case managers will discuss topics such as emergency preparedness, disease management (as appropriate), preventive care and care plan recommendations. The type of interaction (telephone or face-to-face) and contact frequency will be determined based upon the member's individual needs. At a minimum, each member enrolled in case management will have an annual HRA as well as annual updates to the care plan. More frequent HRAs or updates to the care plan will be conducted if dictated by changing needs. Case managers are responsible for sharing information with other agencies serving the member when the member's needs change and with the member's permission.

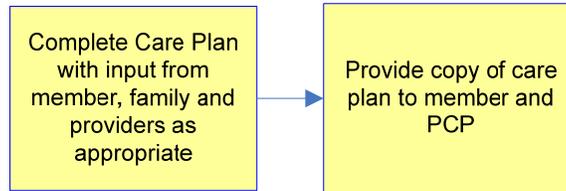
### **Individual Care Plan Development**

Prior to leaving the home, the case manager will review preliminary HRA findings and care plan recommendations with the member to ensure case manager understands the member's preferences and concerns. The plan must be discussed with the member or a representative before becoming final. The case manager will mail a copy of the final care plan to the member.

The care plan should be considered a roadmap for a member's care. It describes the services needed to address the member's needs and help the member accomplish his or her goals, and identifies the resources available to navigate the path. The care plan will include, at a minimum, the following elements:

- All physical health needs, services and providers
- All behavioral health needs, services and providers
- All needs, services and providers related to any substance abuse
- Medications (prescribed and over-the-counter)
- Disease management plan (as appropriate)
- Transportation needs
- Goals/anticipated outcomes
- Medical home
- Name of case manager
- Date of required update of HRA
- Date of required care plan update

The care plan team will consist of the member, any persons identified by the member, the medical home, appropriate specialty providers and community agencies. The completed HRA (including behavioral health assessment), care plan, chronic care management program referral, and all other information obtained during the in-home visit will be captured in WellCare's care management and utilization system, EMMA.



## Ongoing Case Management

Case managers will regularly interact with members to monitor their health, safety and welfare. The type of interaction (telephone or face-to-face) and contact frequency will be determined based upon the member's individual needs. At a minimum, each member participating in case management will have an annual HRA as well as annual updates to his or her care plan. More frequent HRAs or updates to the member's care plan will be conducted if dictated by changing needs. Case managers are responsible for sharing information with agencies serving the member when the member's needs change and with the member's permission. Ongoing relationships the case manager will maintain include:

- Member
- Medical home/PCP
- Specialty providers
- Behavioral health professionals
- Disease management
- Family members/caregiver

## Case Management for Members with Behavioral Health Needs

WellCare recognizes the statistically high incidence of co-occurring physical and behavioral health illnesses and the corresponding need for co-management of members' health needs with their behavioral health providers. It is essential that physical and behavioral health be fully integrated within the case management program. When a member's primary need is behavioral, the case management team will include a licensed clinical social worker with behavioral health expertise who is designated as the case manager. These behavioral health specialists are also available to consult on care plans for other members who have behavioral health needs that are secondary to their physical health needs. The HRA includes the PHQ-9 depression screening and CAGE substance abuse screening. The HRA is reviewed and updated to reflect changes in clinical practice or as standard treatment protocols change. Members who present with potential behavioral health concerns are referred to a provider who can complete a more thorough assessment.

## WellCare Case Management Example #2



On a Friday afternoon a few months ago, a provider called to report that he had admitted a 73 year old female for COPD. He was unaware that she had an alcohol issue until this hospitalization when all she could do was demand vodka. This hospital was not in WellCare's behavioral health network, but the case manager immediately saw the advantage of the enrollee remaining in the same facility so that her medical and behavioral care could be addressed and she could stay with the PCP she had been with for many years. The case manager was able to call the contracting person at the hospital and negotiate a single case agreement. This was all accomplished in about 90 minutes. The member received her detoxification and COPD treatments and continued on to substance abuse treatment.

### Case Manager Responsibilities

The following activities, though not exhaustive, are illustrative of case manager responsibilities. Specific functions will vary depending on the case manager's assigned members and the needs of those members.

- Provide overall care management and coordination of care for members;
- Ensure that family members, informal caregivers and others are present for the member's HRA, as desired by the member;
- Conduct the HRA;
- Consult with the member's medical home and expand interdisciplinary teams to include other medical, social and behavioral health professionals as appropriate to address the member's entire spectrum of needs;
- Develop a care plan reflective of the member's desired goals, outcomes, and needs;
- Initiate enrollment in a disease management program, where appropriate, and deliver disease management health coaching and education;
- Ensure appropriate access to covered services and ongoing monitoring of covered services;
- Provide ongoing communication and coordination with the member's medical home;
- Act quickly to resolve service delivery issues or concerns raised by the member or the member's representative; and
- Conduct face-to-face meetings with the member, as appropriate, and perform reassessments as warranted by the member's condition or desire for modifications to the care plan.

### Case and Disease Management Coordination

WellCare will operate an integrated case management/chronic care management model that addresses medical and behavioral health needs within a single care plan. Each member identified as having a chronic condition will receive targeted chronic care management based on

his or her specific needs. Members whose circumstances require face-to-face case management will be assigned a local case manager who will provide the disease management services as part of the integrated case plan.

### **Case Management Services Coordination with Primary Care Providers**

Primary care providers are our partners in managing the health care needs of members and play a critical role in the case management process. WellCare's case managers collaborate with a member's PCP (and/or specialist if applicable) in the development of an individualized case management plan. The personalized care plan, including prioritized goals, timeframes for re-evaluation, and resources to be utilized, is sent to the PCP (with the member's consent) for review and to solicit further input regarding additional goals and services. The case manager will include in the care management plan recommendations for goals and services contributed by the PCP and any ancillary providers who deliver health services to the member. The member's compliance with care and services provided by the PCP is an important part of monitoring compliance progress, behavior and lifestyle changes and the efficacy of treatment. WellCare encourages providers to use the care plan during appointments with the member as a tool to ensure coordination of efforts to improve the member's health.

Physicians are also encouraged to provide feedback on any proposed changes to a care plan and to recommend updates as needed. We understand that providers have limited time and resources; case management staff assists them with member-related tasks including intensified member education, referrals to community support, and by acting as additional eyes and ears for the provider between scheduled visits.

### **Provider Input into Strategies to Influence Member Behavior**

Each Plan's Utilization Management Medical Advisory Committee (UMAC) serves as a vehicle for external physician input and recommendations into program strategies. Physician input and feedback is evaluated by corporate staff, appropriate recommended interventions are identified, and programmatic changes are presented to the plan's Quality Improvement Committee (QIC) for approval. Examples include clinical practice guideline development, member incentives, and telephonic outreach strategies. WellCare will evaluate the use of member incentives post implementation after we have a base of experience upon which to assess potential interventions.

Providers also have input into Plan operations through the chronic condition and case management care plan review process; through direct interaction with high risk prenatal program case managers and chronic condition care managers; and through provider focus groups.

### **F.3**

***Describe your approach for coordinating the following carved out services which will continue to be provided by the Medicaid fee-for-service program:***

- ***Dental***
- ***Specialized Behavioral Health***
- ***Personal Care Services***
- ***Targeted Case Management***

WellCare's approach to care coordination includes planning for both services covered by WellCare, for which the plan is receiving capitation from DHH (CCN-P Covered Services), and those carved-out benefits covered by DHH. Coordination will require a special emphasis on educating members and providers about their responsibilities for ensuring effective coordination. Accordingly, WellCare will focus our efforts on promoting activities that:

- Increase network providers' awareness of their role in coordination;
- Increase the prevalence of medical homes;
- Provide clear channels for fee-for-service providers to communicate within the WellCare system; and
- Prepare members to communicate fully with their primary care provider (PCP) about their needs, particularly when they are receiving carved-out services from the Medicaid fee-for-service program.

WellCare will analyze available claims data from the state to promote preventive health care and encourage members to participate in coordination among their health care providers. Claims data from the state will also be used to identify candidates for case management based on their receipt of services that may have a significant impact on overall health or indicate a need for more intensive coordination.

#### **Provider Awareness**

WellCare's initial and ongoing outreach to all of our providers will emphasize the importance of asking members about any services they may be receiving from fee-for-service providers and integrating that information into their diagnoses, treatment approaches and documentation. Provider education materials, however delivered, will include a list of carved-out services and urge network providers to be proactive in encouraging members under their care to share information regarding where and how they are receiving these services.

#### **Implementing Medical Homes to Enhance Coordination of Member Care**

The medical home is an evolving concept. When fully implemented by a provider, the medical home structure increases the provider's awareness and capacity to oversee all aspects of his or her patients' needs. WellCare realizes that providers may be at different stages of medical home development and that not all providers possess the resources needed to fully manage and coordinate both in-network and out-of-network patient care, especially for patients with complex or special care needs.

Our ability to ensure that dental, specialized behavioral health, and personal care services delivered by fee-for-service providers are coordinated with care delivered by our network providers will depend in part on the extent to which our network providers are willing and able to become medical homes for our members.

### **Member Awareness**

All new members will receive a welcome call from WellCare that includes an initial health screening questionnaire. Through this questionnaire, WellCare will identify current health care needs, determine what level of coordination the member is likely to require and screen for a potential referral to case management.

WellCare members will receive information in the welcome materials that stress the importance of sharing information with their PCPs about all health services they are receiving including the importance of coordinating these services when they are provided in a fee-for-service setting. WellCare wants the member to understand that, for example, conditions treated by a dental provider can be important information for the PCP when providing care.

Members may call WellCare Member Services and request information or assistance related to a non-covered service. The customer service representative will make every effort to connect the member with a local provider who can deliver that service. Our customer service representative will access the Louisiana Medicaid website ([http://www.lamedicaid.com/provweb1/provider\\_demographics/provider\\_map.aspx](http://www.lamedicaid.com/provweb1/provider_demographics/provider_map.aspx)) and provide the contact information for Medicaid fee-for-service providers in the member's area.

### **Coordination through Case Management**

Many members who are receiving services from a fee-for-service provider may benefit from case management and will be referred to the case management unit. Those members who require additional assistance with coordination due to their special needs will receive individualized hands-on assistance with coordination efforts. The case manager visits with the member face-to-face and completes a Health Risk Assessment (HRA) and case plan. The HRA provides the case manager with all the information about the member's current and emerging needs required to develop the member's care plan. The plan includes those needs that may be met by a provider outside the capitated benefit.

The care plan is developed with input from the member, any persons identified by the member, the medical home, appropriate specialty providers and community agencies. The case manager is responsible for contacting current providers, including those providing dental services, specialized behavioral health services, personal care services, targeted case management and school-based health care. Input from the team members is incorporated into the care plan and the case manager monitors the member's adherence to all services recommended in the plan.

### **Ongoing Case Management**

Our case management system includes ongoing contact with the member, and providers monitor the member's health, safety and welfare on more frequent basis. The type of interaction (telephone or face-to-face) and contact frequency will be determined based on the member's individual needs. At a minimum, each member will have an annual assessment as well as annual updates to his or her case plan. Case managers are responsible for making appropriate

referrals and sharing information with current contracted and fee-for-service providers serving the member when the member's needs change.

### Dental Service Coordination

A case management referral may be made if a prior authorization request or dental service claims identify a diagnosis or condition triggering a need for service coordination, health risk assessment and care plan. When WellCare receives a prior authorization request for a medical or surgical dental procedure, the utilization management staff will contact the member to collect additional information to determine if other services are needed and to promote coordination with the member's physician and other providers. WellCare will also use available claims data from the state to send annual reminder letters to members who have not received a dental cleaning and annual exam in the past 12 months.

As previously stated, WellCare will distribute provider education and other outreach materials, including the provider handbook, that will include the list of carved-out services and urge WellCare network providers to be proactive in asking members under their care about where and how they are receiving carved-out services. Member outreach will be through welcome calls and the Member Handbook and will encourage members to share information with their providers.

### Specialized Behavioral Health Coordination

Members who are receiving specialized behavioral health services may be candidates for more intensive coordination through WellCare's case management program. When claims data indicates that a member is receiving these services from a Medicaid fee-for-service program provider, a referral will be made to a case manager with behavioral health experience or nursing experience to undertake an outreach effort. The case manager will contact the member and explain the available services. With the member's consent a comprehensive assessment of member needs will be completed and the fee-for-service provider will be invited to participate in assessment and case planning activities. WellCare Health Services staff will proactively make referrals for members to behavioral health providers; and interact with these providers as required to ensure complete consideration is given to the member's physical health care needs while they are receiving behavioral services and/or psychotropic medications. WellCare will work with Community Mental Health Boards and affiliated providers to make all necessary referrals promptly and include them as needed in the case management process. See our response to Section F.2 for details on our overall approach to case management.

### Personal Care Services Coordination

Members who are receiving personal care services will be referred to case management – either by self-referral, by a direct referral from the member, a caregiver, provider, or WellCare staff, or through claims analysis that indicates that the member is receiving these services. In addition, during case and disease management interactions with members not currently receiving personal care services, our staff will be in a prime position to recognize needs that extend beyond base clinical needs and identify those services that will further support patient recovery. Specifically, our clinical staff will be able to evaluate and assess members' activities of daily living (ADLs) and identify where they may benefit from the provision of personal care services. Examples include, but are not limited to, bathing assistance, housekeeping services, and other tasks members are unable to perform due to physical constraints. If additional

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resources are needed, the member-centered case management team will coordinate the process by directly contacting DHH providers, or the agency, to initiate the referral process for the member to receive personal care services appropriate to his or her condition and recovery.

### Targeted Case Management

Many of WellCare's members may be covered by Louisiana's comprehensive targeted case management programs. Members who receive targeted case management will be assigned a case manager by WellCare. The WellCare case manager's goal will be to supplement, not supplant, existing targeted case management services. The WellCare case manager, with the member's permission, will contact the assigned targeted case manager to coordinate efforts and to ensure that the member has access to all covered medical services. The WellCare case manager will provide an orientation to the WellCare system of care to both the member and targeted case manager and develop a care plan that incorporates all the member's medical, behavioral and social needs. The case manager will be responsible for ongoing coordination including facilitating communication between providers, including the targeted case manager. See our response to Section F.2 for details.

#### **F.4**

***For members who need home health services upon discharge from an acute care hospital, explain how you will coordinate service planning and delivery among the hospital's discharge planner(s), your case manager(s), your disease management staff member(s), and the home health agency. Further explain how you will monitor the post-discharge care of enrollees receiving home health services in remote areas.***

#### **WellCare Discharge Planning Process Overview**

WellCare has enhanced our discharge planning processes through implementation of a short-term, post-hospitalization care management program. The enhanced process is designed to address the problem of repeated hospital admission by patients who experience preventable barriers to and gaps in care after being discharged from a hospital or other health care facility. The program includes the following elements:

- Identifying high risk members during the hospital or facility stay;
- Conducting a pre-discharge interview with the member/caregiver to identify potential barriers to/gaps in care and post-discharge contact information;
- Post-discharge contact within 24-72 hours to determine barriers to/gaps in care, and immediate needs intervention by a transitional care manager (RN) during the post-discharge period;
- Identifying members who have difficulty accessing services because they reside in remote areas;
- Providing appointment assistance, prescription assistance, coordination of care with physicians and the member's case manager (if applicable), for continued follow-up; and
- Determining if longer-term case management is needed.

The goal for the transitional care management (TCM) program is to assure that members are stabilized at home after being discharged from a hospital or other health care facility and thereby reduce re-admissions. Members will play an active part in all phases of this process. Measureable outcomes include member attendance at a physician visit within thirty (30) days after discharge from hospital or facility and re-admission rates.

#### **Home Health Services Coordination**

##### Coordination with Hospital Discharge Planners

The goal of discharge planning is to begin, as soon as possible after an admission, facilitating cost effective quality post-inpatient care. The discharge plan includes a comprehensive evaluation of the member's health needs and identifies the services and supplies required to facilitate appropriate care following the member's discharge from an institutional setting. WellCare's concurrent review/discharge planning staff will work with each hospital's discharge planning staff to arrange for appropriate durable medical equipment and/or home health supplies and services as needed. Coordination will include service authorizations, identification of network providers, and approval of out-of-network providers as needed. WellCare will refer a member requiring post-discharge home health services to WellCare's transitional care management unit for follow-up 24-72 hours after discharge. The transitional care manager will call the member and determine whether home health services were delivered in a timely

manner and whether the member has experienced any problems with home health service coordination. The transitional care manager will refer any member to a transitional care nurse if short-term (< 30 days) follow-up is required. Transitional care management will follow the member to ensure proper coordination of the home health service as well as any other health needs the member may have. The care manager will have primary responsibility for performing the functions described in this response.

#### Coordination with WellCare Disease Management

As WellCare concurrent review/discharge planning staff complete the discharge planning process, they will identify members who may be candidates for inclusion in specific WellCare disease management or chronic condition programs as well as adjunctive or therapeutic home health services. Examples include telehealth biometric monitoring for congestive heart failure, oxygen or pulse oximetry for COPD, or 17-P injection services for pregnant women with a history of preterm labor. The transitional care management unit will work with the chronic care managers responsible for further condition specific follow-up and recommend members for coordination of these services as appropriate.

#### Coordination with WellCare Case Management

WellCare concurrent review/discharge planning staff will immediately refer members with ongoing or previous case management to the Case Management department for continued service coordination and reassessment. Home health service needs will be facilitated by the assigned case manager working with the home health entity. If the transitional is coordinating post-discharge care because initial assessment identified a need for short-term services, and it is determined that home health services are required beyond thirty days, the care plan will be revised and the member referred to Case Management for continued coordination and follow-up with the home health care entity.

#### Monitoring Home Health Services in Rural Areas

A member receiving home health services in a rural area will be followed by the transitional care management staff if it is determined that services are needed for less than thirty days and the member has not previously been enrolled in case management. Members with longer term needs will be assigned to a WellCare case manager for face-to-face assessment and care plan development. If network provider home health services are not available in the rural area, the transitional care management nurse will work with available non-participating resources to secure the needed services for the member.

Once the care plan is completed, it is shared with the member's physician and home health provider (with the consent of the member) for additional input. Staff will telephonically manage coordination and monitor home health services for the member.

## **F.5**

***Aside from transportation, what specific measures will you take to ensure that members in rural parishes are able to access specialty care? Also address specifically how will you ensure members with disabilities have access?***

### **Expanded Network**

A core value at WellCare is our commitment to offer all our members the best possible access to care regardless of their location or special needs. Accordingly, we are aggressively seeking relationships with providers of every type in all areas of Louisiana, including all public health departments and FQHCs. Nevertheless, there may be circumstances when a specialized provider is simply not available in a particular area of the state and where additional resources may be needed by our members.

### **Telemedicine**

Telemedicine holds great promise for bringing high quality health care to rural populations, particularly in Louisiana which has made very substantial strides in the utilization of this technology.

WellCare is initiating discussions with local resources such as the Louisiana Rural Health Information Exchange (LARHIX) that links rural hospitals to the LSU Health Science Center in Shreveport. Through discussions with leaders from LARHIX we have learned that this organization makes telemedicine opportunities available to 22 rural hospitals within the state. These services are available for 12 different specialties including cardiology, endocrinology, ENT and nephrology. Participating local hospitals are connected to LSU-Shreveport and when the rural nurse facilitator in the local hospital receives a patient the nurse facilitator is able to initiate a live interactive consultation with the LSUHSC specialist via telemedicine. This project will eventually connect all 24 rural hospitals from central Louisiana north to the medical center in Shreveport. It will allow rural patients to receive specialized health care, and in many cases continue to be cared for, in their own communities. While we continue our contracting outreach efforts with LSU, we intend to include these services as a component of any final agreement reached with the health system.

WellCare will partner with existing entities interested in implementing a telemedicine program that builds on this existing telemedicine network in place across the State. We will also contact other active programs within the State of Louisiana. This initiative will include expanding the availability and use of telemedicine among network providers and entering into collaborative arrangements with key players in the state involved in the widespread use and adaptation of telemedicine applications. WellCare believes this initiative will help maximize members' access to resources outside their geographic boundaries. The goal of this initiative is to increase access to care by promoting the technology and resources necessary to enable members to continue receiving care locally.

### **Telehealth**

Home health monitoring can be very useful for patients who suffer from chronic or long-term medical conditions, particularly those who have historically required frequent visits to the hospital or who have reduced access to providers. Home health monitoring of specific

conditions (e.g., cardiac conditions) can be extremely beneficial to patients, reducing hospital re-admissions and allowing for better care management. It can also assist in transitioning a member from an institutional setting to a community/home-based setting.

Our telehealth home care services program will build on the experience of our plan in New York. We will cover telehealth home care services to assist in the effective monitoring and management of members whose medical, functional, and/or environmental needs can be appropriately and cost effectively met at home through the application of telehealth interventions.

Telehealth is the robust, continuous monitoring of a member's health that allows a provider to maintain consistent contact with the member at reduced cost. Conditions and clinical circumstances eligible for telehealth home care services will include, but not be limited to, congestive heart failure, behavioral problems that limit self-management, and technology-dependent care (e.g., continuous oxygen, ventilator care, total parenteral nutrition and enteral feeding). WellCare's reimbursement for telehealth home care services will include, at a minimum, monitoring of a member's vital signs, medication management, member education, equipment management, and monitoring for changes in a member's condition that necessitate professional intervention. Case managers will assist in identifying members who would benefit from telehealth home care services, help coordinate these services, and review information to identify any necessary follow-up.

### **Members with Special Needs**

WellCare's members with special needs will benefit from all of the strategies discussed above. However it is essential that we deliver these services in a manner that is consistent with a member's abilities. If a member is hearing impaired, WellCare will collaborate with our telemedicine partners to provide a closed captioned option or translator services to assist the member during the telemedicine visit. Similarly, any patient instructions for visually impaired members will either need to be in Braille for standardized instructions or recorded on playback media that is aligned with member resources. WellCare will also use our member-centric care management team community outreach staff to identify available community resources that would enhance implementation of the above strategies. One example we intend to explore is designing a home visit program designed to act as additional eyes and ears for the specialist provider between scheduled telemedicine visits. While we continue our contracting outreach efforts with LSU, we are also considering developing a residency program vehicle in which students under a preceptor model could be used for the basis of such a home visit program.

## F.6

### ***Detail the strategies you will use to influence the behavior of members to access health care resources appropriately and adapt healthier lifestyles.***

WellCare understands the significant impact of member behavior on health outcomes. Health education and outreach serve as powerful and effective bridges to engage members in adopting healthy practices. WellCare has demonstrated success in implementing intervention strategies that change member behavior. Our success is due to the fact that we employ strategies aligned to the response triggers in a given market rather than taking a cookie-cutter approach. Our intervention strategies are tailored for each market and the environment in which we operate. WellCare's tailored intervention strategies include those interventions that are developed for monitoring HEDIS measures, those designed for chronic care/disease management programs, and interventions focused on preventive care such as attending scheduled EPSDT screening appointments.

Some examples of the general types of intervention strategies we have implemented in other markets that have proven successful:

- Mailing postcards to members that have not had a dentist visit in six months and then following up with a phone call;
- Providing member incentives as a reward for performing certain healthy behaviors, such as keeping physician appointments and participating in health prevention programs;
- Providing members with appointment reminders; and
- Conducting outreach to educate members on the importance of preventive services.

The challenge is to create intervention strategies for Louisiana CCN that adequately address identified member needs and are provided in a manner that is meaningful and relevant to members. WellCare intends to employ the following strategies to positively influence member behavior to improve access and foster the development of healthier lifestyles:

### **Strategies for CCN**

#### Strategy #1 – Initial Member Orientation to WellCare

Strategies to influence the behavior of members extend beyond the standard approach to member education. The first step in the process of developing and implementing effective intervention strategies is to understand our members and their needs. The welcome call is our initial opportunity to actively engage a member and influence his or her use of health care resources. Similarly, a health risk assessment (HRA) serves as WellCare's initial, comprehensive introduction to a member. The HRA enables us to better understand the member, identify his or her care needs and to map out the resources and services needed and available to address identified needs. The HRA also enables us to identify where there are gaps in care. WellCare's intervention strategies are aimed at helping members address these gaps in care.

As a standard practice for all markets, WellCare provides members, as a component of initial orientation, access to a wealth of information through resources such as our call center, our website (WellCare.com), member materials (including member handbook), programs, providers and case managers. This information addresses topics such as:

- Member rights and responsibilities;
- Covered services and how to access services;
- Reporting of suspected fraud and abuse;
- The process for selecting or changing PCPs; and
- Available community and state resources.

### Strategy #2 – Provider Outreach to Members to Encourage Engagement

Providers will be educated during their orientation process regarding their role in working with members toward the goal of improving and promoting better health. For example, network providers will be expected to coordinate follow-up office visits with a member following an ED visit, to ensure the condition has been appropriately addressed and to provide necessary care and, ultimately, to reduce unnecessary ED utilization. Primary care providers will be provided patient rosters, utilization reports, and other information that can be used to initiate office visit reminders. Other communications will be provided to help providers get members to access preventative services.

WellCare will also leverage its provider panel as a key contact point to discuss with members the importance of a healthy lifestyle. Panel providers will be expected to counsel patients on all facets of healthy habits including the importance of routine annual check-ups, compliance with treatment plans, maintaining a balanced diet, and routinely exercising. Providers will be expected to help members identify available community resources that could help them adopt healthier habits.

### Strategy #3 – Ongoing Routine Member Communication

WellCare seeks to continually build on the initial member orientation provided at enrollment. An important strategy we utilize to influence behavior and encourage healthy lifestyles is to maintain thoughtful and routine communication with members. We do this by sending out member communications such as newsletters that contain information on how to access care and tips for health improvement. Communication is not limited to print materials; it also includes routine preventive care reminders, health promotion program notices (member incentive programs), and other materials that resonate with members.

WellCare uses every member contact with one of our call centers as an opportunity to counsel on points that lead to healthy behaviors. Members contacting our call centers are assisted on myriad issues that relate to behavior modification including: counseling on how to access care; removing any barriers to accessing care, such as assisting with scheduling appointments and transportation; and providing additional community resources that will assist in improving access to care.

WellCare provides all members access to a 24-hour, 7 days a week medical advice line staffed by nurses who assist members with medical issues and questions. In most cases, members call in with an issue and assume that the most appropriate course of action is to see a doctor. In responding to specific issues, we have been successful in educating members, where appropriate, regarding more appropriate alternative strategies prior to seeking medical assistance. Recent data indicates that 85 percent of members calling the medical advice line are redirected to pursue a more appropriate course of action when information is provided.

#### Strategy #4 – Post Inpatient/ED Utilization Follow-up

WellCare and our case managers focus on improving health outcomes and reducing emergency room (ED) utilization by promoting a medical home/PCP structure and encouraging proactive delivery of services. The goal is to influence behavior in order to decrease inappropriate ED use and increase office visits. WellCare will work with high volume hospitals to obtain day-after reports listing our members who have had ED visits. Using these reports, the outreach team will contact members after their ED visits and use this contact as an opportunity to educate members about the appropriate use of ED services and the availability of other services and supports. The outreach team will also obtain (or provide) the following information during this contact:

- Reason for ED visit;
- Previous contact with PCP;
- Provide PCP name and contact information, as needed;
- Provide information about urgent care centers available;
- Prescriptions provided and need for assistance obtaining medication;
- Need for follow-up visit with PCP;
- Need for assistance with transportation;
- Education regarding 24/7 medical advice line; and
- Need for disease management and/or case management referral.

This outreach and education approach has worked well in Georgia with positive results. Monthly analysis of data shows a steady increase in the average (mean) number of office visits after this education.

In 2010 Louisiana was 3<sup>rd</sup> highest among states in the number of ED visits (556 visits per 1000 population) (Source: Statemaster.com. June 2011. [http://www.statemaster.com/graph/hea\\_eme\\_roo\\_vis-health-emergency-room-visits](http://www.statemaster.com/graph/hea_eme_roo_vis-health-emergency-room-visits)). We are confident the implementation of our ED outreach strategy will positively impact ED utilization rates for our members.

#### Strategy #5 – Provider Incentive Programs

WellCare has used provider incentive programs in other states as a strategy to improve HEDIS, encounter data and other utilization rates. We will implement this strategy in Louisiana with emphasis on defined baseline administrative and clinical measures for year one of the contract to ensure complete and timely reporting of claims/clinical data by providers. This information in turn will be used to design member incentive programs and outreach strategies that positively influence member behavior. During years two and three of the CCN-P contract, we will expand the provider incentive program to additional key HEDIS reporting measures that are time dependent (i.e., those requiring 12 – 24 months of continuous enrollment). Providers will have the opportunity to earn a defined per member per month (PMPM) bonus payment for meeting or exceeding defined performance benchmarks (Pay for Performance). Detailed information on the proposed Pay for Performance program is provided, including PMPM payment thresholds, in our response to Section S.1.

## Strategy #6 – Member Incentive Programs/Expanded Benefits

Providing member incentives and/or expanded benefits is an effective tool to encourage individuals to focus more closely on their overall health. We have experience providing a multitude of member incentives and expanded benefits that have had a positive impact on individual health status. These strategies have also been keys to the overall improvement of some of our core utilization/quality measures. We will use this strategy in Louisiana by initially offering the following expanded benefits: (1) unlimited office visits; (2) an adult vision benefit; and (3) cell phones for defined target populations in disease management/chronic care management programs. We anticipate adding member incentive programs within nine to twelve months after program implementation. Incentive programs are most effective in affecting member behavior when such programs are designed based on the demographics of the actual enrolled population in order to ensure maximum utilization of such programs.

The following are examples of member incentive programs related to childhood obesity that we have implemented in our Georgia and New York Medicaid markets. We plan to develop a similar program for Louisiana. Currently, 35.9 percent of children in the state between the ages of 10-17 years are considered overweight or obese (Source: National Initiative for Children's Healthcare Quality, "Childhood Obesity in Louisiana State Fact Sheet". March 1, 2011. <http://www.dhh.louisiana.gov/offices/publications/pubs-270/Louisiana%20childhood%20obesity%20NICHQ.pdf>).

### *Member Incentive Program # 1 - Georgia – Obesity Initiative (children under the age of 19)*

In Georgia, WellCare introduced a childhood obesity initiative in which we conducted a medical record review for members age three through seventeen years to determine which member records documented any of the following: BMI percentile; counseling for nutrition; and/or counseling for physical activity. Our HEDIS 2010 rates of 36.50 percent for BMI, 42.34 percent for counseling for nutrition and 38.69 percent for counseling for physical activity were significantly lower than our benchmark (44.28 percent for BMI percentile, 56.93 percent for counseling for nutrition and 46.96 percent for counseling for physical activity based on [HEDIS 2009 (CY 08)] 75<sup>th</sup> percentile rate) demonstrating opportunity for improvement. To help improve our HEDIS rates, we implemented several interventions, including providing members' fitness, exercise, and good nutrition *pocket doctors* as a routine part of office education and visit. We will be able to determine the effectiveness of these interventions when we calculate our HEDIS 2011 rates.

### *Member Incentive Program #2 - New York – Obesity PIP (children under the age of 19)*

In New York, we have a Medicaid performance improvement project (PIP) for pediatric obesity. WellCare will measure success under this PIP using the HEDIS measure *Weight Assessment and Counseling for Nutrition and Physical Activity*, which measures BMI percentile, counseling for nutrition, and counseling for physical activity. Interventions include member education and outreach through targeted mailings of informational materials, targeted automated voice messaging, articles in the member newsletter, and member incentives (e.g., \$25 gift card for submitting a PCP-completed form documenting a preventive care visit). We also conducted a focused community intervention program in one borough of New York City. Our quality improvement staff identified no- or low-cost local exercise and/or diet management programs and conducted a targeted mailing to eligible adolescent-age members, informing them of these programs and encouraging them to attend. The results of this PIP are not yet available.

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## Strategy #7 – Regional Community Advisory Committees

WellCare recognizes the power of connecting with our members and communities to both drive individual member behavior and to affect systemic change in the health care system to improve service and health outcomes. With this in mind, WellCare will form regional community advisory committees (RCACs) in Louisiana made up of WellCare members, doctors, nurses, nonprofit advocates and public health stakeholders. RCACs will provide guidance in designing and implementing community-based, public-planning efforts to address community health issues. Each RCAC will meet regularly to discuss issues and topics relevant to the local communities in which WellCare will operate, including but not limited to the following:

- Health education regarding chronic diseases like asthma and diabetes;
- Emergency preparedness planning and supports; and
- Barriers to accessing health care related to culture and linguistics.

Currently in our Florida and New York markets, WellCare utilizes the World Health Organization's expanded version of Wagner's Chronic Care Model to conduct community resource mapping through which gaps in service are identified and community-based strategies for addressing those gaps are developed. We are also proposing to adapt the model for our Georgia, Illinois and Missouri markets by September 2011. RCACs will also participate in this WellCare initiative by serving as:

- The voice of our members as well as the community-at-large in community resource mapping;
- A sounding board for proposed member-focused process improvements prior to implementation; and
- A two-way conduit of information for addressing gaps in service availability and identifying barriers to accessing health care.

Each RCAC will have a chairperson who is seated on the executive community advisory committee (ECAC). The role of the ECAC will be to:

- Help identify trends across multiple parishes;
- Elevate regional community challenges and issues;
- Identify common service gaps in order to help build economies of scale; and
- Summarize collective progress towards annual goals and objectives.

The chair of the ECAC will report to the WellCare of Louisiana senior management team. Based in part upon feedback from the ECAC, the senior management team will identify opportunities for improvement, ensure effective progress towards goals and identify important community health care trends. This information will be summarized into a quarterly report which is then published for public health leaders and stakeholders, including state and local agencies, members, providers, and public assistance agencies like the Department of Children and Family Services and the Area Agency on Aging, communities-at-large and our WellCare staff.

## **Implementing Intervention Strategies**

WellCare will bring our tested and proven approach to developing intervention strategies to Louisiana Medicaid; and will begin the process by developing a plan to serve as the roadmap for additional intervention strategies beyond those covered in this response. As a component of our quality assessment and performance improvement (QAPI) program we will also have protocols for measuring overall effectiveness of our interventions. It is important to note that the plan will be a living document that evolves as new issues are identified and strategies are evaluated. The plan will consist of the following components.

### Identify members and issues

We will use the following mechanisms to identify the populations and issues that most warrant targeted attention:

- Member surveys;
- Member HRA results;
- Feedback from case managers;
- Claims data review and analysis to determine patterns of care and specific members warranting intervention;
- Focus group sessions; and
- Medical record reviews.

### Develop strategies based on member needs

Once we have identified the target members, we will develop the appropriate intervention strategies, which will include the following:

- Determining target issues and topics based on identified target groups and needs;
- Determining messages, objectives and goals;
- Designing and developing specific programs; and
- Developing targeted materials (e.g., Q&As, fact sheets, CDs, brochures, flyers, webinars, power point presentations).

### Provide information to members

We will determine the most effective and appropriate means of sharing information with identified target groups. It is important to note that the mode of communication may vary depending on the target group as well as the information to be conveyed. The following options will be considered:

- Written and verbal communication – direct mail, interactive voice response, customer service interactions, educational materials available at provider offices, and WellCare website;
- Case and chronic care managers;
- Public service announcements; and
- Group meetings.

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### Monitor and evaluate results

WellCare will conduct ongoing monitoring and evaluation to determine the effectiveness of our intervention strategies. These activities will include:

- Analysis of claims data;
- Review of member and provider complaints;
- Feedback from case managers and chronic care managers; and
- Member surveys.

WellCare will not limit our interventions to the strategies discussed. We will look to continually develop additional targeted strategies appropriate for use as the needs of the current eligible population changes; for example, coverage groups currently not included in the CCN program (i.e., dual eligibles) may be considered for the long term expansion of the program.

Regardless of the selected intervention strategies, the following principles will guide our design. WellCare will:

- Develop strategies that are locally based. We will bring the strategies to local communities and parishes by using schools, churches, civic centers as program venues. To the extent possible, we will also look to community leaders to help facilitate sessions, meetings, etc.
- Enter into partnerships with local organizations and entities such as school-based clinics, local public health departments and civic associations. As an example, the Department of Public Health has agreed to sign a letter of intent to contract its clinics (including physician-staffed school-based clinics and school-based nurses) on behalf of the Department of Education.
- Provide members the information that they will need to change behaviors, including providing members with information about long term strategies to stay motivated and deal with barriers to behavior change.
- Provide for access to social and other supports that help people maintain changes in behavior.
- Promote community education by providing materials to churches, schools, grocery stores and provider offices to share with members.
- Use multiple forums to provide information to members, including, but not limited to, health fairs, seminars, classes, etc.

WellCare's goal for Louisiana CCN is to help members establish long term behavior changes. We know that in order to do this, we need to mobilize not only individual members but their families and communities as well. We believe that we have identified a strategy to do this and have the experience and commitment to make it happen. Additional examples of our experience modifying member behavior are noted in our response to Sections E.1, I.2 and J.6.

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**F.7**

**Many faith based, social and civic groups, resident associations, and other community-based organizations now feature health education and outreach activities, incorporate health education in their events, and provide direct medical services (e.g., through visiting nurses, etc.). Describe what specific ways would you leverage these resources to support the health and wellness of your members.**

WellCare's goal is to identify, supplement and enhance systems and programs that are already working in Louisiana. We will look for opportunities to make programs stronger and direct our members to high quality programs that will enhance their health and well-being.

When entering a new market, WellCare develops a state-specific portfolio of community programs and services and identifies a cadre of community-based entities with whom to partner. This is the core of a community engagement and external relations approach we call *HealthConnections*.

The *HealthConnections* portfolio offers customized state-specific, audience-specific and member-specific programs. WellCare has created a development process by which the programs and services are identified specifically for Louisiana's needs. The process for developing a state-specific *HealthConnections* portfolio is outlined below.

**HealthConnections Development Process  
Medicaid-Specific Programs and Services**

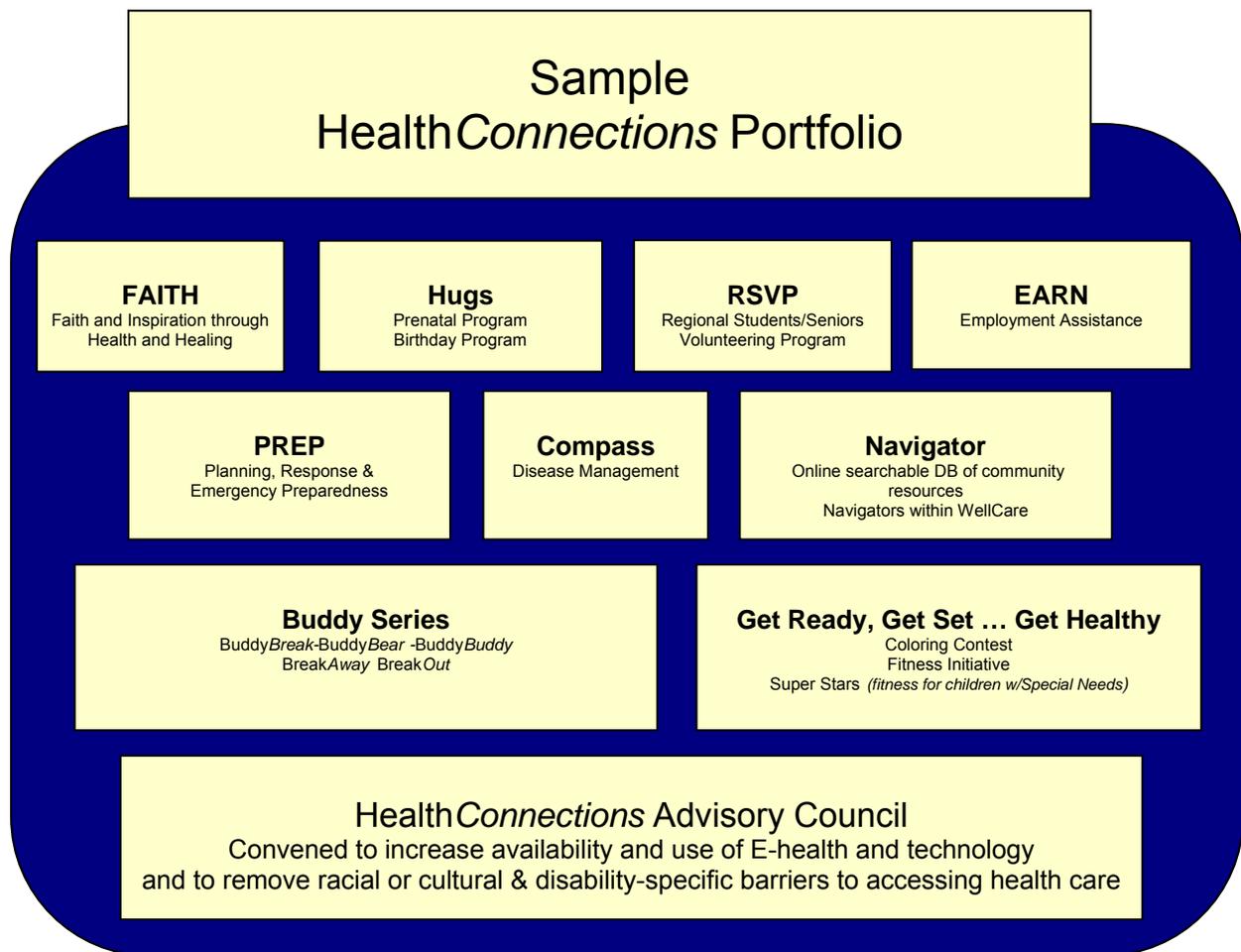
Research	Develop	Deploy	Evaluate
<b>County - by - County Level Detail</b>			
<ul style="list-style-type: none"> <li>- Market Analysis</li> <li>- Cultural &amp; Linguistics Review</li> <li>- Stakeholder Input               <ul style="list-style-type: none"> <li>&gt; Prospective members</li> <li>&gt; Prospective and/or Participating network</li> <li>&gt; Current service entities</li> <li>&gt; Advocates and Community Leaders</li> <li>&gt; Faith Based Organizations</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>- Collate results and develop needs assessment</li> <li>- Review economic structure</li> <li>- Outline market-specific program portfolio</li> <li>- Review program portfolio with state and county level stakeholders</li> <li>- Begin building state-specific <i>HealthConnections</i> model</li> </ul>	<ul style="list-style-type: none"> <li>- Establish program links with community resources</li> <li>- Test links and connections</li> <li>- Establish reporting parameters               <ul style="list-style-type: none"> <li>&gt; Timing</li> <li>&gt; Data elements</li> <li>&gt; Methods</li> </ul> </li> <li>- Establish launch strategy               <ul style="list-style-type: none"> <li>&gt; Soft launch</li> <li>&gt; Limited launch or pilot(s)</li> <li>&gt; Full-scale launch</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>- Review data @ regular intervals</li> <li>- Collate results @ regular intervals for the following options:               <ul style="list-style-type: none"> <li>&gt; Process improvement</li> <li>&gt; Go / No Go check in</li> <li>&gt; Program efficacy</li> <li>&gt; Future development</li> </ul> </li> </ul>

*HealthConnections* is our overall portfolio of programs and services. We create state-specific programs and services based on the market's unique needs.

WellCare's most recent success with *HealthConnections* is in Hawai'i. 'Ohana Health Plan launched several initiatives to focus on members, their families/caregivers and their communities. Additionally, the plan identified existing community-based services and, more importantly, the gaps in those services.

The HealthConnections development approach serves as a means for reaching community stakeholders while intricately weaving WellCare’s health plans into the fabric of the communities in which we operate. In Florida, for example, we have a strong network of more than 2,500 community-based community service organizations (not including faith-based organizations) with which we connect regularly.

Building on our initial research regarding the Louisiana market, WellCare has started building a portfolio of ideal programs and services. Below is a sample portfolio of value-added programs and services offered in other markets. Using this sample portfolio, WellCare will build on this experience in working with the community health leaders to develop programs and services that meet the needs of our members, their families and our communities-at-large.



The sample HealthConnections portfolio above references *My Family Navigator* which will include the searchable database of community resources that exist in Louisiana. Our *My Family Navigator* serves as a single repository for all community-based programs and services with contact information.

Below is an example of a single entry within the *My Family Navigator* database. Each data element serves as a potential component of a search criterion across all entries including:

organization name, contact name, geographic categories (e.g., county/region, city or zip code) and/or key words. This gives the user flexibility in searching for services on a broad-based or specific basis.



The Navigator Database  
**My Family Navigator - Louisiana: State Independent Living Center**

[New Item](#) | [Edit Item](#) | [Delete Item](#) | [Alert Me](#) | [Go Back to List](#)

Name / Title of Organization:	State Independent Living Center
Key Contact - First Name:	Wayne
Key Contact - Last Name:	Blackwell
Key Contact - Title:	SILC Chair
Key Contact - Phone Number:	(225) 219-7553
Key Contact - Email Address:	<a href="mailto:blackwell2@charter.net">blackwell2@charter.net</a>
Organization - Phone Number:	(800) 579-5611
Organization - Fax Number:	(225) 219-7551
Mailing Address - Street:	150 North Third Street, Suite 129
Mailing Address - City:	Baton Rouge
Mailing Address - County / Parish:	East Baton Rouge
Mailing Address - State:	LA
Mailing Address - Zip Code:	70801
Alternate Address:	
Website Address:	
Key Word / Search Criteria:	Center for Independent Living
Notes:	

Created at 6/8/2011 10:57 AM by [Taylor, Pamme](#)  
Last modified at 6/8/2011 10:57 AM by [Taylor, Pamme](#)

### Using *HealthConnections* in Louisiana

Currently, *My Family Navigator* is being designed for use primarily by neighborhood outreach workers (NOWs) as a partner relationship management tool and by our case managers and clinical teams including those who support the member-centered model of care. This means that when members ask for help, a case manager or outreach worker can access *My Family Navigator*, search by criteria such as food assistance and come up with a referral to a local agency that can help. In addition, WellCare case managers will access the system when developing a care plan with the member and proactively refer members to programs and agencies that can enhance the member's safety and well-being.

The system is accessible to member services staff in our call center and, in the future, the system will be accessible to our medical home providers who will be responsible for addressing ancillary needs for our members. When a provider determines that a member may benefit from additional supports to address the member's needs, the provider will have access to this tool to make real time referrals. Once available, WellCare will conduct outreach and training to prepare network providers to use this valuable tool as a part of the physician's daily practice.

## Participation in Community Programs

WellCare is committed to active participation in health improvement activities in Louisiana. Our neighborhood outreach workers are available to local organizations to provide training on health related topics and attend, or in some cases sponsor, health related events.

### The Family Cafe

WellCare has been a premier sponsor, supporter and partner to The Family Café – a 501(c) (3) not-for-profit organization that provides information and training directly to Floridians with all types of disabilities and their families/caregivers. Each year, The Family Café connects thousands of families with critical information, training and community supports through its 3-day conference in Orlando, Florida. Celebrating its 13th anniversary, The Family Café annual conference and summit on disabilities hosts more than 10,000 families and caregivers and an additional 250 vendors and community service organizations. With nearly 175 break-out sessions and eight tracks, the event offers a wide range of opportunities for attendees to learn about opportunities and services with: Smart Money, Employment Options, Disaster and Emergency Preparedness, Advocacy, Education and Youth and Birth through Age Five. Family-friendly entertainment is also provided including a performance by Dueling Pianos, a demonstration of “Sportsability Sampler” by the Florida Disabled Outdoors Association and much more.

WellCare staff is encouraged to get involved and give back to the community on a personal level through events like our Day of Caring:

Show you care by volunteering to paint a multipurpose room at the MacDonald Training Center, help plant a garden at the Alpha House, assist with household chores at a senior retirement complex, or sort donations at the PARC thrift store.

## WellCare Day of Caring

In partnership with the United Way Tampa Bay.

**Saturday**  
06/25/11

*Time: 8:30 a.m.—1 p.m.*

### Select an organization:

- Alpha House of Tampa Bay
- MacDonald Training Center
- PARC
- Seniors in Service of Tampa Bay

It only takes a few hours to make a big difference in our community.

Go to WellCareLink and click on weCare for more information and to register to volunteer.

Join us for a day of caring.

Registration closes  
Friday, June 17.



### Pictures from 2010's Day of Caring:



**F.8**

***Submit a statement of any moral and religious objections to providing any services covered under Section §6 of RFP. If moral and religious objections are identified describe, in as much detail as possible, all direct and related services that are objectionable. Provide a listing of the codes impacted including but not limited to CPT codes, HCPCS codes, diagnosis codes, revenue codes, modifier codes, etc. If none, so state. Describe your plans to provide these services (e.g., birth control) to members who are entitled to such services.***

There are no services covered under section six in the RFP to which WellCare would object to providing, reimbursing, or covering, based on moral or religious grounds.

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INSERT TAB HERE  
Section G  
Provider Network

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Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		<b>Section G: Provider Network (Section § 7 of RFP)</b>	<b>200</b>		
<b>Section G Page 1</b>	<b>All</b>	<p><b>G.1</b></p> <p>Provide a listing of the proposed provider network using the List of Required In-Network Providers as described in this RFP, including only those providers with whom you have obtained a signed LOI or executed subcontract. LOIs and signed subcontracts will receive equal consideration. LOIs and subcontracts should NOT be submitted with the proposal. DHH may verify any or all referenced LOIs or contracts. Along with the provider listing, provide the number of potential linkages per PCP.</p> <p>Using providers with whom you have signed letters of intent or executed contracts, provide individual GeoAccess maps and coding by GSA for: 1) hospitals, 2) primary care providers, FQHCs, and RHCs; and 3) Specialists. You should provide individual maps as well as overlay maps to demonstrate distance relationships between provider types.</p> <p>The CCN should provide an Excel spreadsheet of their proposed provider network and include the following information: (Sample spreadsheet is available in the Procurement Library)</p> <ol style="list-style-type: none"> <li>11. Practitioner Last Name, First Name and Title - For types of service such as primary care providers and specialist, list the practitioner's name and practitioner title such as MD, NP (Nurse Practitioner), PA (Physician Assistant), etc.</li> <li>12. Practice Name/Provider Name - - Indicate the name of the provider. For practitioners indicate the professional association/group name, if</li> </ol>	<b>50</b>		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		<p>applicable.</p> <p>13. Business Location Address - Indicate the business location address where services are provided including but not limited to, 1st line of address, 2nd line of address, City, State, Postal Code</p> <p>14. Provider Type and Specialty Code - Indicate the practitioner's specialty using Medicaid Provider Type and Specialty Codes.</p> <p>15. New Patient - Indicate whether or not the provider is accepting new patients.</p> <p>16. Age Restriction - Indicate any age restrictions for the provider's practice. For instance, if a physician only sees patients up to age 19, indicate &lt; 19; if a physician only sees patients age 13 or above, indicate &gt; 13.</p> <p>17. If PCP - the number of potential linkages.</p> <p>18. If LOI or contract executed.</p> <p>19. Designate if Significant Traditional Provider.</p> <p>20. GEO coding for this location.</p>			
<b>Section G Page 3</b>	<b>All</b>	<p><b>G.2</b></p> <p>Describe how you will provide tertiary care providers including trauma centers, burn centers, children's hospital, Level III maternity care; Level III (high risk) nurseries, rehabilitation facilities, and medical sub-specialists available twenty-four (24) hours per day in the GSA. If you do not have a full range of tertiary care providers describe how the services will be provided including transfer protocols and arrangements with out of network facilities.</p>	<b>15</b>		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
Section G Page 6	All	<p><b>G.3</b></p> <p>Describe how you will handle the potential loss (i.e., contract termination, closure) in a GSA of a) a hospital and b) all providers within a certain specialty.</p>	10		
Section G Page 9	All	<p><b>G.4</b></p> <p>The CCN is encouraged to offer to contract with Significant Traditional Providers (STPs) who meet your credentialing standards and all the requirements in the CCN's subcontract. DHH will make available on <a href="http://www.MakingMedicaidBetter.com">www.MakingMedicaidBetter.com</a> a listing of STPs by provider type by GSA. Describe how you will encourage the enrollment of STPs into your network; and indicate on a copy of the listing which of the providers included in your listing of network providers (See G.1) are STPs.</p>	20		
Section G Page 11	All	<p><b>G.5</b></p> <p>Based on discussions with providers in obtaining Letters of Intent and executed subcontracts as well as other activities you have undertaken to understand the delivery system and enrollee population in the GSA(s) for which a proposal is being submitted, discuss your observations and the challenges you have identified in terms of developing and maintaining a provider network. Provide a response tailored to each GSA of the following provider types/services:</p> <ul style="list-style-type: none"> <li>• Primary Care</li> <li>• Specialty Care</li> <li>• Prenatal Care Services</li> <li>• Hospital, including Rural Hospital</li> <li>• Office of Public Health</li> <li>• Private Duty Nursing/Home Health Services;</li> </ul>	5		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		<ul style="list-style-type: none"> <li>• FQHC</li> <li>• School Based Health Clinic</li> </ul>			
Section G Page 21	All	<b>G.6</b> Describe your process for monitoring and ensuring adherence to DHH's requirements regarding appointments and wait times.	20		
Section G Page 23	All	<b>G.7</b> Describe your PCP assignment process and the measures taken to ensure that every member in your CCN is assigned a PCP in a timely manner. Include your process for permitting members with chronic conditions to select a specialist as their PCP and whether you allow specialists to be credentialed to act as PCPs.	10		
Section G Page 26	All	<b>G.8</b> Describe your plan for working with PCPs to obtain NCQA medical home recognition or JHCAO Primary Home accreditation and meeting the requirements of Section § 14.	5		
Section G Page 29	All	<b>G.9</b> Describe how you will monitor providers and ensure compliance with provider subcontracts. In addition to a general description of your approach, address each of the following: <ul style="list-style-type: none"> <li>• Compliance with cost sharing requirements;</li> <li>• Compliance with medical record documentation standards;</li> <li>• Compliance with conflict of interest requirements;</li> <li>• Compliance with lobbying requirements;</li> <li>• Compliance with disclosure requirements; and</li> <li>• Compliance with marketing</li> </ul>	5		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		requirements.			
Section G Page 34	All	<b>G.10</b> Provide an example from your previous experience of how you have handled provider noncompliance with contract requirements.	5		
Section G Page 36		<b>G.11</b> Describe in detail how you will educate and train providers about billing requirements, including both initial education and training prior to the start date of operations and ongoing education and training for current and new providers.	10		
Section G Page 39		<b>G.12</b> Describe how you will educate and train providers that join your network after program implementation. Identify the key requirements that will be addressed.	15		
Section G Page 41		<b>G.13</b> Describe your practice of profiling the quality of care delivered by network PCPs, and any other acute care providers (e.g., high volume specialists, hospitals), including the methodology for determining which and how many Providers will be profiled. <ul style="list-style-type: none"> <li>• Submit sample quality profile reports used by you, or proposed for future use (identify which).</li> <li>• Describe the rationale for selecting the performance measures presented in the sample profile reports.</li> <li>• Describe the proposed frequency with which you will distribute such reports to network providers, and identify which providers will receive such profile reports.</li> </ul>	15		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
Section G Page 51		<p><b>G.14</b></p> <p>Describe the process for accepting and managing provider inquiries, complaints, and requests for information that are received outside the provider grievance and appeal process.</p>	10		
Section G Page 53		<p><b>G.15</b></p> <p>Describe in detail your proposed approach to providing non-emergency medical transportation (NEMT) services, including, at a minimum:</p> <ul style="list-style-type: none"> <li>• What administrative functions, if any, you will subcontract to another entity;</li> <li>• How you will determine the appropriate mode of transportation (other than fixed route) for a member;</li> <li>• Your proposed approach to covering fixed route transportation;</li> <li>• How you will ensure that pick-up and delivery standards are met by NEMT providers, including training, monitoring, and sanctions;</li> <li>• How you will ensure that vehicles (initially and on an ongoing basis) meet vehicle standards, including inspections and other monitoring;</li> <li>• Your approach to initial and ongoing driver training;</li> <li>• How you will ensure that drivers meet initial and ongoing driver standards;</li> <li>• How your call center will comply with the requirements specific to NEMT calls; and</li> <li>• Your NEMT quality assurance program (excluding vehicle inspection).</li> </ul>	5		

## Section G: Provider Network

### G.1

**Provide a listing of the proposed provider network using the List of Required In-Network Providers as described in this RFP, including only those providers with whom you have obtained a signed LOI or executed subcontract. LOIs and signed subcontracts will receive equal consideration. LOIs and subcontracts should NOT be submitted with the proposal. DHH may verify any or all referenced LOIs or contracts. Along with the provider listing, provide the number of potential linkages per PCP.**

**Using providers with whom you have signed letters of intent or executed contracts, provide individual GeoAccess maps and coding by GSA for: 1) hospitals, 2) primary care providers, FQHCs, and RHCs; and 3) Specialists. You should provide individual maps as well as overlay maps to demonstrate distance relationships between provider types.**

**The CCN should provide an Excel spreadsheet of their proposed provider network and include the following information: (Sample spreadsheet is available in the Procurement Library)**

- 1. Practitioner Last Name, First Name and Title - For types of service such as primary care providers and specialist, list the practitioner's name and practitioner title such as MD, NP (Nurse Practitioner), PA (Physician Assistant), etc.**
- 2. Practice Name/Provider Name - - Indicate the name of the provider. For practitioners indicate the professional association/group name, if applicable.**
- 3. Business Location Address - Indicate the business location address where services are provided including but not limited to, 1st line of address, 2nd line of address, City, State, Postal Code**
- 4. Provider Type and Specialty Code - Indicate the practitioner's specialty using Medicaid Provider Type and Specialty Codes.**
- 5. New Patient - Indicate whether or not the provider is accepting new patients.**
- 6. Age Restriction - Indicate any age restrictions for the provider's practice. For instance, if a physician only sees patients up to age 19, indicate < 19; if a physician only sees patients age 13 or above, indicate > 13.**
- 7. If PCP - the number of potential linkages.**
- 8. If LOI or contract executed.**
- 9. Designate if Significant Traditional Provider.**
- 10. GEO coding for this location.**

### Attachments

Attachment G.1.a includes WellCare's CCN Network Provider Listing based on the template provided in the procurement library. There are three Network Listings included, one for each GSA (A, B, C). All fields noted above have been included in the listing. A placeholder has been created for PCP linkages and will be completed during readiness review. The list includes all providers that have signed a letter of intent (LOI) or have a contract with WellCare. The systems companion guide was used to determine provider type and specialty codes. Using Appendix E as the requested specialty list there were some specialties that did not have a corresponding

code in the companion guide (e.g., endocrinology and metabolism, hematology/oncology). Therefore, we created temporary codes and listed them at the top of each document in Attachment G.1.a.

**Additional Specialty Codes:**

Z1 - Endocrinology and Metabolism	Z4 - Neonatology	Z7 - DME
Z2 - Hematology and Oncology	Z5 - Nuclear medicine	Z8 - Home Health
Z3 - Infectious Disease	Z6 - Rheumatology	

Included as Attachment G.1.b are five Appendix E documents representing unique provider counts by specialty. The five versions include one for each GSA (A, B, C) and two total statewide count documents. One statewide document is a sum of the counts in GSA documents A, B, and C, which may count providers twice if they have multiple locations across GSAs. The additional statewide document provides unique provider counts by specialty regardless of how many GSAs the provider may practice in.

GeoAccess overlay maps and individual maps for each GSA are included as Attachment G.1.c. Ingenix GeoNetworks version 2011, 3, 0, 0 was used to build the maps. The overlay maps reflect distance relationships between provider types. The first overlap map reflects hospitals, PCPs, and FQHCs/RHCs. The remaining 6 overlay maps reflect the specialties in Appendix E. The GeoNetworks software is only able to display 8 different symbols in the legend. Therefore, the specialties were divided into 6 groups so all could be represented. The individual maps display provider geographic locations of each individual specialty type requested.

Attachment G.1.d includes a signed Attestation of Provider Network Submission (Appendix MM). We realize that this was not specifically required by the RFP, but we have included it to provide assurance of the accuracy of the information that we have provided concerning our proposed provider network.

WellCare has entered into an agreement with Verity Healthnet (Verity) to supplement WellCare's provider contract network. Verity has provided WellCare with a roster of contracted providers who, as of the date of WellCare's RFP response, have indicated they are willing to participate in WellCare's network, or from whom Verity has obtained LOIs indicating their willingness to participate in the WellCare network subject to entering into a definitive written agreement to participate with Verity. WellCare has included only these Verity providers as part of our network submission with our response to this RFP.

## G.2

***Describe how you will provide tertiary care providers including trauma centers, burn centers, children’s hospital, Level III maternity care; Level III (high risk) nurseries, rehabilitation facilities, and medical sub-specialists available twenty-four (24) hours per day in the GSA. If you do not have a full range of tertiary care providers describe how the services will be provided including transfer protocols and arrangements with out of network facilities.***

WellCare is committed to Louisiana and to being part of positive change for Louisiana Medicaid recipients. WellCare currently provides Medicare Advantage services in 17 Louisiana parishes. Through our Medicare Advantage plans, we currently serve 3,488 Louisiana members. We have operated in the State for five years, have a local track record, and work with over 2,600 providers within the State (including tertiary care providers) to provide quality care to our Medicare members.

WellCare expects that the vast majority of tertiary care providers in Louisiana will contract with us. As part of our current network development efforts, we have made substantial progress in ensuring the availability of tertiary care providers for our prospective members. Highlights of some of our efforts regarding each designated tertiary care provider are as follows.

- Trauma Centers – We have had several conversations with the Louisiana State University Medical Center (LSU). LSU has communicated during these discussions its willingness to contract with WellCare if WellCare is awarded a CCN-P contract. Medically necessary services provided by trauma centers would be approved at in-network benefit levels regardless of the provider’s participation status.
- Burn Centers – We have a signed agreement with Hospital Corporation of America Delta Division (HCA) and with Baton Rouge General Health that encompasses all of its hospitals and physicians including burn services. We have had conversations with LSU, and they have stated that they are interested in contracting with WellCare post RFP award. Any burn services, where medically necessary, would be approved at in-network benefit levels regardless of the provider’s participation status.
- Children’s Hospitals – WellCare has an LOI from Shreveport Shriners Hospital and Women’s and Children’s in Lake Charles, LA. Additionally, as noted above, WellCare has an executed contract with HCA (Women and Children’s in Lafayette). We have also had conversations with LSU, FMOL and Children’s Hospital in New Orleans (receive statewide referrals). They have informed us that if WellCare is selected as a CCN, they are interested in contracting with us. While LSU is not a children’s hospital, they offer many pediatric services throughout the State. We are confident in our ability to contract with both systems post RFP award.
- Level III Maternity Care and Level III (High Risk) Nurseries – We have contacted every facility with this level of service in the State and have successfully executed LOIs with many facilities that offer these services in local communities, including Ochsner and HCA. We are confident in our ability to contract with the majority of these facilities throughout the State. Where medically necessary, Level III maternity care and high risk nursery services would be approved at in-network benefit levels regardless of the provider’s participation status.

- Rehabilitation Facilities – We have contracts for rehabilitation services with many hospitals within Louisiana, including BRGH, Ochsner and Lake Charles Memorial and expect a fully comprehensive network prior to the effective date in any GSA.
- Medical Sub-Specialists – We have contracts for these services within many parishes, including Ochsner, Acadian Health Alliance, and Lake Charles Medical Center, and expect a fully comprehensive network prior to our effective date in any GSA. Many of our current network deficiencies are in this area. See Attachment G.5.a for specific information regarding this issue.

On an ongoing basis, our normal procedures for monitoring access to care will contribute to our having early warning of any potential issues regarding access to tertiary care providers.

### **Monitoring Access**

WellCare’s assessment of access to care begins during initial network development and continues on a regular basis after initiation of enrollment. We employ a variety of data driven, quantitative methods to identify and address potential access issues before they become a problem. We monitor access to all providers, including tertiary care providers, through review, tracking, and trending of member and provider complaints to identify both isolated (provider-specific) and systemic access concerns.

Ongoing for CCN, WellCare will utilize GeoAccess mapping and accessibility reports to evaluate provider network adequacy. We will track the number of practices offering evening and weekend hours as part of our access analysis. Intensive mapping, reporting and outreach activities with Louisiana providers have been underway for approximately four months to support our network development efforts (using anticipated member enrollment counts and distribution in lieu of actual membership), and will continue for at least the program’s first year while enrollment stabilizes across plans. Our Network Development department, in collaboration with our provider advisory councils and local staff, will continue to generate mapping and accessibility reports and create a deficiency summary and network access plan to address any identified gaps.

### **Addressing Gaps**

If gaps are identified and tertiary care is not readily available within a GSA, access to out-of-network tertiary care providers will, as a general rule, be approved (retroactively if under emergent or urgent circumstances) by our medical management team.

Specific options to ensure availability of 24/7 tertiary care, consistent with our existing approaches in other markets, will include:

- Use of single case agreements.
- Use of short-term letters of agreement (LOAs).
- Member transfer to a provider in our Medicaid programs in a nearby state (e.g., Florida or Georgia) if the member’s health warrants specialty care only available from the provider network in one of our nearby plans, and the member is sufficiently stable to handle the transfer. WellCare would arrange the transportation for the member or reimburse for transportation expenses. This also would include reimbursing the member for any overnight lodging. Case managers will facilitate the service coordination process

for the transferring member and actively engage with intake staff to ensure continuity of care and minimize any disruptions in care.

- Contract with providers in bordering states (beyond states where we have an existing contract) with the experience and expertise necessary to address member needs. For example, we currently have an LOI with a tertiary care hospital in Mississippi. As noted above, WellCare would arrange the transportation for the member or reimburse for the transportation expenses, including reimbursing the member for any overnight lodging. Case managers will facilitate the service coordination process for the transferring member and actively engage with intake staff to ensure continuity of care and minimize any disruptions in care.

We will also look to our provider advisory councils to help us address gaps in access to tertiary care. At least one provider advisory council will be located in each GSA and will consist of providers from acute care disciplines, community organizations and academic programs. Provider advisory councils will serve as “sounding boards” for us to receive feedback from network providers and provide a structure and process for ongoing dialogue and problem solving. (See our response to Section J.3 for additional information on provider advisory councils.)

We recognize that provider advisory councils will play a limited role in increasing availability of level III tertiary care providers in our network, but we believe that they can be very helpful in our outreach efforts to tertiary care providers such as sub-specialties. Because they will be local and their members have ties to the community, provider advisory councils can help us conduct recruitment activities to reduce gaps and increase the number of tertiary care providers available to our members.

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### G.3

***Describe how you will handle the potential loss (i.e., contract termination, closure) in a GSA of a) a hospital and b) all providers within a certain specialty.***

We believe that our ability to respond to the loss of providers, whether institutional or individual, begins with building the strongest possible network in the first place and working continuously to maintain it. It is WellCare's policy to contract for more provider capacity than needed to operate at expected enrollment levels. This provides a cushion should enrollment exceed expectations or should we lose providers. During the first year we will continuously recruit new providers with the goal of reaching a network capacity that supports 120 percent of projected enrollment without compromising access.

Through our Louisiana Medicare Advantage plans operations, WellCare has developed extensive contacts with hospitals, individual providers, and academic medical institutions. We will build upon our existing local provider relations foot print in Baton Rouge and New Orleans. Both local and corporate provider relations functions will be staffed throughout the State to meet or exceed performance requirements and expectations. We will update our GeoAccess reports at routine intervals to scan for access gaps and capacity fluctuations which might prompt a need for additional provider contracting.

Moreover, WellCare has experience developing and maintaining comprehensive, reliable networks in states that, like Louisiana, have substantial rural areas. Our Georgia Medicaid/CHIP plan operates in all 169 Georgia counties and has consistently met or exceeded network access standards, including in the very rural southern portion of the state. In Hawai'i, we are the only statewide plan serving SSI and members receiving long-term care services, including on the State's rural and remote islands of Lanai and Molokai. Our experience managing uninterrupted care delivery in these jurisdictions has heightened our ability to respond flexibly to changes in provider availability.

#### **Response to Loss**

When, despite our best efforts, we lose a hospital or all providers within a specialty in a GSA, we have multiple strategies that we will use to quickly deploy the resources needed to provide member care. Historically, when confronted with a deficiency in our other markets, we have acted swiftly to institute long-term solutions to the problem.

We will respond to the loss of a hospital or loss of all providers within a certain specialty in a GSA in much the same way; our first priority will be to ensure that care is available for our members. We anticipate that in Louisiana our efforts to prevent or respond to, the termination or closure of a hospital will be particularly focused, due to the large scale impact such a loss could have on our members and the difficulty in establishing an alternative network replacement.

In the event of a potential (or actual) loss of a hospital or all providers within a specialty in a GSA, we will initiate a number of actions:

- Immediately initiate communications with affected members to ensure they understand the situation and their options for continued access to care. Our Member Services department will lead this effort and will determine the means and frequency of communications.

- Upon identification of an issue and prior to termination or closure, immediately deploy provider relations representatives to reach out to providers to determine if the issue can be mitigated and to implement a strategy for resolution. If the issue cannot be resolved, and the providers pursue termination of their contract with WellCare, they are still contractually obligated to ensure that a transition is undertaken in an orderly manner that maximizes member safety and continuity of care. Providers shall continue providing covered services to members through the lesser of the period of (1) active treatment for a chronic or acute medical condition or up to 90 days, (2) the postpartum period for members in their second or third trimester of pregnancy, or (3) such longer period required by DHH. Furthermore, providers are required to cooperate with WellCare to minimize disruption in care during the transition of members to other network providers.
- Seek out other network hospitals within the GSA that are equipped to address member specific conditions and illnesses and that will enable us to fulfill applicable DHH travel distance standards.
- Allow members to receive services from out-of-network hospitals and providers. At the same time, we will invite these out-of-network hospitals and providers treating our members to apply for enrollment in the network, subject to meeting credentialing standards. If these hospitals and providers decline to join the network, we will offer them a single-case or short term letter of agreement (LOA) to provide care to members. In many cases, WellCare has been successful in converting out-of-network providers to full network status, once they have become familiar with WellCare and see that their claims are being paid accurately and timely.
- Engage our provider advisory councils (PACs) located in the affected GSA to assist in outreach and recruitment of new specialty providers. (See our response to Section J.3 for a description of provider advisory councils.) These PACs will be valuable resources for network development and recruitment of providers who may have been reluctant initially to join a health plan network. In our experience, peer-to-peer communications become particularly valuable when a need for additional providers or new institutional arrangements arise.
- On a limited and case specific basis we would look to providers for our Medicaid programs in nearby states (e.g., Florida and Georgia) for assistance. This option would be used on a case-by-case basis and limited to situations where:
  - A member's health condition warrants specialty care only available from the provider network associated with one of our nearby plans;
  - The member is sufficiently stable to handle the transfer; and
  - The member and/or guardian agree to the transfer.

WellCare would arrange the transportation for the member or reimburse for the transportation expenses. This also would include reimbursing the member for any overnight lodging. We currently use this approach in our programs for certain transplant procedures and rare surgeries. We would envision utilizing this approach on a more large scale basis in connection with the CCN program in the event of a hurricane or other natural disaster in Louisiana.

- Contract with providers in bordering states (beyond states where we have an existing contract) with the experience and expertise necessary to address member needs. For example, we currently have an LOI with a tertiary care hospital in Mississippi. As noted above, WellCare would arrange the transportation for the member or reimburse for the

transportation expenses, including reimbursing the member for any overnight lodging. Also as noted above, this option would be limited to situations where:

- A member's health condition warrants specialty care only available from the provider network associated;
- The member is sufficiently stable to handle the transfer; and
- The member and/or guardian agree to the transfer.

These are all strategies we currently use effectively in all markets when facing a potential or actual provider loss. These strategies have served us well in responding to the immediate need of markets like Louisiana that are prone to hurricanes (e.g., Florida and Georgia). For example, in the midst of hurricanes Katrina and Rita, we were challenged with providing care to our members and protecting their health and welfare. This speaks to our experience and our ability to quickly activate emergency care during and immediately following a natural disaster.

As a large, nationwide company, WellCare brings to the CCN program the availability of extensive resources that allow us to rapidly recruit, credential and train new providers in the event of a loss of providers or unexpected fluctuations in membership. In such instances, we will field whatever staff is necessary to expand the network and to remain in compliance with all program access standards.

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#### **G.4**

***The CCN is encouraged to offer to contract with Significant Traditional Providers (STPs) who meet your credentialing standards and all the requirements in the CCN's subcontract. DHH will make available on [www.MakingMedicaidBetter.com](http://www.MakingMedicaidBetter.com) a listing of STPs by provider type by GSA. Describe how you will encourage the enrollment of STPs into your network; and indicate on a copy of the listing which of the providers included in your listing of network providers (See G.1) are STPs.***

WellCare has increased on the ground resources in Louisiana to conduct intensive outreach to the provider community in preparation for the CCN program. WellCare's goal is to contract with most if not all of the significant traditional providers (STPs) in each GSA. We have attempted to contact 100 percent of the STPs available on the DHH website ([www.MakingMedicaidBetter.com](http://www.MakingMedicaidBetter.com)) by both mail and telephone. Furthermore, we have attempted to meet with many of the STPs in the State. We have executed LOIs or contracts with 846 STPs in Louisiana.

#### **Significance of STPs**

We believe that STPs are uniquely qualified to provide high-quality care to members. They are well-suited to meet member needs because they are located where members live and are uniquely qualified to serve the population. In Louisiana in particular, given the rural nature of so many of the parishes, STPs have filled a very important void in service delivery for persons living in these underserved areas. Moreover, many of our members will have long-standing relationships with these providers. We want to support and enhance these relationships in order to facilitate continuity of care for our members.

WellCare's network development staff makes every effort to ensure that covered services are available from a comprehensive panel of providers in all communities in which WellCare operates. Network development effort will not cease upon implementation. Ensuring and enhancing provider access and availability and ensuring high quality choices to our members are ongoing processes.

We will continue to monitor access to STPs through various mechanisms, including regularly contacting them to confirm that they are continuing to accept new WellCare members, creating and reviewing GeoAccess reports to monitor geographic access (distance from members to STPs), and monitoring grievances regarding access to STPs. (See our response to Section G.6 for additional information regarding network monitoring activities.)

In addition, WellCare will continue to actively monitor the [www.MakingMedicaidBetter.com](http://www.MakingMedicaidBetter.com) listing of STPs to compare the providers with those in our network. On a regular basis we will contact providers on this listing as gaps in our network and geographic areas of need are identified. We will deploy provider relations representatives to contact these STPs, educate them about the benefits of joining the WellCare provider network, and encourage their participation.

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## Continuity of Care

WellCare understands the importance of the member/provider relationship, particularly members' relationships with their PCPs, for continuity of care. WellCare will make every effort to maintain existing relationships with STPs as members transition to CCN.

As noted in our response to Section F.1, during the transition of care process, our continuity of care policies will be implemented. Members transitioning to WellCare will have the ability to retain existing services and providers through the care planning process. Members currently under treatment for one or more acute or chronic conditions who are receiving services from out-of-network providers may request to continue their existing course of treatment from those providers for a ninety (90) day transition period. On a case-by-case basis, WellCare may allow a member to continue to receive a course of treatment from an out-of-network provider beyond the transition period. In this instance the member has to be willing to continue receiving care from the provider, and the case manager, in consultation with the PCP/medical home, must determine that the member's health and treatment would be better served by the continuation of treatment by the out-of-network provider.

If a member's existing provider is not in our network, we will contact the provider to discuss and encourage his or her enrollment in our network. Where appropriate, WellCare will also ask members who have a relationship with a PCP who is not in the WellCare network to collaborate with us in our STP outreach and to help us determine the PCP's interest in becoming part of the WellCare provider network. Provider relations representatives will follow-up with members following their outreach to their PCPs. If a member indicates that an STP has expressed an interest in becoming part of the WellCare provider network, a provider relations representative will follow-up with the STP.

WellCare is committed to having STPs in our provider network as long-term partners.

## G.5

***Based on discussions with providers in obtaining Letters of Intent and executed subcontracts as well as other activities you have undertaken to understand the delivery system and enrollee population in the GSA(s) for which a proposal is being submitted, discuss your observations and the challenges you have identified in terms of developing and maintaining a provider network. Provide a response tailored to each GSA of the following provider types/services:***

- ***Primary Care***
- ***Specialty Care***
- ***Prenatal Care Services***
- ***Hospital, including Rural Hospital***
- ***Office of Public Health***
- ***Private Duty Nursing/Home Health Services;***
- ***FQHC***
- ***School Based Health Clinic***
- ***General Provider Network Assessment***

### **General**

WellCare has aggressively developed our provider network in anticipation of serving individuals in the CCN program in all three GSAs. WellCare has operated a Medicare+Choice/Medicare Advantage program since 2005 in 17 Louisiana parishes and is currently contracted with over 2,600 providers for this Medicare product. Our network development efforts have focused on expanding those longstanding relationships into Medicaid as well as entering new geographic areas for both Medicaid and Medicare. We will continue network development efforts to promote member choice and to ensure that services are broadly available throughout each of the GSAs.

Building on our existing Medicare network, we have secured contracts and letters of intent (LOIs) statewide with over 7100 providers in over 4500 provider locations. WellCare has completed a GeoAccess analysis by parish and GSA. By GSA, we have:

- GSA A: Contracts/LOIs with over 2033 provider locations, including over 336 contracts and LOIs with significant traditional providers (STPs). Also included are large hospital systems such as Ochsner, East Jefferson and HCA as well as many individual practitioners and ancillary providers.
- GSA B: Contracts/LOIs with over 1377 provider locations, including over 315 contracts and LOIs with STPs. Also included are large hospital systems such as Ochsner, HCA, Baton Rouge General, Lafayette General, Lane Regional Medical Center, Iberia Medical Center, Opelousas General Health System, Point Coupee General Hospital and the rest of the Acadian Health Alliance, as well as many individual practitioners and ancillary providers.
- GSA C: Contracts/LOIs with more than 1098 provider locations, including over 232 contracts and LOIs with STPs. Also included are large hospital systems such as Christus, Lake Charles and HCA health systems, as well as individual practitioners and ancillary providers.

GeoAccess maps for each GSA are included as Attachment G.1.c. Exhibit G.5.a below shows the overall contract/LOI status for WellCare statewide as of June 17, 2011.

**Exhibit G.5.a – All GSA LOI Analysis**

Louisiana Medicaid Network Build	Total (by provider)	Total Providers Targeted
Declined -- No Reason Given	509	<b>14,996</b>
Declined -- Willing to Contract Post RFP Award	567	
Cannot Contact	295	
Not Called	0	
Agreed to sign LOI; receipt pending	69	
Received Incomplete LOIs	34	
<b>Completed LOIs</b>	<b>4508</b>	

*Note: The numbers reported reflect LOIs/contracts received to date and will continue to be updated as additional LOIs and contracts are received.*

Our experience in attempting to build a comprehensive statewide network in Louisiana has provided insight into some core provider concerns and GSA-specific issues that continue to arise in the provider contracting process. General observations and challenges tend to fall in at least one of the categories below for all service/specialties for each GSA:

- Category 1: Plans are unable to secure certain providers/specialty types in a GSA/region because they are employees or affiliates of multi-specialty systems, such as LSU, and these systems have elected not to enter agreements with most plans until after contract award. Providers in these instances do not enter into agreements directly with plans, but are part of the system agreement for services.
- Category 2: Providers (specialties) are not available within a given GSA or region thus requiring referral into another region or GSA for coverage, or the resource is available in the GSA but not in sufficient number to serve the entire population within the service area.
- Category 3: Providers are concerned about additional fee schedule reimbursement reductions and, as a result, will limit or cease acceptance of Medicaid patients.
- Category 4: Providers are concerned that they will receive a disproportionate share of Medicaid patients for treatment as a result of other providers electing not to accept Medicaid patients. This is especially true for some hospitals.
- Category 5: Some providers have decided that they are not interested in joining a CCN-P network, but have not specified the reason for their decision. Their level of individual program support is unknown.

Category 6: Providers are available in a parish that have not signed a contract or LOI to date but have expressed interest in doing so following CCN award.

Category 7: Some providers have a financial interest in another CCN-P and have not signed with any other CCN during the LOI phase, but have indicated willingness to contract following CCN award.

### Primary Care

We have secured contracts and LOIs statewide for primary care with more than **1426** provider locations. We believe that we meet network adequacy in 28 out of 64 parishes statewide and are confident we will secure contracts with most PCPs statewide who accept Medicaid.

Network adequacy issues for primary care resulting from limited availability of a provider type in a given locale were noted during our network build efforts. Such network access gaps will be addressed through methods outlined in our response to Section G.3. These include transportation coordination to the closest surrounding providers, use of single case agreements, and alternative interventions such as telemedicine/telehealth (see our response to Section F for additional details).

### Primary Care Network Build Challenges/Observations

GSA A	GSA B	GSA C
<ul style="list-style-type: none"> <li>We have secured contracts and LOIs in GSA A for primary care with more than 470 provider locations.</li> <li>We meet network adequacy in four of nine parishes in GSA A.</li> <li>A significant number of providers are affiliated with multi-specialty systems such as LSU that have elected not to enter agreements with plans until after contract award.</li> </ul>	<ul style="list-style-type: none"> <li>We have secured contracts and LOIs in GSA B for primary care with more than 470 provider locations.</li> <li>We meet network adequacy requirements in 16 of 21 parishes in GSA B.</li> <li>A significant number of providers are affiliated with multi-specialty systems such as LSU that have elected not to enter agreements with plans until after contract award.</li> <li>Some primary care providers in this region that are not affiliated with LSU are limiting direct contracting with prospective plans and instead are electing to join “IPA like” entities that will handle contracting on their behalf (e.g., Verity Healthnet).</li> </ul>	<ul style="list-style-type: none"> <li>We have secured contracts and LOIs in GSA C with more than 486 provider locations.</li> <li>We meet network adequacy in six of 34 parishes in GSA C.</li> <li>A significant number of providers are affiliated with multi-specialty systems such as LSU that have elected not to enter agreements with plans until after contract award.</li> </ul>

## Specialty Care

We have secured contracts and LOIs statewide for specialty care with more than **2718** provider locations. The most significant contracting challenges for specialty care in all GSAs are associated with pediatric sub-specialties (cardiology, surgery and allergy), and tertiary specialties. These services are predominately provided by larger multi-system providers such as Willis Knighton, LSU and Children’s Hospital, that have indicated that they will not finalize their contracting activities until CCN awards are made. These systems have all indicated willingness to contract with WellCare post CCN award.

### Specialty Care Network Build Challenges/Observations:

GSA A	GSA B	GSA C
<ul style="list-style-type: none"> <li>• Current contracts and LOIs for 1474+ specialty care provider locations (includes specialists affiliated with Ochsner, Tulane Medical Group, and HCA contracts/LOIs).</li> <li>• Providers not available within GSA A or region thus requiring referral into another region or GSA for coverage, or the resource is available in the GSA A but not in sufficient number to serve the entire population within the service area. Specialties affected include:               <ul style="list-style-type: none"> <li>○ Neonatology</li> <li>○ Nuclear Medicine</li> <li>○ Pediatric Allergy</li> <li>○ Cardiovascular Surgery</li> </ul> </li> <li>• Providers available in the parish; however they have not signed a contract or LOI to date but have expressed interest in doing so following CCN award. Specialties affected include:               <ul style="list-style-type: none"> <li>○ Colo-rectal Surgery</li> <li>○ Ambulance Services</li> <li>○ Physical Therapy</li> <li>○ Private Physical Therapy</li> <li>○ Private Speech Therapy</li> </ul> </li> <li>• We will be able to provide access to specialty care utilizing our current contracts with HCA, East Jefferson and other contracted STPs in</li> </ul>	<ul style="list-style-type: none"> <li>• Current contracts and LOIs for specialty care with 755+ provider locations (includes specialists affiliated with Ochsner, Acadian Health Alliance, BRGH, and HCA contracts/LOIs).</li> <li>• A significant number of providers are affiliated with multi-specialty systems such as LSU that have elected not to enter agreements with plans until after contract award.</li> <li>• Providers not available thus requiring referral into another GSA for coverage, or the resource is available in the GSA but not in sufficient number to serve the entire population within the service area. Specialties affected include:               <ul style="list-style-type: none"> <li>○ Endocrinology</li> <li>○ Neonatology</li> <li>○ Nuclear Medicine</li> <li>○ Pediatric Allergy</li> <li>○ Pediatric Cardiology</li> <li>○ Cardiovascular Surgery</li> <li>○ Colo-Rectal Surgery</li> <li>○ Surgery Pediatric</li> <li>○ Thoracic Surgery</li> </ul> </li> <li>• Providers available in the GSA that have not signed a contract or LOI to date, but have expressed interest in doing so following CCN award. Specialties affected</li> </ul>	<ul style="list-style-type: none"> <li>• Current contracts and LOIs for specialty care with 489+ provider locations.</li> <li>• A significant number of providers are affiliated with multi-specialty systems such as LSU that have elected not to enter into agreements with plans until contract award. Specialties affected include:               <ul style="list-style-type: none"> <li>○ Colo-rectal Surgery</li> <li>○ Pediatric Allergy</li> <li>○ Pediatric Cardiology</li> <li>○ Endocrinology</li> <li>○ Infectious Disease</li> <li>○ Neonatology</li> <li>○ Neurological Surgery</li> <li>○ Pathology</li> <li>○ Physical Therapy</li> <li>○ Radiology (Therapeutic)</li> <li>○ Rheumatology</li> <li>○ Surgery (Pediatric)</li> </ul> </li> <li>• Providers not available within GSA C or regions thus requiring referral into another region or GSA for coverage, or the resource is available in the GSA but not in sufficient number to serve the entire population within the service area. Specialties impacted include:               <ul style="list-style-type: none"> <li>○ Allergy and Immunology</li> <li>○ Anesthesiology</li> <li>○ Dermatology</li> <li>○ Emergency Medicine</li> <li>○ Hematology / Oncology</li> <li>○ Radiology</li> </ul> </li> </ul>

GSA A	GSA B	GSA C
<p>GSA C and with future contracts with LSU, North Oaks and other STPs in GSA B.</p>	<p>include:</p> <ul style="list-style-type: none"> <li>○ Dermatology</li> <li>○ Gastroenterology</li> <li>○ Pulmonology</li> <li>○ Rheumatology</li> <li>○ Plastic Surgery</li> <li>○ Urology</li> </ul> <ul style="list-style-type: none"> <li>● We will be able to provide access to specialty care utilizing our current contracts with BRGH, Acadian Health Alliance, HCA and other contracted STPs in GSA B and with future contracts with LSU, FMOL and other STPs in GSA C.</li> </ul>	<ul style="list-style-type: none"> <li>○ Diagnostic</li> <li>● Providers that have expressed they are not interested in joining a CCN-P network without specific reason impacts the following specialties within GSA C:             <ul style="list-style-type: none"> <li>○ Neonatal</li> <li>○ Neurology: providers serving Calcasieu, Cameron, Beauregard, Allen, are undecided on participation</li> </ul> </li> <li>● Providers available; however they have not signed a contract or LOI to date but have expressed interest in doing so. Specialties impacted include:             <ul style="list-style-type: none"> <li>○ Cardiovascular Surgery</li> <li>○ Colo-rectal Surgery</li> <li>○ Nephrology</li> <li>○ Neurological Surgery</li> <li>○ Plastic Surgery</li> <li>○ Podiatry</li> <li>○ Pulmonology</li> <li>○ Speech Therapy</li> <li>○ Thoracic Surgery</li> <li>○ Urology</li> </ul> </li> <li>● We will be able to provide access to specialty care utilizing our current contracts with Lake Charles, Acadian Health Alliance, and HCA as well as with future contracts with LSU, Willis Knighton and other STPs in GSA C.</li> </ul>

### Prenatal Care Services

We have secured contracts and LOIs for prenatal care services with more than **202** provider locations. We meet network adequacy with obstetrics and gynecology in all parishes except for Concordia. Additional information is provided at the end of this response regarding the challenges observed in securing these services for Concordia. We expect access in this specialty to expand greatly as we contract with Touro Infirmery, LSU, Franciscan Missionaries of Our Lady Health Systems (FMOL), North Oaks Medical System, Willis Knighton and Woman’s Hospital. Each entity expressed willingness to contract with WellCare following CCN award.

### Prenatal Care Network Build Challenges/Observations

GSA A	GSA B	GSA C
<ul style="list-style-type: none"> <li>• We have secured contracts and LOIs for prenatal care services with over 78 provider locations in GSA A.</li> <li>• We meet network adequacy for obstetrics and gynecology in all parishes within the GSA.</li> </ul>	<ul style="list-style-type: none"> <li>• We have secured contracts and LOIs for prenatal care services in GSA B with over 61 provider locations.</li> <li>• We meet network adequacy for obstetrics and gynecology in all parishes within the GSA.</li> </ul>	<ul style="list-style-type: none"> <li>• We have secured contracts and LOIs for prenatal care services with more than 63 provider locations in GSA C.</li> <li>• We have a current GeoAccess adequacy deficiency in Concordia parish. We have been in contact with Dr. Guedon and his group, and he has indicated willingness to consider contracting with WellCare post CCN award.</li> <li>• A significant number of these providers are affiliated with multi- specialty systems such as LSU that have elected not to enter agreements with plans until after contract award.</li> </ul>

### **Hospital, including Rural Hospital**

Statewide, we have secured **97** contracts and LOIs for hospital services. We meet network adequacy, or are contracted for hospital services with all hospitals within a parish, in 53 of the 64 parishes. See below for information regarding specific GSAs.

### Hospital Network Build Specific Challenges/Observations

GSA A	GSA B	GSA C
<ul style="list-style-type: none"> <li>• We have secured contracts and LOIs in GSA A for hospital services with over 21 provider locations.</li> <li>• We meet network adequacy in 6 out of the 9 parishes in GSA A.</li> <li>• Hospital access in Orleans parish remains impacted by the loss of the Medical Center of Louisiana at New Orleans (Charity Hospital) during Hurricane Katrina. This will require diligence on our part to secure surrounding facility relationships.</li> </ul>	<ul style="list-style-type: none"> <li>• We have secured contracts and LOIs for hospital services with over 38 provider locations in GSA B.</li> <li>• We meet network adequacy in 19 of the 21 parishes in GSA B.</li> <li>• Key providers such as FMOL, Woman's Hospital, LSU, have indicated they intend to suspend most contracting with prospective CCN-P plans until after contract awards (all have specifically expressed their intent to work with WellCare post-award).</li> </ul>	<ul style="list-style-type: none"> <li>• We have secured contracts and LOIs for hospital services with more than 37 provider locations in GSA C.</li> <li>• We meet network adequacy in 18 out of the 34 parishes in GSA C.</li> <li>• Provider are concerned that CCNs may steer from rural hospitals due to in some cases higher overall reimbursement levels compared with non rural hospitals.</li> <li>• Additional market observations include an overall concern from providers that hospital reimbursement be appropriate.</li> </ul>

GSA A	GSA B	GSA C
<ul style="list-style-type: none"> <li>• There are providers that have a financial interest in another CCN-P and have not signed with any other CCN during the LOI phase. They have indicated willingness to contract following CCN award.</li> <li>• Additional market observations include an overall concern from providers that hospital reimbursement be appropriate.</li> </ul>	<ul style="list-style-type: none"> <li>• Additional market observations include an overall concern from providers that hospital reimbursement be appropriate.</li> <li>• Facilities are concerned they will receive a disproportionate share of Medicaid patients for treatment if other facilities elect not to accept Medicaid patients.</li> </ul>	

### Office of Public Health

We have an LOI with the Office of Public Health that includes **67** public health units. We have met on two occasions with the Office of Public Health representatives, Takeisha Davis, MD, Director for Community Health and Assistant State Health Officer, and Matthew Valliere, Assistant Director of the Center of Community and Preventive Health. We discussed innovative programs WellCare has developed in other states, including disease management and health care screening partnership opportunities. Both parties have agreed to further contract discussions for base services and other initiatives following the awarding of CCN-P contracts. The Office of Public Health was highly responsive and presented no challenges to being included in CCN-P provider networks.

### Office of Public Health Network Build Challenges/Observations

GSA A	GSA B	GSA C
<ul style="list-style-type: none"> <li>• We have an LOI with OPH that includes 10 public health units in GSA A.</li> <li>• Agreement on scope of services will need to be completed before finalizing contract with OPH.</li> </ul>	<ul style="list-style-type: none"> <li>• We have an LOI with OPH that includes 21 public health units in GSA B.</li> <li>• Agreement on scope of services will need to be completed before finalizing contract with OPH.</li> </ul>	<ul style="list-style-type: none"> <li>• We have an LOI with OPH that includes 38 public health units in GSA C.</li> <li>• Agreement on scope of services will need to be completed before finalizing contract with OPH.</li> </ul>

### Private Duty Nursing/Home Health Services

WellCare has contracted with **47** home health agencies statewide that provide all necessary home health services. Specific challenges/gaps are denoted below for the specific GSA. This specialty represents the most responsive group of providers willing to contract in all GSAs to provide services.

Private Duty Nursing/Home Health Services Network Build Challenges/Observations

GSA A	GSA B	GSA C
<ul style="list-style-type: none"> <li>WellCare has contracted with 11 home health agencies in GSA A and currently meets network adequacy requirements in every parish within the GSA.</li> <li>No major challenges/issues denoted for this service category.</li> </ul>	<ul style="list-style-type: none"> <li>WellCare has contracted with 19 home health agencies in GSA B and currently meets network adequacy requirements in every parish within the GSA.</li> <li>No major challenges/issues denoted for this service category.</li> </ul>	<ul style="list-style-type: none"> <li>WellCare has contracted with 47 home health agencies in GSA C and currently meets network adequacy requirements in every parish within the GSA.</li> <li>No major challenges/issues denoted for this service category.</li> </ul>

**FQHC/RHC**

WellCare has contracted with **54** of Louisiana’s 157 FQHCs/RHCs. We have attempted to contract with all FQHCs and RHCs within the State, and will continue to seek contract relationships with an additional 64 entities who indicated willingness to contract with WellCare following contract award, as well as with the remaining provider-based rural health clinics affiliated with rural hospital systems. A common observation across all FQHC/RHC entities is a concern that they continue to receive reimbursement, including PMPM access fees paid under the Medicaid program. There also is a move among the public health clinics to participate in a pseudo-exclusive arrangement with a single CCN, which could adversely impact access for other CCN-Ps.

FQHC/RHC Network Build Challenges/Observations

GSA A	GSA B	GSA C
<ul style="list-style-type: none"> <li>WellCare has contracted with seven of 21 FQHCs in GSA A.</li> <li>There are 20 FQHC providers that have a financial interest in another CCN-P and have not signed with any other CCN during the LOI phase. They have indicated willingness to contract following CCN award.</li> </ul>	<ul style="list-style-type: none"> <li>WellCare has contracted with 17 out of 55 FQHC/RHCs in GSA B.</li> <li>There are 17 FQHC providers that have a financial interest in another CCN-P and have not signed with any other CCN during the LOI phase. They have indicated willingness to contract following CCN award.</li> <li>A significant number of providers have elected not to enter agreements with plans until a contract is awarded.</li> </ul>	<ul style="list-style-type: none"> <li>WellCare has contracted with 30 out of 81 FQHC/RHCs in GSA C.</li> <li>There are 14 FQHC providers that have a financial interest in another CCN-P and have not signed with any other CCN during the LOI phase. They have indicated willingness to contract following CCN award.</li> <li>A significant number of providers have elected not to enter agreements with plans until contract award.</li> </ul>

## School Based Health Clinic

WellCare is excited about the opportunity to improve both access and quality of health care received by the children of Louisiana through the use of school based clinics. Through our LOI with the Office of Public Health (OPH), we intend to contract for any and all school based services provided under the auspice of OPH. We have executed an LOI for the **25** school based clinics associated with OPH. Additionally, we have reached out to several FQHCs that operate school based clinics and expect to contract with them following CCN award.

### School Based Health Clinic Network Build Challenges/Observations

GSA A	GSA B	GSA C
<ul style="list-style-type: none"> <li>We have an executed LOI for the two school based clinics associated with the Office of Public Health in GSA A.</li> <li>There are school based health clinics affiliated with FQHC providers that have a financial interest in another CCN-P and have not signed with any other CCN during the LOI phase. They have indicated willingness to contract following CCN award.</li> </ul>	<ul style="list-style-type: none"> <li>We have an executed LOI for the five school based clinics associated with the Office of Public Health in GSA B.</li> <li>There are school based health clinics affiliated with FQHC providers that have a financial interest in another CCN-P and have not signed with any other CCN during the LOI phase. They have indicated willingness to contract following contract award.</li> </ul>	<ul style="list-style-type: none"> <li>We have an executed LOI for 34 school based clinics associated with the Office of Public Health in GSA C.</li> <li>There are school based health clinics affiliated with FQHC providers that have a financial interest in another CCN-P and have not signed with any other CCN during the LOI phase. They have indicated willingness to contract following CCN award.</li> </ul>

Our network includes large hospital and physician systems as well as individual practitioners and ancillary providers. We have initiated very substantial outreach efforts to ensure that specialized services are available in each service area to meet travel time and distance standards and to provide maximum provider choice for members. We have reached out by telephone and conducted in-person meetings with all current Medicaid providers in Louisiana.

As noted above, WellCare will engage in continuous provider recruitment activities throughout the life of our contract with DHH, as is customary in our existing markets. We are confident we will have a comprehensive, high quality provider network with broad access to all specialties well in advance of the scheduled network adequacy assessments for all GSAs. We believe our current experience in Louisiana and progress in our Medicaid network build efforts in Louisiana demonstrate our ability to build this type of network. Furthermore, many providers currently operating in Louisiana who have not yet signed a contract or LOI with WellCare have indicated a willingness to do so following award of a contract.

We acknowledge the continuing challenges associated with improving access to quality care in rural Louisiana and are prepared to augment traditionally delivered services by:

- Promoting the use of telemedicine;
- Providing a medical advice line;
- Intensive case management;

- Contracting with physician groups with extended office hours and alternative language options;
- Recruitment of providers who traditionally do not accept Medicaid patients; and
- Encouraging the use of physician extenders to expand the scope of providers' current practices.

As stated earlier, we have contacted all Medicaid providers by telephone and have requested in-person meetings with all hospitals and most large physician groups. We have personally met with representatives of the following Louisiana health systems:

GSA A	GSA B	GSA C
LSU, Ochsner Health System, Tulane, HCA Delta Division, Tulane Medical Group, Acadian Ambulance, Office of Public Health, Excelth FQHC, Touro Infirmary, Northoaks Health System, St. Tammany Parish Hospital, Fairway Medical Center, East Jefferson Medical Center, West Jefferson Medical Center, West Jefferson Physician Services, Riverside Medical Center, and Kindred Hospital.	LSU, Ochsner, HCA Delta Division, Regional Health Center, Lafayette General, Woman's Hospital and Children's Hospital, FMOL, Baton Rouge General, Pointe Coupee General Hospital, West Feliciana Parish Hospital, St. Charles Parish Hospital, Acadian Ambulance, Office of Public Health, Capital City Family Health Center FQHC, St. Charles Community Health Center FQHC, Innis Community Health Center FQHC, Opelousas General Hospital, Lane Regional Hospital, Greater Baton Rouge Surgical Hospital, Sage Rehabilitation Hospital, and Acadian Health Alliance.	LSU, Willis Knighton, HCA Delta Division, Acadian Ambulance, Office of Public Health, David Raines Community Health Center FQHC, Northshore Specialty Hospital, St. Catherine's Specialty Hospital, St. Theresa's Specialty Hospital, Southwest Mississippi Medical Center, , Bunkie General Hospital, Lake Charles Medical Center, Lake Charles Medical and Surgical Clinic, SWLA PHO (Christus Health System), Dequincy Medical Center, and Dubuis Medical Center.

We are also working to further develop relationships in the provider community that extend beyond the standard payer/caregiver relationship. We have met with representatives of, or participated in events sponsored by, the Louisiana Primary Care Association, the Louisiana Hospital Association, the Louisiana Rural Hospital Coalition and the Louisiana Healthcare Quality Forum.

Additional information is provided in Attachment G.5.a, detailing a summary of specialty specific gaps and provider interactions and feedback in the course of attempting to address deficiencies.

**G.6**

**Describe your process for monitoring and ensuring adherence to DHH’s requirements regarding appointments and wait times**

WellCare’s assessment of the adequacy of its provider network and the impact on member access to care begins during the initial network development phase and continues regularly after program implementation. We employ a variety of data driven, quantitative methods to identify and address potential provider network access issues before they become significant problems. We also measure access by reviewing, tracking and trending member and provider complaints to identify both isolated (provider-specific) and systemic access concerns.

**Appointment Standards**

WellCare provider relations representatives educate providers and their office staff about appointment standards (appointment and wait time requirements) during initial orientation sessions, and reinforce the importance of the standards at least semi-annually through formal education sessions and face-to-face site visits. Appointment standards are also outlined in provider contracts and handbooks. WellCare will adhere to all required DHH appointment standards, including, but not limited to:

- Emergent or emergency visits;
- Urgent care;
- Non-urgent sick care ;
- Maternity care;
- Routine, non-urgent, or preventative care;
- Lab and X-ray services;
- Follow-up visits in accordance with ED attending provider discharge instructions; and
- In-office waiting time for scheduled appointments.

WellCare currently has appointment standards that in most instances are equal to or exceed DHH requirements. This demonstrates our commitment to ensuring timely access to needed care. We will continue this standard of excellence for the Louisiana CCN program.

<b>WellCare Appointment Standards</b>	
<b>PCP - Urgent</b>	<b>&lt; 24 hours</b>
<b>PCP - Non-Urgent</b>	<b>&lt; 1 week</b>
<b>PCP - Routine</b>	<b>&lt; 30 days</b>
<b>WAIT TIMES</b>	<b>&lt; 30 minutes</b>

WellCare contracts with the Myers Group to monitor compliance with all required appointment standards through telephone calls to provider offices to determine the availability of urgent and routine appointments. WellCare tests provider compliance with appointment standards by randomly selecting and calling a statistically valid sample of the total network each quarter (stratified by provider type and service area). In the event of a member grievance, a call will be placed to the provider’s office within one business day to test appointment accessibility. We also

execute inter-rater reliability tests to ensure that information gathered by the Myers Group regarding telephone compliance reconciles with our own experience. We also systematically review member grievances for indications that specific providers are not compliant with office wait times.

Practices flagged as non-compliant are either mailed or hand-delivered a letter specifying the area of deficiency and requesting that the provider correct any non-compliance issue and respond within 10 days of receipt. The letters also inform the provider that they will receive a second round phone audit within 30 – 90 days to determine their compliance status. If providers fail the second round phone audit, they are either mailed or hand-delivered a letter requesting that they provide a corrective action plan (CAP) within 30 days of date of receipt. If a CAP is not received after the second notification, the provider information is sent to the medical director or the designated provider relations representative for intervention. Evident lack of progress by the practice results in providers being referred for further disciplinary action up to and including termination from the network.

### **Responding to Identified Issues**

Our first steps are always to explore with providers why they are failing to meet appointment standards and to offer assistance in addressing any resolvable issues. Individual providers who fail to meet appointment standards after our regional staff has attempted to work through the issues with them will be issued a corrective action plan (CAP) and required to demonstrate that they have corrected the problem. After a corrective action plan has been issued to a provider, a provider relations representative follows-up with the provider to confirm that the appointment standard is now being met. If the problem persists, the provider will be referred to the medical director's office for further intervention and action, including potential termination.

If WellCare identifies an area where multiple providers are failing to offer timely appointments, WellCare's Network Development department will determine whether the problem is systemic and related to a need for additional capacity. If so, Network Development will implement a network access plan to add urgent care capacity, recruit additional providers for the network and/or assist existing providers to expand their capacity (e.g., helping pay the salary of a physician extender, or offering financial incentives to providers willing to expand their practice or extend their office hours).

We cannot underestimate the role of provider advisory councils (PACs) in monitoring provider compliance with appointment standards. Acting on the strength of their local presence and longstanding community ties, the PACs will serve as our eyes and ears, providing invaluable feedback on intervention strategies and program implementation issues.

## G.7

***Describe your PCP assignment process and the measures taken to ensure that every member in your CCN is assigned a PCP in a timely manner. Include your process for permitting members with chronic conditions to select a specialist as their PCP and whether you allow specialists to be credentialed to act as PCPs.***

WellCare believes that the relationship between a member and his or her PCP is the heart of a good managed care system and the best predictor of good health outcomes. Therefore, we will auto-assign members a PCP immediately upon enrollment unless the member has chosen a PCP during initial conversations with the state's enrollment broker. During the new member welcome call, we will confirm the PCP assignment and educate the member about the opportunity to change the PCP assignment at any time.

### **PCP Assignment Process**

Any member who chooses or is assigned to our plan without having selected a PCP will be automatically assigned one immediately upon enrollment. WellCare employs an algorithm to assure that all members have an appropriate PCP match. The criteria consist of:

- The use of fee-for-service claims to identify previous member-PCP relationships. If a member has an existing primary care relationship, we will maintain it so long as the PCP is in our network. Continuity of care for the member is a core value.
- Reassigning where there is a prior PCP relationship for a member who was in our plan and is reinstated after a break in enrollment.
- Keeping family members together in the same medical home if this is appropriate, e.g., children with the same pediatrician.
- Ensuring that our members are assigned to PCPs closest to their homes.

Beyond these core criteria, WellCare also looks at other factors to aid in maximizing the appropriateness of the assignment.

- Verification that the member is age appropriate for the PCP.
- Verification that the PCP is identified as speaking the member's primary language.
- Verification that the PCP is accepting new patients and has not exceeded his or her panel limit.

An expectant or new mother can call our Member Services call center and request a specific PCP for her child. If the mother does not make a selection, the criteria described above will be used to assign a PCP to the newborn. As with all other members, the mother may request a change in the newborn's PCP assignment at any time.

All our members are notified by mail of their enrollment. Included in the new member materials, is information about the PCP assignment, PCP contact information, the member ID card with the PCP assignment printed in it, and notification of the member's option to change his or her PCP by contacting member services.

To further support the member-PCP relationship, WellCare confirms each PCP's member panel on a monthly basis. As a part of this process, WellCare provides each PCP with a monthly

membership report that contains: a listing of new members, existing members, and members who are no longer on the PCP's panel; member data such as address and phone number to assure that the PCP has the information necessary to contact the member; and Overdue for Visit reports that alert our PCPs to members who are due for a visit.

### **Choosing a Specialist for a PCP**

In our programs, the roles and responsibilities of a PCP include:

- Delivering primary care services and making referrals to specialists and other care providers;
- Providing a baseline assessment;
- Working in collaboration with care coordinators to ensure all appropriate services are available to members;
- Monitoring the care management process;
- Formulating a treatment plan;
- Counseling and educating patients on safe health behaviors, self-care skills and treatment options and providing screening tests and immunizations;
- Identifying members with special health care needs; and
- Discussing advanced medical directives with each adult member at the first medical appointment and charting that discussion in the member's medical record.

Specialists may be credentialed to serve as PCPs when they agree in writing to assume these responsibilities.

### Members with Chronic Conditions

When a member is identified as having, or being at high risk for, chronic physical, developmental, behavioral, neurological or emotional conditions that require more complex care, the member may choose or be assigned to an appropriate specialist as his or her PCP. These members are also assigned case managers who will work in conjunction with the specialist PCPs to assure that all their needs are met.

### **Evaluating our PCP Assignment Strategies**

WellCare uses multiple tools to continuously evaluate the effectiveness of our PCP assignment strategies. We review:

- Member health status as measured by HEDIS measures;
- Member grievances regarding the assignment process;
- Utilization of the emergency room;
- The rate of adherence to the EPSDT periodicity screening schedule, if applicable; and
- Reductions in risky behaviors.

From the initial assignment of a PCP and throughout a member's enrollment in our plan, we continuously analyze our assignment procedures to maximize healthy outcomes and member satisfaction with his or her care. As a result of our reviews and findings, PCP adjustments are

made to ensure that each member is fully supported by a qualified and appropriate PCP and that PCPs have the capacity to provide the necessary member care to each member assigned to them.

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## G.8

### ***Describe your plan for working with PCPs to obtain NCQA medical home recognition or JHCAO Primary Home accreditation and meeting the requirements of Section § 14.***

WellCare recognizes and supports the concept of patient-centered medical homes (PCMHs). We believe providing members with a medical home, integrated with comprehensive case management, will result in enhanced member access to care, promotion of wellness and preventive care, and improved coordination of health care services.

Furthermore, we agree with DHH's definition of a PCMH - a system of care led by a team of primary care providers who partner with the patient, the patient's family and the community to coordinate care in all settings, from specialists and hospitals to pharmacies, behavioral health programs, and home health agencies. We also concur with DHH that primary care providers including physician-led and nurse practitioner-led primary care practices should be incorporated in the PCMH.

Key components of the PCMH include coordination of care and managing information. Primary care providers must be able to track care over time and across settings; health information technology is an essential tool in achieving this goal.

Our plan is to work with PCPs, particularly during the initial application process, to provide them the support and resources necessary to become fully functioning, quality medical homes for our members, with emphasis on the initial application process. WellCare is prepared to promote and facilitate the capacity of primary care practices to function as PCMHs and to receive Physician Practice Connections® Patient-Center Medical Home™ (PPC-PCMH) NCQA recognition or JCAHO primary home accreditation.

### **Collaboration**

WellCare recognizes the financial, technological and informational challenges that PCPs face when attempting to achieve NCQA PPC-PCMH recognition. We also believe that any long-term successful program of promoting improved health outcomes must have incentives aligned for the physician community as well as for members. WellCare believes that a concerted and consistently applied approach developed jointly by all CCN participating health plans and DHH would be the most effective way to support CCN program PCPs in obtaining full medical home status.

In the spirit of true collaboration, WellCare proposes to assist in the development of a Louisiana Collaborative that will include DHH, plans selected for the CCN program, and entities such as the Louisiana Health Care Quality Forum and others focused on PCMH recognition. The Louisiana Collaborative would develop and make available resources and tools to assist PCPs in effectively and efficiently establishing medical homes within their practices and would facilitate communication with and among providers across plans.

WellCare also proposes to financially contribute to the cost of PCP's obtaining medical home status by allocating a sum of money equal to that contributed by other selected CCN vendors, up to but not to exceed \$50,000 over a three year period. The Louisiana Collaborative would agree on how this money would be used, including potentially paying the \$80.00 NCQA PPC-PCMH survey tool fee for interested PCP practices.

## Ongoing Assistance to PCPs

WellCare offers several resources to support PCPs in obtaining medical home recognition beyond the initial survey phase. Using the NCQA PPC-PCMH standards as an example, the following demonstrates key WellCare data resources currently available to providers to assist in meeting each of the six PPC-PCMH 2011 standards. These data resources will work in conjunction with provider management systems, therefore giving providers additional tools to use to help them obtain medical home recognition.

### PCMH™ Standards and WellCare Resources

#### *Standard 1: Enhance Access and Continuity:*

- WellCare outlines timely access and wait time requirements in the provider handbook.
- WellCare completes access surveys to ensure timely access to care appointment wait times.
- WellCare provider relations representatives follow-up with non-compliant providers when issues are identified.
- WellCare monitors member grievances and as appropriate shares findings with affected PCPs.

#### *Standard 2: Identify and Manage Patient Populations:*

- WellCare provides member demographics, functional status, medical history, health care data and other relevant member information and health care history.

#### *Standard 3: Plan and Manage Care:*

- WellCare makes available clinical guidelines and other practice standards for identified conditions. The information is available on WellCare's website and upon request.

#### *Standard 4: Provide Self-Care and Community Support:*

- WellCare instructs providers regarding how to access health education materials and provides ongoing support for practices to educate members.

#### *Standard 5: Track and Coordinate Care:*

- WellCare monitors provider compliance with tracking test results and abnormal results through medical record review process.
- WellCare provides information regarding on availability of electronic medical record tools and resources.
- WellCare educates providers on advanced electronic communication resources and tools.
- WellCare educates providers about government funds that are available for implementing electronic medical records and advanced electronic communication resources.

*Standard 6: Measure and Improve Performance:*

- WellCare will create provider profiles based on HEDIS measures and clinical performance. The profiles will be distributed to providers and used to help educate providers on how to improve their performance on deficient measures.
- WellCare annually conducts the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and obtains member feedback on service delivery and provider relations.
- WellCare reviews and analyze claims and medical records to determine service utilization patterns.

WellCare is committed to providing the resources necessary to support PCPs in obtaining medical home recognition. Our commitment to the PCMH model of care will be integrated into all aspects of the WellCare operations, including but not limited to provider recruitment, training, staff training, provider network monitoring, quality assessment initiatives and utilization management.

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## G.9

**Describe how you will monitor providers and ensure compliance with provider subcontracts. In addition to a general description of your approach, address each of the following:**

- **Compliance with cost sharing requirements;**
- **Compliance with medical record documentation standards;**
- **Compliance with conflict of interest requirements;**
- **Compliance with lobbying requirements;**
- **Compliance with disclosure requirements; and**
- **Compliance with marketing requirements.**

WellCare monitors provider compliance with contract terms through a combination of site inspections, provider profiles, audits, standardized reports, and investigations of complaints, grievances and appeals. The following describes WellCare's provider monitoring activities.

### **Provider Education**

We believe that successful monitoring cannot begin until providers fully understand all requirements and expectations. Provider education regarding contract requirements begins upon enrollment in the WellCare provider network and continues on an ongoing basis throughout providers' enrollment in our network. Initial provider training will occur as close to CCN go-live date as possible in order for the information to remain fresh. WellCare will conduct provider orientation activities with our Louisiana network in the 60 days leading up to the first member enrollments. Provider participation will be logged and tracked during the 60-day period. Approximately two weeks before go-live, we will re-contact all providers who have not yet undergone training and direct them to online training resources or schedule a live session.

Going forward, as new providers are placed on active status, our policy will be to conduct training prior to their entry into the network but never later than 30 days after they become active.

Providers will receive resource materials to supplement their training, including a provider handbook, quick reference guides, job aids (which are instruction guides for requesting authorizations, making referrals, filing claims, etc.), forms and documents to assist them in their day-to-day administrative tasks with WellCare. (See our response to Sections G.11 and G.12 for additional information on WellCare provider education and training.)

Providers who are found to be non-compliant with any contract requirement are subject to additional education and training and imposition of a corrective action plan (CAP). Providers who fail to correct their non-compliance issue are ultimately subject to contract termination.

### **Site Inspections**

WellCare conducts site inspection evaluations (SIE) as part of credentialing as required by NCQA and in accordance with state requirements. In addition, a SIE is conducted in response to a member grievance or at any point a compliance issue warrants an inspection.

### Individual Practitioners

An SIE for individual practitioners includes, but is not limited to the following elements:

- Accessibility/environment/adequacy and privacy of waiting and examination room space;
- Safety;
- Office protocol and appointment availability;
- Medical records;
- Confidentiality and HIPAA compliance; and
- After-hours triage.

Practitioners who do not meet the threshold score of 85 percent receive appropriate interventions, which may include advising, educating and/or issuance of a CAP. WellCare evaluates the effectiveness of interventions at least every six months until the deficient office remediates the deficiencies.

### Organizational Providers

An SIE for organizational providers includes, but is not limited to, the following elements:

- Facility review;
- Safety;
- Medication storage;
- Facility protocol;
- Medical records;
- HIPAA compliance; and
- Quality management program related to the education, training, qualifications, and competency of unlicensed practitioners.

As with individual practitioners, organizational providers that do not meet the threshold score (85 percent) receive appropriate intervention, and we evaluate the effectiveness of the intervention at least every six months until the deficient facility remediates the deficiencies.

### **Other Monitoring Activities**

In addition to conducting SIEs, WellCare contracts with a vendor to regularly test provider appointment availability during business hours to inquire about the next available appointment for urgent or routine needs. Calls are also made after hours and on weekends to test primary care provider call coverage. Providers who fail in either area are counseled and re-tested within 30 – 90 days. If the provider fails the follow-up audit, he or she will be requested to provide a corrective action plan (CAP). Provider relations representatives review complaints, grievances, appeals, and member PCP change reports to identify providers who appear to have a pattern of poor performance. If there is evidence that the provider is noncompliant with contract requirements, staff will make a referral to the WellCare credentialing committee for further investigation and action.

WellCare's Utilization Management Workgroup is responsible for identifying and investigating any potential over- or under-utilization of care by network providers. The Workgroup receives profiles that compare individual practitioners to other providers in their peer group (profiles are also shared with providers themselves). Providers who fall outside the norms and who do not have a valid reason for being outliers will be counseled by a medical director or provider relations representative (as deemed appropriate) and monitored closely by the Workgroup. Failure to come within practice norms over time can result in corrective actions up to and including termination.

WellCare's Quality Improvement department is responsible for conducting provider medical record audits as part of HEDIS data collection and other quality improvement activities. Providers who fail the audits are, at a minimum, issued CAPs and re-audited to verify compliance with program and contract requirements. Failure to cure the identified deficiency can result in contract termination.

Providers will also receive profiles that compare them to other providers in their peer group regarding their HEDIS results. Providers who fall outside the norms and who do not have a valid reason for being outliers will be counseled by a medical director or provider relations representative (as deemed appropriate) and monitored closely by the Quality Improvement department. Failure to come within practice norms over time can result in corrective actions up to and including termination.

## **Ensuring Compliance with Requirements**

### Compliance with Cost Sharing Requirements

WellCare specifies in its provider contracts and provider handbook what types of co-payments may be collected. The provider contract and provider handbook emphasize that providers may not seek payment from members (other than allowable co-payments) except in very limited circumstances (e.g., provision of non-covered services with member's written acknowledgement of financial liability). Provider relations representatives review these prohibitions with network providers and office staff during site visits and verify that program rules are being followed.

If a member contacts us to question or complain about a provider's billing activity, our Provider Relations department is notified. A provider relations representative contacts the office to discuss the matter with the provider and office manager (without divulging the member's name). The provider and office staff may be required to undergo re-training on allowable and prohibited billing practices.

Provider compliance with cost sharing requirements is monitored through our Special Investigation Unit (SIU), which is responsible for the detection, prevention, investigation, reporting, correction and deterrence of fraud, waste and abuse (see our response to Section O.1 for more information on fraud and abuse monitoring). SIU creates claims queries that allow identification of members and providers with suspicious activity or unusual patterns of behavior that might indicate fraud or abuse. If a provider is identified as a fraud, waste or abuse concern based upon these queries, the SIU conducts a more thorough review of the provider's entire billing history and attempts to identify all areas that are unusual or suspicious. This may result in expanded investigations with multiple lines of inquiry.

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### Compliance with Medical Record Documentation Standards

WellCare adheres to 42 CFR Part 456 and NCQA standards for medical record keeping. The standards are delineated in provider contracts and handbooks and include, but are not limited to documentation requirements, storage, maintaining patient confidentiality, record retention, and member access and record transfer rights.

As noted previously in this response, Provider Relations reviews compliance with these standards as part of SIEs (if conducted) at the time of initial contracting and re-credentialing, as appropriate. One of the goals of these reviews is to ensure that the provider's medical records meet the required documentation standards. Providers are given the results at the time of the audit, and a CAP is required if the provider does not score above 80 percent. Quality Improvement staff also review provider compliance during medical record audits. Provider medical record deficiencies can result in additional education and training and/or the issuance of CAPs. Failure to correct the deficiencies can result in termination.

### Compliance with Conflict-of-Interest, Lobbying, and Disclosure Requirements

WellCare includes specific language in its provider contracts related to conflict of interest, lobbying, and disclosure requirements. Signed attestation statements are obtained from providers during the contracting process and are a component of our provider credentialing application materials for the disclosure requirements that are comprehensive and broad enough to cover all references. Conflict of interests and lobbying requirements are covered as a component of the provider contract. WellCare's Corporate Compliance department will monitor and track negative activity received from feedback from providers and other applicable sources.

We also adhere to the following:

- *Prohibition on Payments to Public Employees and Family Members:* WellCare affirms that no direct or indirect prohibited payments have or will be made to state or federal employees or immediate family members. WellCare's Corporate Compliance department is responsible for ensuring plan-wide adherence to this policy.
- *Restrictions on Lobbying:* WellCare affirms that, to the best of our knowledge, we do not use federal funds for lobbying and disclose lobbying conducted with non-federal funds in accordance with 45 CFR Part 93.
- *Disclosure Requirements:* WellCare affirms that we will adhere to disclosure requirements, as specified in 42 CFR 455 Subpart B.

WellCare monitoring for provider compliance with conflict of interest, lobbying and disclosure requirements is consistent with the activities noted above under Other Monitoring Activities.

### Compliance with Marketing Requirements

As part of our initial and ongoing provider training, provider relations representatives inform providers that all marketing materials referencing WellCare that are not directly related to a specific course or treatment for a specific patient must undergo prior review by the health plan and DHH. This policy is also included in our provider contracts and the provider handbook. Provider relations representatives conduct unannounced drop-in visits to monitor provider activities regarding marketing requirements as well as other requirements.

WellCare's provider contract also specifies that providers must have WellCare's prior written consent in order to conduct any kind of communication, whether oral or in written form, about the plan that is not related to treatment of a particular medical condition or payments. WellCare also reserves the absolute right to deny the use of our service mark, names, and descriptions in provider marketing materials for any reason. WellCare monitoring for provider compliance with marketing requirements is consistent with the activities noted above under Other Monitoring Activities.

WellCare is committed to full compliance in all areas of its operations, including sales and marketing. The receipt, investigation and resolution of regulatory inquiries related to marketing activities are part of the standard course of business for all plans participating in government programs, including WellCare.

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**G.10**

***Provide an example from your previous experience of how you have handled provider noncompliance with contract requirements.***

Exhibit G.10.a – Georgia Medicaid Quarterly Access Survey Responses are the results for the Georgia audit performed between 2/21/2011 – 4/11/2011. (Note that the denominator used for calculating appointment availability metrics is based on the provider offices completing the survey and excludes incomplete surveys due to bad phone numbers, etc.) Georgia Medicaid audits are performed four times per year. At this time we audited all providers who failed the survey in the third quarter of 2010. Ninety-seven percent of providers passed all standards while three percent failed a second time. The list of those providers that failed the second time was sent to the medical director and the provider relations manager for review and determination of next steps.

**Exhibit G.10.a – Georgia Medicaid Quarterly Access Survey Responses**

Completed Surveys	Total Number of Appointment Requests	Total Number Appointments - Meet Waiting Time Standards	Total Number Appointments - Exceeding Waiting Time Standards	Average Waiting Time - Percentage of Requests that <b>Exceed</b> the Waiting Time Standards	Average Waiting Time - Percentage of Requests that <b>Meet</b> the Waiting Time Standards	Appointment Time Standard
<b>PCPs-Adult</b>						
Sick Care Pass	463	444			96%	< or = 24 hours
Sick Care Fail	463		19	4%		> 24 hours
Routine Care Pass	463	447			97%	< or = 14 Calendar Days
Routine Care Fail	463		16	3%		> 14 Calendar Days
<b>PCPs-Pediatric</b>						
Sick Care Pass	159	153			96%	< or = 24 hours
Sick Care Fail	159		6	4%		> 24 hours
Routine Care Pass	159	144			91%	< or = 14 Calendar Days
Routine Care Fail	159		15	9%		> 14 Calendar Days
Health Check Care Pass (new members)	159	157			99%	< or = 90 Calendar Days
Health Check Care Fail (new members)	159		2	1%		> 90 Calendar Days
<b>Dental -Adult &amp; Pediatric</b>						
Urgent Care Pass	135	124			92%	< or = 48 hours
Urgent Care Fail	135		11	8%		> 48 hours
Routine Care Pass	135	121			90%	< or = 21 Calendar Days
Routine Care Fail	135		14	10%		> 21 Calendar Days
<b>OB/GYN</b>						
OB/GYN only; for initial obstetrical visit Pass	113	111			98%	< or = 14 Calendar Days
OB/GYN only; for initial obstetrical visit Fail	113		2	2%		> 14 Calendar Days
<b>Mental Health Providers</b>						
Routine Care Pass	153	153			100%	< or = 14 Calendar Days
Routine Care Fail	153		0	0%		> 14 Calendar Days
<b>Urgent Care Providers</b>						
Urgent Care Pass	1	1			100%	< or = 24 hours (7:00am - 7:00pm member access) to include 24 hour after hour answering services
Urgent Care Fail	1		0	0%		> 24 hours

## G.11

***Describe in detail how you will educate and train providers about billing requirements, including both initial education and training prior to the start date of operations and ongoing education and training for current and new providers.***

One of the key determinants of success of CCN will be the readiness of the provider networks. If providers are unable to submit claims easily or receive timely service authorizations, their relationship with the plans will be permanently damaged. Conversely, if health plans devote the necessary resources up front to ensuring providers are ready for the transition, the long-term benefit to the program will be substantial.

We have successfully conducted large scale provider training initiatives in several states, including Florida, Georgia, Illinois, New York and Hawai'i. Our success has been predicated on a strategy of placing experienced provider relations representatives in the field and offering personalized and intensive training to our network.

During the last year, we have spent considerable time meeting with providers in Louisiana to learn as much as possible about their concerns and how WellCare can best meet their needs through training and ongoing support. We are building this provider feedback into our training initiatives.

### **Initial Training and Education**

#### General Approach

WellCare's provider training initiative is designed to provide a comprehensive overview of all program requirements, expectations and WellCare operations. Training on billing and claims submission processes is an integral component of WellCare's overall provider training and education.

To be effective, initial provider training must occur prior to the program go-live date, but close enough to go-live for the information to remain fresh. WellCare will conduct provider orientation activities with our Louisiana network in the 60 days leading up to the first member enrollments. Provider training sessions will include group sessions and one-on-one sessions with individual providers.

Provider participation will be logged and tracked during the 60-day period. Approximately 30 days before go-live, we will re-contact all providers who have not yet undergone training and direct them to online training resources or schedule a live session. As new providers are placed on active status, our policy will be to conduct training prior to their entry into the network but never later than 30 days after they become active. Provider handbooks approved by DHH will be posted on our website, and we will make them available to providers as soon as possible but never later than five business days after the provider is included in the network. The provider handbook is supplemented with quick reference guides, which are step-by-step instruction guides for requesting authorizations, making referrals, filing claims, etc.

Outreach methods will include telephone calls, mailings, fax blasts, postings on the training portion of our website, and visits from provider relations representatives as well as attendance at public meetings where we may meet and engage providers. WellCare promotes the use of

self-service models as a means to make training easier, more flexible for providers and available when providers are ready to use them.

### Additional Training and Education on Billing Requirements

Beyond the general training requirements noted above, WellCare places additional emphasis on ensuring that providers understand billing and claims processing requirements especially in new or expansion markets. This training is tailored to address the specific needs of each market and to minimize any delays in provider reimbursement related to incorrect billing. Extensive training resources will be devoted to Louisiana providers to ensure they are fully aware of the billing requirements for our Medicaid product, which may be significantly different from those they are currently accustomed to for our Medicare line of business.

Initial provider training encompasses education regarding contract requirements and administrative requirements and tasks, including review of provider resources available online such as the provider handbooks, quick reference guides, clinical coverage guidelines, clinical practice guidelines, job aids (i.e., resource guides), training and education and newsletters. WellCare's provider resources cover topics such as claims/billing, authorizations, credentialing, case/disease management, and compliance. Additionally, WellCare will identify DHH specific guidelines and standards and incorporate those into our provider resources and trainings, including DHH specific claim or encounter submission guidelines or standards upon which we will tailor our core processing system business rules for claims submission and payments.

WellCare follows industry standard billing and claims submission guidelines regarding formats and time frames unless otherwise stipulated in the provider contract. Providers may submit institutional and professional (i.e., industry-standard CMS-1500 and UB-04 forms) claims via paper, a clearinghouse, or through WellCare's Direct Data Entry (DDE) portal on the WellCare provider website. The DDE is an efficient alternative to utilizing a clearinghouse or vendor, and gives providers control over their electronic claims submissions to WellCare. Corrected claims processes are outlined in the provider handbook, and can be resubmitted via paper, clearinghouse or DDE in the same industry standard formats. The provider handbook and job aids also provide information on how to request an authorization for services by phone, fax and via our website. Additionally, WellCare's website also allows providers to access claims status reports, submit claim inquiries, and resubmit corrected claims.

Although initial training is provided to cover each of these previously mentioned claims submission concepts/interdependencies, WellCare has mechanisms to monitor for billing issues and conducts outreach to providers as warranted.

### **Ongoing Training and Education**

As new providers are placed on active status, our policy is to conduct training prior to their addition to the network but never later than 30 days after they become active. Providers will receive ongoing updates, training and education covering the topics delineated above in at least one of the following ways: online training available on [www.WellCare.com](http://www.WellCare.com), website articles, web casts and provider newsletters, targeted e-mails or mailings to providers regarding important plan/program changes, self-study programs and in-services conducted by provider relations representatives. Through monitoring by provider relations representatives and review and

analysis of data, such as claims data, additional training is provided on areas of identified needs, such as billing and claims processing.

For future consideration, WellCare will explore the use of interactive webcasting as an additional tool to use for all training, including training on billing and claims processing requirements. This initiative is under consideration in our Illinois market. We will use the results of the Illinois pilot to help determine the effectiveness of this model for CCN.

### **Additional Hands-On Assistance to CCN Providers Regarding Billing Inquiries**

Although most CCN providers will be familiar with billing Medicaid, due to multiple new payers entering the market, providers will require intensive training on the various billing and claims processing requirements. WellCare's Provider Relations department staff will provide hands-on assistance to providers, in fulfilling all our billing requirements, including training on EDI claims filing, clean claims requirements, paper filing, prior authorization requirements, and filing timelines. This assistance will supplement and extend beyond the DHH required Provider Claims Educator function by providing direct one-on-one assistance to providers as needed.

WellCare faced similar environments in Hawai'i and New York upon expansion of managed care to the SSI and long-term care populations. We employed a strategy that combined development of materials tailored to the long-term care provider community with an emphasis on in-person training, both in group and one-on-one settings. We fielded sufficient numbers of provider relations representatives to ensure that training could be offered throughout our service areas (statewide in Hawai'i) on weekdays and weekends, during the day and in the evening.

For CCN, training sessions regarding billing requirements will be offered during evenings and weekends and through online modules to accommodate provider and office staff schedules, particularly for part time workers. WellCare will maintain a significant provider relations presence after the transition to CCN to ensure we can respond rapidly to providers requesting assistance. We will also develop targeted education training sessions and materials to address billing and claims processing issues.

Provider relations representatives will monitor provider billing and claims processing issues to provide proactive interventions. Provider relations representatives will use Salesforce.com (an online resource for tracking and monitoring provider interactions) as a resource to identify provider patterns warranting additional attention. WellCare will also monitor claim denial rates on a weekly basis and offer assistance to providers who appear to be having difficulties.

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## G.12

**Describe how you will educate and train providers that join your network after program implementation. Identify the key requirements that will be addressed.**

Our Provider Relations department will conduct training for new providers who join our network any time after program implementation. Training will be the same in scope as that offered to providers in the period prior to implementation (see our response to Section G.11).

Providers will receive information regarding available resources (e.g., provider handbook, WellCare.com, newsletters), information about the provider hotline and how to access it, and relevant WellCare contact information. Similar to training for initial program implementation, ongoing training participation will be logged and tracked and made available via a variety of modes such as self-service models, one-on-one sessions and group sessions.

Initial training will also include a review of the provider handbook and other reference materials and will cover the following key requirements and topics:

- Introduction to WellCare and organization core values;
- Policies, procedures, and key contacts;
- Program overview, including covered populations and services and critical success factors for the provider new to managed care;
- Provider responsibilities for making referrals and coordination with non-capitated services;
- Utilization management (including pharmacy management) and prior authorization;
- Transition of care, service coordination, chronic care management and behavioral health programs;
- Information about the patient-centered medical homes approach to care delivery and related WellCare expectations, requirements and initiatives;
- Member and provider rights and responsibilities, including rights related to complaints, grievances and appeals;
- Billing requirements and claims submission processes;
- Encounter and reporting processes;
- Fraud, waste and abuse education;
- Medical records requirements and relationship to HEDIS reporting;
- Provider complaints, grievances and appeals;
- Provider profiling, including monitoring for care gaps, medical records requirements and HEDIS reporting;
- Cultural competency, health care literacy and ADA compliance requirements;
- WellCare interpreter/sign language assistance; and
- Ongoing education opportunities.

As new providers are placed on active status, we will conduct training prior to their addition to the network but never later than 30 days after they become active.

Providers will receive ongoing updates, training, and education on the topics delineated above in at least one of the following ways: online training available on [www.WellCare.com](http://www.WellCare.com), website articles, web casts and provider newsletters, targeted e-mails or mailings to providers regarding important plan/program changes, self-study programs and in-services conducted by provider relations representatives.

Post implementation, our experience has been that the biggest issue for providers is billing and claims submission. For this reason, we will continue our aggressive hands-on approach to providing assistance to providers on billing and claims processing related issues (see our response to G.11). We will continue to track and trend claims data to determine if systemic issues exist, that warrant attention. We will also develop targeted education training sessions and materials to address billing and claims processing issues.

### **Incorporating Provider Feedback on Training and Education**

WellCare values the feedback of its providers and uses this information to update training and education initiatives so that they are better aligned with member needs and interests. WellCare analyzes provider grievances and appeals to help evaluate provider satisfaction. The data are analyzed, tracked and trended on a monthly basis to determine patterns and presented quarterly to the Utilization Management Medical Advisory Committee (UMAC).

Network providers are surveyed on an annual basis to assess provider satisfaction. Our Provider Relations department reviews and analyzes survey results and develops action plans to address those areas identified as needing improvement. If determined appropriate, we may also obtain provider feedback and guidance on a large scale basis, such as by means of professional or association meetings. Particular emphasis will be placed on the extent to which providers continue to have issues with billing and claims processing issues and on developing training and education approaches to effectively address these lingering issues.

### G.13

**Describe your practice of profiling the quality of care delivered by network PCPs, and any other acute care providers (e.g., high volume specialists, hospitals), including the methodology for determining which and how many Providers will be profiled.**

- **Submit sample quality profile reports used by you, or proposed for future use (identify which).**
- **Describe the rationale for selecting the performance measures presented in the sample profile reports.**
- **Describe the proposed frequency with which you will distribute such reports to network providers, and identify which providers will receive such profile reports.**

WellCare measures provider performance through a combination of HEDIS studies, performance improvement projects, and evaluation of provider adherence to clinical practice guidelines. For each of these activities, actual performance is compared to benchmarks established in accordance with federal/state and professional association guidelines. Monitoring occurs through claims and encounter analysis, medical record review, case manager oversight of individual member utilization, and provider profiling.

### Provider Profiling

As part of our quality assessment and performance improvement (QAPI) program, WellCare profiles network PCPs using a variety of reports documenting quality of care and utilization of specialists, inpatient/outpatient services, and pharmacy. WellCare will create a suite of profile reports of PCPs, certain high-volume specialists, and hospitals for Louisiana, drawing on our current reports as well as developing new reports. During initial provider orientation and upon distribution of the initial profiles, we will educate providers on the reports and how they can be used to improve their standard of care. Additionally, we will inform providers of the parameters of the WellCare pay for performance quality incentive (P4Q) program, which rewards providers for meeting target HEDIS rates. As described in our response to Section S.1, in Louisiana we intend to include several HEDIS measures in our P4Q program.

### HEDIS Rate Profile Report

PCPs play the central role in ensuring our members receive all necessary preventive and primary care services and are referred as appropriate to specialists and other providers. WellCare profiles all PCPs to verify these responsibilities are met and provides PCPs with regular HEDIS rate profile reports that compare each PCP's compliance rate to that of his/her peers and to an appropriate benchmark (such as the annual HEDIS National Medicaid 75th percentile) for the HEDIS measures selected. We have the capability to include any HEDIS or HEDIS-like measure using administrative data, but we generally focus on specific selected measures that vary by state. In Louisiana, we propose to include, at minimum, rates related to diabetic eye exams, diabetic HbA1c tests, monitoring diabetic nephropathy, lead screening, breast cancer screening, chlamydia screening, cervical cancer screening, well child visits, and adult preventive visits.

HEDIS rate profile reports are reviewed as part of a provider relations (PR) visit. Therefore, the schedule for distributing HEDIS rate profile reports is tied to the schedule of PR visits. In Louisiana we will provide HEDIS rate profile reports to high-volume network PCPs on a monthly

basis. We will also provide HEDIS rate profile reports to low-volume network PCPs, but this will be done on a quarterly or semi-annual basis depending on the PR visit schedule. While all PCPs will be profiled, the reports will denote PCPs with panel sizes too small to be statistically valid in a given reporting period. This technique will be used for all provider profile reports. Exhibit G.13.a on page 45 presents an example of a HEDIS rate profile report for our Georgia health plan.

In addition to administrative measures, we could develop a separate rate profile report for clinical measures, including some or all of the HEDIS and non-HEDIS measures listed in Appendix J. Since reviewing these reports with providers would require clinical staff (as opposed to PR staff), these reports will be provided and reviewed quarterly or semi-annually and will focus on high-volume providers and outliers. For example, in New York we developed provider profiles for clinical measures, and the medical director and nurses visited large provider groups to discuss their results, which were benchmarked against New York state targets.

#### Overdue for Visit Report

We also provide PCPs with member Overdue for Visit reports. Although not itself a profile report, the Overdue for Visit report identifies the PCP's members who are past due for certain services. These reports include the same measures as the HEDIS rate profile report discussed above and are also reviewed during PR visits. Thus, we will provide these reports to our Louisiana PCPs according to the same schedule as for HEDIS rate profile reports.

Our intent in furnishing Overdue for Visit reports is to assist PCPs in identifying and contacting patients who are past due for appointments. Provider performance in reducing Overdue for Visit patient counts will be tracked and evaluated as part of WellCare's broader profiling activities.

WellCare also supports PCP efforts through various member engagement strategies, including telephonic outreach to members with care gaps and the Care Gap alert feature in our member services call center (see response to Section J.1 for additional information). Please see our response to Sections J.1 and J.4 for examples of our experience with improving HEDIS measures in other markets.

Exhibit G.13.b on page 46 (labeled Noncompliant Member report) presents an example of an Overdue for Visit report for our Georgia health plan.

#### High ED Utilization Report

WellCare produces monthly and annual emergency department (ED) utilization profile reports that document ED utilization and expenditures by PCP in order to identify outlier PCPs. The summary report is accompanied by detailed reports on members who are frequent users of the emergency department and enables follow-up by WellCare and the member's PCP. We will use these reports for Louisiana Medicaid. Exhibit G.13.c on page 47 presents an example of the 12-month summary report for our Hawai'i health plan.

#### Summary Primary Care/Specialist/Hospital Utilization Report

Providers, including PCPs and certain high volume specialists, will be given summary, risk adjusted reports that compare their primary care, specialty physician, ED, and in-patient

utilization to those of their peer groups. These reports, which will be issued quarterly, will serve as critical tools for quality improvement within the network. Exhibit G.13.d on page 48 presents a sample of the primary care/specialist/ED report, and Exhibit G.13.e on page 49 presents a sample of the hospital utilization report that will also be provided to hospitals. These Exhibits are examples of proposed reports and do not reflect actual data for a specific market.

### Follow Up and Corrective Action

Providers who demonstrate low performance on any of the profile reports will initially be targeted for improvement through peer counseling through the applicable provider advisory council, accompanied, when appropriate, by a provider relations representative. Providers who fail to improve will be referred for a targeted medical record review and quality improvement (QI) intervention.

Medical record review will be conducted using a quality-focused medical records evaluation tool to assess the provider's compliance with established standards of care and elements of documentation required by the state and/or accrediting organizations. Upon completion of the review, a summary of findings will be created and shared with the provider and a written acknowledgement obtained. If a provider's overall results are below 80 percent, an additional sample of records may be selected for review. A corrective action plan (CAP) will be required if the score from the initial review process and/or composite score from the initial and the additional review sample are below 80 percent overall. We will monitor improvements called for under the CAP and assist the provider with addressing any remaining deficiency area before the scheduled re-audit.

### PCP Prescription Drug Utilization

WellCare generates monthly reports summarizing pharmacy utilization patterns for PCPs categorized by PCP type and geography/region. This includes identifying PCPs with utilization patterns of over- or under-utilization or failure to write generic drugs. WellCare will develop similar profiles for Louisiana to identify opportunities for improvement and collaboration with the provider community. Exhibit G.13.f on page 50 presents an example of a prescription drug utilization profile report for one of our Florida health plans.

### **Sample Quality Profile Reports**

The following reports are provided as Exhibits:

- Exhibit G.13.a – Provider HEDIS Rate Profile Report
- Exhibit G.13.b – Provider Overdue for Visit Report
- Exhibit G.13.c – Summary ED Utilization Report
- Exhibit G.13.d – Summary Primary Care/Specialist Utilization Report
- Exhibit G.13.e – Summary Hospital Utilization Report
- Exhibit G.13.f – PCP Prescription Drug Utilization Report

### **Performance Measure Selection Rationale**

WellCare selects HEDIS and utilization measures with a direct relationship to the quality and cost of the care being provided to our members. The measures proposed for Louisiana have been validated through use in our other programs; however, they will be refined as we gain experience in the State.

### **Frequency of Distribution**

Reports will be distributed on a monthly, quarterly, semi-annual and/or annual basis, as described in the preceding narrative. The reports will be provided to PCPs, high volume specialists and/or hospitals as described above.

Exhibit G.13.a – Provider HEDIS Rate Profile Report

WellCare of Georgia, Inc.

PROVIDER RATES BY PROVIDER ID

6/13/2011

Provider Name: [REDACTED] ; Claims Received Thru: 4/30/2011  
 Provider ID: 344031  
 Address: [REDACTED]  
 COLUMBUS, GA, 31901  
 Phone: [REDACTED] Fax: [REDACTED]

Measure	# Members	# Compliant	Provider Rate	Health Plan Rate	Health Plan Goal
<b>Medicaid</b>					
IPA: [REDACTED]					
Childhood Imm (2)	50	28	56.0%	62.6%	82.1%
Diabetes LDL-C Test	10	2	20.0%	28.8%	79.5%
Diabetic Eye Exam	10	0	0.0%	11.6%	62.3%
Diabetic HbA1c Test	10	2	20.0%	40.6%	86.2%
Diabetic Monitor Nephropathy	10	4	40.0%	48.7%	82.2%
Lead Screen	50	20	40.0%	68.9%	65.9%
Preventive Visit (20-44)	232	94	40.5%	55.8%	85.6%
Well Child 15 Mos	73	15	20.5%	18.6%	67.4%

Key - RED: > 10% from Goal    ORANGE: 5-10% from Goal    GREEN: < 5% from Goal or above Goal

Exhibit G.13.b – Provider Overdue for Visit Report

WellCare of Georgia, Inc.

Noncompliant Member Report by Provider ID

6/13/2011

Provider Name: [REDACTED]  
 Provider ID: 344031  
 Address: [REDACTED] STE 201  
 COLUMBUS, GA, 31901  
 Phone: [REDACTED] Fax: [REDACTED]

Claims Received Thru: 4/30/2011

Member ID	Member Name	Phone	Sex	DOB	Childhood Imm (2)	Diabetic LDL-C Test	Diabetic Eye Exam	Diabetic Monitor Nephropathy	Diabetic HbA1c Test	Lead Screen	Preventive Visit (20-44)	Well Child 15 Mos
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]							X	
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]							X	
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]							X	
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]								X
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]							X	
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]		X	X	X	X		X	
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]			X					
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]								X
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]							X	
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]						X		
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]							X	
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]						X		
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	X					X		
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]							X	

"X" - Indicates member is in need of service

Exhibit G.13.c – Summary ED Utilization Report

Hawaii PCP ER Utilization

ZAB Dual

ER Visits & Membership for 11/01/09 through 10/31/10

\* Includes PCPs with at least one member with an ER Visit within the time period

\*\* Includes Active Members Only

PCP ID	PCP Name	STATE	Zip	ER Users	ER Visits	Paid	Members Panel	Panel MMs	% of Members Using ER	Visits / 1000	Avg Visit/ User	PMPM
		HI	33631	1,948	4,175	\$517,089	11,848	110,583	16%	453	2.1	\$4.68
		HI	96815	21	43	\$8,455	111	1,084	19%	476	2.0	\$7.80
		HI	96720	18	48	\$7,563	86	657	21%	877	2.7	\$11.51
		HI	96813	12	51	\$6,568	35	201	34%	3,040	4.3	\$32.62
		HI	96814	21	39	\$5,751	118	1,204	18%	389	1.9	\$4.78
		HI	96819	18	34	\$4,148	100	1,027	18%	397	1.9	\$4.04
		HI	96720	8	32	\$4,126	53	515	15%	745	4.0	\$8.01
		HI	96814	14	20	\$4,067	91	1,009	15%	238	1.4	\$4.03
		HI	96797	21	38	\$3,832	122	1,090	17%	418	1.8	\$3.52
		HI	96817	10	13	\$3,712	70	775	14%	201	1.3	\$4.79
		HI	96706	2	20	\$3,500	6	29	33%	8,276	10.0	\$120.69
		HI	96817	21	31	\$3,329	287	2,950	7%	126	1.5	\$1.13
		HI	96819	16	26	\$3,165	91	996	18%	313	1.6	\$3.18
		HI	96792	9	24	\$3,163	45	369	20%	780	2.7	\$8.57
		HI	96815	4	44	\$3,078	22	152	18%	3,470	11.0	\$20.23
		HI	96819	10	25	\$2,760	74	701	14%	428	2.5	\$3.94
		HI	96797	13	32	\$2,683	68	595	19%	645	2.5	\$4.51
		HI	96797	18	24	\$2,670	180	1,920	10%	150	1.3	\$1.39
		HI	96744	10	20	\$2,659	47	414	21%	580	2.0	\$6.43
		HI	96792	14	24	\$2,550	49	461	29%	624	1.7	\$5.53

Exhibit G.13.d – Summary Primary Care/Specialist Utilization Report<sup>1</sup>

Provider	Total Members	Normalized Risk Score	ED Visits per Member per Year	PCP Visits per Member per Year	SCP Visits per Member per Year	Average Primary Care Billing Level	Average Specialist Billing Level
Garcia, Socorro	746	1.00	0.24	1.81	4.73	3.55	3.27
Johnson, Robert	1,250	1.00	0.27	2.40	3.52	3.32	3.22
Jones, Mary	1,163	1.02	0.20	2.56	3.33	3.30	3.20
Martinez, Jose	511	0.59	0.23	2.31	4.15	3.27	3.22
Miller, James	344	1.01	0.27	2.14	3.66	3.16	3.15
Smith, John	681	1.02	0.26	2.99	2.39	3.15	3.13
Thomas, Frank	225	0.59	0.29	1.54	2.52	3.10	3.16
<b>Overall</b>	<b>4,920</b>	<b>1.00</b>	<b>0.24</b>	<b>2.36</b>	<b>3.53</b>	<b>3.30</b>	<b>3.20</b>

<sup>1</sup> This is a sample of a proposed report and does not reflect actual data (or provider names) for a specific market.

Exhibit G.13.e– Summary Hospital Utilization Report<sup>2</sup>

Provider	Total Members	Normalized Risk Score	Med/Surg Admissions /1000	Med/Surg Days /1000	Med/Surg ALOS	OB Admissions /1000	OB Days /1000	OB ALOS	Non-Acute Admissions /1000	Non-Acute Days /1000	Non-Acute ALOS
Garcia, Socorro	746	1.00	195.4	703.4	3.6	7.6	26.7	3.5	4.2	63.9	15.2
Johnson, Robert	1,250	1.00	166.2	648.2	3.9	9.1	30.2	3.3	3.2	43.3	13.5
Jones, Mary	1,163	1.02	185.3	815.3	4.4	7.4	24.5	3.3	2.6	31.6	12.2
Martinez, Jose	511	0.59	210.9	885.8	4.2	6.0	16.5	2.8	2.6	34.0	13.1
Miller, James	344	1.01	255.6	1073.5	4.2	4.3	12.2	2.8	2.4	34.8	14.5
Smith, John	681	1.02	64.7	226.5	3.5	0.5	1.2	2.4	0.1	4.4	44.0
Thomas, Frank	225	0.59	65.4	235.4	3.6	5.2	12.2	2.3	0.9	15.7	17.4
<b>Overall</b>	<b>4,920</b>	<b>1.00</b>	<b>167.4</b>	<b>662.1</b>	<b>4.0</b>	<b>6.4</b>	<b>20.8</b>	<b>3.3</b>	<b>2.6</b>	<b>35.5</b>	<b>13.9</b>

<sup>2</sup> This is a sample of a proposed report and does not reflect actual data (or provider names) for a specific market.

**Exhibit G.13.f– PCP Prescription Drug Utilization Report**

			Pharmacy Utilization												
Product Type	Region	Month	All							Targeted Drug Classes					
			Mems	Prov PMPM	Reg PMPM	Prov SPMPM	Reg SPMPM	Prov GDR	Reg GDR	Mems	Prov PMPM	Reg PMPM	Prov SPMPM	Reg SPMPM	Prov GDR
MEDICAID	FL	11-Feb	9	60.78	29.44	1.11	0.66	90.00%	85.46%	9	47.87	15.15	0.11	0.149	0.00%
		11-Mar	9	94.68	32.98	0.89	0.741	87.50%	85.54%	9	89.91	17.14	0.11	0.168	0.00%
		11-Apr	6	213.63	29.67	1.17	0.667	71.43%	85.85%	6	210.08	15.26	0.5	0.15	33.33%
	FL	11-Feb	391	99.73	32.6	2.24	0.79	84.26%	85.98%	391	54.02	16.28	0.5	0.17	66.67%
		11-Mar	405	118.77	35.4	2.38	0.878	86.59%	86.11%	405	67.62	17.62	0.5	0.19	73.27%
		11-Apr	394	82.97	32.72	2.28	0.797	88.99%	86.46%	394	44.58	16.42	0.44	0.171	73.56%
SSI	FL	11-Feb	9	60.78	117.64	1.11	1.93	90.00%	82.92%	9	47.87	64.54	0.11	0.461	0.00%
		11-Mar	9	94.68	131.17	0.89	2.187	87.50%	82.82%	9	89.91	71.85	0.11	0.525	0.00%
		11-Apr	6	213.63	121.44	1.17	2.055	71.43%	83.14%	6	210.08	66.07	0.5	0.488	33.33%
	FL	11-Feb	143	184.12	116.4	4.01	2.266	82.72%	83.86%	143	115.55	63.9	0.87	0.533	64.00%
		11-Mar	147	221.93	127.18	4.01	2.526	84.04%	84.08%	147	146.97	68.11	0.89	0.584	69.47%
		11-Apr	146	166.77	122.08	4.05	2.394	87.50%	84.19%	146	104.53	66.07	0.88	0.555	73.64%
TANF	FL	11-Feb	248	51.07	18.12	1.23	0.535	87.17%	87.53%	248	18.55	8.06	0.28	0.108	71.43%
		11-Mar	258	60	19.46	1.45	0.592	90.62%	87.61%	258	22.42	8.85	0.28	0.121	80.28%
		11-Apr	248	33.63	17.32	1.24	0.522	91.86%	88.26%	248	9.28	7.87	0.18	0.105	73.33%

## **G.14**

***Describe the process for accepting and managing provider inquiries, complaints, and requests for information that are received outside the provider grievance and appeal process.***

WellCare understands the importance of provider satisfaction and its impact on the quality of patient care. Accordingly, WellCare has a comprehensive process in place to respond to, track and monitor provider inquiries and complaints. Key elements of the process are accurate triage of provider inquiries and complaints, and timely, well-informed resolutions. When possible, provider complaints and inquiries are addressed immediately, while those requiring greater expertise and/or time are routed to the appropriate WellCare unit for follow-up and resolution. Following is a description of the provider complaint process WellCare will implement for the Louisiana CCN program.

A complaint is defined as a formal dispute by the provider regarding WellCare's policies, procedures, or any aspect of its administrative functions. Providers may submit complaints in writing or orally. Complaints must be submitted within 30 days of the occurrence giving rise to the complaint. WellCare encourages providers to informally resolve complaints.

For CCN, WellCare will operate a provider hotline, 7am to 7pm Central Time, Monday through Friday. The provider hotline will be staffed by trained customer service representatives (CSRs) armed with a wealth of information and resources to respond timely to provider inquiries and complaints. CSRs will also assist providers in filing formal complaints. CSRs will be backed-up by a provider resolution team of highly trained WellCare associates located in our Tampa office, available to take transferred calls regarding complex claims or other more involved provider issues.

Upon receipt of an inquiry or complaint, the CSR will assess the nature of the issue and determine how best to triage the call. The first priority for the CSR is to determine if he or she can resolve the inquiry/complaint immediately. Complaints regarding claims or billing are escalated to the provider resolution team and are resolved within 30 days from the date of receipt; however, the internal goal is to resolve such complaints within 10 days. Providers who have exhausted the complaint process and have a denied or underpaid claim have the option to utilize WellCare's claims dispute process. WellCare's claims dispute process is described in our response to Section Q.1.

During the complaint process, WellCare will collect all relevant information and thoroughly investigate each provider complaint. The following information is captured for each provider complaint: the provider name and ID, date, nature of complaint or inquiry, and resolution and date. WellCare regularly reviews data and generates reports for the purpose of identifying opportunities for improved service to providers. Reports will be submitted to DHH on a monthly basis.

As an example of our responsiveness in addressing provider complaints, we present WellCare's complaint resolution experience in Florida and Georgia in 2010 (Exhibit G.14.a – 2010 Complaint Statistics). The statistics demonstrate that the majority of complaints for both programs are resolved during the initial call.

WellCare's complaint process is described in the provider handbook.

**Exhibit G.14.a – 2010 Complaint Statistics**

**2010 Complaint Statistics**

	<b>Florida</b> 231,061 Provider Calls	<b>Georgia</b> 176,805 Provider Calls
Provider Complaints Logged*	106	23
Total Number of Claims Related Inquiries	96,981	97,378
Claims Issues Escalated (Real Time)	24,741 (25%)	12,751 (13%)
<b>Provider First Call Resolution</b>	<b>89%</b>	<b>90%</b>

\*Inquiries CSRs could not resolve real time or where claims issues qualified for transfer to PRT.

## G.15

**Describe in detail your proposed approach to providing non-emergency medical transportation (NEMT) services, including, at a minimum:**

- **What administrative functions, if any, you will subcontract to another entity;**
- **How you will determine the appropriate mode of transportation (other than fixed route) for a member;**
- **Your proposed approach to covering fixed route transportation;**
- **How you will ensure that pick-up and delivery standards are met by NEMT providers, including training, monitoring, and sanctions;**
- **How you will ensure that vehicles (initially and on an ongoing basis) meet vehicle standards, including inspections and other monitoring;**
- **Your approach to initial and ongoing driver training;**
- **How you will ensure that drivers meet initial and ongoing driver standards;**
- **Your NEMT quality assurance program (excluding vehicle inspection).**

### **General Approach**

Transportation is an integral component of access to care for our Medicaid members. Currently, through subcontractors, WellCare coordinates non-emergency medical transportation (NEMT) services for our Medicaid members in four states (Hawai'i, Illinois, New York, and Ohio). In each of these markets we ensure compliance with requirements regarding eligibility for NEMT, appropriate mode of transportation, use of fixed route transportation, pick-up and delivery standards, vehicle standards and inspections, credentialing of providers, including driver training, and a comprehensive quality assurance program.

If awarded a CCN contract, WellCare plans to contract with LogistiCare to provide NEMT services to our CCN members. LogistiCare is the recognized industry leader in providing NEMT services. LogistiCare currently contracts with MCOs and state governments to provide NEMT services in 35 states and the District of Columbia. As the most experienced NEMT full-risk broker in the country, LogistiCare performs 110,000 trips daily on a five-day per week basis and provides hospital discharge and urgent transportation 24/7/365 nationwide across areas as diverse as dense metropolitan areas to remote rural communities.

### **Subcontracted Functions**

The administrative functions that we will delegate to a vendor will include the recruitment and contracting of network transportation providers, credentialing of drivers, claims payment, customer service, reservations, dispatch, vehicle inspections, and transportation provider complaints.

While WellCare will delegate the authority to perform specific functions to our transportation vendor, we retain overall accountability for completion of the functions delegated. We are responsible for ensuring the vendor's compliance with our standards as well as contractual and federal and state regulatory standards. Oversight activities will include but are not limited to:

- Executing a written agreement with the transportation vendor that specifies the activities to be delegated and those to be retained by WellCare, including data reporting standards;
- Evaluating the vendor's ability to fulfill delegation obligations through review of the vendor's programs, policies, procedures and service delivery, including use and handling of protected health information;
- Performing ongoing performance monitoring via review of submitted data reports and ensuring that corrective action is taken in a timely manner to address any opportunities for improvement identified;
- Completing an annual formalized performance review and re-approving all applicable programs, including the vendor's quality assurance program; and
- Imposing sanctions or revoking delegation if the vendor's performance is inadequate.

Our vendor management process includes a monitoring process and holds vendors to high levels of accountability in order to improve overall member satisfaction and to ensure that contractual and regulatory standards are maintained.

### **Appropriate Mode of Transportation**

When a member/provider calls to request NEMT services, we (through our vendor) will first verify the member's Medicaid eligibility and enrollment in WellCare of Louisiana. If the individual is eligible for Medicaid and enrolled with our plan, we will determine the appropriateness of the request, including whether transport is to a covered medical service, whether free transportation is available to the member, and whether the provider is within reasonable proximity.

Once we determine the appropriateness of the request we will authorize the least costly, appropriate mode of transportation based on the member's medical condition and special needs. Modes of transportation will include public transportation, friends and family providers, multi-passenger van, sedan, wheelchair van, stretcher van, and ambulance (as medically necessary for non-emergency transport). In addition to mode of transportation, we will determine the level of assistance required (e.g., curb-to-curb, door-to-door, or door-through-door). The authorized mode of transportation and level of service will be included in the member's electronic file to assist with future requests.

### **Fixed Route Transportation**

We will develop a database with information on available public transit, including routes, stops, and schedules, and we will work with transit authorities to discuss opportunities for collaboration, including advance bulk purchase of tickets. We will distribute tickets, tokens or passes to members for whom public transit is available and appropriate.

Properly identifying those transportation requests that qualify for the public transit mode of transportation, based upon the rules established by/approved by DHH, is key to maximizing the use of public transportation. To determine the appropriateness of fixed-route public transit services for members, we will consider a number of factors, including travel time and a member's medical condition or special needs.

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## **Pick-up and Delivery Standards**

We will use a combination of training, monitoring, and performance metrics to make sure transportation providers are meeting applicable pick-up and delivery standards, including the RFP requirement that members arrive to their appointments on time, but not more than one hour before an appointment, and that members do not have to wait more than one hour after the conclusion of the appointment for transportation home. Drivers will be required to log pick-up and drop-off times, and this information will be compared to the scheduled pick-up and drop-off times to determine if standards are being met. We will also monitor member grievances to identify instances and trends. In addition, we will ride along on trips to observe pick-up and delivery times first hand. If a provider/driver is not meeting the pick-up and delivery standards, we will initiate corrective action while retaining the right to terminate any transportation provider not in compliance with applicable standards.

## **Vehicle Standards**

We will train providers regarding vehicle standards to ensure that safe, reliable, and quality vehicles will be available to safely transport members. We will conduct inspections according to appropriate levels of the Federal Motor Carrier Safety Administration's North American Standard Inspection requirements. Inspections will occur prior to beginning service and on an ongoing basis in order to ensure that operator fleets remain in compliance with specified vehicle requirements. The inspector will outline any deficiencies that need to be corrected and schedule a re-inspection within a set timeframe of the original inspection date. We will have a process in place to verify that the provider has corrected all deficiencies before a vehicle may return to service and ensure that all vehicles meet vehicle standards by utilizing identification and compliance data to track each provider and vehicle in the transportation network. We will also perform unannounced vehicle inspections and as needed in response to member comments, operational trending analysis, and/or in connection with a random vehicle inspection program at health care facilities as clients are dropped off for appointments.

## **Driver Training**

We will require all drivers to complete driver training, including defensive driving, safety, CPR and first aid before transporting any members. Drivers will be required to complete specified training modules every three years. Training will be provided through online courses; however drivers of wheelchair transport vehicles will be required to attend an in-person, hands on wheelchair securement class.

Online training courses are developed around the defensive driving curriculum of the National Safety Council, the Passenger Service and Safety (PASS) program developed by the Community Transportation Association of America (CTAA), and programs from other nationally recognized driver training organizations. This online training program will be made available to all network transportation providers at no cost.

The online training includes instruction in defensive driving techniques, securing wheelchairs and child safety seats, lift operation, passenger assistance techniques and general customer service. It is highly interactive and includes audio, text, video, graphics, examples, and knowledge checks to optimize knowledge retention and diverse learning styles. After taking this course, drivers will be familiar with our expectations and each driver will be equipped with the

knowledge and skills required to be safe, responsible and courteous. In addition, all providers will be trained on our policies and procedures, including state-specific requirements, before providing transportation.

### **Driver Standards**

We will require that all drivers meet initial and ongoing standards, including age, licensure, liability insurance, training, criminal history check, driving record, and compliance with federal and state laws. Drivers will also be required to comply with documentation requirements, including pick-up and drop-off points, trip mileage according to odometer readings, dates of transport, signatures, and any other information required by WellCare. In addition, drivers will be required to comply with behavior and safety requirements (e.g., being courteous, patient, and helpful to all passengers, refraining from smoking in the presence of any member, abstaining from the use of alcohol, narcotics, or drugs that would impair performance while providing NEMT services, and ensuring that passengers, including children, are properly secured).

We will monitor adherence to driver standards through our systems and through on-site and field observations. We will record information such as insurance details, coverage area, dates during which drivers were on active duty, and reasons for any termination or suspension of service, as well as extensive details, including renewal dates, for the various kinds of insurance we require of our drivers. We capture specific data about individual drivers, including information on driver identification, license status, training, screenings, and driving violations to prevent a transportation provider from being reimbursed for any trip provided by a driver not fully compliant and on active status.

### **Quality Assurance Program**

WellCare will have a comprehensive quality assurance program to ensure a high level of service for members. We believe that quality assurance is achieved by establishing performance standards and monitoring processes, implementing comprehensive policies and procedures to support the standards, regularly reviewing data pertaining to quality metrics, and fostering an organizational culture that recognizes and values the benefits that quality assurance brings.

Quality assurance activities will include scheduled and unscheduled visits to transportation provider's offices to review records and procedures, ride-alongs, accident and incident reporting, review of performance data, vehicle inspections, review and re-credentialing of drivers, review of member grievances, and member and transportation provider surveys. Also, we will develop a standardized provider report card that will be shared with transportation providers on a regular basis to help ensure quality.

Members will be able file grievances through WellCare's member services or via our vendor's customer service. In addition, health care facilities will be provided a web portal by the vendor for sharing any service-related concerns they may have. Our vendor maintains policies and procedures for receiving, tracking, resolving, and responding to verbal and written grievances in a timely manner. The policies and procedures ensure grievances are quickly and successfully resolved and that the necessary follow-up reporting is provided.

Member satisfaction and transportation provider surveys are also conducted. Transportation providers offer a valuable source of information about member satisfaction and how to resolve

member issues. We will work with transportation and health care providers to help identify member satisfaction issues, systemic operational issues, and opportunities for improvement.

Corrective action plans will be established as needed, and if a plan is not met, we will reduce volume to those providers or even remove them from the network. Based on the seriousness of the non-compliance, the provider may be suspended immediately from providing any trips pending an investigation of the circumstances. The result of the investigation could result in the provider being suspended until the provider achieves satisfactory compliance on the matter or termination from the network.

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INSERT TAB HERE  
Section H  
Utilization Management

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Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		<b>Section H: Utilization Management (UM) (Section § 8 of RFP)</b>	<b>80</b>		
<b>Section H Page 1</b>	<b>All</b>	<b>H.1</b> Describe how you will ensure that services are not arbitrarily or inappropriately denied or reduced in amount, duration or scope as specified in the Louisiana Medicaid State Plan.	<b>30</b>		
<b>Section H Page 4</b>	<b>All</b>	<b>H.2</b> If the UM guidelines were developed internally, describe the process by which they were developed and when they were developed or last revised.	<b>10</b>		
<b>Section H Page 5</b>	<b>All</b>	<b>H.3</b> Regarding your utilization management (UM) staff: <ul style="list-style-type: none"> <li>• Provide a detailed description of the training you provide your UM staff;</li> <li>• Describe any differences between your UM phone line and your provider services line;</li> <li>• If your UM phone line will handle both Louisiana CCN and non-Louisiana CCN calls, <ul style="list-style-type: none"> <li>○ explain how you will track CCN calls separately; and</li> <li>○ how you will ensure that applicable DHH timeframes for prior authorization decisions are met.</li> </ul> </li> </ul>	<b>20</b>		
<b>Section H Page 9</b>	<b>All</b>	<b>H.4</b> Describe how utilization data is gathered, analyzed, and reported. Include the process for monitoring and evaluating the utilization of services when a variance has been identified (both under- and over- utilization) in the utilization pattern of a provider and a member. Provide an example of how	<b>20</b>		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		your analysis of data resulted in successful interventions to alter unfavorable utilization patterns in the system. Individuals who will make medical necessity determinations must be identified if the criteria are based on the medical training, qualifications, and experience of the CCN medical director or other qualified and trained professionals			

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## Section H: Utilization Management

### H.1

***Describe how you will ensure that services are not arbitrarily or inappropriately denied or reduced in amount, duration or scope as specified in the Louisiana Medicaid State Plan.***

#### Overview

WellCare will ensure that services are not arbitrarily or inappropriately denied or reduced in amount, duration or scope as specified in the Louisiana Medicaid State Plan by:

- Having qualified and trained staff make utilization management (UM) decisions;
- Using established UM criteria that are objective, nationally recognized, and based on sound scientific medical evidence;
- Requiring that all denials be made by our medical director; and
- Conducting ongoing monitoring (auditing and testing) to ensure that UM staff are making consistent and accurate UM decisions.

#### Qualified and Trained UM Staff

We have a team of licensed physicians and nurses who are trained in the principles, procedures and standards of WellCare's UM program, and who perform UM activities in accordance with their scope of practice and position job description. Licensed nurses (registered nurses or licensed practical nurses) determine medical necessity for prior authorization and conduct concurrent review, discharge planning, and retrospective reviews. All medical necessity denial determinations are made by our medical directors, who are all board certified, licensed and credentialed physicians.

WellCare recruits highly qualified individuals with experience and expertise in UM or applicable related experience. Qualifications and educational requirements are delineated in the job descriptions for each respective position. Each new UM staff member is provided a minimum of two weeks of intensive hands-on orientation and training, and several weeks of on-the-job oversight with a staff preceptor. (Please see our response to Section H.3 for additional information on the training we provide our UM staff.)

WellCare supports continuing education and training for UM staff to maintain and increase skills and competency in performing UM functions. WellCare provides formal training, including seminars and workshops, to all UM staff on an annual basis to cover topics that include, but are not limited to, ICD-9 and CPT coding, UM criteria application, new clinical developments, and utilization management updates.

#### Established UM Criteria

WellCare uses UM criteria that are objective, nationally recognized, and based on sound scientific medical evidence. Network physicians with an unrestricted license as well as other licensed professionals with knowledge and/or clinical expertise in the area actively participate in the review, development, and adoption of all UM criteria. UM criteria are reviewed no less than annually.

WellCare's primary decision support tool is InterQual™ clinical guidelines for inpatient and outpatient services. McKesson's InterQual™ Review Manager is a leading evidence-based clinical decision tool that is nationally recognized, and based on sound scientific medical evidence. It offers easy access to InterQual™ criteria as well as extensive medical references, glossaries, and safety warnings. In addition to InterQual™ guidelines, WellCare uses proprietary clinical coverage guidelines (CCGs) developed internally to provide more detailed guidance on services that may be unique to our members or a new/emerging technology or service (see response to Section H.2 for additional information on our CCGs). Other resources utilized in concert with InterQual™ guidelines and CCGs include but are not limited to Hayes, Inc. Online™ (medical technology) and state Medicaid manuals.

In all of our Medicaid markets, we are required to provide covered services in an amount, duration, and scope that is not less than the amount, duration, and scope for the same services furnished under fee-for-service Medicaid. Therefore, we are very familiar with state Medicaid plans and manuals and incorporate these criteria into our UM processes to ensure that we are not providing services that are less in amount, duration, and scope than the applicable Medicaid fee-for-service program. For example, we have staff review all of a state's Medicaid coverage requirements and create a master list of benefits with applicable limits for our UM staff to use when reviewing authorization requests for Medicaid members from a particular state. We also develop our CCGs to take into account state Medicaid requirements.

WellCare's nurses and physicians use UM criteria as appropriate in all phases of the clinical review and decision-making process. WellCare's nurses and physicians document the UM criteria used to assist with each UM decision and apply the appropriate criteria based on a member's needs, age, co-morbidities, complications, progress of treatment, psychosocial situation and home environment, and assessment of the local delivery system.

When the established UM criteria are not appropriate to determine coverage or medical necessity, our nurses consult the medical director for consideration of the application of additional utilization criteria. The medical director may confer with other medical directors, board certified specialists, or other outside resources. For example, the medical director has access to the Medical Review Institute of America (MRIoA), which is a URAC-accredited and NCQA certified external review organization under contract to WellCare to provide independent review.

### **Auditing and Testing**

WellCare conducts ongoing auditing of clinical documentation and review decisions to ensure accurate and consistent application of applicable criteria according to established policies and procedures. WellCare monitors the appropriate application of UM criteria/guidelines, processing authorizations, and concurrent review and discharge planning documentation on an ongoing basis. If a UM staff member falls below the established performance standards, WellCare UM managers provide coaching and additional tools and training to assist the person in achieving the desired performance expectations.

WellCare also conducts inter-rater reliability (IRR) testing at least annually. IRR testing is a key process used by WellCare to ensure that licensed clinical staff apply UM criteria in a consistent manner. WellCare conducts IRR testing for medical directors and all UM staff involved in utilization decisions using a commercially available IRR program product from McKesson. The annual assessment ensures that all UM staff use the same criteria and information to conduct

reviews and that the same decision would be made among the reviewers based on the same circumstances.

An associate scoring less than 80 percent will receive additional focused training and be re-tested until the associate demonstrates adequate performance. WellCare most recently conducted assessments in August of 2010. The initial testing included 285 specific assessments, with a 96.5 percent pass rate. Twelve review associates were provided with focused training on the specific criteria sets they failed. Upon re-testing, all achieved a satisfactory passing score.

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## H.2

***If the UM guidelines were developed internally, describe the process by which they were developed and when they were developed or last revised.***

WellCare's primary decision support tool is InterQual™ clinical guidelines for inpatient and outpatient services. McKesson's InterQual™ Review Manager is a leading evidence-based clinical decision tool that is nationally recognized, and based on sound scientific, medical and/or behavioral health evidence.

In addition to InterQual™ guidelines, WellCare uses proprietary clinical coverage guidelines (CCGs) that are developed internally. WellCare's proprietary CCGs are developed to address specific clinical issues and medical services that are new or emerging, exhibit significant variation in utilization and practice patterns, or are not usually available as a covered benefit under Medicaid. Examples of current CCGs include guidelines for different types of breast pumps, chelation therapy, and tilt table testing.

Our corporate medical director or designee uses the following information sources in the development of a CCG: medical textbooks, evidence-based and peer-reviewed medical literature, physicians and other medical experts, Hayes, Inc. Online™ (medical technology), state-specific Medicaid manuals, and federal and state requirements. Once a draft CCG is developed it is subjected to a series of oversight and approval steps before it is adopted, including review by our Utilization Management Medical Advisory Committee (UMAC) and Quality Improvement Committee (QIC). CCGs are reviewed at least annually (12 months from effective date/revision date) and revised as necessary. CCGs are reviewed on a rotating calendar on the first and third Thursday of every month with a specific set of CCGs reviewed. The most recent review took place June 16, 2011, and previous to that date was June 2, 2011.

WellCare recognizes the importance of including providers in the development of UM criteria, including CCGs, and engages them in an active and ongoing way. In Louisiana, network providers will be included in the development and review of UM criteria, including CCGs, through the provider advisory councils (PACs), which we will establish, at a minimum, in each GSA. Empowering providers at the local level will allow for targeting and tailoring specific approaches according to local need. This collaborative approach will allow us to continually modify and improve our program to ensure maximum benefit to members and minimal administrative burden to providers.

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### H.3

#### **Regarding your utilization management (UM) staff:**

- **Provide a detailed description of the training you provide your UM staff;**
- **Describe any differences between your UM phone line and your provider services line;**
- **If your UM phone line will handle both Louisiana CCN and non-Louisiana CCN calls,**
  - **explain how you will track CCN calls separately; and**
  - **how you will ensure that applicable DHH timeframes for prior authorization decisions are met.**

#### **Training of UM Staff**

WellCare recruits highly qualified individuals with experience and expertise in UM or applicable related experience. Each new UM staff member is provided a minimum of two (2) weeks intensive hands-on orientation and several weeks of on-the-job oversight with a staff preceptor. The following topics are covered during the program:

- New employee orientation;
- Use of technical equipment (phones, computers, printers, facsimile machines);
- UM Plan, policies and procedures, and standard operating procedures;
- MIS data entry;
- Application of UM criteria/guidelines, including coverage requirements for each state's Medicaid program;
- Requirements for clinical documentation; and
- Regulatory requirements including but not limited to HIPAA.

WellCare supports continuing education and training for UM staff to maintain and increase skills and competency in performing UM functions. WellCare provides formal training, including seminars and workshops, for all UM staff on an annual basis to cover topics that include, but are not limited to, ICD-9 and CPT coding, UM criteria application, and case and utilization management updates. We also offer updates on various clinical topics and courses that meet continuing education requirements for license renewal.

Communication, coaching, and mentoring occur on an ongoing basis. In addition, we continuously monitor the application of UM criteria/guidelines, the processing of service authorizations, and documentation. If a UM staff member falls below the established performance standards, WellCare UM managers provide coaching and additional tools and training to assist the person achieve the desired performance expectations. We have four UM staff members who are InterQual™ Certified Instructors. This provides us on-site resources to answer any questions and to provide on the spot training in addition to the annual update training when new InterQual™ guidelines are released.

WellCare conducts inter-rater reliability (IRR) testing at least annually. WellCare conducts IRR testing for medical directors and all UM staff involved in utilization decisions using a commercially available IRR program product from McKesson. An associate scoring less than 80

percent is provided with focused training, and re-tested until the associate demonstrates competency and understanding of the use and application of InterQual™ criteria by achieving a satisfactory score.

### **Differences between UM Phone Line and Provider Services Line**

As discussed in response to Section L.1, WellCare proposes to operate one toll-free member services/provider services line (call center) for Louisiana Medicaid. Calls will be answered by an automated attendant and callers will be given a menu of options, including the option to route the call to either member or provider services. The options for provider services will include prompts to verify the status of authorizations and to request an authorization. If the provider selects to verify the status of an authorization, the provider is connected to a customer services representative (CSR) who has access to online information regarding the status of authorization requests. (Providers can also access this information online through our website.)

If the provider selects the option for requesting an authorization, the provider is connected directly to the health services intake department, which is the entry point for all UM requests. Although providers generally submit requests for routine service authorizations through a fax or web submission process, they are encouraged to call Health Services for urgent requests, to ask about the UM process, or to discuss particular cases/UM decisions. In addition to selecting the appropriate option from the main menu, providers may be transferred to the health services intake department by first speaking with a customer service representative (CSR) who can identify the correct department in Health Services to meet the provider's need. Health services intake may transfer provider calls to a clinical department to answer questions about specific UM criteria, discuss clinical requirements for authorization, or exchange clinical information about a specific case under review.

### Routing Calls

Calls to provider services are handled by CSRs. Calls to Health Services are initially handled by non-clinical intake coordinators who determine the nature of the request, prioritize the request, verify member eligibility, identify the UM criteria for the service requested, and obtain the appropriate UM decision information to make a decision based on the UM criteria. All persons answering calls can perform intake of authorization requests and answer questions on the UM process, specific UM requirements, or UM procedures. Depending on state requirements, the intake coordinator can immediately approve some requests that do not require a clinical decision using the rules outlined in job aids and decision support tools available to them. Licensed health professionals are available to intake coordinators for questions and guidance during the intake process.

If a phone request requires clinical review, the intake coordinator forwards the documentation electronically and does a warm transfer of the call to a UM nurse. The UM nurse conducts a review of the request and may consult with and/or escalate any issues to a medical director. For phone requests, once an authorization request is approved, authorization specifics are provided to the requestor at the time of the call.

In order to support call routing and escalation, intake coordinators have online access to an authorization authority matrix to identify which requests require clinical review, instructions on transferring calls during business hours, and an on-call resource calendar (for after hours calls).

They will also have access to the *My Family Navigator* database, which will be a searchable database of community resources that exist in Louisiana (e.g., for calls seeking non-covered services) (see our response to Section F.7 for additional information on the *My Family Navigator* database and HealthConnections).

### Communication

The process for handling calls from individuals with Limited English Proficiency and persons who are hearing impaired is the same for both calls to provider services and Health Services. We have intake coordinators and UM nurses who are bilingual in English and Spanish. UM staff use our phone translator vendor to communicate with members with Limited English Proficiency, and UM staff use TTY/TDD devices to communicate with members who are hearing and/or speech impaired.

### Monitoring Quality and Accuracy of Information

Similar to calls to provider services, Health Services has a process for ensuring the quality and accuracy of information provided by UM staff. In order to ensure the quality and accuracy of information provided by intake coordinators, we record and audit calls and audit the accuracy of data entry for faxed requests. The metrics for quality and accuracy include, as applicable, greeting, member enrollment verification, collection of appropriate information, identification of correct UM criteria, communication and professionalism, issue resolution, wrap-up, and documentation. We do not currently record calls with UM nurses, but we plan to do so in the near future with the installation of a new telecom system in late 2011. We currently monitor the quality and accuracy of information provided by UM nurses through regular auditing of clinical documentation and review decisions.

### Monitoring to Ensure Adherence to Performance Standards

We use the same monitoring process for ensuring adherence to performance standards for calls to both provider services and Health Services. During normal business hours, an e-mail is sent out hourly by WellCare's command center to various departments, including supervisors, managers and directors in Health Services indicating the service level, average speed to answer, and abandonment rate for that day for each state's call queues. This information is also provided in daily and monthly reports and can also be reported on an ad hoc basis. If the department goal is not met, the director will determine why the goal was not met and implement appropriate changes to achieve our performance goals. As necessary a corrective action plan is initiated to bring telephone statistics up to our standards, which are equal to or exceed DHH's requirements.

### After Hours Procedures

During non-business hours, our call center's automated attendant provides callers with operating hours and other information. Providers can utilize the automated attendant 24 hours a day, seven days a week to verify eligibility, check claim status, and check authorizations status. After hours, the automated attendant includes a prompt that connects providers to the health services intake department. Our intake coordinators answer calls 24 hours per day, seven days a week and transfer calls to the on-call nurse manager and/or medical director as needed, including any requests that require a clinical review. This after-hours option is generally used by

providers for inpatient notifications and discharge planning but can also be used for urgent requests.

### **Tracking CCN Calls Separately and Meeting DHH Time frames**

As noted above, WellCare will have a dedicated toll-free number for member/provider services for Louisiana Medicaid, and we will track Louisiana CCN calls separately from our other lines of business. We also track calls that are routed to different queues, including calls to and within Health Services (e.g., calls transferred to a prior authorization nurse).

We have systems in place to ensure prior authorization decisions meet the time frames specified by each of our contracts. For example, for the CCN program, this will include making 80 percent of standard service authorization determinations within two business days of obtaining appropriate medical information. All requests are tracked from the time of receipt until the response is provided to the provider, and a report is sent twice daily to UM managers indicating the status and age of each pending authorization. For fax and web requests, managers can view pending authorizations to ensure each is handled within the timeframes specified in the contract. As necessary, we will implement action plans to improve performance. For example, in 2010 we addressed concerns regarding prior authorization timeliness by: (1) undertaking focused training with nurse and physician reviewers; (2) implementing a new reporting/auditing initiative to monitor decision turnaround times; and (3) developing an online authorization application allowing PCPs to view the status of all authorization requests for their member panel.

#### H.4

**Describe how utilization data is gathered, analyzed, and reported. Include the process for monitoring and evaluating the utilization of services when a variance has been identified (both under- and over- utilization) in the utilization pattern of a provider and a member. Provide an example of how your analysis of data resulted in successful interventions to alter unfavorable utilization patterns in the system.**

#### **Monitoring Under- and Over-Utilization**

WellCare monitors and analyzes data to determine both under- and over-utilization and institutes corrective action for the provider and/or company to correct any patterns of potential or actual under- or over-utilization. Our tools for monitoring under- and over-utilization include:

- Inpatient daily census
- Monthly inpatient utilization reports
- Physician profiling
- Medical record review

#### Inpatient Daily Census

We monitor the inpatient daily census report for hospitals and post-acute care facilities for appropriateness of admission and length of stay, re-admissions, quality of care issues, unexpected complications, and/or unexpected deaths. The report is also reviewed to facilitate timely and appropriate discharge planning. Our medical director communicates with the concurrent review staff and contacts members' PCPs to address any issues arising out of the review. Quality of care issues are referred to quality improvement (QI) for further investigation.

#### Monthly Inpatient Utilization Reports

We produce utilization summary reports monthly for each line of business. The report contains several measures including, but not limited to, admits per thousand by type (medical/surgical, deliveries, neonatal intensive care unit (NICU), psychiatric), days per thousand by type, Cesarean-section rate, NICU average length of stay (ALOS), mid rate, catastrophic rate, re-admit rate, and membership comparison. We compare these measures to established goals and data.

Our medical director collaborates with other WellCare staff to identify thresholds to trigger further investigation of potential over-, under-, or inappropriate utilization. If our medical director identifies a pattern of over-, under-, or inappropriate utilization, he or she may direct the UM department to conduct an expedited study for the purpose of collecting any additional information considered necessary for planning corrective actions. If the problem appears to be within WellCare's control (e.g., unclear clinical guidelines or staff training issue), our medical director submits written recommendations to the relevant department head for follow-up. This may include recommendations for quality improvement through modification of WellCare's policies and procedures or UM criteria, or additional clinical staff training. It also may include the development of new case management guidelines based on specific patterns evidenced in a particular population or condition.

If the problem is isolated to a particular provider, or small group of providers, our medical director communicates directly with the provider(s). Further action may then be taken by the QIC, as appropriate. If the issue is specific to particular members, the case manager(s) will intervene with the members.

Utilization data is reported to WellCare's UMAC and QIC for review and discussion. The QIC recommends interventions when a trend is identified and monitors the efficacy of intervention taken in order to help ensure appropriate utilization.

### Provider Profiling

As described in response to Section G.13, we prepare and review provider profiling reports as a part of our data analysis efforts. The reports contain the following measures:

- Administrative HEDIS measurements;
- Emergency department (ED) utilization; and
- Prescription drug utilization.

In addition, for Louisiana, we will prepare risk adjusted reports with the following measures:

- Primary care;
- Specialty physician;
- ED utilization; and
- Hospital utilization.

Providers who demonstrate low performance on any of the profile reports will initially be targeted for counseling from a peer on the applicable provider advisory council (PAC) accompanied, when appropriate, by a provider relations representative. Providers who fail to improve will be referred for a targeted medical record review and quality improvement (QI) intervention (please see our response to Section G.13 for additional information on the corrective action process).

### Medical Record Review

All records reviewed as part of our medical record review process are reviewed for under- and over-utilization. Areas of concern are identified to the physician and office. Areas of under- and over-utilization with related quality issues are referred to the medical director for the peer review process.

## **Examples of Successful Intervention**

### Reduction in Re-admissions

In 2009 we launched a pilot program in Florida to reduce the overall re-admission rate by focusing on a group of high risk members who had a history of multiple admissions. The initiative involved retraining staff to increase member engagement in case management activities, aggressive discharge planning and post-discharge follow up, trending of most

frequent barriers to care, and reporting outcomes, including overall inpatient admissions and days, re-admission rates, and case management program outcomes.

In 2010, the positive impact of the pilot became evident. The pilot identified the value of immediate post-discharge interventions by a multi-disciplinary team, including both telephone and face-to-face encounters. Due to the success of the pilot, we are expanding this strategy for re-admission prevention by introducing transitional care management (TCM) in all markets during 2011. The TCM program will include specialized staff who will perform pre-discharge interviews with high risk members to identify gaps in care, and post-discharge follow up with high risk members within 24-72 hours of discharge. TCM nurses will provide support, interventions, referrals and care coordination to assure that members are stabilized in their home environments after discharge.

### Reduction in Inappropriate Use of the Emergency Department

In Georgia we have had success reducing inappropriate utilization of emergent services with our ED telephonic outreach program. A member outreach associate contacts a member who has had an ED visit within 48 hours of the visit (as identified through daily ED reports from participating hospitals) to identify the reason for the visit and to offer education about appropriate use of EDs and alternatives available to members. The outreach associate uses a database that contains questions for the member about key aspects of the ED visit. Information gathered from the member includes: the reason for the ED visit; whether the member knows the name of his or her PCP; whether the member needs a listing of urgent care centers, information about our medical advice line, or assistance with transportation; and whether the member sent home from the ED with medication.

Analysis by month indicates a downward trend in average (mean) number of ED visits following outreach education. Our analysis of this program has found the following:

- A downward trend in average (mean) number of ED visits following outreach education.
- An upward trend in the average (mean) number of office visits following education.
- Educational outreach appears to have a more immediate impact on the overall number of ED visits than on office visit frequency.

### Increase in Use of Appropriate Asthma Medications

A recent WellCare example of a successful intervention to alter unfavorable utilization patterns is related to asthma. In conjunction with the 2009 HEDIS measure: Use of Appropriate Medications for People with Asthma, WellCare sorted patients via their inhaled corticosteroid (ICS) use. Letters suggesting the additional maintenance ICS therapy were sent to the providers of members who did not have prescriptions filled for an ICS. Letters were also sent to providers of members who had consistent ICS therapy; these letters suggested to the providers that they increase the dose of the members' ICS or add a long-acting beta agonist. Providers of members who did not consistently have prescriptions filled for ICS inhalers received letters notifying them of the members' potential non-compliance. Based on a subsequent analysis of claims data we found that 28 percent of the members for whom WellCare suggested the addition of maintenance ICS therapy had ICS added.

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Section I

EPSDT

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Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		<b>Section I: EPSDT(Section § 6 of RFP)</b>	<b>25</b>		
<b>Section I Page 1</b>	<b>All</b>	<b>I.1</b> Describe your system for tracking each member’s screening, diagnosis, and treatment including, at minimum, the components of the system, the key features of each component, the use of technology, and the data sources for populating the system.	<b>5</b>		
<b>Section I Page 4</b>	<b>All</b>	<b>I.2</b> Describe your approach to member education and outreach regarding EPSDT including the use of the tracking system described in I.1 above and any innovative/non-traditional mechanisms. Include: <ul style="list-style-type: none"> <li>• How you will conduct member education and outreach regarding EPSDT including any innovative/non-traditional methods that go beyond the standard methods;</li> <li>• How you will work with members to improve compliance with the periodicity schedule, including how you will motivate parents/members and what steps you will take to identify and reach out to members (or their parents) who have missed screening appointments (highlighting any innovative/non-traditional approaches); and</li> </ul> How you will design and monitor your education and outreach program to ensure compliance with the RFP.	<b>10</b>		
<b>Section I Page 8</b>	<b>All</b>	<b>I.3</b> Describe your approach to ensuring that providers deliver and document all required components of EPSDT	<b>5</b>		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		screening.			
Section I Page 10	All	<b>I.4</b> Describe how you will ensure that needs identified in a screening are met with timely and appropriate services.	5		

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## Section I: EPSDT

### I.1

***Describe your system for tracking each member's screening, diagnosis, and treatment including, at minimum, the components of the system, the key features of each component, the use of technology, and the data sources for populating the system.***

WellCare is highly invested in ensuring that the children we serve receive timely and appropriate health screening, preventative care and necessary treatment. Our Early Periodic Screening Diagnosis and Treatment (EPSDT) program is focused on educating and promoting EPSDT services through parents and caregivers, providers, community partners and data systems.

WellCare currently employs a set of EPSDT solutions which are based on defined administrative protocols, leverage multiple sources of encounter and other clinical data, and are administered under the provisions of our quality assessment and performance improvement (QAPI) program. The tracking system can be expanded as necessary to accommodate market specific nuances.

### **Components of the System**

WellCare currently employs multiple applications from its integrated information systems suite for tracking each member's screening, diagnosis, and treatment. These include the core processing system (CPS) for member claims and benefit information; the quality reporting system using McKesson's CareEnhance Resource Management Software (CRMS) to provide an integrated clinical and financial view of care delivery to measure and improve performance; and the enterprise data warehouse for access to claims, encounter, immunization, pharmacy, and related clinical information.

WellCare's CPS, based on the Dell Services Xcelys platform is the system of record for WellCare's member, provider, claim, benefit, and reporting functions. CPS provides eligibility and benefit information for all active members. CPS includes a rules-based periodicity letter generation application that identifies members due for periodic clinical services, including EPSDT services, and provides customer service representatives with visibility into HEDIS specific EPSDT information.

WellCare's clinical performance measurement and improvement efforts are supported by our HEDIS system, McKesson's CareEnhance Resource Management Software (CRMS), version 5.73, which provides an integrated clinical and financial view of care delivery. CRMS is an application that streamlines the complex HEDIS reporting process by centralizing existing claims, membership, medical records and other narrative information the user selects, to create a single source of clean data. CRMS is used to report HEDIS measures and aggregates the clinical information from multiple sources, both internal to WellCare's information suite and external, such as state immunization databases. CRMS and related processes support the identification of care gaps that are driven by HEDIS measures and generate provider profile reports. The data sources used to support HEDIS reporting are also used for tracking each member's screening, diagnosis and treatment.

WellCare's assessment, planning and coordination functions are supported by our Enterprise Medical Management Application (EMMA). EMMA provides the foundation for the development

of a customized case management and care coordination system to provide patient-centered case management and care coordination services to our members.

WellCare's enterprise data warehouse contains member, claim, and encounter data for all of our members. This includes Medicare and Medicaid membership, professional and institutional claims, pharmacy, dental, vision, and lab data as available. The enterprise data warehouse is used as a source for internal data necessary for CRMS and related processing.

### **Use of Technology**

WellCare uses the integrated information systems suite to track EPSDT services through the integration of claims data and quality improvement reporting information, including care gap identification. These systems are utilized to notify members of needed EPSDT services, alert customer service representatives to HEDIS care gaps and missing HEDIS specific EPSDT services, inform PCPs of missing HEDIS services for their members, and inform PCPs of their quality performance relative to their peers and industry benchmarks.

On a monthly basis, WellCare will consult with the Louisiana Immunization Network for Kids (LINKS) to determine which EPSDT eligible members received immunizations. This list of members, in addition to claims and encounters in the data warehouse, will be used to identify those members who have not followed up with an EPSDT appointment. Parents of members who have not followed up will be sent a letter to inform them that their children are due to see a PCP. The following month, the membership list will be run through the claims and encounters in the data warehouse again to determine if they have been seen. Parents of members who still have not been seen will receive outreach to assist them with making an appointment. These members will be tracked in a database to ensure follow-up.

For dental visits, WellCare will, on a monthly basis, identify EPSDT eligible members who are eligible for a dental visit through data available from DHH. Parents whose children have not had a dental visit will be sent a letter to inform them of the importance of dental care and oral health for their children. Data will be re-examined the following month and outreach conducted for children who have not accessed dental care.

As a corporate initiative, WellCare has undertaken a program of outreach calls to parents to facilitate primary care for their children and targeted provider notification of children in need of screenings.

### **Outreach Calls to Parents**

We will review care gap reports and compare utilization and paid claims/encounter data to EPSDT periodicity schedules for children turning 12 months of age who have missed two or more EPSDT visits. WellCare will initiate telephonic outreach calls to the parents/guardians of these children to educate them on the importance of scheduling the next visit, identify any barriers to care (e.g., transportation) that need to be addressed and will schedule the appointment whenever possible.

### **Outreach to Providers**

WellCare works with providers to maintain adherence to guidelines and increase HEDIS results in all of our programs. Through review and analysis of claims/encounter data and medical

record review, we measure provider performance and target those providers who have low HEDIS rates and/or unsatisfactory adherence to the guidelines.

In addition, providers are educated on the importance of following the EPSDT schedule for immunizations through provider newsletters, WellCare's provider website, and during on-site visits by provider relations representatives. Our goal is 100 percent adherence across all providers.

Ensuring that children who lack immunizations are identified and immunized, as soon as possible is a high priority for WellCare. WellCare understands that many Louisiana children receive their immunizations at local health departments. Beyond stressing provider adherence to guidelines for preventive care, as part of our clinical initiative to increase vaccination coverage for children across Louisiana, we will invite local health departments to join our network. We will reimburse the clinics for the cost of immunizations, whether or not they elect to become network providers. We also will take steps to avoid unnecessary immunizations by accessing the LINKS system to verify immunization status.

### **Provider Pay for Performance Quality Incentive (P4Q) Programs**

Aligning incentives with our provider partners is a core component of our strategy to improve our HEDIS scores. Providers who demonstrate continued significant performance improvements are recognized through our pay for performance quality incentive (P4Q) programs. Our current P4Q program models take the form of either measure threshold programs, where WellCare rewards PCPs (or IPAs or other medical groups) for achieving target rates for certain HEDIS measures for the members assigned to their panels, or bonus-for-service programs, where WellCare rewards providers with an additional bonus for providing (or arranging to provide) a specified service that is aligned with a particular HEDIS measure. We have experience operating P4Q programs in all seven of our current Medicaid states and plan to develop a physician incentive model that is appropriate for Louisiana (see our response to Section S.1).

Our P4Q programs focus on mainstream HEDIS measures of health care quality and access for a Medicaid population, such as:

- Adolescent well care visits
- Lead screening for children
- Childhood immunizations
- Use of appropriate medications for people with asthma
- Well child visits (15 months 6 + visits)
- Well child visits (ages 3 – 6).

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## 1.2

**Describe your approach to member education and outreach regarding EPSDT including the use of the tracking system described in 1.1 above and any innovative/non-traditional mechanisms. Include:**

- **How you will conduct member education and outreach regarding EPSDT including any innovative/non-traditional methods that go beyond the standard methods;**
- **How you will work with members to improve compliance with the periodicity schedule, including how you will motivate parents/members and what steps you will take to identify and reach out to members (or their parents) who have missed screening appointments (highlighting any innovative/non-traditional approaches); and**
- **How you will design and monitor your education and outreach program to ensure compliance with the RFP.**

### **Member Outreach and Education**

WellCare uses a combination of written, web-based material, telephone contacts, and face-to-face encounters to provide critical information to members regarding EPSDT services at the time of enrollment and throughout their enrollment with WellCare. The importance of health screens and follow-up treatment is emphasized, and the EPSDT program is explained. Instructions are given as to how members can obtain preventive and expanded services and the role of the PCP. WellCare continues to reach out to members throughout enrollment to reinforce the need for well-child care and to assist members in obtaining these services. Key informational and outreach activities include:

#### Enrollment and Orientation

Enrollment and initial orientation is WellCare's first opportunity to educate members and about the importance of preventive care. WellCare staff has a thorough understanding of the EPSDT program and the importance of encouraging participation. Our enrollment checklist ensures that this topic is covered in all enrollment and orientation presentations. New member packets will include a member health status self-assessment form to help identify children's current immunization and check-up status. New members also will receive a welcome call to introduce WellCare, encourage participation in preventive programs, make sure the member understands the PCP concept and how to contact the PCP, and to answer any questions the member may have.

#### Initial PCP Visit Scheduling

WellCare encourages members to schedule a visit with a PCP upon enrollment. Members will be sent a letter if they have not been seen within 45 days of enrolling in WellCare. The letter will outline the preventive services recommended at the appropriate age and will inform members to access these services through their PCP at no cost. WellCare will facilitate coordination of appointments for care and will follow up with families with EPSDT eligible children who have failed to access EPSDT screens and services after 120 days of enrollment. WellCare also will provide a monthly list to each PCP of the provider's EPSDT eligible children who have not had an encounter during the initial 120 days of enrollment. WellCare outreach staff and/or the PCP will contact the member's parents or guardians to schedule an appointment.

Outreach	Timeframe	Topic
Welcome Call	Upon enrollment	Orientation to EPSDT benefit
Letter Mailed	45 days after enrollment	Recommended preventive services
Additional Outreach	120 days after enrollment	Provide assistance scheduling an appointment

## Improving Compliance with Periodicity Schedules

### Overdue for Visit Report

The medical home plays an important role in member education. WellCare's medical homes are encouraged to reach out to members and stress the importance of EPSDT visits. PCPs also will be provided with a member Overdue for Visit list on a monthly basis. This list will identify members in the patient panel who are past due for their next preventive visit as recommended under EPSDT or adult preventive health guidelines. The intent of furnishing the list is to assist providers in identifying and contacting patients who are past due to schedule an appointment. Provider performance in reducing Overdue for Visit patient counts will be tracked and evaluated as part of WellCare's broader EPSDT tracking and profiling activities.

### Targeted Member Materials

WellCare's Member Handbook is our key written means of informing all new members about EPSDT services. All written materials will be available in alternative formats and in a manner that takes into consideration members' special needs. Member materials will be available upon request in Spanish and Vietnamese and any other languages required by DHH or based on the needs of the members we serve. Interpreter services will be provided as needed for all languages.

WellCare will provide written notification to its families with EPSDT eligible children when appropriate periodic assessments or recommended services are due. Members are sent a periodicity letter in their birthday month, regardless of whether they have been seen, that outlines the preventive services recommended at the appropriate age according to the Preventive Care Guidelines of the U.S. Preventive Services Task Force and the American Academy of Pediatrics.

### Customer Service Proactive Member Counseling

WellCare's call center plays an important role in providing information on EPSDT to our members. Each time a member calls with an issue involving a child, our representative has an opportunity to reinforce the member's understanding of the importance of well-child care and the services available through EPSDT. Customer service representatives will employ advanced technology, including our HEDIS care gap software, which enables CSRs to retrieve member records and instantly identify missed preventive care while the member is on the line. Once the HEDIS care gap is identified, the CSR will educate the parent/guardian about the need for preventive services, including well child visits, immunizations, lead screening and other important preventive services. The CSR will encourage the parent/guardian to allow them to

assist in scheduling an appointment with their primary care provider via a three-way teleconference. The parent/guardian will receive a reminder call of the appointment as appropriate. If the member has transportation issues, the customer service representative will assist in making necessary arrangements.

WellCare also supports provider efforts through the HEDIS care gap alert feature in our call centers; any time a member contacts the call center, our customer service representative (CSR) is able to access a screen with information on past due preventive visits and assist in scheduling the visit while the member is on the line. The CSR will deliver the care gap message during the call to help educate the member on potential missing annual visits. In addition, the CSR will offer to help set up the appointment with their provider and execute a three way call with the member and provider to set up the appointment. Customer service representatives will capture details of each call in our system providing us with the ability to produce electronic records that document synopses of all calls.

### **Community Partner Collaboration**

Community outreach staff located in Louisiana will be available to make home visits to members who, due to disability, lack of transportation, or other barriers, have difficulty accessing their PCPs. These locally based staff also will be responsible for developing community collaborations to encourage the use of routine, preventive care. For example, Community Service Center staff will contact local school-based health centers and facilitate linkages with local PCPs to promote information sharing and joint efforts to encourage the use of EPSDT services.

Community outreach activities further support provider efforts to improve EPSDT rates as well. Outreach staff will support providers by interfacing directly with non-compliant members and helping members overcome barriers to accessing regular care for their children.

### **Targeted Interventions**

WellCare will implement several targeted clinical and administrative interventions to improve outcomes for members receiving these critical services, including:

- Telephonic outreach to educate the parent or guardian of the child on the importance of well child visits, immunizations and lead screenings;
- Providing assistance with scheduling visits, including through initiation of three-way calls with the provider's office;
- Following-up with reminder calls about upcoming appointments; and
- Educating new mothers about the importance of scheduling their postpartum appointment and their baby's well child visit, including childhood immunizations, which will include assistance with appointment setting both for herself and her newborn baby.

### **Program Design and Compliance**

WellCare approaches the design of EPSDT programs for each market with the improvement goals of the applicable state Medicaid agency as its guiding principle. We utilize our existing program structure, which incorporates all required NCQA/HEDIS elements for design, and build upon that infrastructure to further incorporate all state specific requirements. During

implementation planning, our Compliance department will map all CCN contract requirements related to EPSDT into our Compliance 360 compliance tracking platform. Each provision is then assigned to the defined area subject matter experts with implementation oversight for this contract category. In this instance, department heads for Health Services, Quality Improvement, Network Management, and Customer Service will all be identified in the system as having the oversight responsibility for: (1) reviewing contract provisions on EPSDT; (2) revising current methods or developing new protocols for compliance; (3) implementing the protocols; (4) conducting the post evaluation activities to measure effectiveness and amend program functions as necessary based on outcomes; and (5) providing attestation information into Compliance 360, proofing the overall compliance with CCN-P contract requirements for the design and implementation of EPSDT outreach programs, and monitoring protocols to ensure continued compliance.

WellCare's Louisiana Quality Improvement Committee (QIC) is the primary body that provides global oversight of the EPSDT outreach and education program in Louisiana. Through the QAPI program, defined roles are established for each functional area of the organization tasked with some element of EPSDT tracking, outreach and improvement. Annual QIC work plans will incorporate defined activities tied to some form of EPSDT improvement. Evaluations of work plan activities (effectiveness, compliance with DHH requirements, etc.) will be conducted at defined periods established under the QAPI program and work plan. These activities will also be monitored via Compliance 360.

Quality improvement projects are used in the QAPI program as the tools to be utilized to formally initiate improvement opportunities related to clinical measures. In conjunction with Compliance 360, WellCare will develop quality improvement projects for EPSDT to drive for lasting improvements within our enrolled population.

### **I.3**

#### ***Describe your approach to ensuring that providers deliver and document all required components of EPSDT screening.***

WellCare's network providers receive initial and on-going training regarding the importance of a thorough EPSDT screening and documentation. WellCare's EPSDT program policy requires that each provider complete the following elements and document the same in the member's medical record:

- Comprehensive health history;
- Developmental history;
- Unclothed physical exam (as appropriate for the child's age and health history);
- Vision, hearing and dental screening;
- Nutritional assessment;
- Appropriate immunizations;
- Health education and guidance; and
- Appropriate lab testing including mandatory lead screening.

In addition to ongoing education about the importance of the program, as previously described, WellCare distributes monthly notices to providers about members who are not in compliance with periodicity schedules as described below.

#### **Monitoring and Improving Provider Compliance**

WellCare collects data on EPSDT through analysis of regular claims and encounter data and uses this data to monitor provider performance and implement additional provider interventions to improve compliance. Providers are given monthly reports that show specifically which members are not in compliance with recommended preventive care guidelines. Providers and WellCare outreach staff then will encourage parents to bring children in for required screens. As mentioned earlier, WellCare may make enhanced payments to providers to encourage them to assist in facilitating appointments for children who are overdue for screens or immunizations.

WellCare also monitors provider compliance with screening requirements through medical chart audits. These audits are conducted annually. Individual PCPs who do not meet the threshold for standards of clinical preventive pediatric care are notified and a corrective action plan is developed. Information from the chart audits also is used as part of the routine annual quality improvement planning process.

#### **Provider Outreach with HEDIS Rate Profile and Overdue for Visit Reports**

PCPs play the central role in ensuring that our members receive all necessary preventive and primary care services and that members are referred as appropriate to specialists and other providers. WellCare profiles all PCPs and medical groups to verify these responsibilities are met. Our profile reports compare providers' compliance rates to those of their peers and to the annual HEDIS National Medicaid 75th percentiles (or other targets) for the top tier HEDIS measures selected. We typically prepare our profile reports on a monthly basis and leverage our market provider relations representatives to disseminate them to our key providers.

We also produce and share with providers our Overdue for Visit Reports. These reports are produced at the PCP-level and identify members in the patient panel who are not compliant with specific HEDIS measures. The list will identify members in the patient panel who are past due for their next preventive visit as recommended under EPSDT or adult preventive health guidelines. The intent of furnishing the list is to assist providers in identifying and contacting members who are past due to schedule an appointment. Provider performance in reducing Overdue for Visit patient counts will be tracked and evaluated as part of WellCare's broader profiling activities. Provider relations representatives will review opportunities to further reduce overdue visits during regularly scheduled visits with high volume providers.

#### **I.4**

***Describe how you will ensure that needs identified in a screening are met with timely and appropriate services.***

Treatment is one of the most important and often overlooked elements in the design of an EPSDT program. WellCare's EPSDT approach addresses treatment as an integral part of the screening and detection process.

#### **Medical Homes**

Closing the loop and ensuring that recommended services are rendered is a key value of the medical home concept. Medical home providers will be responsible for following up with members and referral providers to determine that the services a child needs are provided. If the medical home identifies a member who is in need of a higher level of assistance coordinating services; the provider will refer the member to WellCare case management for further assessment. WellCare's case management staff will work with the member and family to ensure that all necessary treatment is accessed in a timely and appropriate way.

#### **Use of Data**

WellCare uses modifier codes for billing purposes that can also be used to monitor whether required treatment is delivered timely. We will utilize claims data to determine if treatment is provided in the following way:

- Review claims for any modifier code indicating that an EPSDT service was delivered and follow-up is required;
- Review claims data the following month to determine if the follow-up care or service was delivered as necessary; and
- Engage provider relations representatives to address providers that do not arrange and deliver the required treatment in a timely manner.

#### **Medical Record Audits**

As in our existing Medicaid markets, medical record reviews will be conducted using a quality-focused medical records evaluation tool to assess compliance with established standards of care and elements of documentation required by regulatory statutes, oversight agencies and accreditation organizations. Upon completion of the review, a summary of findings will be created and shared with the provider and a written acknowledgement obtained.

If, upon review, a provider's overall results are below 80 percent, an additional sample of records may be selected for review. A corrective action plan (CAP) will be required if the score from the initial review process and/or composite score from the initial and the additional review sample are below 80 percent overall. Improvements called for under the CAP will be monitored and the provider will be assisted in addressing any remaining deficiency area before the scheduled re-audit. Remediation is dependent upon the deficiencies, but could include additional training by provider relations representatives, limitations on panel size until deficiency is corrected, and peer review.

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INSERT TAB HERE  
Section J  
Quality Management

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Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		<b>Section J: Quality Management (Section 14 of RFP)</b>	<b>125</b>		
<b>Section J Page 1</b>	<b>All</b>	<b>J.1</b> Document experience in other States to positively impact the healthcare status of Medicaid and or CHIP populations. Examples of areas of interest include, but are not limited to the following: <ul style="list-style-type: none"> <li>• Management of high risk pregnancy</li> <li>• Reductions in low birth weight babies</li> <li>• Pediatric Obesity (children under the age of 19)</li> <li>• Reduction of inappropriate utilization of emergent services</li> <li>• EPSDT</li> <li>• Children with special health care needs</li> <li>• Asthma</li> <li>• Diabetes</li> <li>• Cardiovascular diseases</li> <li>• Case management</li> <li>• Reduction in racial and ethnic health care disparities to improve health status</li> <li>• Hospital readmissions and avoidable hospitalizations</li> </ul>	<b>30</b>		
<b>Section J Page 18</b>	<b>All</b>	<b>J.2</b> Describe the policies and procedures you have in place to reduce health care associated infection, medical errors, preventable serious adverse events (never events) and unnecessary and ineffective performance in these areas.	<b>10</b>		
<b>Section J Page 22</b>	<b>All</b>	<b>J.3</b> Describe how you will identify quality improvement opportunities. Describe the process that will be utilized to select a performance improvement project, and	<b>15</b>		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		the process to be utilized to improve care or services. Include information on how interventions will be evaluated for effectiveness. Identify proposed members of the Quality Assessment Committee.			
Section J Page 30	All	<p><b>J.4</b></p> <p>Provide a description of focus studies performed, quality improvement projects, and any improvements you have implemented and their outcomes. Such outcomes should include cost savings realized, process efficiencies, and improvements to member health status. Such descriptions should address such activities since 2001 and how issues and root causes were identified, and what was changed.</p>	15		
Section J Page 51	All	<p><b>J.5</b></p> <p>Describe your proposed Quality Assessment and Performance Improvement (QAPI). Such description should address:</p> <ul style="list-style-type: none"> <li>• The Performance Improvement Projects (PIPs) proposed to be implemented during the term of the contract.</li> <li>• How the proposed PIPs will expand quality improvement services.</li> <li>• How the proposed PIPs will improve the health care status of the Louisiana Medicaid population.</li> <li>• Rationale for selecting the particular PIPs including the identification of particular health care problems and issues identified within the Louisiana Medicaid population that each program will address and the underlying cause(s) of such problems and issues.</li> <li>• How you will keep DHH</li> </ul>	20		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		<p>informed of QAPI program actions, recommendations and outcomes on an ongoing and timely manner.</p> <ul style="list-style-type: none"> <li>• How the proposed PIPs may include, but is not necessarily, limited to the following:               <ul style="list-style-type: none"> <li>○ New innovative programs and processes.</li> <li>○ Contracts and/or partnerships being established to enhance the delivery of health care such as contracts/partnerships with school districts and/or School Based Health Clinics.</li> </ul> </li> </ul>			
Section J Page 58	All	<p><b>J.6</b></p> <p>Describe how feedback (complaints, survey results etc.) from members and providers will be used to drive changes and/or improvements to your operations. Provide a member and a provider example of how feedback has been used by you to drive change in other Medicaid managed care contracts.</p>	10		
Section J Page 65	All	<p><b>J.7</b></p> <p>Provide, in Excel format, the Proposer's results for the HEDIS measures specified below for the last three measurement years (2007, 2008, and 2009) for each of your State Medicaid contracts.</p> <ul style="list-style-type: none"> <li>• If you do not have results for a particular measure or year, provide the results that you do have.</li> <li>• If you do not have results for your Medicaid product line in a state where you have a Medicaid contract, provide the commercial product line results with an indicator stating the product line.</li> </ul>	25		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		<ul style="list-style-type: none"> <li>• If you do not have Medicaid HEDIS results for at least five states, provide your commercial HEDIS measures for your largest contracts for up to five states (e.g., if you have HEDIS results for the three states where you have a Medicaid contract, you only have Medicare HEDIS for one other state, provide commercial HEDIS results for another state).</li> <li>• If you do not have HEDIS results for five states, provide the results that you do have.</li> <li>• In addition to the spreadsheet, please provide an explanation of how you selected the states, contracts, product lines, etc. that are included in the spreadsheet and explain any missing information (measure, year, or Medicaid contract). Include the Proposer's parent organization, affiliates, and subsidiaries.</li> </ul> <p>Provide results for the following HEDIS measures:</p> <ul style="list-style-type: none"> <li>• Adults' Access to Preventive/Ambulatory Health Services</li> <li>• Comprehensive Diabetes Care-HgbA1C component</li> <li>• Chlamydia Screening in Women</li> <li>• Well-Child Visits in the 3,4,5,6 years of life</li> <li>• Adolescent well-Care.</li> <li>• Ambulatory Care - ER utilization</li> <li>• Childhood Immunization status</li> <li>• Breast Cancer Screening</li> <li>• Prenatal and Postpartum Care (Timeliness of Prenatal Care and Postpartum Care)</li> </ul>			

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		<ul style="list-style-type: none"> <li>Weight Assessment and Counseling for Nutrition and Physical Activity in Children/Adolescents</li> </ul> Include the Proposer's parent organization, affiliates, and subsidiaries			

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## Section J: Quality Management

### J.1

**Document experience in other States to positively impact the healthcare status of Medicaid and or CHIP populations. Examples of areas of interest include, but are not limited to the following:**

- **Management of high risk pregnancy**
- **Reductions in low birth weight babies**
- **Pediatric Obesity (children under the age of 19)**
- **Reduction of inappropriate utilization of emergent services**
- **EPSDT**
- **Children with special health care needs**
- **Asthma**
- **Diabetes**
- **Cardiovascular diseases**
- **Case management**
- **Reduction in racial and ethnic health care disparities to improve health status**
- **Hospital readmissions and avoidable hospitalizations**

WellCare's business is focused solely on government-sponsored health care programs, primarily Medicaid/CHIP and Medicare. As a result, we have extensive experience designing and implementing initiatives to positively impact the health care status of Medicaid/CHIP populations. The following is a summary of our experience in several states with programs that address the health issues and conditions that we believe are of particular interest to Louisiana.

Beyond the examples cited in this section, please note our condition-specific chronic care/disease programs described in our responses to Section E. As described there, we currently have chronic care/disease management programs for asthma, chronic obstructive pulmonary disease (COPD), diabetes, congestive heart failure (CHF), hypertension (HTN), HIV/AIDS, coronary artery disease (CAD), and depression. These programs are not static and can be modified to meet the specific needs of a given market or replaced with other programs based on the acuity levels of our members.

### **Management of High Risk Pregnancy**

WellCare maintains high risk pregnancy intervention programs in each market in which we provide Medicaid managed care services. The core of our high risk pregnancy management program includes:

- Early identification of at-risk members;
- Risk assessment; and
- Assignment of case managers

The following examples demonstrate WellCare's current approach to managing high risk pregnancy and associated interventions in our Florida, Georgia, and Illinois markets.

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### Florida – Prenatal Program

Our prenatal program for Florida Medicaid, which is provided through a vendor, includes risk assessment and education, and OB case management. Risk assessment and education includes telephonic outreach to members who are pregnant; risk assessment and stratification, including a second trimester mid-pregnancy assessment and a post-partum depression screening; member education and support, including a 24/7 hotline staffed with experienced perinatal nurses and web-based educational resources; and physician engagement. OB case management is provided by experienced high-risk perinatal nurse case managers who develop individualized member care plans, provide comprehensive education, and coordinate community-based resources and home care services. In a 2009 satisfaction survey 93 percent of participants reported that they were satisfied with the program. It is estimated that this program reduced NICU stays by 190 days per 1000 live births.

### Georgia – Prenatal Care Program

In 2009, our Georgia prenatal program was provided by the same vendor as our Florida program and had very similar components, including both risk assessment and education and OB case management. The vendor continues to provide risk assessment and education, but as of January 2010, OB case management functions were transitioned to WellCare of Georgia case managers, who are nurses specializing in OB. WellCare case managers perform the same functions as indicated in the Florida program, including development of individualized member care plans, providing comprehensive education, and coordination of community-based resources and home care services.

In 2009 there were over 9,000 members enrolled in the Georgia prenatal program. Based on a survey with a 40 percent response rate, an average of 94 percent of program participants were satisfied with the program. In 2009, the NICU admission rate for members enrolled in the prenatal care program was 10.24 percent, which was lower than the national benchmark of 15.08 percent.

### Illinois – Hugs and High Risk OB

In Illinois, our care management, support, and education program for pregnant members is called Harmony Hugs (Hugs). We make targeted telephone calls to each pregnant member during which we urge her to enroll in Hugs. Upon enrollment, Hugs assists members with scheduling and completing all recommended prenatal visits and connects them with other available social and community resources, such as WIC, that can improve the health of both mother and baby. Hugs members also receive prenatal care letters and booklets that emphasize the importance of prenatal care and explain what to expect during pregnancy. The materials also contain information about a post-partum visit and include recommended schedules for childhood immunizations and well child visits.

Illinois members who participate in the Hugs program have increased rates of prenatal care and increased compliance with the post-partum visit as compared to pregnant women not in Hugs. In calendar year 2009, 68 percent of members in Hugs were compliant with the recommended frequency of prenatal visits, compared with 42 percent of members not in Hugs. Similarly, 68 percent of Hugs participants were compliant with the recommended postpartum visits as compared to 47 percent of members not in the Hugs program. As part of our Hugs program, we

identify members who are classified as high risk OB and refer them into our high risk OB (HROB) case management program.

### **Reductions in Low Birth Weight Babies**

WellCare's interventions in high risk pregnancies and in the use of condition management programs have aided in the reduction of occurrences of low birth weights among our enrolled population across our Medicaid markets. Examples of this success are demonstrated again for our Florida, Georgia, and Illinois markets.

#### Florida and Georgia

In 2009, 2.67 percent of members in our prenatal program in Florida delivered very low birth weight babies (less than 1500 grams), and 15 percent delivered low birth weight babies (less than 2500 grams). For that same year, 1.37 percent of members in our prenatal program in Georgia delivered babies weighing less than 1500 grams and 10.12 percent delivered babies weighing less than 2500 grams.

#### Illinois

In 2008 and 2009, the babies of members in the Illinois Hugs program experienced significantly better birth weight outcomes than the overall membership. During 2009, only 0.3 percent of participants in Hugs delivered very low birth weight babies (babies weighing less than 1500 grams), as compared with 1.5 percent of all members who gave birth in that year. In that same year, 5.6 percent of deliveries to Hugs participants were low birth weight babies (weighed between 1500 and 2500 grams), compared to 14.8 percent of total deliveries.

### **Pediatric Obesity (children under the age of 19)**

#### Georgia – Obesity Focus Study

Child and adolescent obesity has become a major health concern in most states. WellCare introduced a child and adolescent obesity initiative in Georgia that was later adopted by the State as a best practice for use by all the Medicaid MCOs.

We conducted a medical record review for members age three through 17 years to identify member records that documented any of the following: body mass index (BMI) percentile; counseling for nutrition; and/or counseling for physical activity. Our HEDIS 2010 rates of 36.50 percent for BMI, 42.34 percent for counseling for nutrition and 38.69 percent for counseling for physical activity were significantly lower than our benchmark target (HEDIS 75<sup>th</sup> national percentile) demonstrating opportunity for improvement.

To help improve these HEDIS rates, we:

- Published the revised American Academy of Pediatrics (AAP) periodicity schedule, which recommends an annual BMI assessment from 2-20 years of age, in the provider newsletter;

- Distributed clinical practice guidelines for childhood obesity with recommendations to increase provider awareness of current AAP guidelines for monitoring BMI;
- Partnered with and sponsored YMCA and Boys & Girls Club to conduct health fairs to include education on snacks, brushing teeth, increasing physical activity and fitness programs, good nutrition, and cooking lessons;
- Partnered with various day care centers, instructing WellCare members on healthy snack options and exercising and giving out jump ropes, Frisbees, pedometers and hula hoops;
- Collaborated with the Obesity Action Network through monthly conference calls regarding a provider education initiative to develop online tools; and
- Provided fitness and exercise and good nutrition *pocket doctors* for providers to distribute as a routine part of in-office education.

We will be able to determine the effectiveness of these interventions when we calculate our HEDIS 2011 rates for this measure.

#### New York – Obesity PIP

In New York we have a Medicaid performance improvement project (PIP) for pediatric obesity, initiated in 2009. WellCare will measure this PIP using the HEDIS measure Weight Assessment and Counseling for Nutrition and Physical Activity, which measures BMI percentile, counseling for nutrition, and counseling for physical activity.

Interventions include member education through targeted mailings of informational materials, targeted automated voice messaging, articles in the member newsletter, and a member incentive, which included a state-approved \$25 gift card for submitting a PCP-completed form documenting a preventive care visit. Education and outreach to providers includes letters containing obesity information and articles in the provider newsletter.

In addition, we conducted a focused community intervention program in one borough of New York City. Our quality improvement (QI) staff identified no- or low-cost local exercise and/or diet management programs and conducted a targeted mailing to eligible adolescent members, informing them of these programs and encouraging them to attend.

The results of this PIP are not yet available.

#### **Reduction of Inappropriate Utilization of Emergent Services**

WellCare employs various strategies to ensure members receive care in the most appropriate setting. We specifically work to reduce member use of the emergency department to receive non-urgent/emergent services that could be provided in a physician's office. Our largest Medicaid contract is in Georgia, where there are historically high levels of inappropriate utilization of emergency departments. The following is a summary of interventions that were taken in our Georgia market. We are also providing an example from our Ohio market to provide additional perspective.

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## Georgia – ED Case Management

High utilization of emergency department services triggers referrals for case management. Upon referral a care manager completes an assessment to determine the health and/or social issues that are causing the member to be a frequent user of emergency department services. The care manager may employ the following strategies:

- Provide education to the member about appropriate use of the ED and alternatives;
- Provide education about available urgent care and convenience care facilities in the member's community as well as education around the appropriate usage of these types of facilities;
- Encourage use of the 24-hour medical advice line;
- Review care plan compliance with the member to provide information to the member about the relationship between care plan services and ED use;
- Review member records for eligibility for disease management;
- Review frequency of contact between care manager and member and increase contact as necessary; and
- When patterns of ED use indicate the necessity, consult with the member's medical home and reassess the member for possible changes in need and additional intervention.

As shown in Exhibit J.1.a, this program appears to have been successful in reducing inpatient admissions, re-admissions, and ED visits.

**Exhibit J.1.a – Georgia ED Case Management**

<b>Inpatient Admissions of Members enrolled in CM</b>			
<b>Q1-10</b>	<b>PreEnroll</b>	<b>Post Term</b>	<b>% (+/-)</b>
3 months	113	20	-82%
6 months	135	29	-79%
9 months	147	34	-77%
<b>Q2-10</b>	<b>PreEnroll</b>	<b>Post Term</b>	<b>% (+/-)</b>
3 months	188	47	-75%
6 months	258	74	-71%
9 months	289	95	-67%
<b>Q3-10</b>	<b>PreEnroll</b>	<b>Post Term</b>	<b>% (+/-)</b>
3 months	119	52	-56%
6 months	168	88	-48%
9 months	198	93	-53%
<b>Inpatient Readmissions of Members enrolled in CM</b>			
<b>Q1-10</b>	<b>PreEnroll</b>	<b>Post Term</b>	<b>% (+/-)</b>
3 months	75	20	-73%
6 months	93	29	-69%
9 months	101	34	-66%
<b>Q2-10</b>	<b>PreEnroll</b>	<b>Post Term</b>	<b>% (+/-)</b>
3 months	143	44	-69%
6 months	190	71	-63%
9 months	212	92	-57%
<b>Q3-10</b>	<b>PreEnroll</b>	<b>Post Term</b>	<b>% (+/-)</b>
3 months	91	48	-47%
6 months	130	82	-37%
9 months	146	87	-40%
<b>ED Visits of Members enrolled in CM</b>			
<b>Q1-10</b>	<b>PreEnroll</b>	<b>Post Term</b>	<b>% (+/-)</b>
3 months	90	62	-31%
6 months	155	95	-39%
9 months	203	129	-36%
<b>Q2-10</b>	<b>PreEnroll</b>	<b>Post Term</b>	<b>% (+/-)</b>
3 months	92	78	-15%
6 months	191	144	-25%
9 months	249	186	-25%
<b>Q3-10</b>	<b>PreEnroll</b>	<b>Post Term</b>	<b>% (+/-)</b>
3 months	168	148	-12%
6 months	315	232	-26%
9 months	458	266	-42%

Georgia – ED Telephonic Outreach Program

In Georgia we have also had success reducing inappropriate utilization of emergent services with our ED telephonic outreach program. Member outreach associates contact a member within 48 hours of an ED visit (as listed on daily ED reports from participating hospitals) to identify the reason for the visit and to offer education about appropriate use of EDs and alternatives available. The outreach associates use a database that contains questions for the member about key aspects of the ED visit, including: the reason for the ED visit and whether the member knows the name of his or her PCP, needs a listing of urgent care centers, was sent home from the ED with medication, needs assistance with transportation, and is aware of our medical advice line. Analysis by month indicates a downward trend in average (mean) number of ED visits following outreach education. Our analysis of this program has found the following:

- A downward trend in average (mean) number of ED visits following outreach education.
- An upward trend in the average (mean) number of office visits following education.
- Educational outreach appears to have a more immediate impact on the overall number of ED visits than on office visit frequency.

#### Georgia – ED Materials Outreach Program

In Georgia we have also implemented a member educational outreach initiative that is targeted to the parents of children between the ages of five and eight who have had an ED triage visit. The outreach is comprised of the following mailed materials:

- A cover letter including;
  - WellCare’s awareness of the child’s ED visit
  - A request that the parent/guardian contact the PCP to inform the PCP of the ED visit
  - Reference to the free thermometer and educational book included in the packet
- A nationally recognized book entitled, *What To Do When Your Child Gets Sick*, which contains lay person self-care protocols for common childhood illnesses for ages birth to eight years;
- A digital thermometer for each child that meets the criteria within the household;
- Instructions on how to take a child’s temperature; and
- An education flyer regarding appropriate use of the ED.

Studies have demonstrated that when the book *What To Do When Your Child Gets Sick* is provided together with instruction on thermometer use, increased parental comfort in child care and decreased ED visits result. For example, New York Medicaid had a 6.7 percent decrease in ED visits based on this approach.

A study by UCLA and Johnson & Johnson published in November, 2007 found that this intervention resulted in a 58 percent decrease in ED visits and a 42 percent decrease in clinic visits. We do not yet have definitive results from our intervention effort.

#### Ohio – ED Diversion Program

Our Ohio Medicaid plan has developed an ED diversion program as part of an effort to reduce inappropriate use of the ED. Several causal barriers have been identified that increase the likelihood that a member will use the emergency department for non-emergent services. For example, members who have not established a relationship with a PCP are more likely to seek treatment for minor illnesses in an emergency department. As part of the ED diversion program, a monthly report is generated to identify members with four or more visits to the ED in the past six months. Member outreach coordinators contact members on this list to discuss alternatives to the emergency department and offer assistance in finding a PCP, scheduling an appointment and arranging transportation. The PCP of record also receives a letter advising him or her of members who are frequently using the emergency department.

## EPSDT

WellCare uses various strategies for all of Medicaid markets to improve EPSDT screening rates and to deepen relationships and collaborations with state agencies to further enhance these improvements. The following represent key examples of our initiatives.

### All Medicaid States – Telephonic Outreach to Members with Gaps in Care

WellCare has a telephonic member outreach initiative to contact members identified as being out of compliance with certain key preventive HEDIS measures, including the following related to EPSDT:

- Childhood immunization;
- Lead screening;
- Adolescent well care visits; and
- Well child visits.

This initiative offers education regarding the importance of these preventive screenings and assistance to members in scheduling appointments with their physicians via a three-way phone call. For members experiencing transportation-based barriers to care, appointment scheduling can also include coordinating transportation. After the appointment is scheduled the member receives a reminder call one to three days prior to the scheduled appointment.

We believe our telephonic outreach strategy is proving effective in raising our HEDIS scores. In our New York market, based on preliminary administrative data, we have experienced improvements in HEDIS rates in seven of the eight measures for which we deployed this strategy in 2010, including four measures related to EPSDT.

Exhibit J.1.b below illustrates year-over-year improvement in the EPSDT related HEDIS measures based on preliminary data.

**Exhibit J.1.b – New York TANF Rates for 2010 Telephonic Outreach Measures  
(Year-over-Year Comparison of Administrative Data – April 2011 vs. April 2010)**

Measure	Administrative HEDIS 2010	Administrative HEDIS 2011	HEDIS 2010 NY State Medicaid 90 <sup>th</sup> Percentile	2010-2011 Trend
Lead Screening	80.16%	82.09%	94.00%	Improvement
Adolescent Well Care Visits	60.53%	61.58%	59.00%	Improvement
Well Child Visits 15 months (5 Visits)	68.30%	72.29%	66.00%	Significant Improvement
Well Child Visits 3 – 6 years	78.35%	80.28%	83.00%	Significant Improvement

Georgia and New York – Member Incentive Programs

In 2010, we enhanced our member incentive strategy by designing and implementing pilot gift card incentive programs in our Georgia and New York Medicaid markets. These programs focus on key preventive screenings, including the following related to EPSDT:

- Well child visits within the first 15 months of life; and
- Childhood immunizations by age two.

We target members who are eligible for the specific HEDIS measures, but are identified as not yet compliant for the service required by the measure. Members who complete these screenings by the required dates (as documented by their provider) are eligible to receive a gift card reward from selected national merchants. The gift card reward amounts typically range from \$10 to \$50, and are set in accordance with state-specific guidelines for maximum amounts of annual incentives that Medicaid members can receive. In 2011, we are expanding these incentive programs across most of our Medicaid markets, as well as expanding them to address additional measures.

All Medicaid States – Pay for Performance Quality Program (P4Q)

Providers who meet or exceed our performance standards are recognized through our pay for performance quality incentive (P4Q) programs. Our P4Q programs focus on mainstream HEDIS measures of health care quality and access for a Medicaid population, and generally include the following measures related to EPSDT:

- Adolescent well care visits
- Lead screening in children
- Childhood immunizations
- Well child visits 15 months
- Well child visits 3 – 6 years

We believe that our P4Q program has a positive impact on the health care status of our members. In our Florida market, we have experienced improvements in HEDIS rates in three of the above measures.

Exhibit J.1.c below illustrates a year-over-year improvement in these three measures based on audited 2010 rates and preliminary unaudited HEDIS 2011 rates as of June 3, 2011.

**Exhibit J.1.c – Florida Medicaid (HealthEase) Rates for Selected P4Q Measures (Comparison of HEDIS 2010 and Preliminary Unaudited HEDIS 2011 Rates)**

Measure	HEDIS 2010	Preliminary, Unaudited HEDIS 2011	2010-2011 Trend
Adolescent Well Care Visits	42.82%	46.72%	Improvement
Well Child Visits 15 months (6+ visits)	46.72%	48.66%	Improvement

Measure	HEDIS 2010	Preliminary, Unaudited HEDIS 2011	2010-2011 Trend
Well Child Visits 3 – 6 years	69.71%	73.24%	Improvement

Another example is our Georgia market, which included three of these measures in its 2010 P4Q program.

Exhibit J.1.d below illustrates a year-over-year improvement in two of these three measures based on audited 2010 rates and preliminary unaudited HEDIS 2011 rates as of June 3, 2011.

**Exhibit J.1.d – Georgia Medicaid Rates for Selected P4Q Measures (Comparison of HEDIS 2010 and Preliminary Unaudited HEDIS 2011 Rates)**

Measure	HEDIS 2010	Preliminary, Unaudited HEDIS 2011	2010-2011 Trend
Lead Screening in Children	67.40%	72.99%	Significant Improvement
Well Child Visits 15 months (6+ Visits)	57.42%	59.12%	Improvement

### Children with Special Health Care Needs

WellCare serves children with special health care needs in multiple states, including Florida, Georgia, Hawai'i, Illinois and Ohio. Given the variation in the type and level of services required by children with special health care needs, we believe the most effective approach to improving their health care status is providing them with case management. Case managers help coordinate services, and complement our other initiatives to address the specific needs of the child (e.g., asthma or diabetes). Please see below for a discussion of our experience with case management and our response to F.1 for a description of our proposed approach to case management for the CCN program.

### Asthma

#### All Medicaid States – HEDIS Education and Screening Program

The core component of our strategy for improving the health status of members with chronic conditions, including asthma, is our HEDIS education and screening program (ESP). This is a clinical initiative that utilizes HEDIS disease management (DM) nurses to contact our members who are not compliant for the applicable HEDIS measures. This program:

- Provides members with education on their disease process and tips for self-managing their condition;
- Stratifies members for additional disease management as needed;

- Identifies barriers to care (e.g., transportation); and
- Assists members with scheduling appointments with providers via a three-way phone call to obtain testing and/or evaluation for medication needs.

We piloted this program in 2009 and implemented a significant expansion in 2010. Based on our latest available administrative HEDIS data, as illustrated in the table below, the program appears to be yielding results as evidenced by improvement in our Florida, Georgia, and Missouri Medicaid plans in the HEDIS measure, Use of Appropriate Medications for People with Asthma.

Exhibit J.1.e below illustrates a year-over-year improvement in the HEDIS measure Use of Appropriate Medications for People with Asthma based on audited 2010 rates and preliminary unaudited HEDIS 2011 rates as of June 3, 2011. Significant improvement indicates statistically significant improvement.

**Exhibit J.1.e – Medicaid Rates for HEDIS Asthma Measure in Selected States (Comparison of HEDIS 2010 and Preliminary Unaudited HEDIS 2011 Rates)**

Medicaid Plan	HEDIS 2010	Preliminary, Unaudited HEDIS 2011	2010-2011 Trend
Florida (HealthEase)	83.54%	85.77%	Improvement
Florida (Staywell)	87.95%	87.97%	Improvement
Georgia	89.91%	91.08%	Significant Improvement
Missouri	81.03%	85.42%	Improvement

#### Georgia – Asthma Performance Measure

In addition to our HEDIS education and screening program, we have implemented state-specific initiatives to improve the health status of members with asthma. In Georgia, 2010 interventions included:

- Identifying members noncompliant with pharmaceutical treatment;
- Contracting with a vendor for in-home member assessment and training;
- Reaching out to the PCP and member to arrange an in-home visit;
- Conducting in-home visits to assess member knowledge, provide education, and supply sheet casings, pest control, nebulizers and peak flow meters as needed by the member; and
- Arranging PCP follow-up appointments as necessary.

As noted in Exhibit J.1.c above, our Georgia Medicaid plan has experienced a year-over-year (2010 to 2011) improvement in the HEDIS rate for Use of Appropriate Medications for People with Asthma. Rates for 2011 are preliminary and unaudited at the time of this submission.

## **Diabetes**

As described below, we have implemented various interventions to improve the health status of our members with diabetes. Based on preliminary unaudited HEDIS 2011 data as illustrated in the table under Georgia – Diabetes PIP below, our interventions appear to be yielding positive results.

### All Medicaid States – HEDIS Education and Screening Program

As noted above under Asthma, the core component of our strategy for improving the health status of members with chronic conditions is our HEDIS education and screening program (ESP). For diabetes the applicable HEDIS measure is Comprehensive Diabetes Care.

### All Medicaid States – P4Q

In most states, including Georgia, our P4Q program includes incentives for performance on the HEDIS measure Comprehensive Diabetes Care.

### All Medicaid States – HEDIS Rate Profile Reports

WellCare provides PCPs with regular HEDIS rate profile reports that compare each PCP's compliance rate to that of his or her peers and to the annual HEDIS National Medicaid 75th percentile for specified HEDIS measures, including diabetic eye exam, diabetic HbA1c test, and monitoring diabetic nephropathy.

### All Medicaid States – Overdue for Visit Reports

We also provide PCPs with member Overdue for Visit reports, that identify the PCP's members who are past due for certain services. Services relevant to diabetes include diabetic eye exam, diabetic HbA1c test, and monitoring diabetic nephropathy. The intent of furnishing the list is to assist providers in identifying and contacting patients who are past due to schedule an appointment. Our provider relations representatives visit providers to review the Overdue for Visit report and encourage them to reach out to members needing services.

### Georgia – Diabetes QI Project

In Georgia we used a combination of member and provider interventions to achieve statistically significant improvement in the HEDIS measure, Comprehensive Diabetic Care (CDC). These interventions included many of the initiatives discussed above, including the HEDIS ESP, member incentives (please see discussion under EPSDT above), P4Q, HEDIS rate profiles, and Overdue for Visit reports. Members identified as having diabetes were invited to attend educational sessions held in the community by outreach and pharmacy staff and we conducted community-based education sessions to assess member knowledge, provide education, and supply glucometers and testing supplies to members as needed. Also, our quarterly provider newsletters highlighted recommended diabetic preventive care schedules (e.g., eye exam (annually) and HbA1c testing (every three months)).

Based on our latest available administrative HEDIS data as illustrated in Exhibit J.1.f below, the combination of initiatives appears to be yielding results as evidenced by the improvement in our Georgia Medicaid Comprehensive Diabetic Care (CDC) HEDIS rates.

**Exhibit J.1.f – Georgia Medicaid Rates for HEDIS Diabetes Measures (Comparison of HEDIS 2010 and Preliminary Unaudited HEDIS 2011 Rates)**

Measure	HEDIS 2010	Preliminary, Unaudited HEDIS 2011	Target	2010-2011 Trend
Diabetic Eye Exams	37.23%	47.63%	62.30%	Significant Improvement
HbA1c Testing	78.65%	82.30%	86.20%	Improvement
HbA1c Poor Control	45.62%	47.99%	64.90%	Improvement
LDL-C Screening	69.16%	74.82%	79.50%	Significant Improvement
Monitor Nephropathy	70.80%	71.53%	82.20%	Improvement

## Case Management

### All Medicaid States – Case Management

The purpose of WellCare’s case management program is to decrease fragmentation of health care service delivery, facilitate appropriate utilization of available resources, and optimize member outcomes through education, care coordination and advocacy services. In July of 2009 we initiated the use of a satisfaction survey at discharge from case management. The survey results show high satisfaction with case management.

### Hawai’i – Service Coordination

In Hawai’i we have established a community-based, member-centric case management program (called service coordination) for our ABD members. This program assists members by coordinating primary, acute, behavioral, and long-term care services to ensure continuity of care.

Each member is assigned a case manager who assists the member in planning and coordinating his or her health care needs. The service coordination program is evaluated throughout the year through various metrics, including completion of the required health and functional assessments (HFAs), care plan development, monitoring progress with EPSDT requirements, access to services, appropriate utilization of services, completion of nursing facility level of care assessment, and functional eligibility determinations.

The results in our first year of operations (March 2009 to 2010) were dramatic. Monthly nursing facility admissions were reduced by over 30 percent through diversion to community-based long-term care. Admissions continue to fall. Over the same period, in-patient days and hospital re-admissions were reduced by 15 percent and non-emergency ground transportation costs by

over 30 percent compared to fee-for-service. The results are also visible through the impact of service coordination on members' quality of life.

#### Selected States – Specialized Case Management

WellCare provides specialized case management programs/interventions that tie directly to market specific utilization experiences. As demonstrated under the Reduction of Inappropriate Utilization of Emergent Services section of this response, specific case management programs are in place in our markets to focus on the reduction of inappropriate ED use. For more information, please see the information on Georgia's ED case management program under Reduction of Inappropriate Utilization of Emergent Services.

Another example of specialized case management developed to impact market specific outcomes is our focus on the management of high risk pregnancies. Please see information on OB case management under the Management of High Risk Pregnancy section of this response.

#### Reduction in Racial and Ethnic Health Care Disparities to Improve Health Status All Medicaid States – Cultural Competency Program

A key goal of our cultural competency program is to decrease health care disparities among minority populations. WellCare has a cultural competency steering committee whose charge is to ensure that all of our members, regardless of their cultural orientation, have equal access to quality health care services and outcomes. This committee is chaired by the WellCare Chief Medical Officer, Ann Wehr, M.D. Actions to impact cultural competency goal attainment and eliminate health care disparities include:

- Assessment of member demographics;
- Associate training and development;
- Staff available to verbally assist members with low reading comprehension or visual disabilities;
- Written member materials available in member languages;
- Clinical and administrative bi-lingual staff to assist members with Spanish language interpretation;
- Member, provider, and staff ready access to a language line for other translation/interpretation services;
- TTY services for the hearing impaired;
- Provider initiatives; and
- Reviewing demographic data to ensure appropriate contracting with providers with respect to their location, language spoken, gender, race, and ethnicity.

#### All Medicaid States – Analysis of HEDIS Rates by Race

We have begun to look at HEDIS results stratified by race to determine whether HEDIS rates are lower for specific groups. If so, we will further investigate the cause of the lower rates (e.g., access to care issues, language barriers, lack of resources within the community, or lack of understanding of cultural nuances) and develop targeted intervention to address the identified disparities.

### Florida – Diabetic Eye Exams for Members who Speak Spanish

Given the large percentage of our Florida Medicaid members who speak Spanish, our Florida plans conduct a PIP on diabetic eye exams for Spanish speaking members. This PIP includes a population that represents a significant percentage of our membership, relates to a high volume/high risk diagnosis, and targets an evidence-based health care disparity.

Published data indicates that Spanish speaking individuals seek and receive fewer health care services than other ethnic groups with the similar diagnoses. The metric is the number of Spanish speaking Medicaid members 18-75 years old with diabetes (type 1 or 2) who were continuously enrolled during the measurement year and had diabetic eye exams as defined by the HEDIS 2010 technical specifications during that period. Although the metric results have not been statistically significant, these metrics have been steadily increasing for HealthEase and increased between 2008 and 2009 for Staywell.

### Georgia – Data Analysis by Category

Starting in 2010, where possible, our Georgia Medicaid plan analyzes performance measures by the categories listed below and reports on the results to the QIC on a quarterly basis for review and follow-up:

- Race
- Ethnicity
- Gender
- Age
- Region
- Urban/Rural
- Primary language

## **Hospital Re-admissions and Avoidable Hospitalizations**

### All Medicaid States – Transitional Care Management

Building on the pilot in Florida, we have developed the transitional care management (TCM) program. This is a short-term, post-hospitalization care management program designed to address repeated hospital admissions by patients who experience preventable barriers to care and/or gaps in care after being discharged from a hospital or other health care facility.

The program includes the following elements:

- Identification of high risk members during the hospital or facility stay;
- A pre-discharge interview with the member/caregiver to identify potential barriers to/gaps in care and post discharge contact information;
- Post-discharge contact within 24 to 72 hours after discharge to determine barriers to/gaps in care; and
- Immediate needs intervention by a transitional care manager (RN) during post-discharge period, including appointment assistance, prescription assistance, coordination of care with physicians, and the member's care manager for continued follow-up.

Our goal for the TCM program is to reduce re-admissions by ensuring that members are stabilized at home after being discharged from a hospital or skilled nursing facility. Measureable outcomes for this initiative include: number of physician visits within first 30 days after discharge from hospital or facility and reduced re-admission rates (either by membership or by re-admissions within the group of managed members).

#### Florida – Multiple Admissions Pilot

In Florida we conducted a pilot program to reduce hospitalizations within a target group of high risk members who had a history of multiple admissions. The initiative involved re-training staff to increase member participation in case management activities, aggressive discharge planning and post-discharge follow up, trending of most frequent barriers to care, and reporting outcomes, including overall inpatient admissions and days, re-admission rates, and case management program outcomes.

The pilot produced mixed results, showing a reduction of overall hospital days, primarily related to an overall reduction in length of stay. The pilot group included both Medicaid TANF and SSI members. The TANF group responded well to the interventions and showed the greater reduction in hospital days. The SSI group did not show a reduction in days or admissions. Further evaluation of this group indicated a very high rate of behavioral health diagnoses, which contributed to the high rate of medical admissions. In 2010, the pilot program was expanded to increase behavioral health support. Overall, this model was judged successful, and will be adapted to other markets.

#### **Other Initiatives**

##### All Medicaid States - Initiatives to Increase Use of Preventive Health Services by Adults

Many of the initiatives described above are designed to increase the use of preventive health services such as preventive visits, breast cancer screening, and Pap tests by adult members. For example, our telephonic outreach to members with gaps in care (described under EPSDT above) identifies members due for cervical cancer screening, breast cancer screening, and chlamydia screening. Our HEDIS rate profile reports and Overdue for Visit reports include adult preventive visits, breast cancer screening, and Pap tests.

##### All Medicaid States - Care Gap Alert Enhancement to our Call Centers

Our strategy for improving health care status is dependent on being able to communicate appropriate information in a timely manner to those members who have gaps in care. One channel that we identified as representing significant opportunity is inbound member calls.

To test this concept, we implemented a pilot program for our New York Medicaid line of business in the latter half of 2010. The pilot was designed such that when a member who had a specific gap in care called into member services, his or her record was flagged so that the customer service representative (CSR) could be made aware of the gap. The CSR, using a prescribed script, informed the member about the gap in care and offered assistance with appointment scheduling and transportation coordination. The pilot focused on mainstream HEDIS measures for preventive services to ensure that the content was appropriate for communication by non-clinical CSRs.

As a result of the pilot program, we determined that this was an effective channel for addressing member gaps in care. In 2011, we are implementing a major expansion of these *care gap alert* capabilities as part of a broader investment in technology and processes that enhance member services. Our enhanced care gap alert capabilities were brought on line in our Georgia Medicaid market (our largest Medicaid state) in April 2011, and will continue to roll-out in a phased manner across all our call centers throughout 2011.

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## J.2

***Describe the policies and procedures you have in place to reduce health care associated infection, medical errors, preventable serious adverse events (never events) and unnecessary and ineffective performance in these areas.***

### **Patient Safety Plan**

WellCare is committed to providing a safe health delivery system for our members. WellCare's policies and procedures related to quality of care (QOC) issues define and provide for the monitoring of widely accepted QOC indicators. Through tracking and trending of relevant metrics, WellCare can identify and take corrective action as necessary to resolve issues that could potentially jeopardize the safety of members.

The goals of our patient safety activities are to:

- Promote patient safety as an integral component of health care delivery; and
- Reduce instances of potential QOC issues that put patient safety at risk.

To help ensure patient safety for Louisiana CCN members, the scope of our QI activities will include both the review of medical and pharmaceutical care (in support of the state's pharmacy benefits management system) and administrative issues, as is currently done in existing WellCare markets. Sources of patient safety data/potential QOC issues may include provider- to provider communication, results of office site visits, medical record review findings, clinical practice guideline compliance, case and chronic care/disease management participation, utilization management, member grievances, appeals review and analysis, and provider actions to improve safety. We will review and follow-up as necessary on any potential QOC issues. Also, QOC issues are reviewed as part of the re-credentialing process.

Patient safety incidents, including "never events" and potential QOC issues, are logged to enable efficient tracking and trending of data over time. In addition, summary statistics are prepared that specify the final disposition of each case. Incidents are segmented as either substantiated or unsubstantiated and adverse or non- adverse depending on whether there is evidence of a deviation from the standard of care. Incidents are classified into categories, including:

- Procedural issues
- Delay or omission of care
- Post-operative complications
- Medication issues
- Death or serious disability
- Patient safety
- Inadequate assessment/misdiagnosis
- Re-admit within 30 calendar days
- Member perception

A nurse reviewer reviews all potential QOC issues to determine the nature of the issue. If additional information is required, an information request letter is sent to all applicable

provider(s). The nurse reviewer prepares a written analysis of the information and initial findings. The nurse reviewer reviews the case and findings with the medical director to determine if there is evidence of a deviation from the standard of care.

This determination is based upon the assessment of the provider response and medical record documentation measured against provider and/or WellCare policies and procedures, regulatory and/or accreditation standards, and/or industry accepted clinical practice guidelines. If there is concern that the peer review standard has not been met, the medical director may refer the case to an internal or external peer reviewer with additional specialty expertise.

After conducting the review, the medical director will document the following:

- Severity level (none, minor, major, critical);
- Whether the issue was substantiated (there is evidence of a deviation from the standard of care) or unsubstantiated (no evidence of a deviation from the standard of care);
- Whether there was an adverse event or not;
- Classification (nine categories listed above);
- Any actions to be taken (e.g., no further action, refer to network management; refer to peer review committee, track and trend).

Cases that meet the following criteria will be referred to the Credentialing and Peer Review Committee (credentialing committee):

- Quality review suggests a pattern of inappropriate care; and
- Cases requiring further peer review opinion.

The credentialing committee will document its findings and recommendations, which may include provider monitoring, provider sanctions, or provider termination.

QI staff will document and coordinate follow-up action. If a provider was asked for a response to the issue or if corrective action plans are required, QI staff will prepare a determination letter endorsed by the medical director. If the issue was identified by a member, the QI staff will prepare a member closure letter. In addition, QI will submit quarterly reports to the Utilization Management Medical Advisory Committee (UMAC) that include trended reports, open and closed cases, corrective action plans, and any potential QOC issues or trends that need further discussion or follow-up. Trended system-wide statistics are reviewed for consideration of further member and network education as a way to reduce the occurrence of future quality of care issues.

Any peer review finding of a quality deficiency that results in a network sanction, suspension, or termination will be reported to the National Practitioner Data Bank (NPDB), the applicable state medical board, and any other applicable state or federal regulatory agencies. In addition, any sentinel events are reported as required by state law.

## **Provider Education**

We convey important patient safety information to providers through the provider handbook, articles in the provider newsletters, clinical practice guidelines, an annual patient safety tip

sheet, and visits by provider representatives. For example, the 2010 patient safety tip sheet for our Medicaid plan in Georgia included information on incentives for electronic health records, improving communication with Spanish-speaking patients, ways to avoid post-operative complications, and ways to improve continuity and coordination of care.

## Hospital Requirements

Similar to our Georgia Medicaid plan, we will require network hospitals to have a patient safety program to address high risk areas or complaints regarding clinical care.

Each network hospital must implement a program that meets the following requirements:

- A system of classifying complaints according to severity;
- Uniform reporting standards and examples of adverse events;
- A process to communicate staff expectations for prioritization of high risk events;
- Mechanisms for coordination of care across disciplines and the organization;
- A review by the medical director, physician advisor, chief of staff or department chairperson and a mechanism for determining which incidents will be forwarded to the Credentialing and Peer Review Committee;
- Peer review protected infrastructure to promote reporting and sharing of information on patient safety and medical errors;
- Hospital education to promote integration of patient safety practices into hospitals' clinical practice guidelines and standards;
- Safety alerts and rapid communication of strategies to prevent errors that show a connection to high risk events;
- Avenues for patients to participate in their care decisions and make suggestions on improving patient safety;
- The sharing of evidence-based best practices for reducing medical records, improving patient safety and enhancing quality of care;
- Conducting Failure Mode and Effects Analysis (FMEA) for all sentinel events; and
- Implementation of internal programs for corrective actions and continuous improvement.

The network hospital shall:

- Develop and implement an ongoing, proactive program for defining, identifying and managing risks to patient safety and medical errors throughout the organization with defined executive responsibility for the program;
- Measure the effectiveness of process and system improvements;
- Establish data reporting systems for the collection of data on defined processes that affect patient safety; and
- Implement pertinent best practices for reducing medical errors and enhancing positive care outcomes.

All network hospitals accredited by The Joint Commission are expected to comply with The Joint Commission's most current National Patient Safety Goals.

If a hospital has not been accredited by The Joint Commission or has not implemented a patient safety program, WellCare will require the hospital to submit a plan of action regarding compliance with the patient safety requirements. If the plan of action is approved, the hospital must become compliant within the prescribed time period.

On an annual basis, WellCare will define specific measures to be monitored as indicators of safe clinical care. These will be communicated through the provider newsletters. As in our Georgia Medicaid plan, we will also conduct an annual hospital patient safety survey. The survey includes questions about the hospital's use of electronic medical records, automated order entry, information systems for capturing patient safety data, and reporting safety events to payers. If we identify opportunities for improvement, we will support the hospital's efforts to improve these areas.

In addition, we will encourage our network hospitals in Louisiana to participate in the Leapfrog Hospital Survey, which compares hospitals' performance on national standards of safety, quality and efficiency. We will send a letter to all network hospitals asking them to participate in the Leapfrog Hospital Survey, and we will include language in our Louisiana hospital provider handbook supporting and encouraging participation in the Leapfrog Hospital Survey.

### J.3

***Describe how you will identify quality improvement opportunities. Describe the process that will be utilized to select a performance improvement project, and the process to be utilized to improve care or services. Include information on how interventions will be evaluated for effectiveness. Identify proposed members of the Quality Assessment Committee.***

#### **Identifying Quality Improvement Opportunities**

WellCare systematically monitors and evaluates the quality, appropriateness, and accessibility of care and services provided to our members. Through our monitoring and evaluation activities we identify quality improvement (QI) opportunities and develop and implement interventions/action plans to improve the quality, appropriateness, and accessibility of care and services. We then evaluate the results of the interventions/actions plans to determine if they were effective.

We use Deming's plan-do-check-act (PDCA) cycle of continuous quality improvement (CQI) as the primary method by which we identify quality improvement opportunities. Under the PDCA approach, multiple indicators of quality of care and service are reviewed and analyzed against benchmarks of quality clinical care and service delivery. When variations are noted, root cause analysis is performed, action plans are developed, and re-measurement occurs to ensure progress toward established goals. Based on outcomes identified, we then use this information to implement key initiatives to drive improvement across the spectrum of measurements tracked. Please see our response to Section J.1 and Section J.4 for multiple examples of initiatives we have implemented in order to improve the quality of care and services provided to our members.

We develop and maintain an annual quality assessment and performance improvement (QAPI) plan that identifies the goals of our QAPI program, the scope of the program, the program methodology, and key program initiatives. We develop and maintain an annual QA work plan with defined quality activities to be undertaken in a given year. On at least an annual basis the QI department facilitates a formal evaluation of the QAPI program. The annual evaluation includes, without limitation, the following:

- Summary description of the QAPI, including QI activities;
- Major accomplishments, including an assessment of progress made in influencing network-wide safe clinical practices;
- Measures trended over time including;
  - HEDIS data
  - CAHPS data
  - Other QI measures
  - Other performance measures
- Analysis and evaluation of outcomes including an assessment of the extent to which QI activities were completed and goals met;
- Identification and analysis of issues or barriers to achieving goals and limitations of the data or measure;

- Recommended interventions/actions to demonstrate improvements for the upcoming year, including continuation or retirement of existing performance improvement projects;
- Evaluation of the adequacy of resources, training, scope and content of the QAPI program;
- Provider and member participation in the QAPI programs; and
- Quantifiable improvements in care and service.

The QAPI annual evaluation is developed with participation and support from all applicable parties and is presented to the QIC and the plan's board of directors for final approval and recommendations.

Key indicators of quality of care and service, and the data we review and analyze to identify QI opportunities are described below.

#### Access and Availability

We evaluate access and availability to covered services through various methods. We use GeoAccess reports to evaluate travel distance to PCP, hospitals, specialists, and ancillary (lab and radiology) providers in accordance with time and distance requirements. We review member to practitioner ratio reports to evaluate compliance with the applicable ratio requirements. We conduct quarterly provider audits to measure compliance with appointment schedule requirements, by specified type of visits and provider types, as well as after-hours availability. Access and availability are also monitored on an annual basis via the member satisfaction (CAHPS) survey.

We measure access and availability against state and/or internally-developed standards (whichever is more stringent). Any provider-specific issues are addressed directly with the provider through our provider relations representatives. If systemic issues are identified, we identify the root causes (e.g., not enough of a particular subspecialist), develop and implement an action plan (e.g., identify and recruit additional providers), and then analyze the next cycle of reports to determine the effectiveness of the action plan. (Please see our response to Section G.6 for a description of our process for monitoring and ensuring adherence to DHH's requirements regarding appointments and wait times.)

#### Under- and Over-Utilization

Through the review of utilization patterns, WellCare is able to identify quality improvement opportunities to impact both over- and under-utilization trends. As discussed in our response to Section H.4, WellCare monitors and analyzes data to determine both under- and over-utilization and institutes corrective action for the provider and/or ourselves to correct any patterns of potential or actual under- or over-utilization. We evaluate the effectiveness of the corrective action through ongoing analysis of utilization data.

#### Clinical Practice Guidelines

Based on the health care needs of our members and QI opportunities identified through monitoring and evaluation activities, we adopt and distribute clinical practice guidelines, including preventive health guidelines. We review, revise, and approve these guidelines on an

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annual basis, using nationally-recognized, evidenced-based literature. The guidelines for the CCN program will be developed with input from community physicians via the Utilization Management Medical Advisory Committee (UMAC) and the provider advisory councils (see below under Provider Satisfaction and Input).

Annually we will review compliance with selected clinical practice guidelines through data analysis. When certain guidelines are not satisfactorily adhered to by individual network providers, WellCare staff, up to and including a medical director, intervene with the provider to address the specific compliance issue(s). When a systemic problem is identified, and the guidelines are reaffirmed as appropriate, we will undertake broader educational efforts with the network and then evaluate our efforts through additional data analysis.

### Patient Safety

Through tracking and trending of relevant metrics, we will be able to identify and take corrective action as necessary to resolve issues that can potentially jeopardize the safety of members. For additional information on patient safety please see our response to Section J.2.

### QI Measures/Studies

In addition to formal performance improvement projects (PIPs), we conduct a similar process for several key QI measures. This process includes identifying barriers to achieving the desired results; developing and implementing interventions to address those barriers; setting objective goals by which to measure success; measuring results against those goals to assess effectiveness; and developing and implementing activities to increase or sustain improvement.

Our QI measures are typically HEDIS or HEDIS-like measures that we can calculate on a monthly basis using administrative data (e.g., enrollment files and claims/encounters). We establish objective numerical targets for all of our key measures, which are typically calibrated against either key national benchmarks (e.g., NCQA 75th percentile) or more specific state targets. We compare our results on a measure to the applicable target to determine our proximity to our goals and prioritize areas for improvement.

In all of our Medicaid plans our QI measures include a standard set of HEDIS measures for preventive services (e.g., well child visits, adolescent well care visits, adult preventive visits, lead screening, breast cancer screening, and other key screenings). In addition, in each state we identify other QI measures that are particularly relevant to the state, e.g., diabetes, asthma, dental visits, prenatal and postpartum care; or others defined by the state Medicaid customer as an area of improvement focus for the entire Medicaid program.

### Member Satisfaction

We conduct an annual member satisfaction survey using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, and then analyze the results to identify QI opportunities and design and implement action plans to improve service delivery. We evaluate the effectiveness of our action plan based on the results of the next survey.

We track, trend, and analyze member grievances to evaluate member satisfaction and identify opportunities to improve member satisfaction. If a QI opportunity is identified, preliminary review

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of the root cause is performed and data is provided to the appropriate business owner to identify appropriate interventions or corrective action. We evaluate the effectiveness of the intervention through ongoing trending and analysis of member grievances.

We also track and trend call reason codes for general calls coming in to customer service in order to identify areas of opportunity for improvement to access, availability, and satisfaction of members.

### Provider Satisfaction and Input

We conduct an annual survey of our provider network to assess provider satisfaction with WellCare. Our Provider Relations department reviews and analyzes survey results and develops action plans to address those areas identified as needing improvement. We use results from subsequent surveys to assess the effectiveness of the action plan.

In addition, we track, trend, and analyze provider complaints to evaluate provider satisfaction and identify opportunities to improve provider satisfaction. If a QI opportunity is identified, preliminary review of the root cause is performed and data is provided to the appropriate WellCare director/manager to identify appropriate interventions or corrective action. We evaluate the effectiveness of the intervention through ongoing trending and analysis of provider complaints.

Another key source for identifying quality improvement opportunities in Louisiana will be provider advisory councils (PACs). We will establish at least one council in each GSA. Each council will be comprised of locally-based providers from all regions in the GSA. We may create more than one council in a GSA depending on factors such as geography, number of members, and number of network providers, particularly specialists. The councils will serve as sounding boards for our staff and provide a structure and process for ongoing dialogue and problem solving. The PACs' responsibilities may include involvement in, or providing input regarding, various programs and initiatives, including the QAPI program, the UM plan, peer-to-peer quality profiling, and WellCare training programs.

### Credentialing, Re-Credentialing, and Monitoring Providers

During the credentialing and re-credentialing process, prospective and current providers are evaluated on various factors, such as individual background, education, training, experience, demonstrated ability, patient admitting capabilities, licensure, and regulatory compliance for inclusion in the WellCare network. We will conduct credentialing and re-credentialing in accordance with DHH requirements, NCQA/URAC accreditation standards, and WellCare policy and procedure. WellCare conducts ongoing monitoring of our providers through the collection and review of: Medicare and Medicaid sanctions levied against the provider; state sanctions or limitations on license; grievances; and identified quality of care issues and/or adverse events. As necessary and appropriate to the situation, we intervene with the provider (e.g., advise and educate, issue a corrective action plan) or take corrective action (e.g., warning letter, increased monitoring) that may lead to termination if necessary.

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### Medical Record Review

We conduct medical record reviews to assess and improve both the quality of care delivered to members and the documentation of such care. The focus of a review may include, without limitation, patient safety issues, clinical and/or preventive guideline compliance, over- and under- utilization of services, confidentiality practices and inclusion of consideration of member input into treatment plan decisions. The review process allows for identification of the provider's level of compliance with contractual, accreditation, and regulatory standards achieved in the maintenance of patient records. We conduct provider training as needed to facilitate greater compliance pertaining to this activity in future assessments.

### Peer Review

The WellCare of Louisiana medical director will be responsible for peer review activities and will include peers from the provider advisory councils (PACs) as appropriate. Peer review is conducted during the investigation of quality of care concerns including potential compromises of member safety. There are multiple reasons such investigations may be initiated, including adverse/sentinel events, member grievances, over-/under- utilization comparisons and coordination/continuity of care statistics. Peer review may include the following: evaluation of the appropriateness, adherence to standards and outcome of care generally accepted by professional group peers; morbidity/mortality review; grievances related to medical treatment or inappropriate or aberrant service; and proper maintenance of medical records requirements. As necessary, we will take corrective action and report any provider suspended or terminated from the network to the state and the NPDB. We compile the information on individual providers into a provider profile and use it to coordinate other QI activities, including utilization review, risk management, and resolution and monitoring of member grievances for the purpose of re-credentialing.

### Operational Service Performance

We continuously track and trend statistics regarding our operational performance, for the purpose of identifying quality improvement opportunities and interventions. These statistics include, but are not limited to, call center performance, website usage, turnaround times (e.g., grievances, appeals, prior authorizations), and claims processing metrics. Results that are below our contract requirements or internal goals prompt the development and implementation of a corrective action plan. We evaluate the effectiveness of our corrective action plan through ongoing tracking and trending of the applicable statistics.

### **Process for Selecting a Performance Improvement Project (PIP)**

As specified in Section 14.3.8 of the RFP, DHH may require each CCN to conduct up to four PIPs during the term of the contract. The RFP requires each CCN to perform a minimum of two DHH approved PIPs during the first contract year; one of which has been specified by DHH (number of ED visits per 1,000 member months). Each CCN chooses the second PIP from those listed in Section 2 of Appendix DD of the RFP. As discussed in response to Section J.5, WellCare proposes to select the HEDIS measure Well Child Visits in the First 15 Months of Life (6+ visits) as our second PIP. In the second year we propose to continue both of those PIPs and propose add a PIP for childhood obesity. For the third year we propose to continue those three PIPs and add a PIP for appropriate use of medication for people with asthma.

We generally select a PIP that we determine is meaningful and relevant to our Medicaid members in the particular state. This process includes:

- Analysis of enrollment and claims data to estimate the number of members who would benefit from the PIP and the potential cost impact;
- Review of the state's baseline rates and any relevant WellCare data to determine the room for improvement;
- Conducting research and analysis regarding the benefits of the potential PIP; and
- Reviewing our experience in other states as a basis for improving performance on the proposed PIP.

Our process and rationale for selecting the proposed PIPs for the CCN-P contract is provided in response to Section J.6. For example, we propose to conduct a pediatric obesity PIP because we anticipate that a high percent of our pediatric members will be overweight or obese, obesity is risk factor for many chronic diseases but can be addressed through lifestyle interventions, Louisiana's baseline rate for the applicable HEDIS measure is less than the National Medicaid HEDIS 15<sup>th</sup> percentile, and we have developed several interventions to improve the HEDIS rate.

### **Developing Interventions to Improve Care or Services**

Our general approach to improving care or services is to:

- Identify barriers to achieving the desired results;
- Develop and implement interventions to address those barriers;
- Set objective goals by which to measure success; and
- Measure results against goals to assess effectiveness and make modifications when results do not meet goals.

The vast majority of our interventions to improve care can be classified into one of two categories; member engagement strategies, and provider engagement strategies. Some interventions encompass both categories. The interventions are focused on providing education and encouraging behavior change that is aligned with removing barriers to quality and appropriate care. When implementing these initiatives, we seek to identify the members or providers who would benefit the most from our proactive engagement and the best methods and timing for engagement.

Examples of potential interventions are described below.

#### Telephonic Outreach to Members with Gaps in Care

As described in response to Section J.1 regarding EPSDT, WellCare has a telephonic member outreach initiative to contact members identified as being out of compliance with certain key preventive HEDIS measures. This outreach provides education regarding the importance of missed visits and offers assistance to members with scheduling provider appointments via a three-way phone call. For members experiencing transportation issues as barriers to care, appointment scheduling can also include coordinating transportation assistance. After appointments are scheduled, members receive reminder calls one to three days prior to appointments.

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### Care Gap Alert Enhancement to our Call Centers

As described in response to Section J.1, our care gap alert initiative utilizes our technology to flag members who are experiencing identified gaps in their care. When a member who has a specific gap in care calls into member services, his or her record is flagged so the customer service representative (CSR) is made aware of the gap. The CSR, using a prescribed script, educates the member about the gap in care and offers assistance with appointment scheduling, including a three-way call with the provider's office, and transportation coordination.

### Member Incentive Programs

As described in response to Section J.1 addressing EPSDT, we view incentives as a key component of our strategy to engage members on relevant health care topics. Incentive programs work best when designed to reflect demographics of the enrolled population. Accordingly, we anticipate adding member incentive programs to the CCN program within nine to twelve months after program implementation.

### Provider Pay for Performance Quality Incentive (P4Q) Programs

As described in our response to Section J.1 regarding EPSDT, we have experience operating pay for performance quality incentive (P4Q) programs in all seven of our current Medicaid states. We plan to develop a P4Q program that is appropriate for Louisiana and to include incentives for performance based on achievement of selected HEDIS measures (see our response to S.1 for additional information on our proposed P4Q program for Louisiana).

### Provider HEDIS Rate Profile and Overdue for Visit Reports

As described in our response to Section J.1 addressing Diabetes and our response to Section G.13 addressing provider profiling, we create and disseminate profile reports comparing a PCP's HEDIS rate to those of his or her peers and to an applicable benchmark (e.g., the annual HEDIS National Medicaid 75th percentiles) for selected HEDIS measures.

We also produce and share with providers our Overdue for Visit reports. These reports identify members in the PCP's patient panel who are not compliant with specific HEDIS measures. (See response to Section G.13 for additional information.)

### Other Interventions

In addition to the key initiatives described above, we develop member and provider engagement strategies targeted to the specific PIP. Member engagement strategies might include placing information in member handbooks and newsletters and sending educational mailings. Provider engagement strategies might include sending targeted mailings containing educational material such as clinical practice guidelines and/or providing education information through on-site visits by provider relations or clinical staff, our provider handbook, newsletters, and website.

### **Evaluating the Effectiveness of Intervention**

WellCare conducts an annual QAPI evaluation for each of our Medicaid markets that includes a review and analysis of identified QI measures. In general, we evaluate effectiveness of

interventions by comparing the baseline/benchmark rate to the re-measurement rate to determine whether there has been improvement and whether improvement is statistically significant. Our next steps depend on the results of the initial evaluation. If the re-measurement rate does not meet the state's requirements or our internal goals, we will develop and implement additional interventions, re-measure, and continue the cycle until we do. If the re-measurement rate meets the state's requirements and our internal goals, we will generally continue re-measurements until we are sure that the desired improvement is permanent.

The schedule for re-measurement varies depending on the source of the measure. Measures can occur daily (e.g., call statistics), monthly (e.g., grievances), or annually (e.g., CAHPS survey). The annual QAPI evaluation provides comments on areas where the program can be modified and points to development opportunities that should be included in the following year's work plan.

### **Members of the Quality Assurance Committee**

Our QAPI committee, which we call the Quality Improvement Committee (QIC), provides oversight and approval of our QI activities, and reports to the plan's board of directors.

All identified QI opportunities, action plans/interventions, and evaluations are presented to our QIC for review and feedback. The Louisiana QIC will be chaired by the medical director of WellCare of Louisiana. Other QIC members from WellCare of Louisiana will include directors for quality improvement, clinical services, operations, regulatory affairs, human resources, and provider services as well as additional staff as deemed appropriate by the QIC from time-to-time.

The QIC will also include staff from our corporate office in Tampa, FL, including directors and managers responsible for quality improvement, finance, network development, medical economics, customer service, credentialing, claims, grievance and appeals, human resources, utilization management, case and disease management, and others as deemed appropriate by the QIC from time-to-time. We also plan to include a member advocate representative.

**J.4**

**Provide a description of focus studies performed, quality improvement projects, and any improvements you have implemented and their outcomes. Such outcomes should include cost savings realized, process efficiencies, and improvements to member health status. Such descriptions should address such activities since 2001 and how issues and root causes were identified, and what was changed.**

**Overview**

As part of our quality improvement activities at both the corporate and state level, we have performed hundreds of focus studies, quality improvement projects/performance improvement projects (PIPs), and process and program improvements since 2001. Therefore, we will highlight recent examples focused on Medicaid/CHIP populations, the services that will be provided by the CCN-Ps, and those that resulted in positive outcomes. Many of these examples as well as additional examples of our experience to positively impact the health care status of Medicaid and or CHIP populations are included in response to Section J.1.

**Description of Selected Examples**

Focus Studies/Quality Improvement Projects/Performance Improvement Projects (PIPs)

*Georgia QI Project: Diabetes*

Measure	HEDIS Measure: Comprehensive Diabetes Care
Barriers/Root Causes	<ul style="list-style-type: none"> <li>• Lack of method to reach members to receive needed services due to invalid phone numbers and addresses</li> <li>• Lack of transportation means to attend local education sessions</li> <li>• Lack of member motivation to receive needed services</li> <li>• Lack of provider recognition of importance</li> </ul>

<p>Actions/Interventions</p>	<p><i>Corporate Interventions</i></p> <ul style="list-style-type: none"> <li>• Through the HEDIS Education/Screening program, 1917 calls were conducted from April through December 2010.</li> </ul> <p><i>Georgia Interventions</i></p> <ul style="list-style-type: none"> <li>• Identified members out of compliance with HEDIS measures.</li> <li>• Contacted member to attend educational session held in the community by outreach and pharmacy staff.</li> <li>• Conducted community-based education sessions (or in-home and telephonic if necessary), assessed member knowledge, provided education, and supplied glucometers and testing supplies to members as needed.</li> <li>• Arranged PCP follow-up appointments as necessary.</li> <li>• Completed and uploaded member session information into EMMA tracking tool.</li> <li>• Created an unable to reach letter for Diabetes Education Campaign 2010.</li> <li>• Launched Diabetic Retinal Eye (DRE) exam member incentive program.</li> </ul>
<p>Outcomes</p>	<p>Year-over-Year Comparison of Administrative Data – April 2011 vs. April 2010:</p> <p>HbA1c Testing: <i>Significant improvement</i> from 74.48% to 77.68%</p> <p>Diabetic Eye Exams: <i>Significant improvement</i> from 34.21% to 39.21%</p> <p>LDC-C Screening: Improvement from 66.83% to 68.77%</p>

*Georgia QI Project: Post Partum Care*

<p>Metric</p>	<p>HEDIS Pre/Post Part Care – Post Partum</p>
<p>Barriers/Root Causes</p>	<ul style="list-style-type: none"> <li>• Lack of postpartum continued member Medicaid eligibility past eight weeks</li> <li>• Lack of valid member contact information to facilitate timely postpartum visit</li> <li>• Lack of vendor contractual focus on post-partum visit scheduling</li> <li>• Lack of member understanding of need for timely post-partum visit</li> </ul>

<p>Actions</p>	<ul style="list-style-type: none"> <li>• Revised member literature referencing timing of postpartum visit to ensure emphasis on appointment prior to 8 weeks post delivery.</li> <li>• Continued member stroller incentive.</li> <li>• Outreached members telephonically post discharge and reminded them of the importance of scheduling a postpartum visit and helped facilitate appointment scheduling via a three-way phone call.</li> <li>• Worked to redefine the vendor contract, ensuring focus on pregnancy management that includes conducting telephonic outreach to establish postpartum appointments and arrange transportation.</li> <li>• Emphasized postpartum visit during baby shower education.</li> </ul>
<p>Outcomes</p>	<p>HEDIS 2010 rate of 69.59%, which is 1.36 percentage points above the HEDIS 2009 75<sup>th</sup> percentile of 68.23%, and 3.09 percentage points less than the 90<sup>th</sup> percentile of 72.68%.</p> <p>This represents <i>an improvement from the HEDIS 2009 rate by nearly 3 percentage points.</i></p>

*Georgia QI Project: Adult CAHPS*

A 2008 WellCare of Georgia initiative is an example of how CAHPS results can be used to develop concrete initiatives to improve performance. First, the CAHPS results were analyzed to determine opportunities for improvement. Any CAHPS question with a response of less than the 50th percentile was identified as an opportunity for improvement. Subsequent interventions included providing additional training and resources to customer service representatives to increase their program knowledge and developing online authorization reports enabling PCPs to view all authorization requests for their member panel.

The interventions were successful. *For adults, between 2008 and 2009, of 14 main topics, responses to 11 showed improvement or remained the same. For children, of 11 main topics, 5 showed improvement or remained the same.* While measurements of cost savings, process efficiency attainment, and improvement to member health for this activity is embedded within our global outcomes and cannot be exclusively attributed to this activity, the activity does demonstrate an immediate change in member satisfaction.

*Georgia: ED Case Management*

High utilization of emergency department services triggers referral for case management. Upon referral a care manager completes an assessment to determine the health or social issues that are causing the member to be a frequent user of emergency department services. The care manager may employ the following strategies:

- Provide education to the member about appropriate use of the ED and alternatives;
- Provide education about available urgent care and convenience care facilities in their community as well as education around the appropriate usage of these types of facilities;
- Encourage use of the 24-hour medical advice line;

- Review care plan compliance with the member to provide information to the member about the relationship between care plan services and ED use;
- Review member records for eligibility for disease management;
- Review frequency of contact between care manager and member and increase contact as necessary; and
- When patterns of ED use indicate the necessity, consult with the member's medical home and reassess the member for possible changes in need and additional intervention.

As shown in Exhibit J.4.a, this program appears to have been successful in reducing inpatient admissions, re-admissions, and ED visits.

**Exhibit J.4.a – Georgia ED Case Management**

<b>Inpatient Admissions of Members enrolled in CM</b>			
<b>Q1-10</b>	<b>PreEnroll</b>	<b>Post Term</b>	<b>% (+/-)</b>
3 months	113	20	-82%
6 months	135	29	-79%
9 months	147	34	-77%
<b>Q2-10</b>	<b>PreEnroll</b>	<b>Post Term</b>	<b>% (+/-)</b>
3 months	188	47	-75%
6 months	258	74	-71%
9 months	289	95	-67%
<b>Q3-10</b>	<b>PreEnroll</b>	<b>Post Term</b>	<b>% (+/-)</b>
3 months	119	52	-56%
6 months	168	88	-48%
9 months	198	93	-53%
<b>Inpatient Readmissions of Members enrolled in CM</b>			
<b>Q1-10</b>	<b>PreEnroll</b>	<b>Post Term</b>	<b>% (+/-)</b>
3 months	75	20	-73%
6 months	93	29	-69%
9 months	101	34	-66%
<b>Q2-10</b>	<b>PreEnroll</b>	<b>Post Term</b>	<b>% (+/-)</b>
3 months	143	44	-69%
6 months	190	71	-63%
9 months	212	92	-57%
<b>Q3-10</b>	<b>PreEnroll</b>	<b>Post Term</b>	<b>% (+/-)</b>
3 months	91	48	-47%
6 months	130	82	-37%
9 months	146	87	-40%
<b>ED Visits of Members enrolled in CM</b>			
<b>Q1-10</b>	<b>PreEnroll</b>	<b>Post Term</b>	<b>% (+/-)</b>
3 months	90	62	-31%
6 months	155	95	-39%
9 months	203	129	-36%
<b>Q2-10</b>	<b>PreEnroll</b>	<b>Post Term</b>	<b>% (+/-)</b>
3 months	92	78	-15%
6 months	191	144	-25%
9 months	249	186	-25%
<b>Q3-10</b>	<b>PreEnroll</b>	<b>Post Term</b>	<b>% (+/-)</b>
3 months	168	148	-12%
6 months	315	232	-26%
9 months	458	266	-42%

*Georgia PIP: Adult Access to Preventive Services*

Reason for Selection	Required by the Georgia Department of Community Health (DCH)
Study Question	Will targeted interventions increase the percentage rate of adults, ages 20 – 44 years, who receive an ambulatory or preventive care visit?
Study Indicator	HEDIS Adults' Access to Preventive/Ambulatory Health Services
Barriers/Root Causes	<ul style="list-style-type: none"><li>• Lack of providers understanding the need to perform services</li><li>• Lack of communication of the PCP medical home</li><li>• Lack of member understanding the need to ask for services</li><li>• Lack of member knowledge concerning available transportation</li><li>• Preventive services are not routinely done in the emergency department (ED)</li></ul>

Interventions	<p><i>Provider Interventions</i></p> <ul style="list-style-type: none"> <li>• Updated adult preventive health care guidelines.</li> <li>• Distributed adult preventive health care guidelines through provider handbook.</li> <li>• Distributed adult preventive health care guidelines through provider newsletter.</li> <li>• Reviewed medical records to ensure providers were in compliance with the adult preventive health care guidelines and to give feedback on if improvement was needed.</li> <li>• Posted adult preventive health care guidelines on website.</li> <li>• Confirmed and maintained member access to adult PCP types: general medicine, family practitioners, internal medicine and ob/gyn; this intervention ensured that if members want to access preventive services that their PCPs are available thus allowing members to avoid the ED.</li> <li>• Ensured appointment timeliness access to be above the 90 percent goal so that members are able to schedule preventive health appointments in a timely manner, thus avoiding the ED; this intervention ensured that members have timely access to their PCPs.</li> </ul> <p><i>Member Interventions</i></p> <ul style="list-style-type: none"> <li>• Maintained ED case management focus on frequent utilization of ED for non-emergent needs and provided education to reinforce the PCP medical home.</li> <li>• Provided specific coordination of care for each member with 8 ED visits within a year; a care plan was developed specific for each member; education was provided for diagnosis, medications, and re-enforcement of the concept to utilize the PCP as the medical home.</li> <li>• Realigned staff resources to support deployment of focused member ED outreach program; target population included adult members 18-34 years; members were contacted within 48 hours of triage ED visit, instructed on PCP role, and assisted within care and/or transportation needs; a database was developed to capture call outcomes and enable consistent reporting.</li> <li>• Distributed adult preventive health care guidelines through the 2007 version of the member handbook.</li> </ul>
Outcomes	<p>Baseline (CY 2008): 78.64% (benchmark 87.72%)  Re-measurement #1 (CY 2009): 84.67% (<i>statistically significant increase from baseline</i>) (benchmark 88.27%)</p>

*Georgia PIP: Improving Childhood Immunization*

Reason for Selection	Required by the Georgia Department of Community Health (DCH)
Study Question	Does doing targeted interventions increase the rate of members receiving Combo 2 vaccinations (four DTaP, three IPV, one MMR, two Hib, three hepatitis B, one VZV) by their second birthday?
Study Indicator	HEDIS Childhood Immunization Status
Barriers/Root Causes	<ul style="list-style-type: none"> <li>• Lack of provider knowledge on required screenings</li> <li>• Lack of provider knowledge on members with care gaps</li> <li>• Lack of member knowledge of required immunization schedule</li> <li>• Lack of provider knowledge on required documentation</li> <li>• Lack of member knowledge of required screening and the importance of screening</li> <li>• Lack of member knowledge of required immunization schedule</li> <li>• Lack of provider knowledge on proper coding</li> <li>• Lack of provider knowledge of required participation</li> <li>• Lack of provider knowledge on the updated and required immunization schedule</li> </ul>

Interventions	<p><i>Provider Interventions</i></p> <ul style="list-style-type: none"> <li>• Developed provider coding grid for proper immunization claims submission.</li> <li>• Conducted annual back to school immunization drive with high volume providers.</li> <li>• Developed an algorithm on talking points for PR reps during provider telephone calls and site visits.</li> <li>• Enhanced Georgia provider web portal to provide easy access to member immunization history.</li> <li>• Distributed fax blast to providers in reference to the Vaccine for Children program sign-up.</li> <li>• Placed content in provider handbook that details the required child immunization schedule.</li> <li>• Distributed fax blast to providers in reference to the 2008 childhood immunization schedule updates.</li> <li>• Educated PCPs regarding rates for immunization and need for care (referencing Overdue for Visit reports and HEDIS Provider Toolkit) and probed PCP for plans to schedule immunizations for members overdue for a visit.</li> </ul> <p><i>Member Interventions</i></p> <ul style="list-style-type: none"> <li>• Placed content in member handbook that details the required child immunization.</li> <li>• Conducted telephonic outreach to educate members, establish appointments, arrange transportation and remind of appointments.</li> </ul>
Outcomes	<p>Baseline (CY 2008): 75.91% (benchmark 72.15%)  Re-measurement #1 (CY 2009): 81.02% (<i>increase but not statistically significant</i>) (benchmark 85.36%)</p>

*Georgia PIP: Chronic Kidney Disease*

Reason for Selection	Required by the Georgia Department of Community Health (DCH)
Study Question	Can focused provider education and targeted member education increase the rate of eGFR screening among members at risk for chronic renal disease?
Study Indicator	The percentage of WellCare of Georgia's Georgia Families members ages 5-75 identified with chronic kidney disease (CKD) or diabetes and hypertension as evidenced by claims who have been continuously enrolled during the measurement year for $\geq 9$ months and who have a claims submission of both an estimated glomerular filtration rate (eGFR) and a serum blood test for creatinine on the same date of service during the measurement year

<p>Barriers/Root Causes</p>	<ul style="list-style-type: none"> <li>• Lack of physician knowledge related to clinical practice guidelines</li> <li>• Lack of member knowledge related to the risks of diabetes</li> <li>• Lack of member and provider knowledge of available community resources</li> <li>• Lack of physician knowledge of screening members at risk for CKD</li> <li>• Lack of member knowledge related to the risks of diabetes and hypertension, chronic kidney disease and the importance of eGFR screening</li> <li>• Lack of member knowledge related to the risks of diabetes and hypertension</li> <li>• Delay of lab vendor response to contractual requirement to calculate eGFR from serum creatinine results</li> </ul>
<p>Interventions</p>	<p><i>Provider Interventions</i></p> <ul style="list-style-type: none"> <li>• Released and revised provider clinical practice guidelines for CKD.</li> <li>• Provider relations representatives distributed clinical practice guidelines during on-site visits.</li> <li>• Initiated review of provider medical records to assess compliance to the clinical practice guideline, followed by an exit interview and subsequent education if the provider scored less than 80 percent.</li> <li>• Inserted an article in provider newsletter that summarizes the CKD clinical practice guideline, provides a web link to a GFR calculator, and offered a method for practices without Internet access to receive a hardcopy version of the KDOQI Pocket Cards. The link also provides the physician with the ability to create a member specific treatment plan based on the member's GFR and educational materials for download or purchase.</li> </ul> <p><i>Member Interventions</i></p> <ul style="list-style-type: none"> <li>• Published member educational material based on the diabetes clinical practice guideline in the member newsletter.</li> <li>• Implemented disease management program to proactively identify members with diabetes through claims and encounters monthly; stratified members based on severity of disease.</li> <li>• Created and distributed a diabetes community resource list for use by member outreach coordinators, customer service, disease/case management and utilization review staff.</li> <li>• Invited via mail members with diabetes to attend educational sessions on diabetes.</li> </ul>

Outcomes	<p>Baseline (CY 2007): 35.99% (no benchmark)</p> <p>Re-measurement #1 (CY 2008): 41.57% (<i>increase but not statistically significant</i>)</p> <p>Re-measurement #2 (CY 2009): 48.80% (<i>statistically significant increase from #1 to #2</i>)</p>
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*Georgia: ED Telephonic Outreach Program*

In Georgia we have also had success reducing inappropriate utilization of emergent services with our ED telephonic outreach program. Member outreach associates contact a member within 48 hours of an ED visit (as listed on daily ED reports from participating hospitals) to identify the reason for the visit and to offer education about appropriate use of EDs and alternatives available to members. The outreach associates use a database that contains questions for the member about key aspects of the ED visit, including: the reason for the ED visit and whether the member knows the name of his PCP, needs a listing of urgent care centers, was sent home from the ED with medication, needs assistance with transportation, and is aware of our medical advice line. Analysis by month indicates a downward trend in average (mean) number of ED visits following outreach education. Our analysis of this program has found the following:

- A downward trend in average (mean) number of ED visits post outreach education.
- An upward trend in the average (mean) number of office visits post education.
- Outreach appears to have a more immediate impact on the overall number of ED visits post education rather than on office visits.

*Ohio QI Project – Well Child Visits*

Metric	<p>HEDIS Well Child Visits First 15 Months (6+)</p> <p>HEDIS Well Child Visits 3-6 years</p> <p>HEDIS Adolescent Well Care Visits</p>
Actions	<ul style="list-style-type: none"> <li>• Conducted well child 0-15 months telephonic member outreach initiative; contacted mothers of children 0-15 months identified as being in need of one or more well child preventive visits required; this outreach provided educational reminders about the importance of timely preventive services for children aged 0-15 months old and helped coordinate services with physicians.</li> <li>• Conducted well child/lead screening telephonic member outreach initiative; contacted members identified as being in need of preventive visits and lead screenings; this outreach provided automated telephonic reminders in regards to the importance of timely preventive services and lead screenings; messages included verbiage on the additional \$10 OTC incentive offered for completing these services; the outreach helped coordinate services with the member's PCP by directing the member to contact their PCP for an appointment or with any questions.</li> <li>• Conducted well child member outreach mailing initiative; contacted members identified as being in need of one or more</li> </ul>

	<p>well child preventive visits and provided educational reminders about the importance of timely preventive services and helped coordinate services with physicians by including PCP contact information.</p> <ul style="list-style-type: none"> <li>• Conducted the monthly newborn mailing member outreach initiative to contact members identified as having a live birth within the previous month; each newborn's mother receives a wallet sized immunization record keeper with scheduled reminders of immunizations and space to write the date the immunization was received; each new mother also receives a letter of congratulations with reminders in regards to immunizations, lead screening, well child visits and postpartum checkups.</li> <li>• Implemented and deployed over the counter (OTC) incentive program for all well child measures; members who obtained all well child visits by the end of 2009 received an additional \$10 OTC benefit.</li> <li>• Implemented and deployed P4Q for each qualified claim received from a network PCP for specific well child measures completed between October 15th and December 31 of the calendar year 2009.</li> </ul>
Outcomes	<p>HEDIS Well Child Visit 15 Months (6+): Significant improvement from HEDIS 2009 (47.45%) to HEDIS 2010 (66.18%), but slightly below target (67.39%)</p> <p>HEDIS Well Child Visit 3-6 years: Significant improvement from HEDIS 2009 (54.86%) to HEDIS 2010 (64.37%), and above target (59.70%)</p> <p>HEDIS Adolescent Well Visits: Significant improvement from HEDIS 2009 (27.19%) to HEDIS 2010 (39.98%), and above target (30.20%)</p> <p>Note: These HEDIS measures were not reported to the State/audited; therefore these results are not included in the table of HEDIS measures provided in response to Section J.7.</p>

*Ohio QI Project – Childhood Immunization*

Metric	HEDIS Childhood Immunization Status (combo 3)
Actions	<p>Conducted the monthly newborn mailing member outreach initiative to contact members identified as having a live birth within the previous month; each newborn's mother receives a wallet sized immunization record keeper with scheduled reminders of immunizations and space to write the date the immunization was received; each new mother also receives a letter of congratulations with reminders in regards to immunizations, lead screening, well child visits and postpartum checkups.</p>
Outcomes	<p>Significant improvement from HEDIS 2009 (60.58%) to HEDIS 2010 (63.50%), but below target (76.54%)</p>

*Ohio QI Project – Lead Screening*

Metric	HEDIS Lead Screening in Children
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<p>Actions</p>	<ul style="list-style-type: none"> <li>Conducted well child/lead screening telephonic member outreach initiative; contacted members identified as being in need of preventive visits and lead screenings; this outreach provided automated telephonic reminders in regards to the importance of timely preventive services and lead screenings; the outreach helped coordinate services with the member's PCP by directing the member to contact their PCP for an appointment or with any questions.</li> <li>Conducted the monthly newborn mailing member outreach initiative to reach out to members identified as having a live birth within the previous month; each newborn's mother receives a wallet sized immunization record keeper with scheduled reminders of immunizations and space to write the date the immunization was received; each new mother also receives a letter of congratulations with reminders in regards to immunizations, lead screening, well child visits and post partum checkups.</li> </ul>
<p>Outcomes</p>	<p>Significant improvement from HEDIS 2009 (39.66%) to HEDIS 2010 (49.52%), and above target (48.81%)</p> <p>Note: This HEDIS measure was not reported to the State/audited; therefore, these results are not included in the table of HEDIS measures provided in response to Section J.7.</p>

*Ohio QI Project – Prenatal Care*

<p>Metric</p>	<p>HEDIS Prenatal and Postpartum Care – Prenatal Care</p>
<p>Actions</p>	<p>Conducted the maternity education and prenatal reward program, which provides prenatal, postnatal and newborn care education to pregnant members and encourages certain behaviors in order to improve prenatal and postpartum preventive care participation.</p> <p>The program identifies pregnant WellCare members and provides them with educational information in the form of helpful tips for each of the three trimesters and postpartum care to assist them in having a healthy pregnancy. This material also emphasizes the importance of prenatal and postnatal appointments and encourages these members to schedule and attend all appointments.</p> <p>As a component of this program, the prenatal reward program rewards enrolled expectant mothers for receiving adequate prenatal and postpartum care according to the schedule recommended by their doctor(s).</p>
<p>Outcomes</p>	<p>Significant improvement from HEDIS 2009 (70.90%) to HEDIS 2010 (85.02%), and above target (82.76%)</p> <p>Note: This HEDIS measure was not reported to the State/audited; therefore, these results are not included in the table of HEDIS measures provided in response to Section J.7.</p>

*Florida QI Project – Breast Cancer Screening*

<p>Metric</p>	<p>HEDIS Breast Cancer Screening</p>
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<p>Actions</p>	<ul style="list-style-type: none"> <li>Conducted corporate telephonic member outreach to members with a gap in care, including breast cancer screening.</li> <li>Conducted corporate targeted outbound mailing to members with a gap in care, including breast cancer screening. The mailings provided information on the preventive screenings and supplied the members with network provider offices where they could receive these screenings.</li> </ul>
<p>Outcomes</p>	<p>For HealthEase, significant improvement from HEDIS 2008 (39.40%) to HEDIS 2010 (47.71%), and improvement from HEDIS 2009 (43.31%) to HEDIS 2010, but HEDIS 2010 below target (50.10%). Based on preliminary, unaudited data for HEDIS 2011 as of June 3, 2011, this rate improved to 48.21% (with target rate of 57.40%).</p> <p>For Staywell, significant improvement from HEDIS 2008 (43.44%) to HEDIS 2010 (48.98%), and improvement from HEDIS 2009 (47.08%) to HEDIS 2010, but HEDIS 2010 below target (50.10%). Based on preliminary, unaudited data for HEDIS 2011 as of June 3, 2011, this rate improved to 50.78% (with target rate of 57.40%).</p>

*Florida QI Project – Cervical Cancer and Chlamydia Screening*

<p>Metric</p>	<p>HEDIS Cervical Cancer Screening HEDIS Chlamydia Screening</p>
<p>Actions</p>	<ul style="list-style-type: none"> <li>Conducted corporate telephonic member outreach to members with a gap in care, including cervical cancer and chlamydia screening.</li> <li>Implemented a P4Q program in 2009 for PCPs to deliver specific preventive health screens, including cervical cancer screening.</li> </ul>
<p>Outcomes</p>	<p><i>HEDIS Cervical Cancer Screening:</i></p> <p>For HealthEase, improvement from HEDIS 2009 (48.18%) to HEDIS 2010 (55.23%), but HEDIS 2010 below target (66.50%). Based on preliminary, unaudited data for HEDIS 2011 as of June 3, 2011, this rate improved to 55.61% (with target rate of 72.00%).</p> <p>For Staywell, improvement from HEDIS 2008 (56.20%) to HEDIS 2010 (59.61%), and improvement from HEDIS 2009 (56.93%) to HEDIS 2010, but HEDIS 2010 below target (66.50%).</p> <p><i>HEDIS Chlamydia Screening:</i></p> <p>For HealthEase, significant improvement from HEDIS 2008 (49.85%) to HEDIS 2010 (60.60%), and significant improvement from HEDIS 2009 (51.44%), but HEDIS 2010 below target (61.80%).</p> <p>For Staywell, significant improvement from HEDIS 2008 (49.26%) to HEDIS 2010 (59.49%), and significant improvement from HEDIS 2009 (51.48%) to HEDIS 2010, but HEDIS 2010 below target (61.80%).</p> <p>Based on preliminary, unaudited data for HEDIS 2011 as of June 3, 2011, this rate improved to 61.07% (with target rate of 61.08%).</p>

*Florida QI Project – Lead Screening in Children*

Metric	HEDIS Lead Screening in Children
Actions	<ul style="list-style-type: none"> <li>• Conducted corporate and local telephonic member outreach to members with a gap in care, including lead screening.</li> <li>• Conducted in-home member outreach</li> <li>• Piloted a P4Q program for PCPs to deliver specific preventive health screens, including lead screening.</li> </ul>
Outcomes	<p>For HealthEase, improvement from HEDIS 2009 (40.39%) to HEDIS 2010 (48.91%), but HEDIS 2010 below target (65.90%).</p> <p>For Staywell, significant improvement from HEDIS 2009 (44.53%) to HEDIS 2010 (58.39%), but HEDIS 2010 below target (65.90%).</p>

*Florida PIP: Diabetic Eye Exams in the Spanish Speaking Population*

Reason for Selection	<p>HealthEase of Florida, Inc. has a PIP for improving diabetic care across-the-board. However, the Hispanic population with diabetes represents an underserved group and a significant health care disparity representing 1.3% of the plan’s total membership.</p> <p>After adjusting for population age differences, Mexican Americans, the largest Hispanic/Latino subgroup, are 1.7 times as likely to have diabetes as non-Hispanic whites. In 2006, diabetes was the third costliest outpatient diagnosis for the health plan. It was one of the top six causes of death in the state of Florida in 2006, as reported by the various Regional Health Planning Councils.</p> <p>The Florida Department of Health estimates that in 2005, 6.6% of diabetics had never had a dilated retinal eye exam. Diabetes can cause severe eye problems and potential blindness if the condition is not well-controlled. Thus, this study targets a significant population with a high volume, high risk, and problem prone disease.</p>
Study Question	Do targeted interventions improve the percentage of annual retinal eye exams in HealthEase Spanish speaking members, ages 18-75, with diagnosis of diabetes (type 1 and type 2)?
Study Indicator	The percentage of Spanish speaking HealthEase Medicaid members 18-75 years old with diabetes (type 1 or 2) who were continuously enrolled during the measurement year and received diabetic eye exams during that period.
Barriers/Root Causes	<ul style="list-style-type: none"> <li>• Provider noncompliance</li> <li>• Member lack of awareness</li> <li>• Member noncompliance</li> </ul>

<p>Interventions</p>	<p><i>Provider Interventions</i></p> <ul style="list-style-type: none"> <li>• Creation of diabetic flow sheet to remind providers which tests were due and enable them to track if a patient had all services necessary (including eye exam).</li> <li>• Development of a provider resource guide (toolkit) including items such as clinical practice guideline and member educational materials ready for distribution.</li> <li>• Targeted provider outreach by WellCare Quality Improvement staff member. Noncompliant diabetic member rosters are given to the provider for outreach purposes.</li> <li>• Developing a provider incentive program to reward providers for rendering preventive health services to their members.</li> <li>• Sent letters to provider regarding member incentive program and encourage them to complete the diabetes care brochure and educate to visit the eye care provider for dilated eye exam.</li> </ul> <p><i>Member Interventions</i></p> <ul style="list-style-type: none"> <li>• Telephonic outreach to engage members with a care gap in all preventive diabetic health services; member outreach coordinators facilitated appointments with the member's PCP if requested.</li> <li>• Targeted mailings to those diabetic members with a care gap in eye exams reminding them of the importance of receiving all their preventive health services.</li> <li>• Florida Quality Improvement member outreach coordinators called all Spanish-speaking members who were eligible for the PIP.</li> <li>• Mailed periodicity letters to eligible members educating them on the importance of receiving preventive health services. Letters include information specific to diabetes for those members identified as diabetic.</li> <li>• Enhanced disease management program to better educate members on improving better health outcomes.</li> <li>• Implemented a member incentive (Walgreens \$10 Gift Card) to members due for a diabetic eye exam.</li> <li>• Sent diabetes care brochure to educate members on the importance of having his or her lab work completed and to encourage him or her to receive a dilated eye exam with an eye care profession.</li> </ul>
<p>Outcomes</p>	<p>Baseline (CY 2007): 31.76%.  Re-measurement #1 (CY 2008): 37.50% (<i>increase but not statistically significant</i>).  Re-measurement #2 (CY 2009): 44.68% (<i>increase from #1 to #2 but not statistically significant</i>) (benchmark 62.7%).</p>

*Florida PIP: Improving Compliance with Anti-Depressant Medication Management*

Reason for Selection	Depression has been identified as one of the top diagnoses for behavioral health treatment. Identification and treatment of depression by primary care providers (PCP) is becoming more and more common.
Study Question	Do the interventions implemented improve member compliance with anti-depressant medication management?
Study Indicator(s)	HEDIS Antidepressant Medication Management: (1) Effective Acute Phase Treatment (84 days); and (2) Effective Continuous Treatment Phase (180 days)
Barriers/Root Causes	<ul style="list-style-type: none"> <li>• Lack of provider education around treating depression</li> <li>• Lack of member education</li> <li>• PCP and psychiatrist poor compliance with diagnosis of major depression follow up visits; practitioner writing scripts for refills without follow visits</li> <li>• Lack of PCP and psychiatrist knowledge of the formulary and appropriate medications for depression treatment</li> <li>• Lack of PCP knowledge or experience with screening tools for depression</li> <li>• Member lack of knowledge of available resources</li> <li>• Member lack of knowledge regarding clinical practice guidelines</li> <li>• Provider lack of knowledge regarding clinical practice guidelines</li> <li>• Provider knowledge of QI outcomes varies and may impact improvements</li> <li>• Provider knowledge of standards varies and may impede compliance</li> <li>• Member lack of information and or exposure to disease process</li> <li>• Member motivation and awareness of how food and diet, consistent use of medications can impact mood/depression</li> <li>• PCP knowledge of the disease process and current treatment effectiveness is not on the same level as the psychiatrist</li> </ul>

<p>Interventions</p>	<p><i>Provider Interventions</i></p> <ul style="list-style-type: none"> <li>• Provider newsletter articles, e.g., “PCP’s Treat Depression,” “Treating Behavioral Health Conditions,” “Get the Right Prescription,” “Depression Screening”.</li> <li>• Monthly fax alerts sent to PCPs informing them of the members that have been newly diagnosed with depression and/or placed on an antidepressant.</li> <li>• Behavioral medical director, medical director, and pharmacists conducted provider outreach to high-volume PCPs for training regarding protocols for prescription protocol for anti-depressant medication prescriptions and follow-up treatment.</li> <li>• Identified the top twenty-five providers of behavioral health MD services, and medical, behavioral, pharmacy, and network development staff conducted educational outreach to each provider regarding prescribing behavioral medications and the importance of HEDIS measures.</li> <li>• A depression toolkit was developed for providers, primarily for PCPs treating members with depression; the toolkit includes screening tool, diagnostic codes, the clinical practice guideline, documentation template, and a medication guide for the physician; it also includes educational information for the PCP to distribute to the member.</li> </ul> <p><i>Member Intervention</i></p> <ul style="list-style-type: none"> <li>• Member newsletter articles, e.g., “10 Things You Should Remember About Your Treatment with Antidepressants,” “Your Doctor Has Prescribed an Antidepressant”.</li> </ul>
<p>Outcomes</p>	<p><b>Study Indicator 1:</b>            Baseline (CY 2006): 42.5% (benchmark HEDIS 50th percentile – 46.3%)            Re-measurement #1 (CY 2007): 41.9% (no statistical significance) (benchmark HEDIS 75th percentile – 47.9%)            Re-measurement #2 (CY 2008): 41.4% (no statistical significance) (benchmark HEDIS 75th percentile – 48.3%)            Re-measurement #3 (CY 2009): 46.0% (no statistical significance) (benchmark HEDIS 75th percentile – 52.6%)</p> <p><b>Study Indicator 2:</b>            Baseline (CY 2006): 23.6% (benchmark HEDIS 50th percentile - 30.8%)            Re-measurement #1 (CY 2007): 26.8% (no statistical significance) (benchmark HEDIS 75th percentile – 32.3%)            Re-measurement #2 (CY 2008): 27.8% (no statistical significance) (benchmark HEDIS 75th percentile – 31.3%)            Re-measurement #3 (CY 2009): 27.3% (no statistical significance) (benchmark HEDIS 75th percentile – 35.6%)            Sustained improvement not evidenced but outcomes demonstrate a movement in a positive direction.</p>

*New York QI Project – Chlamydia Screening in Women*

Metric	HEDIS Chlamydia Screening in Women
Barriers	<ul style="list-style-type: none"> <li>• Lack of internal tracking system to monitor women who have not been screened for chlamydia</li> <li>• Members who do not get tested because they believe the test is more complicated than it actually is</li> <li>• Members who do not know the seriousness of undetected/untreated chlamydia infection</li> <li>• Members who erroneously believe they are not at-risk or are unwilling to obtain screening examinations due to psycho-social &amp;/or cultural reasons.</li> <li>• Providers who do not know that teens do not need parental consent for chlamydia screening</li> <li>• PCPs/OB-GYNs who do not take an active role offering screening to every sexually active woman in their care</li> <li>• PCPs/OB-GYNs who do not know their members are due for chlamydia screening</li> </ul>
Actions	<p><i>Provider Initiatives</i></p> <ul style="list-style-type: none"> <li>• Using the corporate QI data base, identified women (and their PCPs) who are eligible for chlamydia screening but have not received the service. PR staff hand delivered HEDIS report cards and Overdue for Visit reports to the 50 provider groups with the most members with gaps in care and delivered them by FedEx to all other providers.</li> <li>• QI staff conducted educational presentations to providers beginning with the top 50.</li> <li>• Give providers monthly report cards and Overdue for Visit lists; PCPs are expected to call their members and schedule an appointment for the screening.</li> </ul> <p><i>Member Initiatives</i></p> <ul style="list-style-type: none"> <li>• Member newsletter article about chlamydia screening and the importance of getting tested.</li> <li>• Corporate QI centralized telephonic outreach program for all women eligible for chlamydia screening; the calls stressed the importance of getting the screening and helped to schedule appointments.</li> <li>• Provider newsletter article stressing the importance of encouraging women to get chlamydia screening was sent to all providers.</li> </ul>
Outcomes	<p>This rate improved from an audited HEDIS 2010 rate of 58.40% to a preliminary, unaudited HEDIS 2011 rate of 64.64%</p>

*HEDIS Outbound Telephonic Outreach to Members with Gaps in Care*

WellCare has a telephonic member outreach initiative to contact members identified as being out of compliance with certain key preventive HEDIS measures, including:

- Adolescent well care;
- Breast cancer screening;
- Cervical cancer screening;
- Chlamydia screening;
- Lead screening; and
- Well child visits.

This outreach provides education regarding the importance of these preventive screenings and can assist the member with scheduling an appointment with his or her physician via a three-way phone call. For members experiencing transportation issues as a barrier to care, appointment scheduling can also include coordinating transportation assistance.

We believe our telephonic outreach strategy is proving effective in raising our HEDIS scores and improving the overall health care status of our members. An example of this is in our New York market, where we have experienced improvements in HEDIS rates in seven of the eight measures for which we deployed this strategy in 2010.

Exhibit J.4.b below illustrates year-over-year improvement in these measures based on the latest available administrative data. In addition, the results noted above for Florida QI projects related to breast cancer, cervical cancer, and chlamydia screening support the effectiveness of this program.

**Exhibit J.4.b – New York TANF Rates for 2010 Telephonic Outreach Measures  
(Year-over-Year Comparison of Administrative Data – April 2011 vs. April 2010)**

Measure	Administrative HEDIS 2010	Administrative HEDIS 2011	HEDIS 2010 NY State Medicaid 90th Percentile	2010-2011 Trend
Cervical Cancer Screening	61.77%	67.12%	78.00%	Significant Improvement
Chlamydia Screening	58.00%	62.72%	71.40%	Significant Improvement
Childhood Immunization (combo 3)	44.15%	44.34%	82.00%	Improvement
Lead Screening	79.98%	82.09%	94.00%	Improvement
Adolescent Well Care Visits	57.65%	61.44%	59.00%	Significant Improvement

Measure	Administrative HEDIS 2010	Administrative HEDIS 2011	HEDIS 2010 NY State Medicaid 90th Percentile	2010-2011 Trend
Well Child Visits 15 months (5 Visits)	68.50%	72.29%	66.00%	Improvement
Well Child Visits 3 – 6 years	76.94%	80.28%	83.00%	Significant Improvement

### Process Improvements

#### *All Medicaid States*

To improve our turnaround performance on prior authorization requests, in 2009 WellCare developed systematic reports to carefully track the time of receipt of authorization requests from providers and to measure the time elapsed until a response is delivered back to providers. We also provided focused training and initiated an auditing initiative to monitor decision turnaround times for expedited and standard requests. The turnaround time improved significantly.

In 2008 we implemented two initiatives to decrease our authorization denial rate. One was a significant effort to educate providers on the requirements for authorization requests, including individual meetings with providers on site and via teleconference. We also hired more utilization management (UM) staff and enhanced electronic workflow to improve the timeliness of communication between providers and UM staff, which allowed for improved communication and response time for authorizations. As a result, the overall denial rate decreased. For example, in New York the medically inappropriate denial rate for CHIP decreased from 5.84 percent to 2.24 percent.

In 2009, our customer service team continued a strong focus on quality via customer satisfaction and first call resolution (FCR) metrics. We have found a direct correlation between first call resolution and member satisfaction. To improve our performance, we implemented FCR champions, who are generally members of the leadership team that provide coaching to CSRs to drive improved results.

To improve claims processing timeframes in 2009 we refined the configuration in the claims processing system to increase the percentage of claims that are auto adjudicated. We increased the auto adjudication rate from 79.5 percent in 2008 to 82.5 percent in 2009. We also continued our outreach to providers regarding EDI, which helped drive the EDI submission rate from 83.5 percent to 85.4 percent.

In 2008, we completed extensive root cause analysis of findings regarding the accuracy of claims payments as reported by an independent audit. Step action tables (SATs) and policies and procedures were revised, enhanced, and documented. Basic and enhanced technical training was created and implemented across all states and lines of business. Processing associates received general and state-specific training for both professional and institutional claim types. As a result, financial accuracy increased to 99.2 percent.

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### *State-Specific*

A new medical record review tool was adopted by our Florida, Georgia, New York, and Ohio Medicaid plans in 2010. This tool included focused questions intended to collect data specific to a physician's performance related to asthma, diabetes, chronic kidney disease, musculoskeletal conditions, medication management and behavioral health conditions. This data will be collected via medical record reviews and compared to corresponding HEDIS indicators for further analysis. Focused provider education will be delivered to physicians and/or their office staff based on findings.

Our Georgia Medicaid plan identified an opportunity for improvement in follow-up on corrective action plans (CAPs) for appointment availability results. Now, if a provider fails an audit, that provider is placed within a separate pool of providers that are re-audited to determine if they have reached compliance. This pool is kept separate from the routine audits. For example, if a provider failed in Q2, they would be re-audited in Q4 to allow provider relations to educate that provider in Q3. This enhancement aids in ensuring compliance to required time frames.

In 2010 we conducted a pilot program in New York to systematically notify PCPs by fax when one of their members was admitted to the hospital. The goal was to encourage physician involvement with members during and after a hospital stay, with the intent of preventing re-admissions due to preventable care gaps after discharge.

Providers were notified of the program through two pre-launch fax blasts which also served to validate that the PCP fax numbers were correct. Beginning with admissions on 5/17/2010, PCPs were sent a fax notification when one of the members on their panel was admitted to the hospital. Provider relations representatives and the regional medical director conducted visits with PCPs to discuss the program and the strategies PCPs should use to schedule post-discharge visits as quickly as possible.

The program was very well received by PCPs. In addition, a review of re-admissions data showed a six percent reduction in the re-admission rate comparing Q4 of 2009 to Q4 of 2010, which exceeded our project goal of five percent. The pilot will be rolled out in other states later this year.

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## J.5

**Describe your proposed Quality Assessment and Performance Improvement (QAPI).**

**Such description should address:**

- **The Performance Improvement Projects (PIPs) proposed to be implemented during the term of the contract.**
- **How the proposed PIPs will expand quality improvement services.**
- **How the proposed PIPs will improve the health care status of the Louisiana Medicaid population.**
- **Rationale for selecting the particular PIPs including the identification of particular health care problems and issues identified within the Louisiana Medicaid population that each program will address and the underlying cause(s) of such problems and issues.**
- **How you will keep DHH informed of QAPI program actions, recommendations and outcomes on an ongoing and timely manner.**
- **How the proposed PIPs may include, but is not necessarily, limited to the following:**
  - **New innovative programs and processes.**
  - **Contracts and/or partnerships being established to enhance the delivery of health care such as contracts/partnerships with school districts and/or School Based Health Clinics.**

## QAPI

WellCare has a robust and comprehensive Quality Assessment and Performance Improvement (QAPI) program that addresses both the quality and safety of clinical care and the quality of services provided to members. The key components of our QAPI for Louisiana Medicaid will include:

- Access/availability monitoring
- Analysis of UM data, particularly under- and over-utilization
- Clinical practice guideline development and review
- Continuity and coordination of care, including PCMH
- Chronic care/disease management
- Case management
- Patient safety review
- CAHPS survey
- Analysis of member grievances
- Provider satisfaction survey
- Analysis of provider complaints
- Provider advisory councils
- Credentialing, re-credentialing, and monitoring providers
- Provider profiling
- Medical record review

- Peer review
- Analysis of operational service performance
- Cultural competency
- Delegation oversight
- QI Studies
- PIPs

## **Proposed PIPs**

### Study Topics and Indicators

As provided in Section 14.3.8 of the RFP, DHH may require WellCare to conduct up to four PIPs during the term of the contract. The RFP requires each CCN to perform a minimum of two DHH approved performance improvement projects (PIPs) during the first contract year; one of which has been specified by DHH (number of ED visits per 1,000 member months). Each CCN may choose the second PIP from those listed in Section 2 of Appendix DD of the RFP.

In our application to DHH in the fall of 2010, we selected the HEDIS measure Well Child Visits in the First 15 Months of Life (6+ visits), and we still intend to select that as our second PIP in the first year. In the second contract year, we propose to continue both of those PIPs and add a PIP for childhood obesity (assuming that we are not limited to Appendix DD). The proposed study indicator for this PIP is the HEDIS measure Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, which currently measures BMI percentile, counseling for nutrition, and counseling for physical activity.

For the third year we propose to continue those three PIPs and add a PIP for asthma (again, assuming that we are not limited to Appendix DD in the third year). The study indicator for this PIP would be the asthma HEDIS measure Use of Appropriate Medication for People with Asthma.

In summary, we propose to implement the following PIPs:

- Year 1: ED utilization and well child visits in the first 15 months of life
- Year 2: Continue PIPs from year 1 and implement pediatric obesity PIP
- Year 3: Continue PIPs from year 1 and year 2 and implement asthma PIP

### Potential Interventions

As discussed in our response to Section J.3, the vast majority of our interventions to improve care can be classified into one of two categories – member engagement strategies or provider engagement strategies – with some interventions encompassing both categories. The interventions are focused on providing education and encouraging behavioral change that is aligned with removing barriers to quality, appropriate care. When implementing these initiatives, we seek to identify the members or providers who would benefit the most from our proactive engagement, as well as the optimal channel, forum and timing to engage them. Examples of potential member and provider interventions for each proposed PIP are identified below.

### *ED Utilization*

Potential member and provider interventions to improve performance regarding ED utilization include:

- Telephonic outreach to members within 48 hours of a non-emergency ED visit to offer education about appropriate use of the ED and alternatives available to the member, including our medical advice line (see, e.g., the description of Georgia's ED telephonic outreach program in our response to Section J.1);
- Telephonic outreach to members with four or more visits to the ED in the past six months to discuss alternatives to the ED and offer assistance in finding a PCP, scheduling an appointment, and arranging transportation (see, e.g., the description of Ohio's ED diversion program in our response to Section J.1);
- Educational materials outreach program, including a nationally-recognized child sick-care book (see, e.g., the description of Georgia's ED materials outreach program in our response to Section J.1);
- Referral to case management for education, review of care plan compliance, and, as necessary, consultation with the member's medical home (see, e.g., the description of Georgia's ED Case Management program in our response to Section J.1); and
- Notifying PCPs of members who are frequently using the ED.

### *Well Child Visits in the First 15 Months*

Potential member and provider interventions to improve performance regarding Well Child Visits in the First 15 Months include:

- Telephonic outreach to members with care gaps (for additional information please see our response to Sections J.1 and J.3);
- Care Gap alert enhancement to our call centers (for additional information please see our response to Sections J.1 and J.3);
- Member incentive program (for additional information please see our response to Sections J.1 and J.3);
- Provider pay for performance quality incentive (P4Q) program (for information on the P4Q program that we propose for Louisiana, please see our response to Section S.1); and
- Provider HEDIS rate profiles and Overdue for Visit reports (for additional information please see our response to Section G.13 regarding provider profiling).

### *Pediatric Obesity*

Potential member and provider interventions for the pediatric obesity PIP include:

- Distributing clinical practice guideline for childhood obesity with recommendation to increase provider awareness of current AAP guidelines for monitoring BMI;
- Provide fitness and exercise and good nutrition *pocket doctors* for providers to distribute as a routine part of office education;
- Conducting targeted member mailings with education and outreach materials;

- Conducting targeted automated voice messaging to members;
- Including relevant articles in the member newsletter;
- Providing member incentives (e.g., gift cards);
- Conducting provider education and outreach including mailings and publishing articles in the provider newsletter;
- Collaborating with provider advisory councils; and
- Collaborating with community/government groups such as the Louisiana Council on Obesity Prevention and Management (LA Obesity Council).

For additional information about most of these interventions, please see the description of our pediatric obesity programs in Georgia and New York included in response to Section J.1.

#### *Use of Appropriate Medication for People with Asthma*

Potential member and provider interventions to improve the use of appropriate medication for people with asthma:

- HEDIS education and screening program (ESP), which uses HEDIS disease management nurses to contact members who are not compliant with the applicable measure (for additional information, please see our description in Section J.1);
- Conducting targeted member mailings with education and outreach materials;
- Including relevant articles in the member newsletter;
- Providing providers with lists of non-compliant members;
- Conducting provider education and outreach including mailings and publishing articles in the provider newsletter;
- Provider pay for performance quality incentive (P4Q) programs (for information on the P4Q program that we propose for Louisiana, please see our response to Section S.1);
- Collaborating with provider advisory councils; and
- Collaborating with community/government groups such as the Louisiana Asthma Surveillance Collaborative (LASC).

As WellCare builds its presence in the Louisiana Medicaid market, we will continually seek out community partners and local consortiums with which we can work to develop innovative programs above and beyond the basic activities defined previously for each PIP.

#### **How Proposed PIPs Will Improve Quality**

Our proposed PIPs will improve and expand the quality of care provided to members by providing outreach and education to providers on recommended well child visits, provider counseling related to pediatric obesity, and improving the appropriate use of medications for members with asthma. Based on our experience in other states, provider education and outreach can positively impact the quality of service delivered by providers. Some of the typical barriers to providing quality services are lack of knowledge or awareness of current practice guidelines, recommended treatment, and/or the disease process, and providing education and outreach helps overcome those barriers.

The PIP for well child visits will improve quality by educating providers about the importance and components of these visits. The PIP for pediatric obesity will improve quality by educating providers about the recommended frequency for conducting a BMI assessment, providing clinical practice guidelines for childhood obesity, and providing fitness and exercise and good nutrition *pocket doctors* for providers to distribute. The PIP for asthma will improve quality by providing outreach and education through empathizing to providers about the appropriate use of asthma medication, including clinical practice guidelines and office visits by QI staff.

In addition, our use of provider incentive payments above and beyond Medicaid fee for service reimbursement for select measures will further aid in our attempt to improve quality. Providers will be more proactive in getting patients in for necessary preventive services and we will develop stronger relationships with them to improve health outcomes.

### **How PIPs Will Improve Health Care Status**

Our proposed PIPs will improve the health care status of Louisiana Medicaid members by focusing on increasing well child visits, increasing provider counseling related to pediatric obesity, and increasing the appropriate use of medications for members with asthma, thus reducing the likelihood of more advanced disease/condition states when such services are delayed or not received at all.

Receiving the recommended services should improve member health care status. Well child visits include medical services important to the health and well-being of infants and provide clinicians the opportunity to assess a child's physical, behavioral, and developmental status. Research shows an association between increased well child visits and a reduction in avoidable hospitalizations and ED use. If a provider calculates a child's BMI and provides related counseling and education, and the member is provided additional education and outreach, it may increase the likelihood that the member will modify his or her behavior to maintain a healthy BMI, which should improve his or her health care status. Appropriate use of asthma medication has a direct impact on health care status, including the ability to breathe. Also, patients with inappropriate use of asthma medications are more likely to be admitted to hospital, be admitted more frequently, and are more likely to go to the emergency department.

### **Rationale for Selecting PIPs**

We selected these PIPs based on information gleaned about the overall health status of the potential CCN membership and based on our experience with Medicaid/CHIP membership in other states with close similarities in acuity to Louisiana.

#### Well Child Visits in the First 15 Months

We selected this PIP for various reasons, including:

- Well child exams include medical services important to the health and well-being of infants, including exams and tests such as vision, hearing, and lab services as well as administration of vaccinations;
- Well child visits provide clinicians the opportunity to assess a child's physical, behavioral, and developmental status and provide any necessary treatment, intervention, or referral to a specialist;

- Well child visits are critical to detect physical, developmental, behavioral, and emotional problems at an early stage;
- Compliance with preventive care guidelines, including the recommended number of visits, can improve child health;
- Research has found associations between increased well child visits and reductions in avoidable hospitalizations and ED use;
- A significant number of children under 15 months will be enrolled in a CCN-P or CCN-S (approximately seven percent of total potential enrollment);
- Louisiana's baseline for this measure is less than the NCQA National Medicaid HEDIS 50th percentile; and
- We have developed several interventions to increase this rate, and we have experience improving this rate.

### Pediatric Obesity

We selected this PIP for various reasons, including:

- According to a recent report released by Pennington Biomedical Research Center, more than 47 percent of children in Louisiana between the ages of two and 19 are overweight or obese;
- Obesity is a major public health threat contributing to increased morbidity and mortality;
- Obesity is a risk factor for many of the leading chronic diseases that lead to premature death, including diabetes and hypertension;
- There is strong evidence that combined lifestyle interventions of a low calorie diet, increased physical activity, and behavior strategies (e.g., self-monitoring) are successful in producing weight loss;
- Many parents do not perceive obesity as an issue and will not institute changes in the quantity or quality of the food or exercise their children get unless an associated health issue has been identified;
- Louisiana's baseline for this measure is less than the NCQA National Medicaid HEDIS 25th percentile; and
- We have developed several interventions to improve this HEDIS rate, including QI projects/PIPs in Georgia and New York (see our response to Section J.1 for a description of these programs), that, with modest modifications can be immediately deployed in Louisiana.

### Use of Appropriate Medications for People with Asthma

We selected this PIP for various reasons, including:

- Asthma is one of the most prevalent chronic diseases;
- According to the 2008 Louisiana Asthma Surveillance Report, 2.22 percent of Louisiana Medicaid members have asthma;
- Appropriate use of asthma medications reduces the severity of symptoms and improves quality of life;

- Appropriate use of asthma medication prevents exacerbations that can increase the risk of emergency department (ED) visits, hospitalizations, and death from asthma;
- Appropriate use of medication could potentially prevent a significant proportion of asthma-related costs (hospitalizations, ED visits, and missed work and school days);
- Despite the effectiveness of asthma medications, their association with some degree of unwanted side effects may lead to reduced treatment compliance;
- According to the Asthma Regional Council (as cited by NCQA), two-thirds of adults and children who display asthma symptoms are considered “not well controlled” or “very poorly controlled” as defined by clinical practice guidelines;
- Studies of Medicaid populations have reported under-utilization of asthma control medications and lower prescription rates compared to privately insured patients;
- Asthma is the leading chronic condition that causes children to miss school; and
- We have developed several interventions to increase this rate that can be immediately deployed in Louisiana.

### **Keeping DHH Informed of QAPI Activities**

We will keep DHH informed of QAPI activities, recommendations, and outcomes through the written description of our QAPI program, the QAPI work plan, the QAPI evaluation, QIC and QIC sub-committee meeting minutes, QAPI reports (Section 14.2.4 of the RFP), reports on performance measures (Section 14.3.3 of the RFP), other programmatic reporting (e.g., grievances, access and availability, chronic care management, case management), PIPs, annual CAHPS surveys, annual provider satisfaction surveys, and external independent review. In addition, if desired, we will participate in any DHH quality forums such as clinical advisory councils, to provide updates on QAPI activities and outcomes.

### **Innovative Programs and Partnerships**

Our PIPs will include various innovative programs and processes, such as telephonic outreach to members with care gaps, the care gap alert enhancement to our call centers, member incentive programs, P4Q programs, Overdue for Visit reports, and provider advisory councils.

We have met with the Louisiana Assembly on School-Based Health Care, and they have signed a letter of intent (LOI) with us on behalf of all of the school-based health centers and clinics in Louisiana. WellCare has met by telephone and in-person with Matthew Valliere and Dr. Takeisha Davis of the Office of Public Health. We discussed various opportunities to make pediatric health care improvements through evidence-based services and information sharing. Both parties have agreed that our highest priority should be to address childhood obesity. WellCare will continue these discussions following contract award to determine how we can best work with the Office of Public Health.

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## **J.6**

***Describe how feedback (complaints, survey results etc.) from members and providers will be used to drive changes and/or improvements to your operations. Provide a member and a provider example of how feedback has been used by you to drive change in other Medicaid managed care contracts.***

WellCare has a structured approach to measuring program effectiveness and improvement. Operating Medicaid managed care programs in seven states has afforded us the opportunity to design effective monitoring strategies that are relevant for each individual market and its associated challenges.

### **Member Feedback Tracking and Usage**

WellCare uses several strategies to monitor the ongoing satisfaction of our members. Members calling into our call center have the opportunity to complete a post call survey to measure member satisfaction; callers are able to opt-in to the survey prior to speaking with a customer service representative (CSR). The survey results are used to determine areas in which additional CSR training is needed and to make overall program improvements.

As a standard practice, we conduct an annual member satisfaction survey, using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. CAHPS results are analyzed and used to help improve service delivery.

### **Provider Feedback and Usage**

Network providers will play an integral role in planning, designing, implementing and monitoring/reviewing our quality activities, including participation on provider advisory councils, quality committees, provider complaints and appeals, provider surveys, hosting visits by provider relations representatives, and ongoing monitoring of care. Their clinical expertise and interaction with members is essential in monitoring quality of care.

Providers are members of three WellCare quality committees: the Utilization Management Medical Advisory Committee (UMAC), the Credentialing and Peer Review Committee, and the Pharmacy & Therapeutics Committee. Through these forums, providers will participate in and provide advice for WellCare activities.

WellCare analyzes provider complaints and appeals to evaluate provider satisfaction. The data are analyzed, tracked and trended on a monthly basis to determine patterns and presented quarterly to the UMAC. The data are sorted by type of provider and by type of complaint to identify the top reasons for provider dissatisfaction. During the UMAC meetings, these top reasons are discussed, and individual owners are assigned to review the details and solve the root cause of the issue.

We will survey network providers on an annual basis and as needed to assess provider satisfaction with the plan. Our provider relations department will review and analyze the survey results and develop an action plan. The results and action plan will be presented to the UMAC, QIC, and board of directors for approval and recommendations.

provider relations staff will conduct regularly scheduled, on-going, face-to-face visits with providers throughout the year. These visits can include discussion of quality initiatives, including reports of members who have gap in care. WellCare has consistently involved providers in ad hoc discussions when implementing new programs or modifying existing programs. Likewise, WellCare seeks provider feedback via ad hoc focus groups.

### **Example of Use of Member Feedback**

A 2008 WellCare of Georgia initiative is an example of how CAHPS results can be used to develop concrete initiatives to improve plan performance. First, the CAHPS results were analyzed to determine opportunities for improvement (e.g., any CAHPS question with a response less than the 50th percentile). Interventions ranged from providing additional training and resources to customer service representatives to increase their program knowledge, to developing online authorization reports enabling PCPs to view all authorization requests for their member panel.

The interventions seem to have been successful. For adults, between 2008 and 2009, of 14 main topics, responses to 11 showed improvement or remained the same. For children, of 11 main topics, 5 showed improvement or remained the same. The Georgia initiative demonstrates that members know what they like and what they do not like. Furthermore, it is a clear example of how member feedback can be used effectively to improve customer service.

## CAHPS® Survey Results – All Groups

Comparison of Key Drivers for Medicaid Adult and Medicaid Child				
Composites / Ratings	Medicaid Adult	Adult Score	Medicaid Child	Child Score
Getting Needed Care	✓	76.2%	✓	80.0%
How Well Doctors Communicate	✓	89.1%	✓	90.8%
Customer Service	✓	76.5%	✓	86.5%
Shared Decision Making	✓	63.3%	NA	60.9%
Coordination of Care	✓	71.8%	✓	77.1%

**Key Driver Legend**

- = Strength (≥75<sup>th</sup> percentile)
- = Monitor (between 50<sup>th</sup> and 75<sup>th</sup> percentile)
- = Opportunity (<50<sup>th</sup> percentile)

## CAHPS® 2009 Action Plans



### What are we doing?

Metric	Action Plan & Prior Intervention	Time-frame
<b>Customer Service Operations: Customer Service</b> – Getting information/help from customer service, Treated with courtesy/respect by customer service  [Medicaid Adult]	1. Medicaid content calls	1. Weekly
	2. CSAT / FCR calls	2. Weekly
	3. Quality calls	3. 2x / week
	4. Knowledge assessments	4. Monthly
	5. Training governance program	5. Ongoing
	6. Quality governance program	6. Ongoing
	7. Frequent / unannounced onsite visits to vendor	7. Ongoing
	8. Robust communication flow via announcements and team meeting agendas	8. Ongoing
	9. Complete reconciliation of GA Medicaid reference tools / FAQs / SATs	9. Complete
	10. Customer Service holding multiple contests designed to reward and recognize outstanding CSR performance	10. Ongoing
	11. Implementation of FCR champion to assist in coaching outliers and reduction of multiple calls	11. Ongoing
	12. Supervisors review calls and attend calibration sessions on a regular basis (minimum 2 times per week)	12. Ongoing
	13. Improvement in knowledge and system navigation through enhanced promotion of WCL	13. Ongoing

\*Key WCGA Metrics are those approved by DCH for the Quality Improvement Activity (QIA) on Member Satisfaction

## CAHPS® 2009 Action Plans



### What are we doing?

Metric	Action Plan	Time-frame
<b>Provider Relations: Getting Needed Care</b> – Ease of getting appointment with Specialist, Getting care, tests, or treatments as necessary  [Medicaid Adult]	1. Plan conducts quarterly telephone audits to ensure appointment availability standards are met	Ongoing
	2. Utilize Geo-Access reports to determine network gaps	Ongoing
<b>Provider Relations: How Well Doctors Communicate</b> – Doctors explaining things in an understandable way, Doctors listening carefully to you, Doctors showing respect for what you had to say, Doctors spending enough time with you or your child  [Medicaid Child]	1. Provider Relations research member issues / grievances to identify opportunities for additional education/intervention.	Ongoing
<b>Provider Relations: Coordination of Care</b> – Provider is informed/up-to-date about care received from other providers  [Opportunity for Adult and Monitor for Child]	1. On-line authorization reports available for PCP's to view auth requests for member panel	Ongoing

2009 CAHPS® Action Plans:  
PIP Measures (est. in 2006)

**What are we doing?**

Metric	Action Plan	Time-frame
<b>Provider Relations: Rating of Personal Doctor</b> – How pleased is the Child Member’s parents/guardian with the Child’s Primary Care Provider	1. Provider Relations research member issues / grievances to identify opportunities for additional education/intervention.	Ongoing
<b>Provider Relations: Coordination of Care</b> – Provider is informed/up-to-date about care received from other providers	1. On-line authorization reports available for PCP’s to view auth requests for member panel	Ongoing

## **Example of Use of Provider Feedback**

Provider satisfaction was the subject of a 2009-2010 performance improvement project (PIP). The study focused on provider satisfaction as assessed through survey data. Study indicators included:

- Provider satisfaction with the number of network providers available for consultation or specialty care;
- Provider satisfaction with provider service field representative timeliness to answer questions and/or resolve problems; and
- Provider satisfaction with the timeliness of UM's precertification process.

During the course of the study, barriers to success were identified, these barriers included:

- Lack of provider knowledge regarding prior approval standards and information required to complete a request.
- Provider perception of increased approval requirements on more types of services due to transition to a managed care environment.
- Geographic challenges to the network: some rural Georgia counties do not contain specialists of specific types or contain specialists unwilling to contract with WellCare.
- Lack of performance standardization or monitoring across the company.
- Provider relations representative lack of knowledge due to limited training programs at implementation.
- Lack of provider satisfaction with the timeliness of UM pre-certification process.
- Lack of database to log provider interactions.
- Need for trending provider concerns to determine causes for dissatisfaction.
- Lack of provider and office staff knowledge regarding the source for verification of member eligibility status.
- Lack of provider understanding regarding required documentation for obtaining prior authorizations.
- Need for additional training on processing standard and expedited authorization requests.

The improvement strategies implemented as part of the study to address the above barriers included:

### Satisfaction with the Specialist Network

- Identified PCP referral patterns and recruited needed specialists (Operations Committee);
- Enhanced interdepartmental processes to continue full compliance with NCQA credentialing standards to ensure a quality provider network (QIC);
- Used feedback from providers regarding network deficiencies to create recruitment strategies (Operations Committee); and

- Documented provider concerns and feedback in the Salesforce database (Operations Committee).

#### Satisfaction with Provider Relations Services

- Implemented and trained the PR representatives on the use of the Salesforce database (Operations Committee);
- Documented provider concerns and feedback in the Salesforce database used by the PR representatives to determine trends in provider dissatisfaction (Operations Committee);
- Developed a new provider orientation process;
- Implemented provider quartiling and PR metrics (Operations Committee);
- Opened a new Customer Service Call Center in Augusta, GA to handle provider calls with Georgia-specific plan information (CSQIC); and
- Notified providers that member eligibility can also be verified online.

#### Satisfaction with Timeliness of Utilization Management

- Promoted the use of a website created for providers to use in requesting authorizations. This led to a reduction in prior authorization call volume by 15 percent from June 2009 to August 2009;
- Implemented monthly monitoring of all expedited authorization requests as part of the process improvement initiative;
- Developed training and workflow documents for standard and expedited classifications of authorizations;
- Created contract and process improvement training emphasizing recognition and processing of urgent/expedited requests;
- Evaluated and revised UM policies, when appropriate, based on feedback from network providers (UMAC);
- Tracked response times for authorization requests to ensure timely responses to providers while allowing adequate time for additional information when necessary for authorization approval (UMAC);
- Published enhanced web functionality article in the provider newsletter (QIC);
- Implemented a new reconsideration process for authorization requests that includes the enhancement of the peer-to-peer process (UMAC); and
- Implemented a new database, EMMA, to enhance timeliness and data tracking (UMAC).

Members of the customer service quality improvement committee (CSQIC) and the Quality Improvement Committee (QIC) reviewed the survey results, discussed root causes and recommended interventions for improvement to the identified attributes which scored between the 25th and 75th percentiles. The CSQIC membership consists of representation from Customer Service, Appeals, Grievance, and several Georgia market departments. The QIC is made up of representatives from Health Services, Credentialing, Network Development, Claims, Customer Service, delegated vendors and market directors.

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## **J.7**

**Provide, in Excel format, the Proposer's results for the HEDIS measures specified below for the last three measurement years (2007, 2008, and 2009) for each of your State Medicaid contracts.**

**If you do not have results for a particular measure or year, provide the results that you do have.**

**If you do not have results for your Medicaid product line in a state where you have a Medicaid contract, provide the commercial product line results with an indicator stating the product line.**

**If you do not have Medicaid HEDIS results for at least five states, provide your commercial HEDIS measures for your largest contracts for up to five states (e.g., if you have HEDIS results for the three states where you have a Medicaid contract, you only have Medicare HEDIS for one other state, provide commercial HEDIS results for another state).**

**If you do not have HEDIS results for five states, provide the results that you do have.**

**In addition to the spreadsheet, please provide an explanation of how you selected the states, contracts, product lines, etc. that are included in the spreadsheet and explain any missing information (measure, year, or Medicaid contract). Include the Proposer's parent organization, affiliates, and subsidiaries**

**Provide results for the following HEDIS measures:**

- **Adults' Access to Preventive/Ambulatory Health Services**
- **Comprehensive Diabetes Care- HgbA1C component**
- **Chlamydia Screening in Women**
- **Well-Child Visits in the 3,4,5,6 years of life**
- **Adolescent Well-Care**
- **Ambulatory Care - ER utilization**
- **Childhood Immunization status**
- **Breast Cancer Screening**
- **Prenatal and Postpartum Care (Timeliness of Prenatal Care and Postpartum Care)**
- **Weight Assessment and Counseling for Nutrition and Physical Activity in Children/Adolescents**

**Include the Proposer's parent organization, affiliates, and subsidiaries.**

WellCare has extensive experience with Medicaid HEDIS measures, including numerous measures not listed above. However, as specified by this question, we are only providing results for the HEDIS measures referenced above. The tables on the following pages provide results for the above referenced HEDIS measures for each of WellCare's Medicaid/CHIP lines of business. This includes plans in Florida (HealthEase and Staywell), Georgia, Hawai'i, Illinois, Missouri, New York, and Ohio. No existing Medicaid/CHIP line of business has been omitted. However, we are missing information for various measures and years.

- **Grey shading** means that the measure did not exist for that year.

- “NA” indicates that the applicable measure was not required by the state in the applicable year and therefore was not audited. (In some cases we calculated the measure in accordance with HEDIS specifications, but if we are not required to report the measure to the state, we do not have the measure audited by our vendor, so we did not include it in the table).
- “NR” indicates that the applicable measure was not reportable due to a low denominator.

In addition, please note the following:

- Until 2010 the Georgia Department of Community Health (DCH), which administers the Georgia Medicaid program, required the reporting of various HEDIS-like measures by managed care organizations and then switched to true HEDIS measures in 2010.
- Similarly, the Ohio Department of Jobs and Family Services (ODJFS), which administers the Ohio Medicaid program, requires health plan reporting of mostly HEDIS-like measures.
- Our Hawai'i contract was implemented in February of 2008, so the first reporting year for HEDIS was calendar year 2009 (HEDIS 2010). Based on the manner in which HEDIS rates are calculated tied to continuous enrollment and other timed elements, the 2010 report for calendar year 2009 would have been the first possible reporting year by technical specification.

**FLORIDA HEALTHEASE**

<b>MEASURE</b>	<b>HEDIS 2008</b>	<b>HEDIS 2009</b>	<b>HEDIS 2010</b>
<b>ADULT ACCESS TO PREVENTIVE/AMBULATORY SERVICES</b>			
AGES: 20-44	NA	69.45%	68.07%
AGES: 45-64	NA	79.99%	79.27%
AGES:65+	NA	69.41%	62.12%
COMBINED	NA	72.50%	70.50%
<b>COMPREHENSIVE DIABETES CARE</b>			
HbA1c TESTING	75.18%	71.35%	78.35%
POOR HbA1c CONTROL	44.28%	52.55%	45.01%
GOOD HbA1c CONTROL <7	NA	NA	NA
GOOD HbA1c CONTROL <8	34.55%	39.23%	45.26%
EYE EXAM	39.42%	39.96%	52.31%
LDL-C SCREENING	75.67%	72.45%	77.86%
LDL-C LEVEL <100	32.36%	27.92%	33.33%
BLOOD PRESSURE CONTROL <130/80	NA	NA	NA
BLOOD PRESSURE CONTROL <140/90	NA	NA	NA
NEPHROPATHY	73.97%	70.80%	76.64%
<b>CHLAMYDIA SCREENING IN WOMEN</b>			
16-20 YEARS OLD	46.22%	48.55%	57.14%
21-25 YEARS OLD (Retired 2010)	53.87%		
21-24 YEARS OLD		56.22%	66.13%
COMBINED TOTAL	49.85%	51.44%	60.60%
<b>WELL CHILD VISITS 3-6 YEARS OLD</b>	72.75%	71.05%	69.71%
<b>ADOLESCENT WELL CARE VISITS</b>	41.61%	47.20%	42.82%
<b>AMBULATORY ER VISITS</b>			
AGE <1 VISITS	12,221	11,846	13,289
AGE <1 VISITS/1000 MEMBER MONTHS	100.26	95.95	109.15
AGE 1-9 VISITS	35,650	36,607	53,676
AGE 1-9 VISITS/1000 MEMBER MONTHS	50.33	50.97	61.88
AGE 10-19 VISITS	17,418	19,131	27,198
AGE 10-19 VISITS/1000 MEMBER MONTHS	39.45	42.61	49.48
AGE 20-44 VISITS	33,406	36,201	46,961
AGE 20-44 VISITS/1000 MEMBER MONTHS	108.41	114.95	119.71
AGE 45-64 VISITS	8,411	9,566	11,434
AGE 45-64 VISITS/1000 MEMBER MONTHS	83.63	92.06	97.06
AGE 65-74 VISITS	661	495	604
AGE 65-74 VISITS/1000 MEMBER MONTHS	29.32	27.03	31.61
AGE 75-84 VISITS	214	204	182
AGE 75-84 VISITS/1000 MEMBER MONTHS	22.57	25.45	23.00
AGE 85+ VISITS	55	58	45
AGE 85+ VISITS/1000 MEMBER MONTHS	21.72	26.10	18.81
TOTAL VISITS	108,036	114,108	153,389
TOTAL VISITS/1000 MEMBER MONTHS	62.99	65.65	73.70

MEASURE	HEDIS 2008	HEDIS 2009	HEDIS 2010
<b>CHILDHOOD IMMUNIZATION STATUS</b>			
DTP	NR	81.75%	83.94%
IPV	NR	90.02%	88.81%
MMR	NR	92.94%	91.00%
HiB	NR	95.13%	94.65%
HEP B	NR	89.05%	91.00%
VZV	NR	90.51%	90.75%
PNEUMOCOCCAL CONJUGATE	NR	73.24%	76.89%
HEP A		NA	NA
ROTAVIRUS		NA	NA
INFLUENZA		NA	NA
COMBO 2	NR	75.43%	79.32%
COMBO 3	NR	65.21%	70.80%
COMBO 4		NA	NA
COMBO 5		NA	NA
COMBO 6		NA	NA
COMBO 7		NA	NA
COMBO 8		NA	NA
COMBO 9		NA	NA
COMBO 10		NA	NA
<b>BREAST CANCER SCREENING</b>	39.40%	43.31%	47.71%
<b>PRENATAL AND POSTPARTUM CARE</b>			
TIMELINESS OF PRENATAL CARE	74.70%	67.64%	64.96%
POSTPARTUM CARE	62.53%	50.85%	50.12%
<b>WEIGHT ASSESSMENT AND COUNSELING FOR NUTRITION AND PHYSICAL ACTIVITY FOR CHILDREN/ADOLESCENTS</b>			
BMI 3-11		NA	NA
BMI 12-17		NA	NA
BMI TOTAL		NA	NA
NUTRITION 3-11		NA	NA
NUTRITION 12-17		NA	NA
NUTRITION TOTAL		NA	NA
PHYSICAL ACTIVITY 3-11		NA	NA
PHYSICAL ACTIVITY 12-17		NA	NA
PHYSICAL ACTIVITY TOTAL		NA	NA

NA - Not Applicable  
 NR - Not Reportable

**FLORIDA STAYWELL**

<b>MEASURE</b>	<b>HEDIS 2008</b>	<b>HEDIS 2009</b>	<b>HEDIS 2010</b>
<b>ADULT ACCESS TO PREVENTIVE/AMBULATORY SERVICES</b>			
AGES: 20-44	NA	71.31%	69.90%
AGES: 45-64	NA	83.60%	81.86%
AGES:65+	NA	67.62%	64.12%
COMBINED	NA	74.76%	72.70%
<b>COMPREHENSIVE DIABETES CARE</b>			
HbA1c TESTING	70.32%	73.54%	73.48%
POOR HbA1c CONTROL	52.55%	46.53%	46.72%
GOOD HbA1c CONTROL <7	NA	NA	NA
GOOD HbA1c CONTROL <8	27.49%	45.80%	43.31%
EYE EXAM	26.03%	41.10%	52.80%
LDL-C SCREENING	70.80%	75.18%	75.91%
LDL-C LEVEL <100	25.55%	33.39%	36.25%
BLOOD PRESSURE CONTROL <130/80	NA	NA	NA
BLOOD PRESSURE CONTROL <140/90	NA	NA	NA
NEPHROPATHY	75.91%	76.28%	75.67%
<b>CHLAMYDIA SCREENING IN WOMEN</b>			
16-20 YEARS OLD	47.10%	49.81%	57.46%
21-25 YEARS OLD (Retired 2010)	52.72%		
21-24 YEARS OLD		54.88%	63.36%
COMBINED TOTAL	49.26%	51.48%	59.49%
<b>WELL CHILD VISITS 3-6 YEARS OLD</b>	76.89%	75.91%	78.35%
<b>ADOLESCENT WELL CARE VISITS</b>	46.23%	50.85%	45.26%
<b>AMBULATORY VISITS</b>			
AGE <1 VISITS	12,105	12,589	13,126
AGE <1 VISITS/1000 MEMBER MONTHS	96.81	95.57	104.42
AGE 1-9 VISITS	36,768	39,389	56,971
AGE 1-9 VISITS/1000 MEMBER MONTHS	48.01	49.50	58.45
AGE 10-19 VISITS	18,245	20,270	27,453
AGE 10-19 VISITS/1000 MEMBER MONTHS	38.46	41.00	46.03
AGE 20-44 VISITS	26,720	30,153	38,372
AGE 20-44 VISITS/1000 MEMBER MONTHS	103.70	109.46	111.27
AGE 45-64 VISITS	8,287	8,639	10,907
AGE 45-64 VISITS/1000 MEMBER MONTHS	82.95	83.49	90.03
AGE 65-74 VISITS	544	570	688
AGE 65-74 VISITS/1000 MEMBER MONTHS	22.48	26.91	29.94
AGE 75-84 VISITS	225	158	194
AGE 75-84 VISITS/1000 MEMBER MONTHS	22.59	18.15	19.73
AGE 85+ VISITS	54	48	44
AGE 85+ VISITS/1000 MEMBER MONTHS	21.46	20.14	17.30
TOTAL VISITS	102,948	111,816	147,755
TOTAL VISITS/1000 MEMBER MONTHS	58.51	61.00	67.22

MEASURE	HEDIS 2008	HEDIS 2009	HEDIS 2010
<b>CHILDHOOD IMMUNIZATION STATUS</b>			
DTP	NR	83.45%	83.94%
IPV	NR	90.51%	92.46%
MMR	NR	94.16%	94.65%
HiB	NR	96.35%	97.81%
HEP B	NR	92.70%	94.40%
VZV	NR	91.97%	92.94%
PNEUMOCOCCAL CONJUGATE	NR	73.24%	80.54%
HEP A		NA	NA
ROTAVIRUS		NA	NA
INFLUENZA		NA	NA
COMBO 2	NR	78.59%	78.83%
COMBO 3	NR	65.21%	71.53%
COMBO 4		NA	NA
COMBO 5		NA	NA
COMBO 6		NA	NA
COMBO 7		NA	NA
COMBO 8		NA	NA
COMBO 9		NA	NA
COMBO 10		NA	NA
<b>BREAST CANCER SCREENING</b>	43.44%	47.08%	48.98%
<b>PRENATAL AND POSTPARTUM CARE</b>			
TIMELINESS OF PRENATAL CARE	72.75%	68.37%	72.02%
POSTPARTUM CARE	63.75%	48.91%	54.99%
<b>WEIGHT ASSESSMENT AND COUNSELING FOR NUTRITION AND PHYSICAL ACTIVITY FOR CHILDREN/ADOLESCENTS</b>			
BMI 3-11		NR	NR
BMI 12-17		NR	NR
BMI TOTAL		NR	NR
NUTRITION 3-11		NR	NR
NUTRITION 12-17		NR	NR
NUTRITION TOTAL		NR	NR
PHYSICAL ACTIVITY 3-11		NR	NR
PHYSICAL ACTIVITY 12-17		NR	NR
PHYSICAL ACTIVITY TOTAL		NR	NR

NA - Not Applicable  
 NR - Not Reportable

**GA MCD & PCK**

<b>MEASURE</b>	<b>HEDIS 2008</b>	<b>HEDIS 2009</b>	<b>HEDIS 2010</b>
<b>ADULT ACCESS TO PREVENTIVE/AMBULATORY SERVICES</b>			
AGES: 20-44	78.39%	75.64%	84.67%
AGES: 45-64	84.64%	84.58%	86.07%
AGES:65+	76.47%	82.93%	77.27%
COMBINED	NA	NA	84.86%
<b>COMPREHENSIVE DIABETES CARE</b>			
HbA1c TESTING	71.95%	NA	78.65%
POOR HbA1c CONTROL	NA	NA	54.38%
GOOD HbA1c CONTROL <7	NA	NA	31.95%
GOOD HbA1c CONTROL <8	NA	NA	38.69%
EYE EXAM	NA	NA	37.23%
LDL-C SCREENING	62.11%	NA	69.16%
LDL-C LEVEL <100	NA	NA	23.36%
BLOOD PRESSURE CONTROL <130/80	NA	NA	25.36%
BLOOD PRESSURE CONTROL <140/90	NA	NA	53.47%
NEPHROPATHY	60.50%	NA	70.80%
<b>CHLAMYDIA SCREENING IN WOMEN</b>			
16-20 YEARS OLD	NA	NA	NA
21-25 YEARS OLD (Retired 2010)	NA		
21-24 YEARS OLD		NA	NA
COMBINED TOTAL	NA	NA	NA
<b>WELL CHILD VISITS 3-6 YEARS OLD</b>	56.13%	NA	58.88%
<b>ADOLESCENT WELL CARE VISITS</b>	26.80%	NA	32.85%
<b>AMBULATORY VISITS</b>			
AGE <1 VISITS	46,967	NA	NA
AGE <1 VISITS/1000 MEMBER MONTHS	97.30	NA	NA
AGE 1-9 VISITS	96,344	NA	NA
AGE 1-9 VISITS/1000 MEMBER MONTHS	54.73	NA	NA
AGE 10-19 VISITS	51,976	NA	NA
AGE 10-19 VISITS/1000 MEMBER MONTHS	47.25	NA	NA
AGE 20-44 VISITS	68,386	NA	NA
AGE 20-44 VISITS/1000 MEMBER MONTHS	114.80	NA	NA
AGE 45-64 VISITS	4,816	NA	NA
AGE 45-64 VISITS/1000 MEMBER MONTHS	88.36	NA	NA
AGE 65-74 VISITS	6	NA	NA
AGE 65-74 VISITS/1000 MEMBER MONTHS	33.71	NA	NA
AGE 75-84 VISITS	0	NA	NA
AGE 75-84 VISITS/1000 MEMBER MONTHS	0.00	NA	NA
AGE 85+ VISITS	0	NA	NA
AGE 85+ VISITS/1000 MEMBER MONTHS	0.00	NA	NA
TOTAL VISITS	268,495	NA	NA
TOTAL VISITS/1000 MEMBER MONTHS	67.23	NA	NA

MEASURE	HEDIS 2008	HEDIS 2009	HEDIS 2010
<b>CHILDHOOD IMMUNIZATION STATUS</b>			
DTP	NA	40.77%	84.43%
IPV	NA	48.74%	91.24%
MMR	NA	82.03%	91.73%
HiB	NA	76.28%	95.13%
HEP B	NA	34.38%	92.94%
VZV	NA	81.59%	93.19%
PNEUMOCOCCAL CONJUGATE	NA	40.03%	81.27%
HEP A		NA	41.12%
ROTAVIRUS		NA	54.01%
INFLUENZA		NA	38.93%
COMBO 2	NA	24.27%	81.02%
COMBO 3	NA	21.62%	75.18%
COMBO 4		NA	37.71%
COMBO 5		NA	47.20%
COMBO 6		NA	35.04%
COMBO 7		NA	25.06%
COMBO 8		NA	20.19%
COMBO 9		NA	23.11%
COMBO 10		NA	13.87%
<b>BREAST CANCER SCREENING</b>	NA	NA	51.27%
<b>PRENATAL AND POSTPARTUM CARE</b>			
TIMELINESS OF PRENATAL CARE	36.43%	NA	82.24%
POSTPARTUM CARE	36.76%	NA	69.59%
<b>WEIGHT ASSESSMENT AND COUNSELING FOR NUTRITION AND PHYSICAL ACTIVITY FOR CHILDREN/ADOLESCENTS</b>			
BMI 3-11		NA	35.39%
BMI 12-17		NA	39.81%
BMI TOTAL		NA	36.50%
NUTRITION 3-11		NA	44.81%
NUTRITION 12-17		NA	34.95%
NUTRITION TOTAL		NA	42.34%
PHYSICAL ACTIVITY 3-11		NA	39.61%
PHYSICAL ACTIVITY 12-17		NA	35.92%
PHYSICAL ACTIVITY TOTAL		NA	38.69%

NA - Not Applicable  
 NR - Not Reportable

HI ABD

MEASURE	HEDIS 2008	HEDIS 2009	HEDIS 2010
<b>ADULT ACCESS TO PREVENTIVE/AMBULATORY SERVICES</b>			
AGES: 20-44	NA	NA	NA
AGES: 45-64	NA	NA	NA
AGES:65+	NA	NA	NA
COMBINED	NA	NA	NA
<b>COMPREHENSIVE DIABETES CARE</b>			
HbA1c TESTING	NA	NA	83.21%
POOR HbA1c CONTROL	NA	NA	52.37%
GOOD HbA1c CONTROL <7	NA	NA	32.37%
GOOD HbA1c CONTROL <8	NA	NA	40.15%
EYE EXAM	NA	NA	43.43%
LDL-C SCREENING	NA	NA	79.01%
LDL-C LEVEL <100	NA	NA	31.93%
BLOOD PRESSURE CONTROL <130/80	NA	NA	36.13%
BLOOD PRESSURE CONTROL <140/90	NA	NA	58.94%
NEPHROPATHY	NA	NA	84.31%
<b>CHLAMYDIA SCREENING IN WOMEN</b>			
16-20 YEARS OLD	NA	NA	26.42%
21-25 YEARS OLD (Retired 2010)	NA		
21-24 YEARS OLD		NA	35.71%
COMBINED TOTAL	NA	NA	31.19%
<b>WELL CHILD VISITS 3-6 YEARS OLD</b>	NA	NA	51.81%
<b>ADOLESCENT WELL CARE VISITS</b>	NA	NA	NA
<b>AMBULATORY ED VISITS</b>			
AGE <1 VISITS	NA	NA	37
AGE <1 VISITS/1000 MEMBER MONTHS	NA	NA	69.03
AGE 1-9 VISITS	NA	NA	544
AGE 1-9 VISITS/1000 MEMBER MONTHS	NA	NA	66.00
AGE 10-19 VISITS	NA	NA	542
AGE 10-19 VISITS/1000 MEMBER MONTHS	NA	NA	46.15
AGE 20-44 VISITS	NA	NA	2,680
AGE 20-44 VISITS/1000 MEMBER MONTHS	NA	NA	105.09
AGE 45-64 VISITS	NA	NA	4,013
AGE 45-64 VISITS/1000 MEMBER MONTHS	NA	NA	89.00
AGE 65-74 VISITS	NA	NA	314
AGE 65-74 VISITS/1000 MEMBER MONTHS	NA	NA	49.45
AGE 75-84 VISITS	NA	NA	61
AGE 75-84 VISITS/1000 MEMBER MONTHS	NA	NA	38.73
AGE 85+ VISITS	NA	NA	11
AGE 85+ VISITS/1000 MEMBER MONTHS	NA	NA	33.74
TOTAL VISITS	NA	NA	8,202
TOTAL VISITS/1000 MEMBER MONTHS	NA	NA	82.55

MEASURE	HEDIS 2008	HEDIS 2009	HEDIS 2010
<b>CHILDHOOD IMMUNIZATION STATUS</b>			
DTP	NA	NA	NR <sup>1</sup>
IPV	NA	NA	NR <sup>1</sup>
MMR	NA	NA	NR <sup>1</sup>
HiB	NA	NA	NR <sup>1</sup>
HEP B	NA	NA	NR <sup>1</sup>
VZV	NA	NA	NR <sup>1</sup>
PNEUMOCOCCAL CONJUGATE	NA	NA	NR <sup>1</sup>
HEP A		NA	NR <sup>1</sup>
ROTAVIRUS		NA	NR <sup>1</sup>
INFLUENZA		NA	NR <sup>1</sup>
COMBO 2	NA	NA	NR <sup>1</sup>
COMBO 3	NA	NA	NR <sup>1</sup>
COMBO 4		NA	NR <sup>1</sup>
COMBO 5		NA	NR <sup>1</sup>
COMBO 6		NA	NR <sup>1</sup>
COMBO 7		NA	NR <sup>1</sup>
COMBO 8		NA	NR <sup>1</sup>
COMBO 9		NA	NR <sup>1</sup>
COMBO 10		NA	NR <sup>1</sup>
<b>BREAST CANCER SCREENING</b>	NA	NA	NR <sup>1</sup>
<b>PRENATAL AND POSTPARTUM CARE</b>			
TIMELINESS OF PRENATAL CARE	NA	NA	80.00%
POSTPARTUM CARE	NA	NA	40.00%
<b>WEIGHT ASSESSMENT AND COUNSELING FOR NUTRITION AND PHYSICAL ACTIVITY FOR CHILDREN/ADOLESCENTS</b>			
BMI 3-11		NA	NA
BMI 12-17		NA	NA
BMI TOTAL		NA	NA
NUTRITION 3-11		NA	NA
NUTRITION 12-17		NA	NA
NUTRITION TOTAL		NA	NA
PHYSICAL ACTIVITY 3-11		NA	NA
PHYSICAL ACTIVITY 12-17		NA	NA
PHYSICAL ACTIVITY TOTAL		NA	NA

NA - Not Applicable

NR - Not Reportable

NR1 - Not Reportable (Denominator Zero)

**IL MEDICAID**

<b>MEASURE</b>	<b>HEDIS 2008</b>	<b>HEDIS 2009</b>	<b>HEDIS 2010</b>
<b>ADULT ACCESS TO PREVENTIVE/AMBULATORY SERVICES</b>			
AGES: 20-44	57.54%	66.26%	67.27%
AGES: 45-64	54.58%	63.27%	67.64%
AGES:65+	100.00%	80.00%	75.00%
COMBINED	NA	NA	67.31%
<b>COMPREHENSIVE DIABETES CARE</b>			
HbA1c TESTING	57.66%	68.07%	66.97%
POOR HbA1c CONTROL	72.75%	67.34%	64.23%
GOOD HbA1c CONTROL <7	15.57%	17.40%	19.04%
GOOD HbA1c CONTROL <8	NA	24.64%	28.83%
EYE EXAM	9.00%	13.32%	14.96%
LDL-C SCREENING	52.31%	58.03%	58.21%
LDL-C LEVEL <100	12.41%	17.70%	18.61%
BLOOD PRESSURE CONTROL <130/80	23.60%	27.37%	23.91%
BLOOD PRESSURE CONTROL <140/90	45.01%	54.01%	51.28%
NEPHROPATHY	59.85%	69.89%	68.43%
<b>CHLAMYDIA SCREENING IN WOMEN</b>			
16-20 YEARS OLD	45.15%	44.50%	45.58%
21-25 YEARS OLD (Retired 2010)	53.33%		
21-24 YEARS OLD		54.83%	56.18%
COMBINED TOTAL	49.28%	48.76%	49.91%
<b>WELL CHILD VISITS 3-6 YEARS OLD</b>	57.42%	65.94%	69.83%
<b>ADOLESCENT WELL CARE VISITS</b>	37.71%	37.71%	37.23%
<b>AMBULATORY ER VISITS</b>			
AGE <1 VISITS	2,047	5,372	6,137
AGE <1 VISITS/1000 MEMBER MONTHS	43.75	95.48	107.45
AGE 1-9 VISITS	9,017	26,291	32,756
AGE 1-9 VISITS/1000 MEMBER MONTHS	16.53	41.55	48.36
AGE 10-19 VISITS	55	16,251	18,913
AGE 10-19 VISITS/1000 MEMBER MONTHS	12.17	30.64	33.20
AGE 20-44 VISITS	7,763	25,316	27,745
AGE 20-44 VISITS/1000 MEMBER MONTHS	30.23	79.47	77.75
AGE 45-64 VISITS	464	1,682	1,687
AGE 45-64 VISITS/1000 MEMBER MONTHS	17.03	46.38	46.14
AGE 65-74 VISITS	0	2	1
AGE 65-74 VISITS/1000 MEMBER MONTHS	0.00	24.10	14.71
AGE 75-84 VISITS	0	0	0
AGE 75-84 VISITS/1000 MEMBER MONTHS	0.00	0.00	0.00
AGE 85+ VISITS	0	0	0
AGE 85+ VISITS/1000 MEMBER MONTHS	0.00	0.00	0.00
TOTAL VISITS	24,805	74,914	87,439
TOTAL VISITS/1000 MEMBER MONTHS	18.66	47.63	51.38

MEASURE	HEDIS 2008	HEDIS 2009	HEDIS 2010
<b>CHILDHOOD IMMUNIZATION STATUS</b>			
DTP	62.04%	67.88%	72.99%
IPV	80.54%	86.62%	87.59%
MMR	76.16%	83.94%	83.94%
HiB	82.97%	91.97%	93.92%
HEP B	85.89%	88.56%	90.02%
VZV	72.26%	81.27%	83.21%
PNEUMOCOCCAL CONJUGATE	50.61%	58.64%	69.83%
HEP A		NA	20.92%
ROTAVIRUS		NA	35.28%
INFLUENZA		NA	21.41%
COMBO 2	53.77%	62.53%	67.40%
COMBO 3	42.82%	51.58%	60.58%
COMBO 4		NA	18.49%
COMBO 5		NA	28.22%
COMBO 6		NA	18.00%
COMBO 7		NA	10.71%
COMBO 8		NA	5.35%
COMBO 9		NA	8.52%
COMBO 10		NA	3.41%
<b>BREAST CANCER SCREENING</b>	35.52%	32.54%	31.54%
<b>PRENATAL AND POSTPARTUM CARE</b>			
TIMELINESS OF PRENATAL CARE	56.45%	56.45%	65.21%
POSTPARTUM CARE	35.04%	40.15%	49.64%
<b>WEIGHT ASSESSMENT AND COUNSELING FOR NUTRITION AND PHYSICAL ACTIVITY FOR CHILDREN/ADOLESCENTS</b>			
BMI 3-11		NA	NA
BMI 12-17		NA	NA
BMI TOTAL		NA	NA
NUTRITION 3-11		NA	NA
NUTRITION 12-17		NA	NA
NUTRITION TOTAL		NA	NA
PHYSICAL ACTIVITY 3-11		NA	NA
PHYSICAL ACTIVITY 12-17		NA	NA
PHYSICAL ACTIVITY TOTAL		NA	NA

NA - Not Applicable  
 NR - Not Reportable

**MO MEDICAID**

MEASURE	HEDIS 2008	HEDIS 2009	HEDIS 2010
<b>ADULT ACCESS TO PREVENTIVE/AMBULATORY SERVICES</b>			
AGES: 20-44	NA	NA	71.87%
AGES: 45-64	NA	NA	66.67%
AGES:65+	NA	NA	NA
COMBINED	NA	NA	71.50%
<b>COMPREHENSIVE DIABETES CARE</b>			
HbA1c TESTING	NA	NA	75.00%
POOR HbA1c CONTROL	NA	NA	55.56%
GOOD HbA1c CONTROL <7	NA	NA	27.27%
GOOD HbA1c CONTROL <8	NA	NA	41.67%
EYE EXAM	NA	NA	22.22%
LDL-C SCREENING	NA	NA	72.22%
LDL-C LEVEL <100	NA	NA	22.22%
BLOOD PRESSURE CONTROL <130/80	NA	NA	36.11%
BLOOD PRESSURE CONTROL <140/90	NA	NA	61.11%
NEPHROPATHY	NA	NA	55.56%
<b>CHLAMYDIA SCREENING IN WOMEN</b>			
16-20 YEARS OLD	57.28%	57.49%	58.84%
21-25 YEARS OLD (Retired 2010)	57.43%		
21-24 YEARS OLD		62.59%	71.88%
COMBINED TOTAL	57.35%	59.80%	64.18%
<b>WELL CHILD VISITS 3-6 YEARS OLD</b>	48.18%	53.53%	59.12%
<b>ADOLESCENT WELL CARE VISITS</b>	25.06%	28.71%	34.06%
<b>AMBULATORY ER VISITS</b>			
AGE <1 VISITS	1,048	1,607	1,799
AGE <1 VISITS/1000 MEMBER MONTHS	127.39	129.64	137.20
AGE 1-9 VISITS	1,871	4,123	6,040
AGE 1-9 VISITS/1000 MEMBER MONTHS	67.20	73.73	78.74
AGE 10-19 VISITS	1,128	2,236	3,547
AGE 10-19 VISITS/1000 MEMBER MONTHS	51.20	55.72	62.46
AGE 20-44 VISITS	1,610	2,972	3,773
AGE 20-44 VISITS/1000 MEMBER MONTHS	101.25	122.89	116.80
AGE 45-64 VISITS	60	124	191
AGE 45-64 VISITS/1000 MEMBER MONTHS	62.89	72.77	80.32
AGE 65-74 VISITS	0	0	0
AGE 65-74 VISITS/1000 MEMBER MONTHS	0.00	0.00	0.00
AGE 75-84 VISITS	0	0	0
AGE 75-84 VISITS/1000 MEMBER MONTHS	0.00	0.00	0.00
AGE 85+ VISITS	0	0	0
AGE 85+ VISITS/1000 MEMBER MONTHS	0.00	0.00	0.00
TOTAL VISITS	5,717	11,062	15,350
TOTAL VISITS/1000 MEMBER MONTHS	76.27	82.34	84.67

MEASURE	HEDIS 2008	HEDIS 2009	HEDIS 2010
<b>CHILDHOOD IMMUNIZATION STATUS</b>			
DTP	36.36%	61.34%	64.23%
IPV	52.27%	78.15%	78.35%
MMR	70.45%	82.35%	82.97%
HiB	56.82%	82.35%	88.08%
HEP B	56.82%	81.09%	82.73%
VZV	63.64%	73.95%	82.48%
PNEUMOCOCCAL CONJUGATE	36.36%	53.36%	58.93%
HEP A		NA	27.98%
ROTAVIRUS		NA	41.36%
INFLUENZA		NA	20.19%
COMBO 2	34.09%	53.78%	59.37%
COMBO 3	27.27%	42.86%	48.91%
COMBO 4		NA	20.44%
COMBO 5		NA	29.68%
COMBO 6		NA	13.14%
COMBO 7		NA	12.65%
COMBO 8		NA	5.11%
COMBO 9		NA	9.00%
COMBO 10		NA	3.89%
<b>BREAST CANCER SCREENING</b>	NA	NA	41.94%
<b>PRENATAL AND POSTPARTUM CARE</b>			
TIMELINESS OF PRENATAL CARE	86.51%	78.83%	74.21%
POSTPARTUM CARE	55.56%	57.66%	51.82%
<b>WEIGHT ASSESSMENT AND COUNSELING FOR NUTRITION AND PHYSICAL ACTIVITY FOR CHILDREN/ADOLESCENTS</b>			
BMI 3-11		NA	20.16%
BMI 12-17		NA	20.92%
BMI TOTAL		NA	20.44%
NUTRITION 3-11		NA	46.12%
NUTRITION 12-17		NA	24.18%
NUTRITION TOTAL		NA	37.96%
PHYSICAL ACTIVITY 3-11		NA	40.70%
PHYSICAL ACTIVITY 12-17		NA	28.10%
PHYSICAL ACTIVITY TOTAL		NA	36.01%

NA - Not Applicable  
 NR - Not Reportable

**NY MEDICAID**

MEASURE	HEDIS 2008	HEDIS 2009	HEDIS 2010
<b>ADULT ACCESS TO PREVENTIVE/AMBULATORY SERVICES</b>			
AGES: 20-44	78.13%	79.20%	80.63%
AGES: 45-64	85.73%	87.52%	88.26%
AGES:65+	91.62%	88.85%	89.81%
COMBINED	NA	NA	NA
<b>COMPREHENSIVE DIABETES CARE</b>			
HbA1c TESTING	82.73%	NA	87.23%
POOR HbA1c CONTROL	37.96%	NA	32.12%
GOOD HbA1c CONTROL <7	NA	NA	NA
GOOD HbA1c CONTROL <8	36.74%	NA	54.20%
EYE EXAM	59.85%	NA	58.21%
LDL-C SCREENING	85.89%	NA	88.69%
LDL-C LEVEL <100	31.87%	NA	41.24%
BLOOD PRESSURE CONTROL <130/80	25.55%	NA	26.46%
BLOOD PRESSURE CONTROL <140/90	60.10%	NA	58.39%
NEPHROPATHY	79.81%	NA	84.12%
<b>CHLAMYDIA SCREENING IN WOMEN</b>			
16-20 YEARS OLD	48.61%	52.56%	57.84%
21-25 YEARS OLD (Retired 2010)	53.13%		
21-24 YEARS OLD		55.72	59.16%
COMBINED TOTAL	51.09%	54.06%	58.40%
<b>WELL CHILD VISITS 3-6 YEARS OLD</b>	78.59%	NA	78.35%
<b>ADOLESCENT WELL CARE VISITS</b>	61.80%	NA	60.53%
<b>AMBULATORY ER VISITS</b>			
AGE <1 VISITS	1,686	1,897	1,625
AGE <1 VISITS/1000 MEMBER MONTHS	69.37	74.38	76.89
AGE 1-9 VISITS	6,934	7,397	7,482
AGE 1-9 VISITS/1000 MEMBER MONTHS	35.34	36.57	41.31
AGE 10-19 VISITS	4,970	5,600	5,699
AGE 10-19 VISITS/1000 MEMBER MONTHS	24.11	25.56	27.94
AGE 20-44 VISITS	14,597	14,993	13,357
AGE 20-44 VISITS/1000 MEMBER MONTHS	32.56	35.38	37.55
AGE 45-64 VISITS	6,030	6,720	6,549
AGE 45-64 VISITS/1000 MEMBER MONTHS	21.58	22.67	23.81
AGE 65-74 VISITS	167	230	247
AGE 65-74 VISITS/1000 MEMBER MONTHS	11.97	12.56	13.01
AGE 75-84 VISITS	42	60	87
AGE 75-84 VISITS/1000 MEMBER MONTHS	11.08	10.17	12.86
AGE 85+ VISITS	6	0	14
AGE 85+ VISITS/1000 MEMBER MONTHS	13.10	0.00	15.09
TOTAL VISITS	34,432	36,911	35,060
TOTAL VISITS/1000 MEMBER MONTHS	29.36	30.96	32.96

MEASURE	HEDIS 2008	HEDIS 2009	HEDIS 2010
<b>CHILDHOOD IMMUNIZATION STATUS</b>			
DTP	78.83%	NA	76.40%
IPV	86.62%	NA	86.37%
MMR	88.32%	NA	88.32%
HiB	88.56%	NA	91.97%
HEP B	87.10%	NA	90.75%
VZV	85.89%	NA	87.59%
PNEUMOCOCCAL CONJUGATE	75.43%	NA	75.18%
HEP A		NA	34.31%
ROTAVIRUS		NA	42.58%
INFLUENZA		NA	48.91%
COMBO 2	70.80%	NA	70.80%
COMBO 3	65.45%	NA	65.94%
COMBO 4		NA	31.39%
COMBO 5		NA	33.58%
COMBO 6		NA	41.36%
COMBO 7		NA	18.25%
COMBO 8		NA	22.63%
COMBO 9		NA	24.57%
COMBO 10		NA	14.36%
<b>BREAST CANCER SCREENING</b>	62.58%	69.44%	71.44%
<b>PRENATAL AND POSTPARTUM CARE</b>			
TIMELINESS OF PRENATAL CARE	NA	74.94%	NA
POSTPARTUM CARE	NA	61.80%	NA
<b>WEIGHT ASSESSMENT AND COUNSELING FOR NUTRITION AND PHYSICAL ACTIVITY FOR CHILDREN/ADOLESCENTS</b>			
BMI 3-11		31.05%	53.23%
BMI 12-17		33.58%	53.37%
BMI TOTAL		31.87%	53.28%
NUTRITION 3-11		43.32%	42.34%
NUTRITION 12-17		37.31%	39.88%
NUTRITION TOTAL		41.36%	41.36%
PHYSICAL ACTIVITY 3-11		29.96%	33.47%
PHYSICAL ACTIVITY 12-17		34.33%	33.13%
PHYSICAL ACTIVITY TOTAL		31.39%	33.33%

NA - Not Applicable  
 NR - Not Reportable

**NY CHP**

<b>MEASURE</b>	<b>HEDIS 2008</b>	<b>HEDIS 2009</b>	<b>HEDIS 2010</b>
<b>ADULT ACCESS TO PREVENTIVE/AMBULATORY SERVICES</b>			
AGES: 20-44	NA	NA	NA
AGES: 45-64	NA	NA	NA
AGES:65+	NA	NA	NA
COMBINED	NA	NA	NA
<b>COMPREHENSIVE DIABETES CARE</b>			
HbA1c TESTING	NA	NA	NA
POOR HbA1c CONTROL	NA	NA	NA
GOOD HbA1c CONTROL <7	NA	NA	NA
GOOD HbA1c CONTROL <8	NA	NA	NA
EYE EXAM	NA	NA	NA
LDL-C SCREENING	NA	NA	NA
LDL-C LEVEL <100	NA	NA	NA
BLOOD PRESSURE CONTROL <130/80	NA	NA	NA
BLOOD PRESSURE CONTROL <140/90	NA	NA	NA
NEPHROPATHY	NA	NA	NA
<b>CHLAMYDIA SCREENING IN WOMEN</b>			
16-20 YEARS OLD	NA	NA	NA
21-25 YEARS OLD (Retired 2010)	NA		
21-24 YEARS OLD		NA	NA
COMBINED TOTAL	NA	NA	NA
<b>WELL CHILD VISITS 3-6 YEARS OLD</b>	77.37%	NA	79.65%
<b>ADOLESCENT WELL CARE VISITS</b>	60.10%	NA	63.19%
<b>AMBULATORY ER VISITS</b>			
AGE <1 VISITS	53	14	7
AGE <1 VISITS/1000 MEMBER MONTHS	30.20	33.02	25.45
AGE 1-9 VISITS	1,117	851	742
AGE 1-9 VISITS/1000 MEMBER MONTHS	19.27	21.38	27.12
AGE 10-19 VISITS	1,176	1,043	999
AGE 10-19 VISITS/1000 MEMBER MONTHS	14.26	16.58	21.30
AGE 20-44 VISITS	0	0	0
AGE 20-44 VISITS/1000 MEMBER MONTHS	0.00	0.00	0.00
AGE 45-64 VISITS	0	0	0
AGE 45-64 VISITS/1000 MEMBER MONTHS	0.00	0.00	0.00
AGE 65-74 VISITS	0	0	0
AGE 65-74 VISITS/1000 MEMBER MONTHS	0.00	0.00	0.00
AGE 75-84 VISITS	0	0	0
AGE 75-84 VISITS/1000 MEMBER MONTHS	0.00	0.00	0.00
AGE 85+ VISITS	0	0	0
AGE 85+ VISITS/1000 MEMBER MONTHS	0.00	0.00	0.00
TOTAL VISITS	2,346	1,908	1,748
TOTAL VISITS/1000 MEMBER MONTHS	16.50	18.50	23.45

MEASURE	HEDIS 2008	HEDIS 2009	HEDIS 2010
<b>CHILDHOOD IMMUNIZATION STATUS</b>			
DTP	63.64%	NA	80.85%
IPV	75.00%	NA	91.49%
MMR	88.64%	NA	87.23%
HiB	79.55%	NA	91.49%
HEP B	76.14%	NA	87.23%
VZV	84.09%	NA	87.23%
PNEUMOCOCCAL CONJUGATE	55.68%	NA	78.72%
HEP A		NA	36.17%
ROTAVIRUS		NA	31.91%
INFLUENZA		NA	48.94%
COMBO 2	59.09%	NA	74.47%
COMBO 3	50.00%	NA	68.09%
COMBO 4		NA	31.91%
COMBO 5		NA	23.40%
COMBO 6		NA	40.43%
COMBO 7		NA	10.64%
COMBO 8		NA	21.28%
COMBO 9		NA	14.89%
COMBO 10		NA	8.51%
<b>BREAST CANCER SCREENING</b>	NA	NA	NA
<b>PRENATAL AND POSTPARTUM CARE</b>			
TIMELINESS OF PRENATAL CARE	NA	NA	NA
POSTPARTUM CARE	NA	NA	NA
<b>WEIGHT ASSESSMENT AND COUNSELING FOR NUTRITION AND PHYSICAL ACTIVITY FOR CHILDREN/ADOLESCENTS</b>			
BMI 3-11		39.83%	57.55%
BMI 12-17		44.00%	61.31%
BMI TOTAL		41.61%	59.37%
NUTRITION 3-11		52.97%	55.19%
NUTRITION 12-17		46.86%	53.27%
NUTRITION TOTAL		50.36%	54.26%
PHYSICAL ACTIVITY 3-11		38.14%	44.34%
PHYSICAL ACTIVITY 12-17		42.29%	49.75%
PHYSICAL ACTIVITY TOTAL		39.90%	46.96%

NA - Not Applicable  
 NR - Not Reportable

**OH MEDICAID**

<b>MEASURE</b>	<b>HEDIS 2008</b>	<b>HEDIS 2009</b>	<b>HEDIS 2010</b>
<b>ADULT ACCESS TO PREVENTIVE/AMBULATORY SERVICES</b>			
AGES: 20-44	NA	NA	NA
AGES: 45-64	NA	NA	NA
AGES:65+	NA	NA	NA
COMBINED	NA	NA	NA
<b>COMPREHENSIVE DIABETES CARE</b>			
HbA1c TESTING	NA	NA	NA
POOR HbA1c CONTROL	NA	NA	NA
GOOD HbA1c CONTROL <7	NA	NA	NA
GOOD HbA1c CONTROL <8	NA	NA	NA
EYE EXAM	NA	NA	NA
LDL-C SCREENING	NA	NA	NA
LDL-C LEVEL <100	NA	NA	NA
BLOOD PRESSURE CONTROL <130/80	NA	NA	NA
BLOOD PRESSURE CONTROL <140/90	NA	NA	NA
NEPHROPATHY	NA	NA	NA
<b>CHLAMYDIA SCREENING IN WOMEN</b>			
16-20 YEARS OLD	NA	NA	NA
21-25 YEARS OLD (Retired 2010)	NA		
21-24 YEARS OLD		NA	NA
COMBINED TOTAL	NA	NA	NA
<b>WELL CHILD VISITS 3-6 YEARS OLD</b>	NA	NA	NA
<b>ADOLESCENT WELL CARE VISITS</b>	NA	NA	NA
<b>AMBULATORY ER VISITS</b>			
AGE <1 VISITS	NA	NA	NA
AGE <1 VISITS/1000 MEMBER MONTHS	NA	NA	NA
AGE 1-9 VISITS	NA	NA	NA
AGE 1-9 VISITS/1000 MEMBER MONTHS	NA	NA	NA
AGE 10-19 VISITS	NA	NA	NA
AGE 10-19 VISITS/1000 MEMBER MONTHS	NA	NA	NA
AGE 20-44 VISITS	NA	NA	NA
AGE 20-44 VISITS/1000 MEMBER MONTHS	NA	NA	NA
AGE 45-64 VISITS	NA	NA	NA
AGE 45-64 VISITS/1000 MEMBER MONTHS	NA	NA	NA
AGE 65-74 VISITS	NA	NA	NA
AGE 65-74 VISITS/1000 MEMBER MONTHS	NA	NA	NA
AGE 75-84 VISITS	NA	NA	NA
AGE 75-84 VISITS/1000 MEMBER MONTHS	NA	NA	NA
AGE 85+ VISITS	NA	NA	NA
AGE 85+ VISITS/1000 MEMBER MONTHS	NA	NA	NA
TOTAL VISITS	NA	NA	NA
TOTAL VISITS/1000 MEMBER MONTHS	NA	NA	NA

MEASURE	HEDIS 2008	HEDIS 2009	HEDIS 2010
<b>CHILDHOOD IMMUNIZATION STATUS</b>			
DTP	83.33%	71.05%	71.53%
IPV	88.89%	86.37%	85.16%
MMR	92.59%	87.59%	89.05%
HiB	90.74%	90.51%	90.75%
HEP B	88.89%	87.83%	87.59%
VZV	94.44%	86.86%	88.32%
PNEUMOCOCCAL CONJUGATE	77.78%	70.32%	71.78%
HEP A		NA	24.09%
ROTAVIRUS		NA	42.34%
INFLUENZA		NA	30.66%
COMBO 2	81.48%	65.94%	67.88%
COMBO 3	72.22%	60.58%	63.50%
COMBO 4		NA	20.92%
COMBO 5		NA	34.79%
COMBO 6		NA	25.55%
COMBO 7		NA	13.14%
COMBO 8		NA	10.95%
COMBO 9		NA	17.27%
COMBO 10		NA	7.54%
<b>BREAST CANCER SCREENING</b>	NA	NA	NA
<b>PRENATAL AND POSTPARTUM CARE</b>			
TIMELINESS OF PRENATAL CARE	NA	NA	NA
POSTPARTUM CARE	NA	NA	NA
<b>WEIGHT ASSESSMENT AND COUNSELING FOR NUTRITION AND PHYSICAL ACTIVITY FOR CHILDREN/ADOLESCENTS</b>			
BMI 3-11		NA	NA
BMI 12-17		NA	NA
BMI TOTAL		NA	NA
NUTRITION 3-11		NA	NA
NUTRITION 12-17		NA	NA
NUTRITION TOTAL		NA	NA
PHYSICAL ACTIVITY 3-11		NA	NA
PHYSICAL ACTIVITY 12-17		NA	NA
PHYSICAL ACTIVITY TOTAL		NA	NA

NA - Not Applicable

NR - Not Reportable

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Section K  
Member Materials

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Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		<b>Section K: Member Materials (Section § 12 of RFP)</b>	<b>50</b>		
<b>Section K Page 1</b>	<b>All</b>	<b>K.1</b> Describe proposed content for your member educational materials) and attach a examples used with Medicaid or CHIP populations in other states.	<b>15</b>		
<b>Section K Page 6</b>	<b>All</b>	<b>K.2</b> Describe how you will ensure that all written materials meet the language requirements and which reference material you anticipate you will use to meet the sixth (6 <sup>th</sup> ) grade reading level requirement.	<b>5</b>		
<b>Section K Page 9</b>	<b>All</b>	<b>K.3</b> Describe your process for producing Member ID cards and information that will accompany the card. Include a layout of the card front and back. Explain how you will ensure that a Member receives a new Member ID Card whenever there has been a change in any of the information appearing on the Member ID Card.	<b>10</b>		
<b>Section K Page 11</b>	<b>All</b>	<b>K.4</b> Describe your strategy for ensuring the information in your provider directory is accurate and up to date, including the types and frequency of monitoring activities and how often the directory is updated.	<b>10</b>		
<b>Section K Page 12</b>	<b>All</b>	<b>K.5</b> Describe how you will fulfill Internet presence and Web site requirements, including: <ul style="list-style-type: none"> <li>• Your procedures for up-dating information on the Web site;</li> <li>• Your procedures for monitoring e-mail inquiries and providing</li> </ul>	<b>10</b>		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		<p>accurate and timely responses; and</p> <ul style="list-style-type: none"> <li>The procedures, tools and reports you will use to track all interactions and transactions conducted via the Web site activity including the timeliness of response and resolution of said interaction/transaction.</li> </ul>			

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## Section K: Member Materials

### K.1

***Describe proposed content for your member educational material(s) and attach a examples used with Medicaid or CHIP populations in other states.***

WellCare is committed to promoting healthy lifestyles and dedicated to helping members find the most appropriate health and wellness information and support available. We want our members to understand how to navigate the health care system and get the most out of their coverage. WellCare broadly defines member education to include any opportunity to provide members information that helps them make informed decisions regarding their health care. We provide education and resources that enable members to play an active role in achieving, protecting and sustaining their health and wellness.

Upon contract award, we will develop a plan detailing the member education activities we will undertake and the materials we will create during the contract period. Our plan will be submitted to DHH for review and approval within 30 calendar days from the date the contract is signed.

WellCare will work with DHH to ensure that all member materials are approved prior to distribution and that they comply with DHH's requirements, including ensuring that materials are geared toward persons who read at no higher than a sixth grade level and are in compliance with the Americans with Disabilities Act of 1990 (Public Law USC 101-336). We will also ensure that member education materials are accurate and do not mislead, confuse, or defraud our members/potential members or DHH as specified in Social Security Act § 1932 (d) and 42 CFR § 438.104, and that they do not discriminate against Medicaid members on the basis of their health history, health status or need for health care services.

Samples of member materials and health educational materials used in other Medicaid programs can be found in the attachments section of our response. Refer to Attachments K.1.a through K.1.e.

### **Welcome Packet**

WellCare will send a welcome packet to new members within the time frames referenced in the RFP (21 days during phase-in and 10 days during steady state). The packet will include a welcome letter that highlights major program features, indicates that the Member ID card will be sent via mail separately, and provides contact information for connecting with WellCare member services. The packet will also include a member handbook and a provider directory.

### **Member Handbook**

As in other states, the member handbook will be available in a hard copy format as well as in an electronic format on our website. Member handbooks have information on the availability of health education services and list contact information for all WellCare points of contact including website addresses and telephone numbers for all call centers. Any additional text provided to us by DHH will be incorporated into the handbook (refer to Attachment K.1.a for a copy of the member handbook mailed to our members in Georgia). Refer to Exhibit K.1.a for a list of items that will be included in the member handbook.

**Exhibit K.1.a – Member Handbook Contents**

<b>Contents of Member Handbook</b>
A general description about how CCNs operate, member rights and responsibilities, appropriate utilization of services including Emergency Room for non-emergent conditions, a description of the PCP selection process, and the PCP's role as coordinator of services
Member's right to disenroll from CCN
Member's right to change providers within the CCN and any restrictions on the member's freedom of choice among CCN providers
Member's rights and protections
The amount, duration, and scope of benefits available to the member under the contract between the CCN and DHH in sufficient detail to ensure that members understand the benefits to which they are entitled and information about health education and promotion programs, including chronic care management
Procedures for obtaining benefits, including prior authorization requirements
Description on the purpose of the Medicaid card and the CCN card and why both are necessary and how to use them
The extent to which, and how, members may obtain benefits, including family planning services and specialized behavioral health services from out-of-network providers
The extent to which, and how, after-hours and emergency coverage are provided
The post-stabilization care services rules set forth in 42 CFR 422.113(c)
Policy on referrals for specialty care, including specialized behavioral health services and for other benefits not furnished by the member's PCP
How and where to access any benefits that are available under the Louisiana Medicaid State Plan but, are not covered under the CCN's contract with DHH, including pharmacy cost sharing for certain adults
That the member has the right to refuse to undergo any medical service, diagnoses, or treatment or to accept any health service provided by the CCN if the member objects (or in the case of a child, if the parent or guardian objects) on religious grounds
For counseling or referral services that the CCN does not cover because of moral or religious objections, the CCN is required to furnish information on how or where to obtain the service
Member grievance, appeal and state fair hearing procedures and time frames
Advance Directives, set forth in 42 FR §438.6(i)(2)
Information to call the Medicaid Customer Service Unit toll free hotline or visit a local Medicaid eligibility office to report if family size, living arrangements, parish of residence, or mailing address changes
How to make, change and cancel medical appointments and the importance of canceling and/or rescheduling rather than being a no show
A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services
How to obtain emergency and non-emergency medical transportation
Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services
Information about the requirement that a member shall notify the CCN immediately if he or she has a Workman's Compensation claim, a pending personal injury or medical malpractice law suit, or has been involved in a auto accident

Contents of Member Handbook
Reporting requirements for the member that has or obtains another health insurance policy, including employer sponsored insurance; such situations shall be reported the CCN
Member responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the CCN or DHH; this shall include a statement that the member is responsible for protecting their ID card and that misuse of the card, including loaning, selling or giving it to others could result in loss of the member's Medicaid eligibility and/or legal action
Instructions on how to request multi-lingual interpretation and translation when needed at no cost to the member; this instruction shall be included in all versions of the handbook in English, Spanish and Vietnamese
Information on the member's right to a second opinion at no cost and how to obtain it

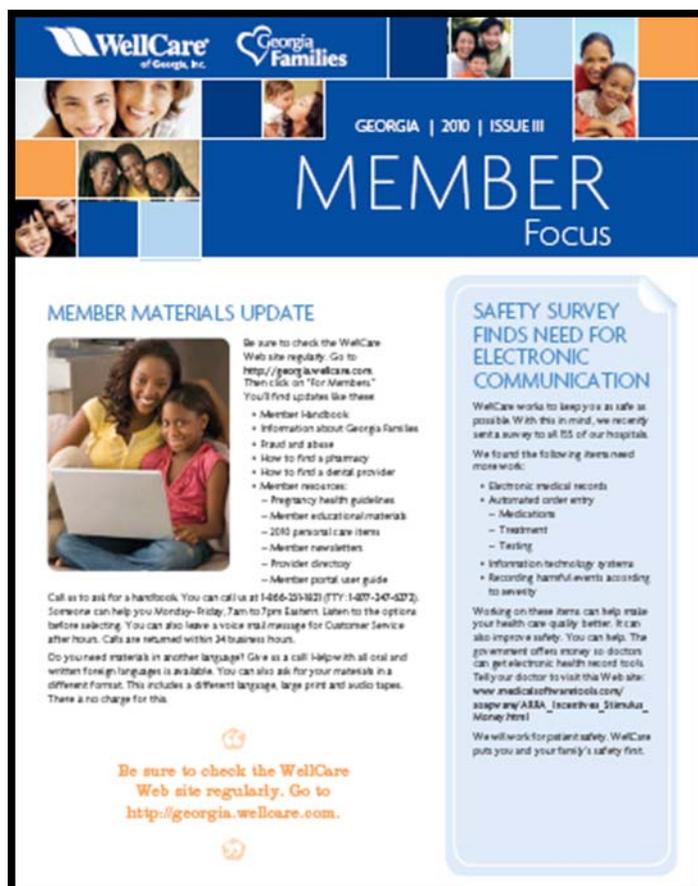
### Provider Directory

The provider directory will include names, locations, telephone numbers of, and non-English languages spoken by current network providers in the member's service area. It will also identify whether providers, including PCPs, specialists, and hospitals, are accepting new patients. In addition, the provider directory will identify PCPs, specialists, hospitals, PCP groups, clinic settings, FQHCs and RHCs in the service area and include notification of any restrictions on the member's freedom of choice among network providers. Provider hours of operation will be included; providers with non-traditional hours (before 8 am, after 5 pm or any weekend hours) will also be identified.

### **Newsletters**

WellCare will regularly mail newsletters to our members. General member education topics will be selected based on contractual requirements and community-identified needs. Refer to Attachment K.1.b for a copy of a newsletter distributed to our members in Georgia. Our member newsletters may contain information regarding:

- Preventive care, access to PCPs and other providers;
- The availability of preventive health care and disease management including information on specific conditions;



- EPSDT screenings;
- The importance of and schedules for screenings for cancer, high blood pressure, and diabetes;
- Risks associated with the use of alcohol, tobacco, and other substances;
- The concept of managed care;
- Information on how members can take personal responsibility for their health and self management;
- The procedures members need to follow such as informing DHH and WellCare of any changes in member status, using the PCP as the primary source of medical care, and the role of the care coordinator;
- Member rights and responsibilities; and
- Other health-related topics.

In addition to member newsletters that are distributed to all of our members, WellCare coordinates a member-tailored outreach and educational campaign.

Claims data collected from our system is updated monthly, analyzed, and based on a proprietary algorithm, used to enroll members in disease management programs when needed. Disease management programs have a significant health education component. Members participating in disease management programs receive health education (via materials and one-on-one interaction with their case managers) regarding their disease state and management of the disease through specific person-centered interventions. WellCare's disease management programs also provide referrals to community education programs and support groups for additional educational opportunities. WellCare uses an opt-out approach, meaning that members will continue to receive health information specific to their conditions unless they contact us to opt out of the program. Refer to Attachments K.1.c through K.1.e for samples of health education materials.

## **Website**

WellCare's websites contain valuable resources to help members manage their health care needs. Information on the benefits and services offered to members is available at any time. Members can call the member call center for assistance with navigating the websites. Our Tampa, FL Command Center is responsible for monitoring the sites to ensure that online activity is flowing smoothly for users. Refer to our response to Section K.5 regarding updates to the websites and our response to Section L.1 for more information regarding the command center.

In addition to contact information for WellCare, we post current and past member newsletters on the sites. We also post the preferred drug list (PDL), clinical guidelines associated with various conditions such as adult obesity, adult and child preventive health, asthma, childhood obesity, cholesterol management, chronic heart failure, chronic kidney disease, COPD, hypertension, and diabetes. These items, and most other general plan information, are available on the public pages of our websites. We also offer the option for members to access member-specific information through a secure portal. A member can register online for this member portal through our websites by entering his or her Member ID number and other identifiable information. Some information is available without registering, and some is only available by registering. Once registered, the member can:

- Check co-payment information based on his or her eligibility status;
- Order ID cards, member handbooks, and provider directories;
- Check the status of authorization requests and claims payments;
- Change address, phone number, and passwords; and
- Change PCPs.

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## **K.2**

***Describe how you will ensure that all written materials meet the language requirements and which reference material you anticipate you will use to meet the sixth (6th) grade reading level requirement.***

WellCare understands that clear communication with our members is critical to delivering access to high quality care and to achieving better health outcomes. Our Marketing Communications department has over 170 cumulative years of developing member materials for individuals in government-sponsored programs. The department ensures that all written materials, including but not limited to the member handbook, basic information, and member notices, are at or below a sixth grade reading level, in an easily understood language and format.

We maintain a staff of writers and editors dedicated to ensuring that our materials are accurate, concise and clear, and written in language appropriate to our members' needs and abilities to understand. Our copywriters and editors:

- Write/edit copy to meet specific reading levels and adhere to approved corporate style and branding standards to ensure consistency in copy and design;
- Correct errors in type, format, grammar, punctuation and spelling;
- Conduct research to regularly check the average reading level and shifts in demographics; and
- Ensure accuracy of material through additional research and escalate any content concerns to key stakeholders for review.

### **Meeting the Reading Level Requirement**

We are aware that many members who speak English as their primary language cannot read at a level that allows them to perform basic tasks such as filling out forms used in everyday transactions, or reading and understanding the written materials they receive, even if those materials are written for no higher than a sixth grade reading level and presented in an easy-to-read manner. In response to this reality, the Marketing Communications department has developed strategies to help assure effective communication with members with limited literacy.

We have developed procedures to ensure that our written English materials accommodate different reading levels. Our materials are reader-centered and written to attract and hold attention, demonstrate respect, and help the reader understand and take action. We have adopted the CMS Tool Kit, an 11-part guide for writing clear and effective communications. Marketing Communications staff members adhere to the guidelines to ensure that our writing is appealing to all reading levels and is written in plain language to promote understanding.

In our effort to minimize communication barriers for our members, we:

- Make the purpose/subject matter of the communication obvious;
- Repeat new concepts and summarize important points;
- Organize the content in a way that makes sense;
- Use headings to signal what's next;

- Communicate with pictures, charts, and colorful graphics;
- Use short sentences, short words, and write in the present tense whenever possible;
- Use technical terms and acronyms only when needed; and
- Choose words that are familiar to our members.

WellCare uses the Flesch-Kincaid Index to assure that written materials are at or below a sixth grade reading level. As an example of our experience and capability, we currently produce materials for Medicaid populations in Illinois, Hawai'i, Missouri, and New York at or below the sixth grade reading level.

### **Meeting the Language Requirements**

The WellCare team's diversity is an asset when developing materials that draw upon and reflect the local culture. Our staff works to reflect readers' regionally distinct values and communication styles. As an example WellCare's member materials for Hawai'i incorporated photographs representative of Hawai'i's population and traditions, and used graphics such as local flora and fauna that are familiar to Hawai'ians to reflect the cultural and natural elements of the community.

For Louisiana, member materials will be available upon request in Spanish and Vietnamese and any other languages required by DHH or based on the needs of the members we serve. Interpreter services will be provided as needed for all languages. In addition, we will make available written materials in any language that is spoken as a primary language for 200 or more members of our plan within a given GSA.

We currently provide many materials such as selected disease management education materials and notices to members in both English and Spanish (e.g., one-page items are often presented in English on one side and Spanish on the other). For more lengthy materials, we will mail the Spanish versions to members who request them.

WellCare's culturally sensitive practices respect readers' diversity through images as well as language, and we will subscribe to the "Person First" policies established by DHH. For example, in presenting material about a condition such as autism, we would refer to a "child who has autism" rather than an "autistic child." We understand the importance of separating a condition from the whole of the person.

We ensure the accuracy of translated written materials by utilizing a standardized process, qualified translation vendors, and a system of quality checks. Once materials are translated, the translation vendor submits the documents to our translation coordinator along with a certification that the material is a true and accurate translation of the English document. When we submit the translated written material to DHH for approval, we will include a certification that the translation is accurate and complete and that the translation is at or below the required reading level.

In addition, for members whose preferred language is one other than English, we will provide real time interpreter services for our member materials. Using Certified Languages International (CLI), which can be accessed through our member services call center, we will read the material to the member in the member's preferred language.

WellCare will prepare large-print versions of written materials for people who can see but cannot read normal size print and will provide written materials in Braille or in audio for members who are blind. As recently as 2010, we served a Medicare population of 40 individuals who requested materials in Braille. WellCare will also provide member materials in audio to members who have low literacy. Materials for members who have a visual impairment or limited reading proficiency are available at no cost to the member.

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### K.3

**Describe your process for producing Member ID cards and information that will accompany the card. Include a layout of the card front and back. Explain how you will ensure that a Member receives a new Member ID card whenever there has been a change in any of the information appearing on the Member ID card.**

WellCare Member ID cards are produced following the processing of information in the enrollment file received from the enrollment broker and at the request of the member.

Upon receiving a request to reissue a Member ID card, or after loading the information from the enrollment broker into our system, member correspondence extracts are created and uploaded to our vendor's FTP site. Our vendor will retrieve the extract file from the FTP site and prepare and mail ID cards to our members within the time frames specified in the RFP (21 days during phase-in and 10 days during steady state).

As a standard practice, WellCare mails the Member ID card separately from other member materials so that the card is easily recognized and received timely. We understand that access to services is critical for members and that having one's ID card in hand when services are needed facilitates access. As specified in our response to Section D.2, all members will be assigned a PCP upon becoming a member of WellCare. All ID cards will list the name of and contact information for the member's PCP. Members can call the call center or use the member web portal to change PCPs and request new ID cards.

The ID card will be accompanied by a letter welcoming the member to WellCare and highlighting major program features. The notice will explain to the member that he or she will receive two identification cards (one issued by DHH and one sent by WellCare), explain the purpose of each card, and how they are to be used in tandem. Refer to Exhibit K.3.a and Exhibit K.3.b for the front and back of the ID card mailed to our members in Georgia.

WellCare will include the following information on the Louisiana Member ID card:

- The member's name and date of birth;
- Member ID number;
- WellCare's name and address;
- Instructions for emergencies;
- The PCP's name and telephone numbers (including after-hours number, if different from business hours number); and
- The toll-free number(s) for:
  - 24-hour Member Services (including filing grievances);
  - Provider Services and Prior Authorization; and
  - Reporting Medicaid Fraud (1-800-488-2917).

Whenever there has been a change in any of the information appearing on the Member ID card or upon request of the member, we will follow the same sequence of events listed above to issue a new ID card within ten calendar days. The ID card will be accompanied by a notice to the member explaining the purpose of the reissued card and what the member should do with the previous card.

Exhibit K.3.a – Front of Card

 	
Member ID #: <000000000000>	Medicaid #: <000000000>
Member: <First MI. Last Name>	
Effective Date: <XX/XX/XXXX>	
Primary Care Physician	CO-PAY INFORMATION
<Dr. First Last Name>	Office Visit _____ \$<XXX>
<Group Name>	Emergency Room _____ \$<XXX>
<XXXX Main Street>	Pharmacy _____ \$<XXX>
<Suite XXXX>	Hospital _____ \$<XXX>
<Atlanta, GA XXXXX>	Ambulatory Surg. _____ \$<XXX>
Phone: <XXX-XXX-XXXX>	
After Hours: <XX-XXX-XXXX>	

Exhibit K.3.b – Back of Card

<a href="http://georgia.wellcare.com">georgia.wellcare.com</a> For emergencies, go to the nearest ER. Contact your primary care physician as soon as possible.	
Customer Service:.....	1-866-231-1821/TTY 1-877-247-6272
24-Hour Health Advice Line:.....	1-800-919-8807
Prior Authorization:.....	1-866-231-1821
Behavioral Health (Magellan):.....	1-800-424-5412
Avesis Vision:.....	1-866-522-5923
Doral Dental:.....	1-800-205-4715
<b>WellCare of Georgia</b> P.O. Box 31370 Tampa, FL 33631-3370	
Medical claims are to be mailed to:	
WellCare of Georgia	Rx Bin: 603286
P.O. Box 31224	Rx PCN: 01410000
Tampa, FL 33631-3224	Rx GRP: 726257
1-866-231-1821	
Call 1-866-231-1821 24 hours a day, 7 days a week.	

#### **K.4**

***Describe your strategy for ensuring the information in your provider directory is accurate and up to date, including the types and frequency of monitoring activities and how often the directory is updated.***

WellCare understands that an accurate, up-to-date provider directory is critical to our members when making choices from among our network providers. Towards that end, WellCare provider relations teams regularly monitor and update our provider directories, both hard copy and online. Our provider relations representatives stay connected with our provider community and are often made aware of changes regarding provider contact information before they occur, allowing us to make changes in a timely manner.

WellCare's provider directory will be organized by parish and then by provider type/specialty and include, at a minimum: provider name, address/locations, telephone numbers, non-English languages spoken, hours of operation (including non-traditional hours), and whether the provider is accepting new members. In addition, the provider directory will include information related to: PCPs and specialists, including how to determine their hospital affiliations, clinics, FQHCs, RHCs, pharmacies, hospitals and ancillary providers. Our online directory will include the same information and any additional information that is required by the file layout DHH will provide. The online directory is available in two formats: downloadable in PDF and searchable.

#### **Ensuring Accuracy**

The information contained in our provider directory will come through a multi-step process designed to assure its accuracy and completeness. Our provider relations team collects and documents all provider contract and credentialing information, creates an electronic file which is reviewed and validated by the medical director/credentialing committee, and transmits that file to our configurations team to load into our core processing system. After a final review and approval of all information by our local provider relations teams, the data is extracted from our core processing system and appended with the provider list to create the provider directory. Our core processing system is the main source for developing our provider directory, whether the version is hard copy, online downloadable, or online searchable.

#### **Directory Updates**

When WellCare discovers that a provider's information has changed, then, as appropriate (this may not be appropriate for quality of care related issues), the provider relations representative will confirm with the provider that the change is accurate. Provider Relations will then forward the correct information to our provider network configuration team when the change is demographic, or to the medical director/credentialing committee for quality of care/licensure related issues. In each case, the validated changes are used to update the provider's information in the core processing system. This allows customer service representatives to have updated provider information to share with callers. Changes made in our core processing system are reflected in our online searchable provider directory within 24 hours. WellCare will update its hard copy provider directory quarterly. The downloadable provider directory is updated at the same time that the hard copy version is updated. Refer to our response to Section K.5 for more information regarding updates to our online directory.

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## K.5

**Describe how you will fulfill Internet presence and Web site requirements, including:**

- **Your procedures for up-dating information on the Web site;**
- **Your procedures for monitoring e-mail inquiries and providing accurate and timely responses; and**
- **The procedures, tools and reports you will use to track all interactions and transactions conducted via the Web site activity including the timeliness of response and resolution of said interaction/transaction.**

WellCare has experience developing fully functional, user-friendly internet websites for Medicaid programs in multiple states, including Georgia and Hawai'i. WellCare websites' functionality is compliant with Section 508 of the Rehabilitation Act enabling access for people with disabilities. WellCare's website for Louisiana will contain information including the member handbook, provider directory, and member education materials, such as newsletters and health education materials.

When a web user completes a Find A Provider search, he or she is prompted to complete a survey. This survey directs the user to a third party survey site that collects survey information and supplies it to the Product Management team. The survey contains questions regarding the content available on the site and document accessibility. Our Product Management team monitors responses monthly to continually improve members' web experiences.

### **Updating Information on Our Websites**

WellCare is committed to maintaining quality websites and has put in place the following content quality control processes:

- The content management system (CMS) stores the website content in a database, allowing content to be changed efficiently when required, including documents such as PDFs.
- Templates, style guidelines and editorial control ensure a visual, navigational and editorial consistency across the websites.
- The quality and accuracy of content is subject to an approval process before the content is published. This includes, when necessary, the applicable regulatory approval by state or federal agencies.
- The CMS stores approved versions of each page enabling the rollback of content to a previous version, if required.
- The web presence is maintained through active replication via three application servers.
- The code is maintained in source control solutions (Subversion & TFS) and is backed-up daily according to our IT policies.
- Each page has stored information that can identify the title, editor and date modified.
- The accuracy of the information on our websites is the responsibility of subject matter experts designated within each functional business area.

Functionality and code on the web sites are maintained by our internal IT department. When changes are needed, the designated subject matter expert issues a work order to WellCare's IT web division for implementation. Work orders are prioritized weekly, except for requests that are regulatory and/or time sensitive; these are worked immediately. For quality control, all code-based changes are reviewed twice before being released. Once a code-based item that is

connected to our core processing systems is implemented, such as the online provider search tool, it is automatically updated on a regular basis following established business rules.

### Monitoring E-mail Inquiries and Providing Timely Response

Using a production-tracking sheet, the member services team currently tracks e-mail inquiries and responses on a daily basis. This process enables the member services team to monitor production, as well as provide the necessary information for management to perform quality checks of all the work submitted, to verify that inquiries were handled correctly and to ensure members' concerns were fully addressed.

Requests for materials and the timeliness of responses are also monitored. We have processes that document when an e-mail request was made, the date the request was sent to a print vendor, and the date when the print vendor mailed the requested information to the member. Whether a member requests general information through an e-mail or the website, the communication is sent to a customer service representative (CSR) on the member services team by e-mail. The CSR reviews the request and triggers an action code which sends an extract file to a print vendor so the request can be fulfilled.

Every e-mail type (e.g., a request for a member handbook, a general question, etc.) has its own service level agreement (SLA), which allows us to monitor and track how each item is being addressed within the expected timeframe. Our state-of-the-art system is able to track the request from the time the CSR receives the request until the member's request is fulfilled.

### Tools and Reports Used to Track Web Interactions

WellCare tracks website statistics using various tools, including through server logs, MySQL, and Web Trends. Our website monitoring reports provide information regarding our member portal, provider portal, and public portal. Exhibit K.5.a below lists the metrics we measure for each portal.

**Exhibit K.5.a – Website Metrics**

Member	Provider	Public
# of eligibility inquiries	# of eligibility inquiries	# of plan information inquiries
# of claims status inquiries	# of claims submissions	# of contact requests
# of temporary ID card prints	# of claims resubmissions	# of online enrollments
# of address changes	# of claims status Inquiries	
# of authorization status transactions	# of claims e-mail Inquiries	
# of ID card orders	# of authorization submissions	
# of registered members to date	# of authorization status lookups	
# of new registered members	# of provider demographic update transactions	
# of contact requests	# of active member lookups	
# of OTC orders	# of registered members to date	
	# of new registered members	
	# of contact requests	

INSERT TAB HERE  
Section L  
Customer Service

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Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		<b>Section L: Customer Service (Section §12 of RFP)</b>	<b>100</b>		
<b>Section L Page 1</b>	<b>All</b>	<p><b>L.1</b></p> <p>Provide a narrative with details regarding your member services line including:</p> <ul style="list-style-type: none"> <li>• Training of customer service staff (both initial and ongoing);</li> <li>• Process for routing calls to appropriate persons, including escalation; The type of information that is available to customer service staff and how this is provided (e.g., hard copy at the person's desk or on-line search capacity);</li> <li>• Process for handling calls from members with Limited English Proficiency and persons who are hearing impaired;</li> <li>• Monitoring process for ensuring the quality and accuracy of information provided to members;</li> <li>• Monitoring process for ensuring adherence to performance standards;</li> <li>• How your customer service line will interact with other customer service lines maintained by state, parish, or city organizations (e.g., Partners for Healthy Babies, WIC, housing assistance, and homeless shelters); and</li> <li>• After hours procedures.</li> </ul>	<b>25</b>		
<b>Section L Page 12</b>	<b>All</b>	<p><b>L.2</b></p> <p>Provide member hotline telephone reports for your Medicaid or CHIP managed care contract with the largest enrollment as of January 1, 2011 for the most recent four (4) quarters, with data</p>	<b>25</b>		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		that show the monthly call volume, the trends for average speed of answer (where answer is defined by reaching a live voice, not an automated call system) and the monthly trends for the abandonment rate.			
Section L Page 14	All	<p><b>L.3</b></p> <p>Describe the procedures a Member Services representative will follow to respond to the following situations:</p> <ul style="list-style-type: none"> <li>• A member has received a bill for payment of covered services from a network provider or out-of-network provider;</li> <li>• A member is unable to reach her PCP after normal business hours;</li> <li>• A Member is having difficulty scheduling an appointment for preventive care with her PCP; and</li> <li>• A Member becomes ill while traveling outside of the GSA.</li> </ul>	20		
Section L Page 17	All	<p><b>L.4</b></p> <p>Describe how you will ensure culturally competent services to people of all cultures, races, ethnic backgrounds, and religions as well as those with disabilities in a manner that recognizes values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each.</p>	15		
Section L Page 21	All	<p><b>L.5</b></p> <p>Describe how you will ensure that covered services are provided in an appropriate manner to members with Limited English proficiency and members who are hearing impaired, including the provision of interpreter services.</p>	15		

## Section L: Customer Service

### L.1

**Provide a narrative with details regarding your member services line including:**

- **Training of customer service staff (both initial and ongoing);**
- **Process for routing calls to appropriate persons, including escalation; The type of information that is available to customer service staff and how this is provided (e.g., hard copy at the person's desk or on-line search capacity);**
- **Process for handling calls from members with Limited English Proficiency and persons who are hearing impaired;**
- **Monitoring process for ensuring the quality and accuracy of information provided to members;**
- **Monitoring process for ensuring adherence to performance standards;**
- **How your customer service line will interact with other customer service lines maintained by state, parish, or city organizations (e.g., Partners for Healthy Babies, WIC, housing assistance, and homeless shelters); and**
- **After hours procedures.**

Building long-term relationships with members is the essence of WellCare's successful approach to managed care. We understand that these relationships are built on the trust that comes from open, helpful, and timely communications between WellCare and members. Guided by these principles, WellCare places the highest importance on the role, responsibilities and operations of our call center. The center:

- Connects members with services and providers ensuring they get the care they need via direct access or referrals;
- Educates members about services and program components, including their rights and responsibilities; and
- Assists members with completing forms, assessments and paperwork needed to file grievances.



WellCare has significant experience developing and implementing member and provider call centers and hotlines, including overseeing the transition from fee-for-service to managed care for Medicaid ABD/SSI/LTC beneficiaries in Florida, New York and Hawai'i, and for Medicare beneficiaries in various states across the nation. We also have experience managing transitions for TANF and CHIP enrollees in seven states. We establish call centers based on market need, state contractual requirements and after an intensive financial, staffing and operational analysis. We work with state-of-the-art vendors who have the technological

capabilities to deliver call center services that meet or exceed state performance standards. We meet the service level agreements (SLAs) of the states we currently serve.

To ensure administrative efficiencies are realized, WellCare is proposing to operate one toll-free member/provider hotline (call center) utilizing customer service representatives (CSRs) who are knowledgeable about the Louisiana Medicaid program, our proposed service areas and the provider networks in these service areas.

CSRs will employ advanced technology, including our care gap software that enables CSRs to retrieve member records and instantly identify missed preventive care appointments while the member is on the line. The CSR will deliver the care gap message during the call to help educate the member about any missing visits. In addition, the CSR will offer to help schedule the appointment with the member's provider while on a three-way call with the member and provider. The CSRs will capture details of each call in our system providing us with the ability to produce electronic records that document synopses of all calls.

## **Call Center Infrastructure**

### Call Routing System

WellCare's member hotline will operate Monday through Friday from 7:00 am to 7:00 pm Central Time, excluding state declared holidays. Calls will be answered by an automated attendant offering a choice of English and at least one other language (attendant will be programmed based on volume of calls in each language). Callers will be given a menu of options, offered in order of frequency requested (e.g., selecting/changing PCP, requesting replacement ID card, arranging transportation, etc.) and will be routed to the first available CSR within their language queue. At anytime during the recording, members will be able to press zero to be transferred into the general queue. Members will be offered the option, at the beginning of every call, to complete a brief automated survey about their service experience at the call's conclusion.

Members may access ancillary services via the member call center. Members may be transferred to the medical advice line from the member call center or call the separate toll free number for the medical advice line. The medical advice phone number will be printed on member ID cards. WellCare provides nationwide access to medical advice and direction 24 hours a day, seven days a week. Our medical advice team is staffed by appropriately trained medical personnel such as physicians, physician assistants, licensed practical nurses (LPNs), and registered nurses (RNs).

WellCare has sufficient telephone line capacity at all call centers to handle incoming calls without blockage; this capacity is monitored on a daily basis. Additional telephone lines are added once utilization capacity reaches 50 percent. We use an automated call distribution system to route calls to the first available CSR. The system allows us to dynamically re-balance workload, including automatically tracking member services staff who are logged into the system or who are unavailable due to breaks or special projects. The system also captures detailed call statistics that will be used for long-term load balancing. In the unlikely event that inbound volumes exceed capacity, calls will be routed to trained representatives in other call centers, thereby ensuring that members will always be able to reach a CSR.

WellCare's automatic call distribution (ACD) system is capable of meeting the requirements in Section 12.16 of the RFP, including:

- Managing all calls received and assigning incoming calls to available staff in an efficient manner;
- Transferring calls to other telephone lines;
- Providing detailed analysis as required for the reporting requirements, including the quantity, length and types of calls received, elapsed time before the calls are answered, the number of calls transferred or referred, abandonment rate, wait time, busy rate, response time, and call volume;
- Providing a message that notifies callers that the call may be monitored for quality control purposes;
- Measuring the number of calls in the queue at peak times;
- Measuring the length of time callers are on hold;
- Measuring the total number of calls and average calls handled per day/week/month;
- Measuring the average hours of use per day;
- Assessing the busiest times and days by number of calls;
- Recording calls to assess whether questions are answered accurately;
- Providing a backup telephone system that shall operate in the event of line trouble, emergency situations including natural disasters, or other problems so that access to telephone lines is not disrupted;
- Providing interactive voice response (IVR) options that are user friendly to members; and
- Informing the member to dial 911 if there is an emergency.

### Escalation Unit

Front line CSRs will be backed-up by an escalation unit of WellCare CSRs, available to handle complex issues requiring additional expertise to research and resolve. Front line CSRs are trained to route member issues to the escalation unit any time they are unable to resolve the issue themselves.

### Interaction with Other Customer Service Lines

When members need to reach other customer service lines maintained by DHH, our CSRs will provide the telephone number for the specific customer service line and will transfer the caller to the external line. Our staff will have access to all external customer service lines maintained by state, parish, or city organizations including but not limited to Partners for Healthy Babies, WIC, housing assistance, and homeless shelters. WellCare will also transfer callers to DHH in order to connect our members to information regarding services such as dental, specialized behavioral health, personal care services and targeted case management. Our state-of-the-art system is capable of tracking the number of calls transferred internally and externally and reports will be provided to the state as needed. WellCare's standard transfer policy is to warm-transfer member calls whenever possible based on the hours of operation and wait times at the receiving number.

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### Resources Available to Our CSRs

As described in our response to Section F.7., CSRs will have access to our *HealthConnections* portfolio, which will include a searchable database of community resources that exist in Louisiana. It serves as a single repository for all community-based programs and services with contact information. CSRs will use the database to connect members to needed resources.

CSRs have on hand a comprehensive transfer directory that provides guidance on how and where to transfer a call depending on the member's needs. They will utilize an intent-driven, knowledge-based system to assist callers. The use of the intent-driven system will allow the CSRs to complete all calls using one system. This process assists the CSR with navigating our system and focuses on relevant call information, enabling us to ensure accuracy of response, maintain compliance, reduce errors and increase the likelihood that the issue is resolved on the first call.

CSRs will have the following information readily available:

- Member account information;
- Transfer directory;
- Listing of frequently asked questions;
- Member handbooks; and
- Announcements on business changes and process enhancements.

### After Hours Procedures

During non-business hours, WellCare maintains an automated Interactive Voice Response (IVR) system with the capability to provide callers with operating hours, instructions on what to do in case of emergency, and the option to talk directly to a nurse or other clinician or to leave a message, including instructions on how to leave a message and when that message will be returned. Calls retrieved from the voicemail box are returned by close of business on the next business day.

The IVR system is available 24 hours a day, seven days a week for members to request member ID cards, provider listings by county, pharmacy listings by zip code and access to the 24-hour medical advice line. The IVR is accessible via WellCare's toll-free member services telephone number. All recordings are in English, and at least one other language, depending on the particular market and service area.

### Special Services for Members with Limited English Proficiency and persons who are Hearing Impaired

WellCare analyzes state-supplied Medicaid data, demographic data from the U.S. Census Bureau, and data from other local studies on populations in each State we serve to learn about the cultural and linguistic needs of members, as well as any health disparities that may exist. We perform these analyses when we enter a new market and regularly thereafter. WellCare also analyzes claims and encounter data to identify the diagnostic categories that are most prevalent in an area. We also review member requests for assistance, including complaints and grievances, to identify opportunities to improve services from cultural and linguistic

perspectives. Finally, we analyze data on member race, ethnicity, and language, that are collected from state electronic databases or through voluntary self-identification by members.

The member call center serving our Louisiana members will be equipped to handle calls from providers and members, including non-English speaking members and members who are hearing impaired. Our member call center, in collaboration with Certified Languages International (CLI), offers phone translation for over 150 distinct languages and dialects including Spanish and Vietnamese. Translation is provided at no cost to the member via a three-way live call between the member, WellCare and CLI.

The member hotline will have an IVR for members who cannot access menus by physical means. The system is set up so that members who do not select an option are routed to a CSR by default. Telephone typewriters (TTY) and telecommunication devices for the deaf (TDD) are used to communicate over the telephone with members who are hearing and/or speech impaired. Our CSRs are trained to communicate with members in a “Person First” manner and have experience with proper protocols and etiquette associated with use of assistive communication devices.

### Staffing

WellCare views our local customer support function as a critical link to our members. We devote significant resources in all of our programs to hire and train well-qualified and compassionate CSRs and to equip our specialists with state-of-the-art systems to support their mission.

We are familiar with the increase in call volume that generally occurs within the first few months of a new program. For the initial on-boarding period, we will staff our call center in anticipation of the high call volume and will gradually reduce this number as call volume decreases, and we are able to gauge the ongoing call volume.

WellCare plans to partner with approved third party vendors to provide some of the services required by the state. All oversight and accountability rests with WellCare, including training and quality oversight activities. WellCare will oversee initial and refresher training and will conduct regular on-site quality monitoring of call center performance. We also will perform ongoing audits to test CSR knowledge of program rules and changes. All staff will undergo the comprehensive training and testing regimen described below prior to initial contact with members. WellCare employees will be available in a quality assurance (e.g., call monitoring) capacity, and WellCare will hold conference calls and in-person meetings with its vendor on a routine and (when necessary) urgent basis to review any issues encountered by either side, and to develop a plan of response. Vendor contracts will be overseen by the call center manager reporting to our customer service director.

As in other Medicaid programs, WellCare will offer educational opportunities on an ongoing basis. Our CSRs will meet or exceed the requirements specified in the RFP by responding to member requests including, but not limited to:

- Explanation of CCN policies and procedures;
- Prior authorizations;
- Access information;
- Information on PCPs or specialists;

- Referrals to participating specialists;
- Resolution of service and/or medical delivery problems;
- Member grievances;
- Transportation for both emergency and appropriate non-emergency situations;
- Member health education programs;
- Questions about covered services;
- Explaining member rights and responsibilities;
- Reporting of suspected fraud and abuse;
- The member handbook, ID card, and provider directory;
- Issues with accessibility standards for access to PCPs or referrals to specialty providers and referring such problems for resolution;
- Scheduling appointments to access EPSDT services;
- Changing demographic information such as address and phone number; and
- Help making appointments with providers.

In addition to receiving calls from members at the call center, WellCare will contact each member by phone within the time frame specified by DHH to:

- Welcome the member to the plan and provide a brief explanation of the program;
- Discuss the availability of oral interpretation and written translation services and how to obtain them at no cost;
- Assist the member in making a selection of a PCP or changing a PCP if one is assigned;
- Educate the member about the concept of the patient-centered medical home, including the importance of making a first appointment with his or her PCP for preventive care before the member requires care due to an illness or condition, and instructions about changing PCPs; and
- Discuss the member's health status including determining if the member is pregnant, has a chronic condition, or any special health care needs and providing assistance in making an appointment with the PCP.

We will make three attempts to contact each member and report to the state on a monthly basis the name, telephone number and Medicaid Recipient ID Number of each member we were unsuccessful at contacting after three attempts.

### **Training and Resources**

A key to WellCare's success has been the development of comprehensive staff training programs to meet and support the goals of our call centers. The goal of our training program is to ensure our staff have the necessary skills to handle the complex needs of our members. WellCare CSRs undergo a comprehensive training and testing regimen prior to placement on the inbound phone queue. Once a member services candidate passes the interview screening process, he or she begins a three-week in-classroom training program. The candidate takes a skills and knowledge test before progressing to the next step. The candidate must obtain a score of 85 percent or greater to continue. From there the candidate undergoes one or two more weeks of training in a transition setting. In this environment, the candidate receives

incoming calls while being closely monitored by supervisors who listen in through our telephone monitoring system. The candidate is issued a daily score card grading him or her on response time, telephone etiquette, accuracy and knowledge of the plan's operations. After completion of this monitoring period, the candidate receives a complete evaluation to determine whether he or she will be placed in the regular phone queue. Candidates are not placed in the queue until they are deemed ready by the supervisor.

The curriculum for Louisiana CSRs will include:

- *Overview of the CCN program, including:* program goals, state partners, eligibility criteria/eligible categories, cultural competency, and Louisiana program requirements;
- *Call Center System and Processes, including:* system features, outbound/inbound call scripts, call routing and escalation protocols and use of translation/interpreter services through Certified Languages International to provide assistance to members with limited English proficiency (LEP);
- *Assisting members with enrollment and disenrollment, including:* selection/assignment of a PCP and establishment of a patient-centered medical home, member materials, including member handbook and ID card, availability and importance of preventive and primary health care, member rights and responsibilities, and referring the member to the state's enrollment broker for disenrollment;
- *Assisting members in obtaining services, including:* care coordination, covered services, scheduling referral visits and enrolling in chronic care management; and
- *Grievances and appeals, including:* explanation of the differences between grievances and appeals, options for filing a grievance or appeal, and assisting members with filing a grievance or appeal.

Respecting diverse cultures is one of WellCare's core values. As part of our new hire orientation program for the Louisiana Medicaid call center staff, we will provide information on cultural competency including assisting economically disadvantaged individuals. We will also require that all new staff complete cultural competency training within three months of their date of hire.

We will conduct ongoing education and training for CSRs including training on disability awareness and client sensitivity. All CSRs will receive ongoing refresher training through team meetings, ad-hoc training sessions and one-on-one-coaching. CSRs will also receive information on program or CCN policy changes through special in-service sessions. Performance-related issues will be addressed through quality oversight programs. The oversight includes monitoring of activities to include supervisor call monitoring, secret shopper calls and live audits, evaluating call disposition against WellCare's quality criteria, and sampling calls completed within the previous 48 hours.

## **Quality Monitoring**

### Monitoring Front Line Staff

We have an extensive Quality Assurance (QA) approach that includes end-to-end audits from WellCare Customer Service QA, end-to-end audits conducted by our vendors via their internal QA department, and independent quality monitoring from an external vendor. The Quality Wheel (Exhibit L.1.a) illustrates the life cycle of our comprehensive approach to quality. First, we

monitor the CSR to measure performance, learn about the CSRs strengths and weaknesses, and coach the CSR to encourage improvement in key performance indicators (KPIs).

Next, we validate the monitoring process by conducting audit and calibration sessions. CSRs will be subject to regular oversight, through a combination of supervisor call monitoring, secret shopper calls, and live audits based on randomly selecting calls completed within the previous 48 hours. CSRs will be subject to all three monitoring activities in the course of a year. Department-level issues will be addressed through special in-service training or clarification/revision of plan policies, as appropriate.

As previously mentioned, we also offer a post call survey to measure member and provider satisfaction. Callers are able to opt-in to the survey prior to speaking with a CSR. The information obtained from these surveys is used to improve the services we provide to our callers and is reported in the aggregate and at the individual CSR level to a customer service quality team, which meets monthly to review plan performance across a variety of functional areas. The team includes directors/managers from Customer Service, Health Services, Quality Improvement and Provider Relations. When needed for evaluation purposes, the quality team can also access the verbatim comments left by callers. If problems with an individual CSR's performance are identified, the CSR will receive additional coaching or training as necessary to improve performance.

We analyze data from repeat callers and from the post-call survey to understand why callers' issues were not resolved during their first interactions with us, and to reach out and repair our relationships with callers who expressed dissatisfaction. Finally, with the assistance of our vendors and the state, we strategize on ways to improve performance for all aspects of our interaction with members through the member call center.

Exhibit L.1.a – Comprehensive Quality Approach/Quality Wheel



Our extensive experience allows us to meet or exceed our clients' needs and expectations. Our infrastructure and staffing capabilities provide the foundation for a well-tuned member services program. We possess the skills and expertise to assist members, connect them to providers and resources in a timely manner, and provide education and outreach to our members.

Monitoring Call Center Operations

Our experience in the states where we serve members demonstrates the quality of service we provide. We have the skills to meet the call center performance standards outlined in Section 12.16.2 of the RFP including:

- Answering 90 percent of calls within 30 seconds or directing the call to an automatic call pickup system with IVR options;
- Ensuring that no more than one percent of incoming calls receive a busy signal;

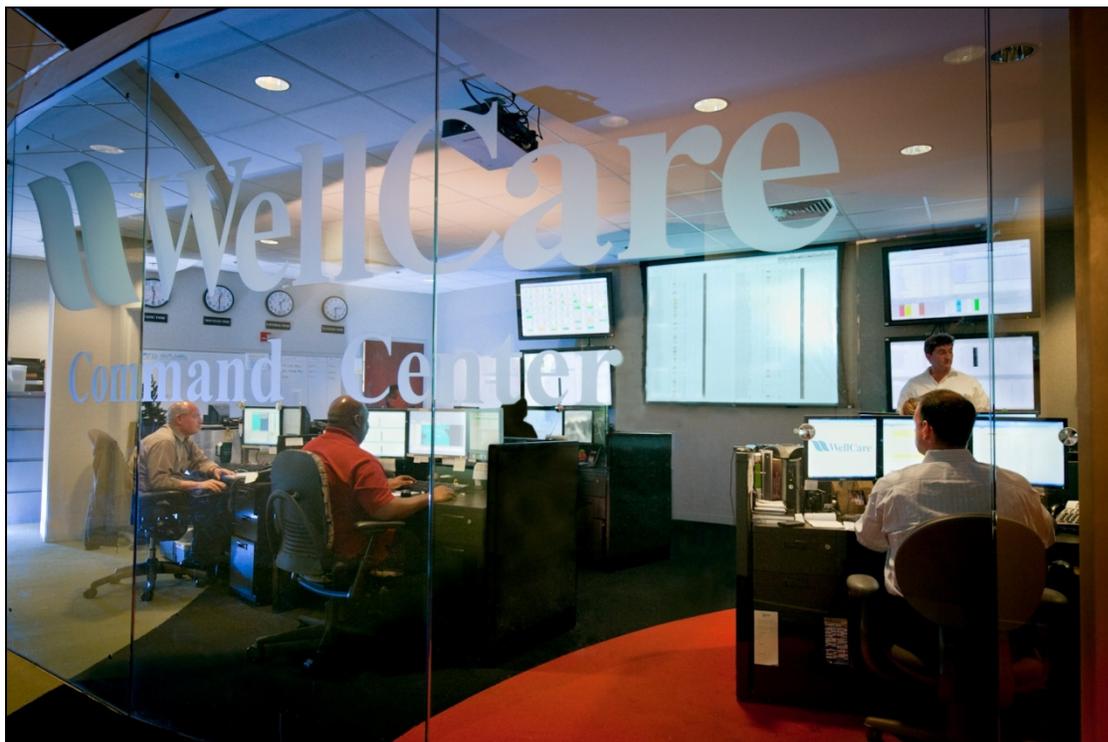
- Maintaining an average hold time of three minutes or less; and
- Maintaining a call abandonment rate of not more than five percent.

In 2010 WellCare’s member service phone lines assisted approximately 1,524,000 Medicaid members in the states we serve, including CHIP, TANF and Aged, Blind or Disabled populations, as well as 545,000 Medicare members.

The member call center serving Louisiana members will have the capability to automatically track and report on performance with respect to program metrics. Based on an agreed upon time frame, we will deliver a report to the state regarding our performance in assisting callers through the member call center and medical advice line.

Our approach to monitoring call center performance in relation to access is focused on ensuring that members are able to obtain assistance from our member call center in the quickest, most efficient manner. Our state-of-the-art command center, based in Tampa, Florida, allows us to monitor performance of the entire call center enterprise in real time (Exhibit L.1.b). Command center staff members are responsible for ensuring superior service levels are being delivered across all lines of business and for assessing the potential impact of adjustments to our operations. The multiple screens in the command center display data and trends including the number of calls in each queue, number of calls waiting to be answered, length of time callers have been waiting to speak to a CSR, the number of CSRs available to assist callers, and website accessibility. Because weather can pose a threat to our operations and could affect the number of calls we receive or change the duration of existing calls, the command center dedicates one monitor to tracking weather conditions and impending weather emergencies.

**Exhibit L.1.b – WellCare’s Command Center**



WellCare's command center uses the IEX TotalView workforce management system to ensure adequate staffing across our call center enterprise. TotalView uses a proprietary formula that takes into account variables such as average handle time, time of day, projected mailings, enrollment periods, population size, and historical performance to project call volume and required staffing. This enables us to forecast call volumes, schedule agents, control call traffic between sites, perform staffing analysis, and report on KPIs. To further ensure accuracy of forecasted call volume and staffing, intervals of 30 minutes are used to understand arrival patterns. By analyzing at the level of the half hour, we can ensure that we are correctly staffed to meet the needs of the customer and to ensure we meet contractual requirements. TotalView allows us to quickly develop weekly, monthly, annual, and multi-year planning scenarios that accurately forecast the impact of changes in key performance drivers on call center service quality and staffing requirements.

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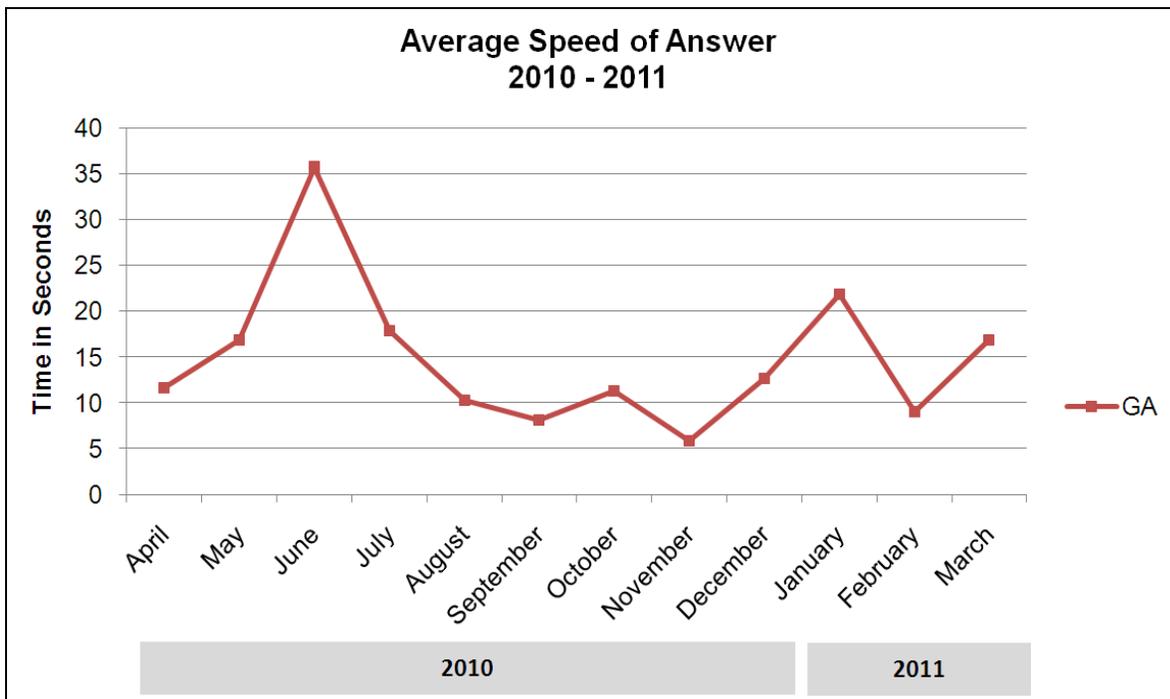
**L.2**

**Provide member hotline telephone reports for your Medicaid or CHIP managed care contract with the largest enrollment as of January 1, 2011 for the most recent four (4) quarters, with data that show the monthly call volume, the trends for average speed of answer (where answer is defined by reaching a live voice, not an automated call system) and the monthly trends for the abandonment rate.**

**Member Hotline Telephone Reports**

The following figures illustrate metrics for Georgia Families (Medicaid and CHIP), WellCare’s managed care contract with the largest enrollment as of January 1, 2011. Exhibit L.2.a illustrates trends for average speed of answer by a live voice for 2010 and 2011. Exhibit L.2.b and Exhibit L.2.c display quarterly call volumes and monthly data regarding average speed of answer by a live voice and abandonment rate for the first quarter of 2011 and the last three quarters of 2010, respectively.

**Exhibit L.2.a – Trends for 2010 - 2011 for Average Speed of Answer (ASA)**



**Exhibit L.2.b – Call Volumes, Average Speed of Answer (ASA) and Abandonment Rate (ABA) for 2011 (Q1)**

**Average Speed of Answer and Abandon Rate**

Year	2011
LOB_Internal_Only_Dashboard	MEDICAID
Status	MEMBER
Quarter	(All)

Location	Month	ASA	ABA %
GA	January	22	2%
	February	9	1%
	March	17	1%
<b>Grand Total</b>		<b>16</b>	<b>1%</b>

**Call Volume**

Year	2011
LOB_Internal_Only_Dashboard	MEDICAID
Status	MEMBER

Volume Location	Quarter
GA	1
<b>Grand Total</b>	<b>122,820</b>

**Exhibit L.2.c – Call Volumes, Average Speed of Answer (ASA) and Abandonment Rate (ABA) for 2010 (Q2 – Q4)**

**Average Speed of Answer and Abandon Rate**

Year	2010
LOB_Internal_Only_Dashboard	MEDICAID
Status	MEMBER
Quarter	(All)

Location	Month	ASA	ABA %
GA	April	12	1%
	May	17	2%
	June	36	5%
	July	18	2%
	August	10	1%
	September	8	1%
	October	11	1%
	November	6	1%
	December	13	1%
<b>Grand Total</b>		<b>14</b>	<b>2%</b>

**Call Volume**

Year	2010
LOB_Internal_Only_Dashboard	MEDICAID
Status	MEMBER

Volume Location	Quarter	2	3	4
GA		122,967	134,392	119,615
<b>Grand Total</b>		<b>122,967</b>	<b>134,392</b>	<b>119,615</b>

### L.3

**Describe the procedures a Member Services representative will follow to respond to the following situations:**

- **A member has received a bill for payment of covered services from a network provider or out-of-network provider;**
- **A member is unable to reach her PCP after normal business hours;**
- **A Member is having difficulty scheduling an appointment for preventive care with her PCP; and**
- **A Member becomes ill while traveling outside of the GSA.**
- **A member has received a bill for payment of covered services from a network provider or out-of-network provider**

WellCare understands that providers may not, under any circumstances, seek any payment from a member other than allowable co-payments at the time of service. The prohibition on billing members is outlined in our provider contracts, addressed in provider training, and reinforced in the provider handbook and other educational materials.

Members will be held harmless as required in Section 23.24 of the RFP. If a member informs a customer service representative (CSR) that he or she has received a bill from a network provider for core benefits or services, the CSR will obtain details about the bill from the member (i.e., provider name, date and type of service, bill amount, etc.) and verify that the member was enrolled at the time of service. The CSR will contact the provider immediately, with the member on the line, to have the bill voided. If the member cannot remain on the line, the CSR will obtain a callback number or e-mail address and contact the member at a more convenient time with the resolution.

If the provider agrees to void the bill, the provider's office will be instructed to send a written notice to the member and to provide a copy to WellCare. The CSR will alert the member, document the occurrence in an issues note in the member's record, and log the action as complete. This will enable WellCare to track similar situations and refer the provider for further action in the event the issue recurs. WellCare has the member's best interest in mind. In the event that the provider does not send a written notice to the member regarding the voided bill or if the member receives an additional bill from the provider, WellCare will attempt to contact the provider with the member on the line, to follow up on the status of the bill.

If the provider refuses to void the bill, the issue will be referred on an urgent basis to the Provider Relations department and a local provider relations representative will contact the office to educate the provider and the provider's staff about the prohibition against member billing. If the office still refuses or fails to modify its policy, the provider will be referred to the medical director for a final attempt at resolution. The medical director will contact the provider and make a final attempt to remedy the situation, which may include imposition of a corrective action plan.

If the provider still refuses to void the bill, the medical director will refer the provider for disciplinary action, up to and including removal from the network. The medical director will notify DHH of the provider's actions, so that appropriate regulatory steps can be initiated.

If the provider is not in the WellCare network, the same steps will be followed, except for network removal. However, our Utilization Management department will be notified and instructed to re-educate the provider, as part of any future service authorization, that members cannot be billed directly.

### **A Member is unable to reach her PCP after normal business hours**

In this scenario, WellCare's first priority will be to address the member's needs and second, to determine why the PCP was unavailable. WellCare's after-hours call center system provides instructions to members on what to do in case of a possible emergency, including dialing 911 or going directly to the nearest emergency room. Members with case managers will also have a number for an on-call case manager who can be reached at any time to assist with an urgent need.

WellCare offers two solutions to members for non-urgent calls. As a first option, members may leave a message on a confidential voice mailbox for retrieval and response by a CSR by close of business on the following business day. Upon contacting the member, the CSR will assist in resolving whatever issue may exist, including contacting the PCP's office with the member on the line. If the member is enrolled in case management, and the nature of the call is care-related, the member's case manager will be notified and will follow up directly with the member.

As a second option, WellCare members have telephone access 24 hours a day, seven days a week to a nurse through the medical advice line. Nurses on the advice line can provide medical guidance and direct the member to the most appropriate level of care and place of service, as well as provide names and locations of network providers. The nurse can also educate the member on a large number of general health topics as well as provide information regarding many common chronic and acute conditions. During this process the nurse may also make referrals to WellCare's other programs including but not limited to: case management, chronic care management, the member's behavioral health plan, and customer service. Referrals may be performed via warm transfer or messaging via voice mail or e-mail.

The CSR or case manager will inquire as to what occurred when the member tried to contact her PCP. The circumstances will be documented and the Provider Relations department notified for follow-up with the PCP's office on the next business day. PCPs are required to have a live voice answering service for after hours calls and the inability of a member to reach her provider would indicate this requirement is not being met.

Depending on the circumstances, the PCP may be referred for further intervention by the medical director's office and may be issued a corrective action plan. The provider relations representative would also make after-hours calls to the office several times in subsequent weeks to confirm the problem has been resolved. Provider Relations would track the incident, and any others like it, as part of monitoring network adequacy. If a pattern emerges across providers in a community, it could be early evidence that the network is under strain and that capacity may need to be increased.

### **A Member is having difficulty scheduling an appointment for preventive care with her PCP**

WellCare CSRs and case managers are trained to intercede on the member's behalf if a member is unable to schedule a timely appointment with his or her PCP, whether for preventive

or other care. Upon contact by the member, the CSR or case manager will call the provider, with the member on the line, to obtain a scheduled appointment that meets the member's needs and complies with the timely access standards in Section 7.5 of the RFP.

If the member expresses any dissatisfaction regarding his or her PCP related to the situation, a grievance would be filed on the member's behalf so the appropriate investigation and follow-up can take place. Failure of a PCP to offer adequate access to preventive care could be an indication of more serious access issues requiring the CCN's intervention.

If WellCare were unable to obtain an appointment with the PCP for the member, we would refer the PCP to the Provider Relations department for follow-up and to ascertain if there is a broader capacity issue. If necessary, we can close a PCP's panel to new members and update this information in our system and in the online directory. In the interim, we would assist the member with changing to another PCP and obtaining a scheduled appointment in conformance with program standards.

### **A Member becomes ill while traveling outside of the GSA**

If a member becomes ill while traveling outside of the GSA, WellCare will advise the member to go to the nearest urgent care center or, in the event of a possible emergency, to call 911 or go to the nearest hospital emergency room. CSRs will do their best to assist the member with locating the nearest urgent care center or emergency room. If the member is in an area where WellCare has an existing network, we will search our provider directory to supply the member with the names and addresses of health care facilities in the area. If the member is in an area that WellCare does not serve, our CSRs will use the Internet to try to locate a nearby facility for the member. The member will be instructed to show his or her WellCare ID card upon arrival at the hospital and ask the hospital staff to call WellCare. The member also will be advised to call his or her PCP at the earliest opportunity.

WellCare will document the member's condition and where the member sought care. If the member is hospitalized, WellCare's Utilization Management department will be notified through claims data and will place a follow-up call to the hospital to assess the member's condition. If the member has an assigned case manager, the case manager will contact the member or the member's caregiver to enable appropriate follow-up. The case manager will document the outcome in the member's record in the Enterprise Medical Management Application (EMMA) and update the member's care plan as necessary. The case manager also will work with the admitting hospital and the member's PCP to ensure coordination of care during the member's stay and post-discharge.

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#### L.4

***Describe how you will ensure culturally competent services to people of all cultures, races, ethnic backgrounds, and religions as well as those with disabilities in a manner that recognizes values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each.***

WellCare promotes a health care delivery system that in all aspects reflects cultural differences represented in the populations we serve. WellCare's culturally responsive system enhances the quality of care delivered, member satisfaction and health outcomes. Our policies and practices extend beyond sensitivity to country of origin, race, religion and ethnicity to include protecting the rights and dignity of persons with disabilities and other special health care needs. In 2009 (most recent year data available), Georgia's External Quality Review Organization gave WellCare a cultural competence compliance rate of 100 percent.

WellCare's approach to cultural competency includes:

- Ensuring we understand health disparities and that our outreach and overall case management strategies address cultural differences among our members;
- Improving health literacy to ensure that all of our members and their caregivers have the understanding they need and are empowered in their choices of care;
- Improving understanding and sensitivity to cultural diversity among our associates and network providers; and
- Improving health outcomes by instilling cultural competency into all parts of the organization, including Member Services, Network Development, Chronic Care/Disease Management, Case Management and Quality Improvement.

Cultural competency is a universal principle, but every state is unique in terms of its specific cultural/linguistic profile and health disparity issues. In Louisiana, demographics suggest that our approach must focus on individual's ancestry as a person's ethnic origin, racial heritage, descent, or roots, which may reflect their place of birth, place of birth of parents or ancestors, as ethnic identities that have evolved within the United States.

New Orleans and French-speaking South Louisiana are juxtaposed against the African-American/British-American culture of North Louisiana. Additionally there are differences within these regional groups and the cultural complexities resulting from the presence of Native Americans and the waves of immigrations by Irish, Germans, Italians, Czechs, Hungarians, Croatians, Filipinos, Latinos (Isleño, Mexican, Cuban, Guatemalan), and East Asians (Chinese, Vietnamese, Laotian, Thai). Each group has added to the cultural environment of Louisiana and in varying ways influenced the traditions found in the state.

#### **Ensuring the Delivery of Culturally Competent Services**

WellCare carefully evaluates the needs of our members from a cultural competency perspective, through review of clinical and demographic data and outreach to stakeholder groups. We begin well in advance of contract award, so that what we learn can inform our network development, clinical priorities and member service design.

We have started our outreach efforts to community-based organizations in Louisiana that support the diverse Medicaid populations, including persons with disabilities. The purpose of this outreach is to gain a better understanding of the concerns and priorities of program stakeholders and to apply what we learn in developing effective methods for member engagement and care management. It also is a first step toward becoming an integral part of the communities we will serve and to reflect, through our programs and network, the diversity and priorities of our members. In Georgia for example, we have a strong network of community-based service organizations with which we consult regularly on issues important to their constituencies, including (but not limited to) the Clinic for Education, Treatment and Prevention of Addiction (CEPTA), the American Heart Association, local Head Start organizations, the Asthma Coalition, and the Augusta Housing Authority.

We ultimately intend to form permanent cultural competency advisory groups for each market that will be comprised of members and representatives of stakeholder organizations. This approach has proven effective for us in other programs. In Hawai'i, we created a task force to provide insight into the cultural concerns of the enrolled population, which includes SSI and long-term care beneficiaries. The task force was comprised of community leaders representing the cultural and geographic diversity of the state. Based on its recommendations, we developed distinct outreach strategies for the Islands' native Hawai'ian, Filipino, Japanese and other enrollment groups. The task force also assisted in recruiting a network of traditional healers for our native Hawai'ian members.

The information we acquire through our outreach activities will be used in developing a comprehensive cultural competency plan for Louisiana. The plan will be shared with DHH prior to implementation and will address all of the following areas.

#### WellCare Employment and Training

WellCare recognizes that employing a diverse staff makes us more effective at helping enrollees overcome linguistic barriers and receive culturally appropriate services. Our hiring philosophy is to attract individuals from diverse backgrounds, particularly those that reflect the populations we serve. (For example, if 10 percent of member calls we receive are from Spanish-speaking members, we hire Spanish-speaking staff to meet the demand). Similarly, our case managers will be drawn from diverse backgrounds. For example, we will initiate local job fairs and contact universities to help us to recruit a diverse staff that is aware of the cultural needs and nuances of our members in each GSA.

As part of initial training, our Louisiana staff will receive information on the cultural and ethnic diversity of our members and how differing member backgrounds can be relevant to health care preferences. Staff also will receive training on how to assist members with sight and hearing impairments and other disabilities. All new staff will complete cultural competency training within three months of their date of hire and will receive annual refresher training and re-evaluations. Staff will receive ongoing refresher training, including training on disability awareness, through regular team meetings, ad-hoc training sessions and one-on-one coaching, as necessary.

#### Provider Network Development and Education

WellCare is actively recruiting traditional Medicaid providers and others with diverse backgrounds in order to build a network that reflects the cultural composition of our membership. In our experience, providers who traditionally serve the Medicaid population are, in

general, respectful of and responsive to members' cultural and linguistic needs and are committed to serving people of all backgrounds. We will document the language abilities and physical accessibility (e.g., accessible medical equipment for chair-bound members) of provider offices during credentialing and update this information on a quarterly basis. This information will be posted in the provider directory provided to members both in hard copy and via WellCare's website.

We will partner with traditional Medicaid providers in developing culturally appropriate clinical and member outreach initiatives. We also will educate the broader network on the importance of cultural competency as part of initial orientation, through our provider handbook and online. WellCare's Cultural Competency Plan is included in the provider handbook and available on the WellCare website. We will address the topic regularly through newsletters and through distribution of appropriate reference materials, such as the national culturally and linguistically appropriate services (CLAS) standards.

Our provider relations staff will serve as a resource to providers with specific questions related to providing culturally competent care. All providers will receive a cultural competency checklist to assess their cultural competency activities. We will arrange for appropriate follow-up assistance to providers in completing the checklist and addressing any identified needs. We also will review member grievances and offer additional, targeted training to providers when a potential problem is uncovered.

#### Access to Services

WellCare's cultural competency plan will include descriptions of plan policies for ensuring culturally appropriate communications and access to care. WellCare writes all member materials at or below a sixth grade reading level. We also encourage staff and providers to look for indicators of literacy problems and to attempt, with sensitivity and discretion, to help members with immediate needs - such as filling out a medical form - while guiding them to community resources available to help improve literacy skills.

Materials will be prepared in English and other languages as justified by the demographics of the membership and/or member translation requests. As requested in sections 12.12.2.28 and 12.19.1 of the RFP, WellCare will ensure that the appropriate interpretation and translation statements are available to members in Spanish and Vietnamese at a minimum. Translation services are provided for written marketing and member education materials for any language that is spoken as a primary language for 200 or more members within a GSA. Materials will be specially prepared in large-print versions for members who cannot read normal size print and in Braille or audiotape for persons who are legally blind. CSRs will ask members who are sight impaired if they would like assistance reading or listening to enrollment, member-related or other support materials.

WellCare uses Certified Language International (CLI) for interpreter services when necessary to communicate with members who speak a language not spoken by one of our associates. CLI provides our members on-demand access to translation services for over 150 languages, 24 hours a day, seven days a week using 100 percent US-based interpreters. The same service is available from CLI at no cost to members when required at provider offices or other places of care.

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### Continuous Quality Improvement

Cultural competency is a priority component of our continuous quality improvement efforts. We employ encounter data analysis, community partnerships and advisory groups to devise culturally and linguistically appropriate services for our members. WellCare also regularly reviews grievances and responses to member satisfaction surveys to analyze gaps in staff, provider and/or overall company performance. WellCare will conduct an annual evaluation of the effectiveness of the cultural competency plan and use the results to develop and implement interventions to improve service delivery.

### Developing Intervention Strategies to Reduce Disparities

As mentioned above, WellCare combines data analysis (i.e., encounters, utilization, clinical reviews), stakeholder collaboration (member surveys, grievances, call center records, provider input) and our extensive experience to develop successful intervention strategies that reduce health disparities among minority and disabled populations. WellCare has begun to analyze HEDIS results stratified by race to determine if there is a difference in quality of care received by people of different races. When a disparity is identified in Louisiana, WellCare will develop targeted interventions to ensure that we are addressing the disparity.

As an example, WellCare has developed culturally and linguistically appropriate health education and disease intervention programs in connection with our chronic care management programs. We accomplish this through culturally/linguistically-appropriate materials; using foreign language translation services, available services for the sight and/or hearing impaired such as Braille, large print, audio format, and the TTY/TDD line; and guidance to appropriate community resources to access literacy education programs.

## L.5

***Describe how you will ensure that covered services are provided in an appropriate manner to members with Limited English proficiency and members who are hearing impaired, including the provision of interpreter services.***

WellCare currently complies, and will continue to comply, with all federal requirements regarding oral interpretation services and written materials, including but not limited to the requirements in 42 CFR § 438.10. We will:

- Provide oral interpreter services in all non-English languages through bilingual staff and Certified Languages International (CLI) as well as interpreter services for members who are deaf or hearing impaired;
- Provide key oral contacts and written materials in alternative formats; and
- Inform members about how to access, at no cost, interpreter services, translated materials, and information in alternative formats.

As part of the welcome call, we will determine whether a member prefers to receive key oral contacts and/or written materials in a language other than English or in an alternative format. We document this information in our system to ensure that the member receives key oral contacts and/or written materials in the preferred language and/or format. We will inform members via the welcome call, the member handbook, our website, customer service representatives (CSRs), and case managers that they can receive key oral contacts and/or written materials in other languages and formats.

We consider respect for diverse cultures a core value. As part of our orientation for newly hired Louisiana call center staff, we will include information on cultural competency and require that all new staff complete cultural competency training within three months of their date of hire. All staff will be required to complete an annual training on cultural competency and are assessed on that training. We also conduct ongoing education and training for CSRs, including training on disability awareness.

### **Key Oral Contacts**

WellCare conducts key oral contacts with members in a language that the member can understand. Key oral contacts include but are not limited to calls to our toll-free lines, contacts with case managers, and face-to-face encounters with providers.

Members calling our toll-free phone lines (e.g., our member services and medical advice lines) are offered a choice of English and Spanish and are connected to the selected language queue. The Spanish language queue is staffed by CSRs who are bilingual in English and Spanish. If the member's language is other than English or Spanish, we will, to the extent possible, use CSRs who are fluent in that language. Otherwise we will offer and, if accepted by the member, deliver interpreter services in the member's preferred language using CLI. We have been working with CLI for two years and are pleased with their ability to translate discussions pertaining to health matters, including those involving medical terminology. CLI requires that every interpreter pass a medical interpreter and credentialing process exam with a score of not less than 90 percent and with no errors of clinical significance.

At a minimum, our staff will include case managers who are fluent in English and Spanish, and we will seek to match members whose primary language is Spanish with a Spanish-speaking case manager. We also plan to include case managers who are bilingual in English and Vietnamese in order to meet the needs of members whose primary language is Vietnamese. If a member's primary language is not English or Spanish and his or her case manager does not speak the applicable language, the case manager will offer and, if accepted by the member, arrange for interpreter services in the member's preferred language during any contact. WellCare prefers live, in-person interpretation during face-to-face contacts, so whenever possible, WellCare will arrange for an interpreter to attend face-to-face contacts between a case manager and a member. For telephone contacts and for face-to-face contacts when an in-person interpreter is not available, or if preferred by the member, we will use CLI.

If a member's primary language is not English, and the provider does not speak the applicable language, we offer interpreter services to members during face-to-face encounters with providers rendering care. WellCare's member services staff will arrange for an interpreter to attend the health care appointment whenever possible. In the event a live, in-person interpreter cannot be provided (e.g., the visit is urgent in nature and there is not sufficient time to arrange for an interpreter), WellCare will direct the provider to use CLI.

Generally, WellCare discourages the use of family members or acquaintances as interpreters for health care appointments. Family members and acquaintances may not be capable of translating medical terminology and patients may hesitate to speak candidly about health problems in their presence. If a member requests interpreter services by a family member or an acquaintance, we do not allow anyone who is under the age of 18 to provide them.

### **Alternative Methods of Communication**

WellCare will make key oral contacts and written materials available in alternative formats, such as sign language and video relay services, and in a manner that takes into consideration the special needs of members who are hearing impaired.

We provide and will continue to provide members a toll-free number to access TDD/TTY. These numbers will be provided on member materials, including but not limited to the member handbook and the member welcome letter. Case managers will also provide the numbers to all members who are deaf or hearing impaired.

If a member is deaf or hearing impaired, and his or her case manager is not fluent in sign language, the case manager will offer and, if accepted by the member, arrange for interpreter services. For face-to-face contacts between a case manager and a member, the Member Services department will arrange to have a certified interpreter, cued speech transliterator, or sign-language interpreter attend the meeting.

WellCare will offer assistance during a health care visit to members who are deaf or hearing impaired. As with language interpreter services, WellCare prefers live, in-person interpretation, so whenever possible our member services staff will arrange for a certified interpreter to be present during a health care visit.

## **Provider Network**

Our provider recruiting efforts focus on developing a network that reflects the diversity of our members in the market we are operating, and traditionally serves the Medicaid population. WellCare seeks to recruit providers from within the communities they serve and regularly analyzes the provider network to ensure it is adequately diverse.

We recruit providers who speak languages other than English and include information on non-English language(s) spoken by each provider in our provider directory, so that members can choose providers who speak their primary language.

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INSERT TAB HERE  
Section M  
Emergency Management Plan

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Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		<b>Section M: Emergency Management Plan (Section § 2 of RFP)</b>	<b>25</b>		
<b>Section M Page 1</b>	<b>All</b>	<p><b>M.1</b></p> <p>Describe your emergency response continuity of operations plan. Attach a copy of your plan or, at a minimum, summarize how your plan addresses the following aspects of pandemic preparedness and natural disaster recovery:</p> <ul style="list-style-type: none"> <li>• Employee training;</li> <li>• Identified essential business functions and key employees within your organization necessary to carry them out;</li> <li>• Contingency plans for covering essential business functions in the event key employees are incapacitated or the primary workplace is unavailable;</li> <li>• Communication with staff and suppliers when normal systems are unavailable;</li> <li>• Specifically address your plans to ensure continuity of services to providers and members; and</li> <li>• How your plan will be tested.</li> </ul>	<b>15</b>		
<b>Section M Page 3</b>	<b>All</b>	<p><b>M.2</b></p> <p>Describe your plan in the following Emergency Management Plan scenario for being responsive to DHH, to members who evacuate, to network providers, and to the community.</p> <ul style="list-style-type: none"> <li>• You have thirty thousand (30,000) or more CCN members residing in hurricane prone parishes. All three GSAs include coastal parish and inland parishes subject to mandatory evacuation orders during a major hurricane. A category 5 hurricane is approaching, with</li> </ul>	<b>10</b>		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		<p>landfall predicted in 72 hours and parishes within the GSA are under a mandatory evacuation order. State assisted evacuations and self evacuations are underway. Members are evacuated to or have evacuated themselves to not only all other areas of Louisiana, but to other States.</p> <ul style="list-style-type: none"> <li>Your provider call center and member call center are both located in Baton Rouge and there is a high likelihood of high winds, major damage and power outages for 4 days or more in the Baton Rouge Area (reference Hurricane Gustav impact on Baton Rouge). It is expected that repatriation of the evacuated, should damages be minimal, will not occur for 14 days. If damage is extensive, there may be limited repatriation, while other members may be indefinitely relocated to other areas in Louisiana or other states.</li> </ul>			

## Section M: Emergency Management Plan

### M.1

**Describe your emergency response continuity of operations plan. Attach a copy of your plan or, at a minimum, summarize how your plan addresses the following aspects of pandemic preparedness and natural disaster recovery:**

- **Employee training;**
  - **Identified essential business functions and key employees within your organization necessary to carry them out;**
  - **Contingency plans for covering essential business functions in the event key employees are incapacitated or the primary workplace is unavailable;**
  - **Communication with staff and suppliers when normal systems are unavailable;**
  - **Specifically address your plans to ensure continuity of services to providers and members; and**
  - **How your plan will be tested.**

WellCare has developed a structured and comprehensive plan for emergency preparedness, which addresses all of the elements described in the question above. The WellCare Corporate Emergency Preparedness Plan (EPP) (see Attachment M.1.a) provides structure for business operations, prior to and during an emergency. Each business area has a formal EPP, such as the IT EPP (see Attachment M.1.b). The aggregation of each business area's EPP and the information technology (IT) disaster recovery (DR) plan (see Attachment M.1.c) form the enterprise EPP. The IT DR Plan is tested annually and was most recently tested and passed in May 2011 (see Attachment M.1.d).

The WellCare Emergency Preparedness Committee (EPC) meets monthly to assure cohesiveness and continuity. The EPC includes representation from all 16 of WellCare's business areas, which are: Health Services, Pharmacy, Operations, Information Technology, Corporate Communications, Legal Services, Corporate Compliance, Human Resources, Finance, Facilities, Sales and Marketing, South Division, North Division, and Florida and Hawai'i Division.

The WellCare Corporate EPP addresses any scenario that results in a disruption to a WellCare facility or critical IT system that exceeds eight hours, including:

- Any incident causing physical WellCare facility damage such as fire, smoke, or water damage;
- Any incident which indirectly affects WellCare facility access such as storm closure, emergency building evacuation, or external threat near the WellCare corporate campus in Tampa, Florida;
- An impending or unexpected regional disaster such as hurricane, flood or tornado;
- Any external incident which potentially could cause a business interruption, such as loss of electrical or telecommunications service;
- Any incident that impacts the central computer installation or damages resident software; and
- Any system interruption or failure resulting from network, operating hardware, software, or operational errors that compromise the integrity of transactions or operational data.

The area plans are regularly maintained and the completeness of the WellCare Corporate EPP is tested twice a year via table top exercises or practice sessions. The structure of the 16 area plans is consistent, so each includes the following data for the applicable area:

- Identification of the critical business functions and/or departments;
- Names of level one associates who are critical to performance and recovery of critical business functions and/or departments;
- Names of area leadership who are members of each area emergency management team;
- Listing of critical vendors, the service each provides and the contact information;
- Listing of software applications required to perform critical functions; and
- Identification of business response, recovery and restoration activities.

The underlying principal and priority of the WellCare Corporate EPP is “People First”. As such, annual emergency preparedness training is provided to all WellCare associates. While the efficient resumption of normal business operations is the goal, in an emergency situation the wellbeing of WellCare’s members, associates and providers is the first imperative. A few examples are:

- Leveraging WellCare’s diversely located call centers to assure all member inquiries and concerns are properly addressed, which is included in the operations Member Services EPP;
- Relaxing authorization requirements for medical services, which is included in the Health Services EPP; and
- Adapting provider operations and claims processing, which is included in the Operations/Provider Services EPP.

## M.2

**Describe your plan in the following Emergency Management Plan scenario for being responsive to DHH, to members who evacuate, to network providers, and to the community.**

- You have thirty thousand (30,000) or more CCN members residing in hurricane prone parishes. All three GSAs include coastal parish and inland parishes subject to mandatory evacuation orders during a major hurricane. A category 5 hurricane is approaching, with landfall predicted in 72 hours and parishes within the GSA are under a mandatory evacuation order. State assisted evacuations and self evacuations are underway. Members are evacuated to or have evacuated themselves to not only all other areas of Louisiana, but to other States.***
- Your provider call center and member call center are both located in Baton Rouge and there is a high likelihood of high winds, major damage and power outages for 4 days or more in the Baton Rouge Area (reference Hurricane Gustav impact on Baton Rouge). It is expected that repatriation of the evacuated, should damages be minimal, will not occur for 14 days. If damage is extensive, there may be limited repatriation, while other members may be indefinitely relocated to other areas in Louisiana or other states.***

### **Coordination with DHH**

WellCare policy requires that we monitor national news, weather services, communications releases from state and federal agencies, including the Federal Emergency Management Administration (FEMA) website for issuance of states of emergency or declarations of major disasters. In the provision of services to CCN-P members WellCare will monitor the DHH website for declarations of public health emergencies to help determine the appropriate responses to current or potential events that may disrupt a member's access to services.

WellCare will respond to these declarations immediately including contacting a DHH designee in Louisiana to coordinate efforts. WellCare's comprehensive emergency management plans will ensure that staff will be prepared to communicate the actions being taken for each unique scenario in order to prepare members, employees and providers for the event. WellCare is committed to a cooperative and proactive relationship with DHH so that a coordinated emergency response will result in the best possible outcomes for our members in Louisiana. In addition, WellCare will coordinate with other Louisiana state agencies involved in emergency management planning, as well as FEMA officials, acting as an advocate for our members.

### **Eligibility and Enrollment**

WellCare understands that during an emergency DHH may not have the ability to send or confirm membership eligibility by sending standard enrollment files. WellCare's Enrollment department has the ability to update our membership information via faxed confirmations from local, county or state offices. If these offices are unavailable, the Enrollment department will work with service providers such as physician offices and pharmacies to validate and update member eligibility information to ensure members are able to receive care.

The enrollment department will coordinate eligibility updates with both internal business areas such as WellCare's Health Services department and Claims department; as well as physician

offices and pharmacies in real time to remove any eligibility barriers and ensure members can receive appropriate and timely care.

During the period of acute crisis, the enrollment department will expand staff hours to support enrollment and eligibility issues as they arise.

### **Communications Actions**

The WellCare communications staff will be responsible for the following actions:

- Issue all associate e-mail(s) and messages on WellCare's internal network (WellCareLink) to promote awareness of the emergency situation by directing associates to emergency information posted on WellCareLink and to emergency hotline updates. This will enable WellCare associates to provide the most updated information available to members.
- Address news media and external inquiries as required.
- Work with WellCare IT to post emergency messages on WellCare.com, as required.
- Utilize pre-prepared emergency communications, as appropriate, for member, associate and community awareness.

### **Members Access to Services**

Our primary objective is to ensure member's access to care. The process of ensuring access begins with education and outreach to prepare members with the information they need to access health care. We plan to do so in the following ways:

- Include information in member handbooks that informs members that they may reach WellCare using the toll-free number on their ID cards to ask for information about available providers.
- Cover emergency preparedness in member newsletters in the month preceding the beginning of hurricane season.
- Communicate with members via public service announcements (PSAs), on our website and local media outlets.
- Encourage all members to receive urgent and emergent care from the closest available provider in the location in which they have relocated to during an evacuation.
- During any state mandated evacuation from any geographic area in Louisiana, WellCare will relax for all affected members any applicable authorization requirements and out-of-network provider restrictions, and determine if it is necessary to relax these policies for an extended period for all affected members. Additionally, after the evacuation has ended, WellCare will review longer term exceptions, in coordination with DHH, for members on a case-by-case basis based on extended relocations due to a loss of home or work for a member.
- If available, provide information to members about how to access pharmacy benefits via the state in the event of an emergency.

Particularly vulnerable members are those receiving on-going life-saving treatments such as dialysis or chemotherapy. WellCare will identify providers for these services throughout

Louisiana and in contiguous states. Our members can call WellCare and a customer service representative will help the member find a provider. Case managers assigned to members will assist their impacted members.

WellCare has health plans operating in several nearby states and will immediately leverage this resource. We will allow our displaced members to access services from those network providers, through single case agreements.

#### MEMBER EXAMPLE

Anna is a single parent of a 7-year old daughter with Type I Diabetes and chronic asthma. Anna lives in New Orleans and has evacuated to Texas and believes she will be unable to return home for approximately 2-weeks. Anna's daughter is experiencing complications with her diabetes and needs supplies for her insulin pump. In addition Anna had to abandon her daughter's nebulizer during evacuation and needs a new one immediately. Anna calls the WellCare customer service number on her ID card, and explains the urgent nature of her daughter's needs. The Customer Service Representatives (CSRs) are prepared for these calls during emergency situations, so the request is quickly sent electronically to a Health Services representative. The CSR will ask Anna for her temporary address and telephone number and update her member record. Within an hour, Anna receives a call back from a WellCare Health Services representative, notifying her that a shipment of insulin pump supplies will arrive by next day delivery at her sister's home, and a local DME company has been authorized to deliver a replacement nebulizer later that same day. Anna will also receive instructions about accessing an out-of-network provider for services as needed.

In addition WellCare will work to contract with providers in other states to provide emergency services to members that have evacuated to these locales.

WellCare members will be instructed to follow emergency management advisories for safe evacuation; ideally, members should take medical equipment and supplies with them, but that is not always possible.

WellCare has experience helping members through hurricanes, tornadoes and other natural disasters in Florida, Louisiana, Texas and Georgia. Before, during, and after these events, WellCare provided guidance, coordinated supply and equipment deliveries, arranged for payment to out of network providers when services were required, and searched local markets for appropriate providers when members remained out of their service area for extended periods.

Members can contact WellCare by calling the customer service number on their ID card, and representatives will be prepared to assist them. The Health

Services team can authorize replacement supplies and equipment, based on the providers' orders kept in our centralized medical management system, and arrange for a delivery to a member's new location. Physicians and other service providers can be located on a member's behalf by Health Services. Health Services will contact providers in other WellCare networks, if applicable, or contact appropriate out of network providers in the local market. Members that were in active case management prior to any evacuation will receive priority treatment in re-connecting them with their case managers as soon as possible.

## Network Providers

WellCare relies on network providers to provide necessary health care services during an emergency. Providers will receive emergency response information and training throughout the year to ensure they are knowledgeable about emergency procedures and prepared to take appropriate action. Training methods will include:

- Initial provider orientation (i.e., provider relations orientation visit/provider handbook);
- Direct mailing information;
- Topics in provider newsletters; and
- Web based and in-person training.

Providers will be able to access up-to-date information via our call center and website. Each provider is required to have an emergency plan and may call on WellCare to assist in developing an appropriate plan as needed. In addition, WellCare will develop a preparedness checklist for use by provider practices and make it available on the WellCare website.

WellCare will communicate with providers who deliver services to affected members of the suspension of authorization requirements and out-of-network restrictions.

## Claims Processing

Prior to a forecasted disaster event, WellCare will submit a request to the CMS Regional Office for approval to utilize the DR condition code or CR modifier on claims for services provided during a declared state of emergency. Providers will be instructed to apply the DR condition code to facility claims and the CR modifier to professional claims to ensure streamlined processing. Claims submitted with this specially approved disaster coding will not be subject to standard authorization, utilization, and medical record requirements.

- DR Condition Code – The title of the DR condition code is disaster related and its use is restricted to identify institutional claims that are or may be impacted by specific health plan policies related to a national or regional disaster. The DR condition code is used only for institutional billing on claim form CMS-1450/UB-04 or in the electronic format ANSI ASC X12 837I.
- CR Modifier – The title of the CR modifier is catastrophe/disaster related and its use is restricted to identify physician or supplier claims that are or may be impacted by specific health plan policies related to a national or regional disaster. The CR modifier is used only for physician/supplier billing on claim form CMS-1500 or in the electronic format ANSI ASC X12 837P.

Claims appropriately submitted with the DR condition code or CR modifier will be paid in good faith and are exempt from penalties for noncompliance, unless it is discovered that fraud or abuse occurred. Providers, whose cash flow may be adversely impacted by a declared state of emergency, may request advanced payment, along with an authorization to offset the advanced payment from pending claims.

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## Community Support

WellCare is committed to supporting our members regarding their health care needs and the community at-large in the event of an emergency. We will activate mobile units to assist with distribution of basic supplies as well as maintaining the required database of physicians, nurses, social workers and other health professionals who are willing to assist in special needs shelters. The database will be housed as a part of our HealthConnections program and is referred to as *My Family Navigator*. In addition, WellCare will create printed versions of the database in the event electrical services are disrupted to enable our members and community resources to connect to important medical assistance.

We will work with local American Red Cross centers, sponsor CPR certification classes, coordinate a disaster preparedness program through our regional community advisory committee structure, and host emergency preparedness training classes for members and their communities during which we will offer an essentials toolkit that individuals can use for their own planning.

WellCare recognizes the importance of connecting services in the weeks and months after a natural disaster. These services are essential to displaced families and extend beyond basic health care needs. Our disaster relief activities will extend beyond immediate response and will work in tandem with local emergency response teams. For example, while using *My Family Navigator*, WellCare will work with our members and our communities to connect those impacted by an emergency to support programs and services and available shelters.

## Call Center Operations

If an incident causes physical damage to a WellCare call center, Louisiana members and providers will not experience a disruption. WellCare has multiple call center locations (see Attachment M.2.a) and our telecommunication and software solutions allow for calls to be seamlessly diverted as required. All call volume is continuously monitored at the command center in Tampa, Florida.

Our approach to monitoring call center performance in relation to access is focused on ensuring that members are able to obtain assistance from our member call center in the quickest, most efficient manner. Our state-of-the-art command center, based in Tampa, Florida, allows us to monitor performance of the entire call center enterprise in real time. Command center staff members are responsible for ensuring superior service levels are being delivered across all lines of business and for assessing the potential impact of adjustments to our operations.

The multiple screens in the command center display data and trends including the number of calls in each queue, number of calls waiting to be answered, length of time callers have been waiting to speak to a customer service representative (CSR), and the number of CSRs available to assist callers. Because weather can pose a threat to our operations and could affect the number of calls we receive or change the duration of existing calls, the command center dedicates one monitor to tracking weather conditions and impending weather emergencies.

WellCare's command center uses the IEX TotalView workforce management system to ensure adequate staffing across our call center enterprise. TotalView uses a proprietary formula that takes into account variables such as average handle time, time of day, projected mailings, enrollment periods, population size, and historical performance to project call volume and

required staffing. This enables us to forecast call volumes, schedule agents, control call traffic between sites, perform staffing analysis, and report on key performance indicators.

If calls from Louisiana members and providers must be rerouted due to a weather emergency, the alternate staff handling those calls temporarily will immediately receive basic information about the Louisiana CCN-P program to ensure the CSRs are able to answer member and provider questions and requests accurately. All CSRs are able to access the necessary member and provider records; update member contact information; update provider information and direct community members to appropriate leadership within the state operation.

### **WellCare Facility Closure**

We currently have facilities other than call centers located in Louisiana; specifically in Baton Rouge. A decision to relocate WellCare staff from these offices to temporary locations outside of the area will be made no less than 72 hours prior to the emergency event. WellCare's South Division emergency preparedness plan identifies those associates who are critical to the continued operations of the plan and will relocate those associates and their families to our Atlanta, Georgia office location. All telecommunications will be re-routed to the Atlanta office prior to associates evacuation from the Louisiana office.

### **Associate Evacuation Example**

Seventy-two hours prior to a hurricane's projected landfall, the WellCare South Division Emergency Management Team (SDEMT) makes the decision to close the Baton Rouge office through the following actions:

1. Secure all protected health information;
2. Notify the facilities team to secure the office suite/building;
3. Make evacuation plans for key associates and their families to travel to the Atlanta office site;
4. Forward all telecommunications to the Atlanta office site;
5. Update the WellCare associate intranet site with office closure information;
6. Update the WellCare public internet site with office closure information; and
7. Continuously monitor and communicate updated information to associates

Between eight and 48 hours after the emergency event has passed, damage assessments at the office suite/building will be conducted. Following this damage assessment, the SDEMT makes the decision to reopen the Baton Rouge office within 120 hours after the emergency event has passed. The SDEMT takes the following actions to bring the Baton Rouge office back online:

1. Make travel arrangements for key associates to return to Baton Rouge;
2. If necessary, ensure associates safety through contracted security staff that will accompany these associates to the Baton Rouge office and stand guard for as long as necessary to ensure the safety of our WellCare the associates;
3. If necessary, WellCare will contract to have food, water, office supplies, generators, etc. brought to the Baton Rouge office suite/building;

4. Continue to update the WellCare associate intranet and public internet sites with office reopening status information;
5. Notify all non-key associates through their individual emergency contact information that the Baton Rouge office is re-opening and arrange for all associates to return to work;  
and
6. Re-establish telecommunications lines from Atlanta to the Baton Rouge office.

To ensure efficient and effective communications, in addition to the member and provider communications mentioned in the previous sections, WellCare has developed communications templates for use with various other internal and external audiences, including its associates and the general public, as needed (see Attachment M.2.b). The templates will be localized to reflect the current critical event or situation.

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INSERT TAB HERE  
Section N  
Grievance and Appeals

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Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		<b>Section N: Grievances and Appeals (Section § 13 of RFP )</b>	<b>25</b>		
<b>Section N Page 1</b>	<b>All</b>	<p><b>N.1</b></p> <p>Provide a flowchart (marked as Chart C) and comprehensive written description of your member grievance and appeals process, including your approach for meeting the general requirements and plan to:</p> <ul style="list-style-type: none"> <li>• Ensure that the Grievance and Appeals System policies and procedures, and all notices will be available in the Member's primary language and that reasonable assistance will be given to Members to file a Grievance or Appeal;</li> <li>• Ensure that individuals who make decisions on Grievances and Appeals have the appropriate expertise and were not involved in any previous level of review; and</li> <li>• Ensure that an expedited process exists when taking the standard time could seriously jeopardize the Member's health. As part of this process, explain how you will determine when the expedited process is necessary.</li> </ul> <p>Include in the description how data resulting from the grievance system will be used to improve your operational performance.</p>	<b>25</b>		

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## Section N: Grievance and Appeals

### N.1

**Provide a flowchart (marked as Chart C) and comprehensive written description of your member grievance and appeals process, including your approach for meeting the general requirements and plan to:**

- **Ensure that the Grievance and Appeals System policies and procedures, and all notices will be available in the Member's primary language and that reasonable assistance will be given to Members to file a Grievance or Appeal;**
- **Ensure that individuals who make decisions on Grievances and Appeals have the appropriate expertise and were not involved in any previous level of review; and**
- **Ensure that an expedited process exists when taking the standard time could seriously jeopardize the Member's health. As part of this process, explain how you will determine when the expedited process is necessary.**
- **Include in the description how data resulting from the grievance system will be used to improve your operational performance.**

WellCare has an effective, user-friendly member grievance system that includes a grievance process, procedures for both standard and expedited appeals, and access to state Fair Hearings. We are committed to the timely and fair resolution of member grievances and appeals in full compliance with 42 CFR 438 subpart F, 42 CFR 431, and other applicable federal and state requirements, and we will cooperate fully with Louisiana's Fair Hearing process as outlined in the State Fair Hearing Companion Guide for CCNs. As specified in the RFP, our in-state staff will include a grievance system manager. Please see Chart C-1 for a flow chart of our grievance process and Chart C-2 for a flow chart of our appeals process.

### Meeting General Requirements

#### Filing a Grievance or Appeal

A member or authorized representative, including a provider authorized to act on behalf of the member, may file a grievance or appeal verbally or in writing. A verbal grievance/appeal may be filed by contacting member services, and a written grievance may be mailed, faxed, or e-mailed to our Grievance and Appeals department. Members are automatically offered the opportunity to file grievances online when using the website for other matters such as making PCP changes.

WellCare customer services representatives (CSRs) are trained to field verbal grievances and appeals from members or their representatives and to provide assistance in filing a written grievance/appeal as requested or needed. The CSR documents the verbal grievance/appeal in our customer management system, creates a ticket, and forwards it electronically to our Grievance and Appeals department for follow-up. Verbal and written grievances/appeals are logged into the grievance/appeals database for resolution, tracking, and reporting. If a member files a verbal grievance or appeal and then follows-up with a written filing, we track the days to resolution from the date of the verbal filing.

CSRs are also trained to identify potential grievances/appeals that are not specifically identified as such by members. For example, to identify potential grievances CSRs pay attention to the caller's tone and listen for key actions words (e.g., angry, frustrated, dissatisfied). If the CSR

believes the call is a potential grievance or appeal, the CSR reminds the member of his or right to file a grievance/appeal and asks the member if he or she would like to do so.

CSRs attempt to resolve identified grievances during the course of the initial call. If they are able to do so, the grievance and proposed resolution are documented and forwarded electronically to the Grievance and Appeals department for follow-up with the member. If the CSR is unable to resolve the grievance during the initial call, the CSR follows the same steps as if the member called and asked to file a grievance (i.e., document the grievance and forward it to our Grievance and Appeals department).

### Grievance Process

WellCare's goal is to resolve grievances as quickly as possible but within no more than 45 calendar days of original receipt of the grievance.

Upon receipt of a grievance, a grievance coordinator is assigned to the case. The coordinator:

- Verifies that the case is a grievance (if not, the coordinator routes it to the appropriate department);
- Reviews the case and verifies completeness;
- Logs the case into the grievance database;
- Sends an acknowledgement letter within the state-specified time frame (generally three days but to be specified by Louisiana);
- Determines whether there is sufficient information to resolve the case and, if not, makes three attempts to contact the member, documents each attempt, and sends a letter requesting additional information);
- Researches and compiles the case with all supporting documents;
- Resolves the grievance in a timely manner;
- Notifies the member, representative, and/or provider (as applicable) of the resolution in writing; and
- Documents the resolution in the grievance database and has the completed case scanned for archiving.

Unless otherwise specified by a state, the notice of resolution includes:

- The date the grievance was filed;
- The date the grievance was resolved;
- The decision, in clear terms and sufficient detail for the member to understand and respond to it;
- A statement of the coordinator's understanding of the grievance;
- The grievance results or grievance resolution;
- The name and title of the grievance coordinator;
- The qualifying credentials of the person(s) completing any potential quality of care or clinical issue;

- References to the evidence or documentation used as the basis for the decision, as applicable; and
- Information on the member's right to appeal (including a Fair Hearing, if applicable), including how to do so and the time frame for doing so.

The Grievance and Appeals department maintains a file on each grievance that includes (at a minimum):

- The member's name and Medicaid identification (ID) number (and documentation of verification of representative, if applicable);
- The date the grievance was filed;
- A description of the issue;
- If applicable, the date of the event that precipitated the grievance;
- The grievance classification (e.g., access to care, fraud and abuse, potential quality of care);
- Documentation of the investigation and findings;
- The date of the resolution;
- Copy of the grievance resolution; and
- The date of member/representative/provider notification.

Potential quality of care and other clinical grievances are investigated with the assistance of clinical staff up to and including our medical director as needed. If the grievance is regarding a network provider, the coordinator works with provider relations, which takes responsibility for further investigation and oversees any corrective actions. Grievances related to providers are also monitored by the credentialing committee as part of ongoing provider monitoring, and the credentialing committee may recommend interventions, including advising or educating the provider, issuing a corrective action plan, or performing a site inspection evaluation.

If the grievance is a potential fraud or abuse issue, the grievance coordinator refers the case to our special investigations unit (SIU). Please see response to Section O.1 for information on our SIU.

### Appeals Process

WellCare's appeals process includes detailed procedures for both standard and expedited appeals. These are described in detail below. We review all appeals, even if submitted as a standard appeal, to determine if they should be processed on an expedited basis.

We maintain a file on each appeal that includes, at minimum:

- The name of the member or provider requesting the appeal;
- Copies of all correspondence from the member or provider regarding the appeal;
- Member or provider requests for an expedited appeal;
- Dates of appeal reviews, documentation of action taken and final resolution;
- Necessary documentation to support any extensions;

- Titles of the staff who reviewed the appeal and, for clinical appeals, the credentials of clinical staff who reviewed the appeal;
- Copy of the final notice of adverse action, and any other notices provided to the member or member's provider that relate to the appeal; and
- Minutes or transcripts of any appeal committee proceeding related to the appeal.

### Standard Appeals

Upon receipt of a standard appeal, the intake coordinator enters the case into the appeals database and forwards the file to an appeals coordinator for processing. The appeals coordinator documents the substance of the requested appeal and sends an acknowledgement letter within the time frame specified by the state. For standard appeals requested verbally, the acknowledgement letter includes a request for a written, signed appeal statement.

For clinical appeals, the appeals coordinator, in consultation with the review nurse, determines if any further information or medical records are needed. The review nurse is responsible for summarizing the medical records in the appeals database and referring the appeal to the medical director. We track the standard appeals process to ensure resolution within the state-specified time frame, which is generally 30 calendar days (as specified by DHH in Section 13.7.1.2 of the RFP).

We offer members and their representatives the opportunity to submit written comments, documents, documentary evidence, allegations of fact or law, and other written or verbal information relating to the standard appeal, in-person and/or in writing. We also allow the member/representative an opportunity to examine the member's case file.

Upon receipt of the appeal form from the nurse reviewer, the medical director determines the medical necessity of the request. If the medical director does not approve and overturn the denial, he/she may request that the case be forwarded to an external physician advisor (PA) for a same-or-similar-specialist review. If the PA recommends approving and overturning the denial, the case is returned to the review nurse who updates the appeals database with the decision. If the PA recommends upholding the denial decision, the case is remanded to a medical director for review of the PA's recommendation. After review the medical director may choose to: (1) adopt the recommendation of the PA to uphold the denial decision; or (2) overturn and approve the request.

All recommendations for upholding denials are reviewed by the appeal committee. The appeal committee consists of a designated group of physicians who collectively review and finalize appeal decisions. The committee members voting on each case may vary since only members not affiliated with the prior decision may participate in the review. For any cases where the request has been forwarded to an external PA for a same-or-similar-specialist review, with a recommendation to uphold the denial, the committee may choose to: (1) adopt the recommendation of the PA; or (2) overturn the recommendation to deny and approve the request. Once the appeal committee has made a determination, the review nurse updates the appeals database with the decision.

We advise the member and/or member's representative of the decision in writing and may also inform the member/representative verbally. Our decision is approved and signed by our medical director or physician designee. If we overturn the action in response to an appeal filed by a

member/representative, we issue an approval notice and provide the service as quickly as the member's health condition requires. If we uphold the action in response to an appeal filed by a member/representative, we issue a Notice of Appeals decision. The Notice of Appeals decision for Louisiana Medicaid will meet the language, format, and content requirements specified by the State. In general, our Notices of Appeal decision include:

- The results and date of the appeals decision;
- The specific reasons for the appeal decision in easily understandable language;
- Reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based;
- Notification that the member, upon request, can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based;
- Notification that the member is entitled to receive, upon request, reasonable access to, and copies of all documents relevant to the member's appeal;
- A list of the titles of the staff who reviewed the appeal and, for clinical appeals, the qualifications or credentials of individuals participating in the appeal; and
- If the appeal is not resolved wholly in the member's favor: (1) the right to request a Fair Hearing within the state-specified time frame and how to do so; (2) the right to request to continue to receive benefits pending a Fair Hearing and how to request the continuation of benefits; and (3) information explaining that the member may be liable for the cost of any continued benefits if WellCare's action is upheld in a Fair Hearing.

As required by federal regulations, if a timely appeal is for continuation of a previously authorized benefit scheduled to be reduced, suspended or terminated, we continue the benefit during the appeal if requested by the member and if the original authorization has not expired. We continue to provide the benefit until: (1) the appeal is withdrawn; (2) at least 10 days have passed since mailing of the resolution letter and no Fair Hearing has been requested; or (3) the decision is upheld in a Fair Hearing.

### **Informing Members and Providers and Providing Reasonable Assistance**

We inform members, verbally, in writing, and online about WellCare's grievance and appeal processes and their right to a Fair Hearing. This information is included in the member handbook and on the member section of our website and addresses member rights to file a grievance or appeal or request a Fair Hearing; outlines the procedural steps for each; and highlights the availability of assistance from WellCare, including interpreter assistance and help in completing any required forms.

Information about WellCare's grievance and appeals process is similarly available to providers in the provider handbook and on our provider website. Information about the appeals process, including how to file an appeal, is also provided to members and providers in any Notice of Action.

The member handbook will be available in English, Spanish, Vietnamese, and any other language that meets DHH's translation standard (i.e., the primary language for 200 or more members within the GSA) as will all notices and correspondence related to grievances and appeals. If we are aware that a member prefers to receive written materials in a language other

than English (e.g., by submitting a written grievance or appeal in a language other than English), we will send notices and letters regarding the member's grievance/appeal in the member's primary language, which will include Spanish, Vietnamese, and any language spoken by more than 200 of our members in the GSA.

When a member whose primary language is other than English calls member services, we provide interpreter services. For Spanish speakers, we have English and Spanish speaking bilingual agents and for other languages we use a phone translation vendor that provides phone translation for over 150 languages and dialects. We use TTY/TDD to communicate over the telephone with members who are hearing and/or speech impaired.

If a member calls member services, a CSR assists the member in understanding the grievance or appeal process (as applicable) and helps him or her with any necessary steps. Our acknowledgement letter for grievances and appeals encourages the member to contact us for assistance with the grievance/appeals process.

### **Ensuring Expertise of Individuals Making Grievance and Appeals Decisions**

All grievance coordinators receive extensive training on procedures, rights of members and providers, how to distinguish grievances and appeals, and how to resolve grievances in a fair and timely manner.

For all appeals we appoint an individual who was not involved in the prior adverse decision to review the appeal. For clinical appeals the appointee must be a clinical peer, hold an active unrestricted license to practice medicine or a health profession, be board certified, and must be neither the individual whose initial action is the subject of the appeal, nor the subordinate of that individual.

### **Expedited Appeals**

We offer members an expedited appeal for any urgent care requests. As required by the RFP, appeals from Louisiana Medicaid members will be handled as expedited appeals when WellCare believes or the member's provider indicates the standard resolution time frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. If a member requests an expedited appeal that is not supported by his/her provider, a nurse reviews the request to determine whether the appeal meets the criteria for an expedited appeal. If the nurse determines that it does not, that decision is reviewed by a medical director. If the medical director agrees that the criteria for an expedited appeal have not been met, the expedited appeal is denied, and the appeal is treated as a standard appeal. We provide the member/representative prompt verbal notification of the decision not to expedite the request, and provide written notice within two calendar days of the verbal notification.

The written notice explains that we have transferred the appeal to the standard appeal time frame and notifies the member of the right to submit a request for a grievance. The notice further explains that if the member secures physician support indicating that applying the standard appeal timeframe could seriously jeopardize the member's life, health or ability to attain, maintain, or regain maximum function, the request will be automatically treated as an expedited appeal.

As with a standard appeal, the appeals coordinator documents the substance of the expedited appeal in the appeals database and determines, in consultation with the review nurse, if any further information or medical records are needed. The review nurse is responsible for summarizing the medical records in the appeals database and referring the appeal to the medical director.

We give members/representatives the opportunity to submit written comments, documents, records evidence and allegations of fact or law and other information relating to the expedited appeal in person and/or in writing, and we inform members/representatives of the limited time available to present evidence.

As with standard clinical appeals, upon receipt of an expedited appeal, the medical director determines the medical necessity of the requested service. This process is the same as for a standard appeal except that, due to the compressed timeframes, recommendations to uphold denials are generally not reviewed by the appeal committee.

If the resolution is in favor of the member, we approve/provide the services as quickly as the member's health condition requires, but no later than 72 hours from receipt of the appeal (unless the time frame is extended in accordance with federal requirements). We notify the member/representative of the decision verbally within 72 hours of receipt of the appeal (unless the time frame is extended in accordance with federal requirements). Verbal notification occurs within 72 hours followed by a written notice to be sent promptly after the verbal notification.

If we uphold the action in response to an expedited appeal filed by a member/representative we notify the member/representative of the decision verbally within 72 hours of receipt of the appeal (unless the time frame is extended in accordance with federal requirements). Verbal notification will occur within 72 hours followed by a written Notice of Appeal decision to be sent promptly after the verbal notification.

As noted under Standard Appeals, the Notice of Appeal decision for Louisiana Medicaid will meet the language, format, and content requirements specified by the State.

### **Using Grievance System Data to Improve Member Care and WellCare's Operations**

We track, trend, and report grievance and appeals data internally and to state regulators. WellCare uses the data internally to identify opportunities to improve member care and to improve operations.

#### Grievance Data

Grievance metrics and trends are reported monthly, quarterly and/or annually to the Customer Service Quality Improvement Workgroup (CSQIW), and data and recommendations from the CSQIW are conveyed to the Utilization Management Medical Advisory Committee (UMAC), the Quality Improvement Committee (QIC), and to WellCare senior management. Trends are monitored and reviewed through ad-hoc workgroups including provider relations, quality improvement, and customer service in order to improve our operational performance. If a trend is identified, preliminary review of the root cause is performed and data is provided with the appropriate business owner to identify appropriate interventions or corrective action.

For example, in response to a high number of member grievances in Illinois regarding timeliness of non-emergency transportation, we required monthly reporting from the vendor as well as attendance at quarterly meetings to discuss timeliness grievances and corrective plans.

In a few states we noted an increase in grievances regarding billing/financial issues (members receiving bills from providers), so we analyzed the individual grievances, identified the underlying reasons for the grievances, and developed action steps to address the issue. These steps included creating a business process improvement team; reviewing the existing balance bill grievance process with customer service to identify gaps; adding reject-specific grievance sub-categories for more accurate reporting of the reasons behind the balance billing issues; and researching rejected claims.

### Appeals Data

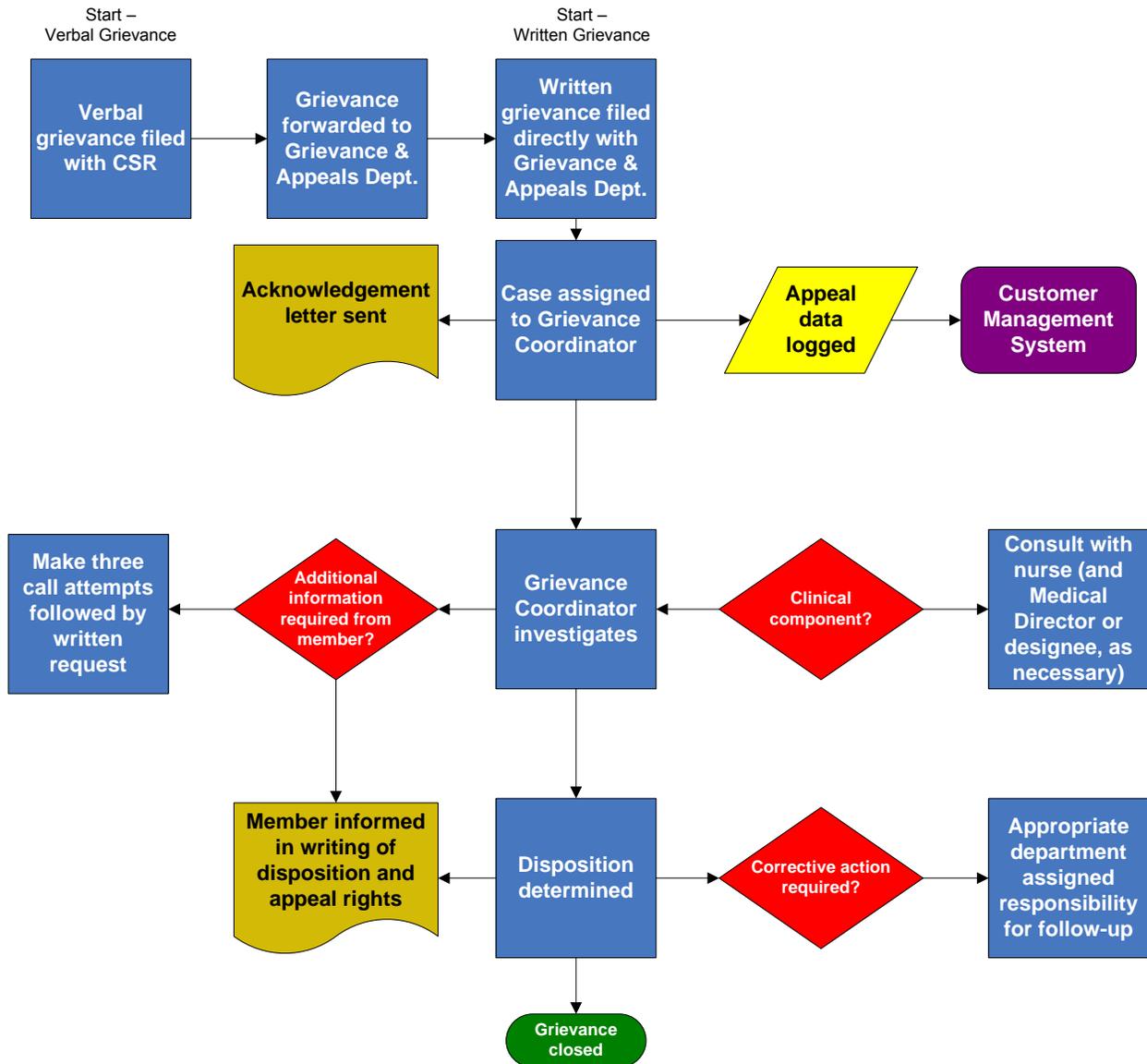
Appeals activities are reported to the CSQIW, UMAC, and QIC. If a trend of medical necessity or benefit coverage overturns is identified, an in-depth review of the decision process is initiated and an intervention plan implemented as appropriate.

For example, in 2009 and early 2010, we analyzed appeal cases and determined that some providers' demographic records were causing claims to be denied as *authorization required but not obtained* since the member's benefit plan requires that network providers need to provide services. Some of the root causes identified included providers with several records, some network and others out-of-network. When the out-of-network record was selected for the claim, it denied in error. Other causes were that some providers who were in our network as part of a professional group, but not as individuals, were billing individually and some providers contracted with us individually were billing as part of an out-of-network group. In June 2010, the claims department undertook an initiative to reduce incorrect provider records. This project resulted in a lower volume of claims denied incorrectly and a subsequent reduction in appeals for this reason.

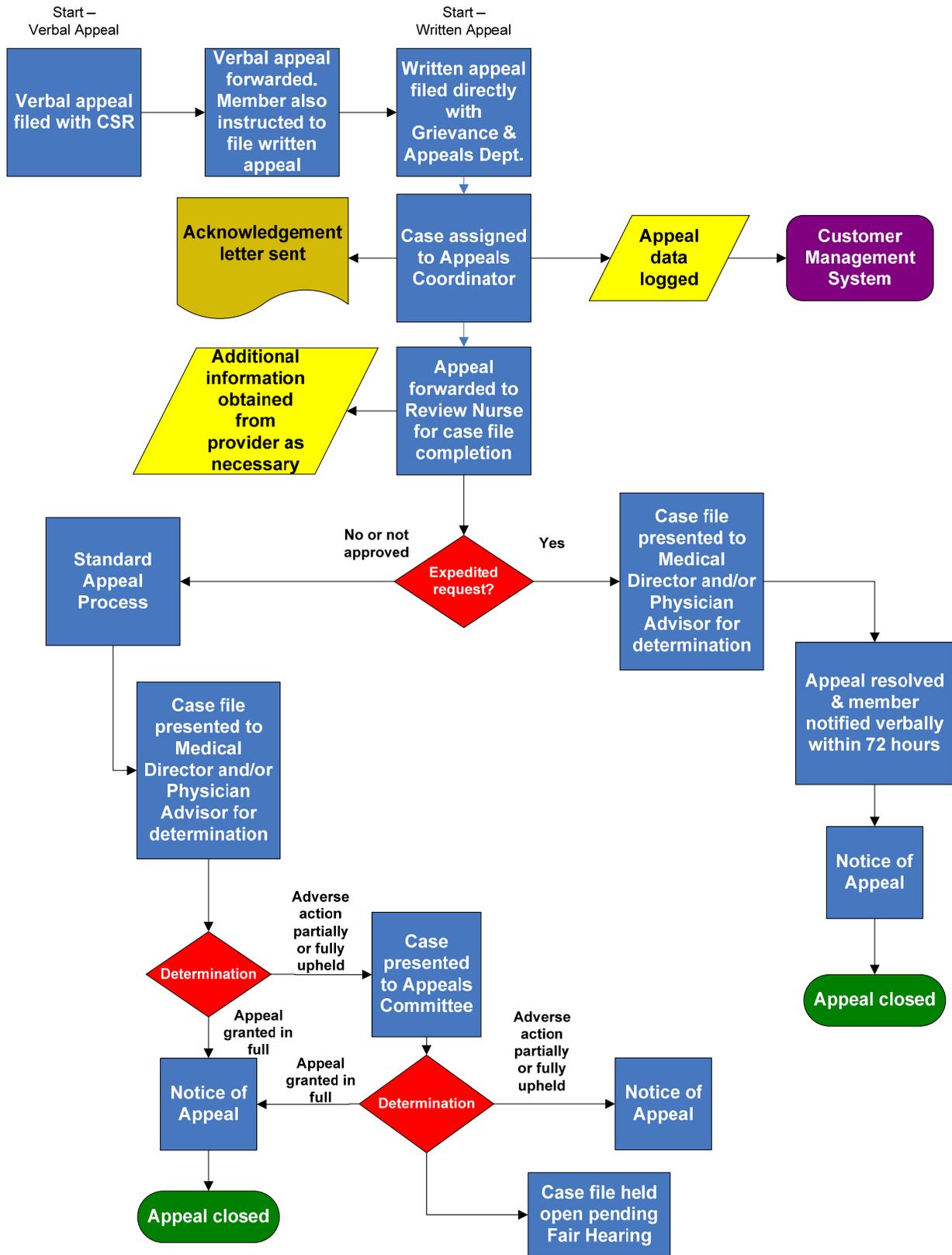
In addition, monthly metrics regarding reasons for appeals and overturns are presented to internal stakeholders, with appeals volume and overturn rates by top providers. Administrative trends are monitored and reviewed through ad-hoc workgroups relating to utilization management, claims, processing errors, and configuration.

In 2009 we put into place an operating efficiencies initiative to improve staff productivity and the accuracy of the processing of appeals. This continued into 2010. This initiative included reviewing and revising policies and procedures, improving internal reporting, and creating or revising job aids and reference documents.

Exhibit N.1.a – Chart C-1 – Grievance Flow Chart



**Exhibit N.1.b – Chart C-2 – Clinical Appeals Flow Chart**



INSERT TAB HERE  
Section O  
Fraud and Abuse

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Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		<b>Section O: Fraud &amp; Abuse (Section § 15 of RFP)</b>	25		
<b>Section O Page 1</b>	<b>All</b>	<b>O.1</b> Describe your approach for meeting the program integrity requirements including a compliance plan for the prevention, detection, reporting, and corrective action for suspected cases of Fraud and Abuse in the administration and delivery of services. Discuss your approach for meeting the coordination with DHH and other agencies requirement.	25		

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## Section O: Fraud and Abuse

### O.1

***Describe your approach for meeting the program integrity requirements including a compliance plan for the prevention, detection, reporting, and corrective action for suspected cases of Fraud and Abuse in the administration and delivery of services. Discuss your approach for meeting the coordination with DHH and other agencies requirement.***

#### Approach and Compliance Plan

##### General

WellCare has implemented a robust program that employs advanced technology and well-defined procedures for prevention, early detection, investigation, reporting, and corrective action for potential fraud, waste and abuse (FWA) in the administration and delivery of services. In the spring of 2010, WellCare participated in a comprehensive CMS review (audit) of the structure and effectiveness of our compliance plan. Although intended as a baseline review to identify areas requiring corrective action, the external reviewer working on behalf of CMS concluded with a statement of “no structural, governance or material findings from the audit.” Our compliance plan for Louisiana will be based on our existing program, tailored as necessary to meet the State’s requirements.

Our Compliance department includes a Special Investigation Unit (SIU) responsible for the detection, prevention, investigation, reporting, correction and deterrence of FWA. Though the SIU is our primary unit for preventing and detecting FWA, our anti-FWA efforts are not limited to SIU personnel. All of our employees are trained to look for unusual or suspicious activity and to report such activity through WellCare’s compliance program. Employees have multiple options for reporting suspected FWA, including a confidential hotline. Employees are informed of their rights and protections as whistleblowers. We provide initial and annual FWA training for all employees and track completion of training by employees. This training is designed to create awareness of FWA and educate employees on their rights and responsibilities when encountering potential FWA.

The SIU maintains written policies and procedures and adheres to standards of conduct that reflect WellCare’s commitment to compliance with all applicable federal and state standards. In support of the overall WellCare compliance program, the SIU maintains training and education materials specific to FWA and assists in providing training to employees, business partners and downstream entities. The SIU promotes the immediate reporting of suspected incidents of FWA by establishing clear lines of communication with employees, business associates and downstream entities and offering confidential reporting through different reporting paths. The SIU assists in supporting and enforcing our established compliance standards, which are clearly communicated through well-publicized disciplinary guidelines. The SIU reports findings related to potential compliance issues related to internal monitoring and auditing. The SIU reports all suspected or confirmed incidents of FWA as defined by state and federal guidelines and, when requested, assists state and federal investigative agencies with FWA investigations.

## Organization and Staffing

The SIU reports to the vice president, Compliance Investigations, who in turn reports to the chief compliance officer (CCO). The CCO reports to WellCare's chief executive officer (CEO) and to the Regulatory Compliance Committee of the Board of Directors.

The SIU is divided into three teams; payment optimizer (PO team), investigations, and specialty. The PO team reviews claims identified by WellCare's FWA technology and includes fraud specialist claims reviewers and a senior medical coder. The investigation team consists of several investigators and is divided into medical and pharmacy groups. To the extent caseloads allow, the investigators are also assigned to specific states or jurisdictions.

The specialty team includes a nurse, senior computer analyst, and file and case coordinator staff. The nurse and analyst resources can be used by either of the other teams. The nurse reviews cases related to medical necessity and unnecessary services, interacts with medical directors and physician staff for medical reviews, provides medical consults for SIU staff, and assists on special projects. The analyst handles report writing for data retrieval, development of algorithms for projects, database programming and development and maintenance of the SAS data system and analytics. The coordinator position answers the fraud hotline, maintains the hotline database, enters case data in the case tracking system, handles select reporting functions, and refers all calls for investigation to the investigation team or, if not fraud related, to the appropriate entity.

Every WellCare market has a locally based director of regulatory affairs (RA) whose responsibilities include providing SIU representation in the state and ensuring adherence to regulatory and contractual requirements. This individual coordinates activities between SIU and the local program and between SIU and the state, including reporting of suspected fraud, waste and abuse to state authorities and providing any requested assistance with the state's investigation. In Louisiana this person will meet the RFP requirements for and will be the in-state compliance officer.

## Preventing and Detecting Fraud, Waste, and Abuse

The SIU uses a multi-faceted approach to prevent and detect suspected or potential FWA, involving both pre-payment and post-payment strategies. This includes a combination of analytical tools, clinical expertise, investigative knowledge, internal and external referrals (e.g., WellCare staff, providers, business partners), and an education and awareness training program to maximize employee, business partner, and downstream entity referrals.

Our partnerships with both state and federal agencies also provide intelligence avenues to enhance our FWA prevention and detection capability. As a member of the National Health Care Anti-Fraud Association (NHCAA), we have access to the information sharing website hosted by the organization which includes input from over 100 insurance companies and the regular posting of current activities ranging from indictments to convictions on providers nationwide. The SIU also participates in NHCAA information-sharing meetings and projects.

### *Pre-Payment Prevention and Detection*

The PO team of the SIU uses a pre-payment analytical tool called Payment Optimizer (PO), a fraud prevention/detection program developed by the Fair Isaac Corporation. The PO tool uses

logic and statistical probability to identify potentially questionable professional claims that warrant further review. The PO tool scores these claims, and the results of the review are made available to the PO team.

PO team associates daily review the claims identified by the PO tool to determine their validity. The PO team uses a combination of claims expertise, Current Procedural Terminology (CPT) knowledge, International Classification of Disease-Ninth Edition (ICD-9) knowledge, local and national coverage determinations, member history, provider history, contract language, Correct Coding Initiatives (CCI) edits, and WellCare business decision documents (BDDs) as bases for determining whether to recommend that a scored claim be allowed or denied.

If a PO team associate recommends denial, the claim in question is placed on hold, and transferred to internal claims personnel to make the final decision on denial. Claims personnel retain discretion to override the SIU recommendation. If the claims personnel concur with the decision the claim is denied and the provider is notified on the explanation of benefits (EOB). The provider may subsequently submit medical records in support of the denied claim, which will prompt clinical and coding review. If the documentation provided supports the previously denied claim, the denial will be reversed.

The PO tool also provides historical data and reporting capability, allowing for analysis of aberrant historical billing patterns.

#### *Post-Payment Data Analysis*

On a post-payment basis, the SIU data analyst creates claims queries that allow investigators to identify members and providers with suspicious activity or unusual patterns of behavior that might indicate fraud or abuse. The SIU takes a series of conditional queries, using Statistical Analysis Software (SAS), and runs them against the SIU main data repository. Examples of the queries include: up-coding, unbundling, misuse of modifiers, unusual CPT codes, double billing, pharmacy abuse, and impossible or unreasonable time in a day based on excessive service counts.

If a provider has been identified as an FWA concern, a more detailed set of reports is generated, allowing investigators to view the entire billing and claims history for that provider. To maximize detection, the SIU thoroughly reviews the entire billing history of the provider, and attempts to identify all areas that are unusual or suspicious. This may result in expanded investigations with multiple lines of inquiry.

#### Investigation, Referral, and Corrective Action

All incidents of suspected FWA are reviewed by SIU personnel and logged into the WellCare case tracking system upon receipt. SIU investigators evaluate the information and perform a series of investigative steps to collect facts and establish a basis for resolving the inquiry, or establishing the basis for escalating the inquiry to a case. Cases are reviewed and prioritized so that cases with the greatest potential program impact are given the highest priority.

The SIU is responsible for the following:

- Screening all reports made to the SIU of suspected FWA and differentiating non-FWA-related reports for appropriate resolution by other business areas;

- Establishing a file for each case of known or suspected fraud or abuse;
- Informing the appropriate market staff (director of regulatory affairs or corporate compliance liaison, as applicable) of known or suspected cases of FWA so that suspected or confirmed cases of FWA are reported to the state agency, using approved referral forms;
- Obtaining necessary supporting documentation for all case files, including copies of medical records, member applications, correspondence, policies, medical bills and claim forms, corporate records, background reports, and other relevant documents;
- Conducting investigations to conclusion in accordance with the procedures established by the SIU;
- Maintaining the case in WellCare's case tracking system;
- Providing all information specified by the state and providing other assistance, as requested, to facilitate the state's investigation;
- Compiling reports as specified in the state contract;
- Maintaining records in conformance with WellCare's document retention policies;
- Educating and correcting providers and/or business partners on proper billing codes and/or procedures when FWA is identified; and
- Coordinating with the Legal department during the course of an investigation as needed.

We pursue restitution in every case where an overpayment is identified. A recovery may come from adjusting claims, denying claims, or formal demands for payment. In order to provide for a more robust recovery effort for non-paying providers, an attorney position has been approved and posted for the SIU. The position's duties will include, where appropriate, recovery of uncollected overpayments either through arbitration or litigation.

### Other Anti-FWA Activities

#### *Prohibited Affiliations*

WellCare screens current and new associates, contractors, and agents against the List of Excluded Individuals/Entities (LEIE) maintained by the Office of Inspector General of the Department of Health and Human Services and the Excluded Parties List System (EPLS). As required by DHH, we will also search the Health Care Integrity and Protection Data Bank (HIPDB). WellCare will not hire or retain an associate, contractor, or agent who has been excluded, debarred or suspended from participating in federal programs. In addition, as part of our credentialing, ongoing monitoring, and re-credentialing process we verify that providers do not have any federal sanctions, including checking the LEIE, National Practitioner Data Bank (NPDB), and the EPLS. As required by DHH, we will also check the HIPDB.

#### *Verifying that Services were Provided*

Although we do not do this in all of our markets, in Illinois we recently implemented a member survey process to verify with members whether services billed by providers were actually received, and we will implement a similar process for Louisiana Medicaid that complies with the explanation of benefits (EOB) requirements in Section 17.3 of the RFP. On a monthly basis our Illinois plan sends a notice to a random sampling of members (typically 500 members) that

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contains billed claim information specific to each member. The notice requests that the member call the SIU hotline if the services identified were not actually received.

In addition, as specified in the RFP, WellCare requires network providers to maintain an individual medical record for each member according to professional practice standards as well as state and federal requirements. The minimum documentation standards are included in the provider handbook, and we will revise them as necessary for our Louisiana Medicaid provider handbook. WellCare conducts periodic reviews of network providers' medical records. One of the goals of these reviews is to ensure that providers' medical records meet the required documentation standards. Providers are given results of the review, and a corrective action plan is required if a provider does not score above 80 percent.

### **Meeting Louisiana's Coordination Requirements**

WellCare is committed to coordinating with state agencies to prevent, identify, and investigate fraud, waste, and abuse, and we will comply with Louisiana's requirements for coordination, including those specified in Appendix EE of the RFP. This will include developing an effective referral process between WellCare, the Program Integrity Section of DHH, the Medicaid Coordinated Care Section of DHH, and the State's MFCU. If, as the result of complaint or case, we believe that fraud or abuse has occurred, we will report the complaint and/or preliminary findings (as applicable) to the Program Integrity Section and the MFCU, and we will cooperate with DHH in its investigation. This cooperation could include in-person interviews and consultation as well as providing access to our offices, documents, and systems. In addition, we would be pleased to meet with Program Integrity and the State's MFCU on quarterly basis to exchange information and collaborate on suspected fraud and abuse. We will also comply with the State's reporting requirements (e.g., information on our activities, including complaints and investigations). We will include these requirements and the steps to meet these requirements in our compliance plan for Louisiana.

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INSERT TAB HERE  
Section P  
Third Party Liability

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Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		<b>Section P: Third Party Liability (Section § 5 of RFP)</b>	<b>25</b>		
<b>Section P Page 1</b>	<b>All</b>	<p><b>P.1</b></p> <p>Describe how you will coordinate with DHH and comply with the requirements for cost avoidance and the collection of third party liability (TPL), including:</p> <ul style="list-style-type: none"> <li>• How you will conduct diagnosis and trauma edits, including frequency and follow-up action to determine if third party liability exists; (2) How you will educate providers to maximize cost avoidance;</li> <li>• Collection process for pay and chase activity and how it will be accomplished;</li> <li>• How subrogation activities will be conducted;</li> <li>• How you handle coordination of benefits in your current operations and how you would adapt your current operations to meet contract requirements;</li> <li>• Whether you will use a subcontractor and if so, the subcontractor's responsibilities; and</li> <li>• What routine systems/business processes are employed to test, update and validate enrollment and TPL data.</li> </ul>	<b>25</b>		

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## Section P: Third Party Liability

### P.1

**Describe how you will coordinate with DHH and comply with the requirements for cost avoidance and the collection of third party liability (TPL), including:**

- **How you will conduct diagnosis and trauma edits, including frequency and follow-up action to determine if third party liability exists; (2) How you will educate providers to maximize cost avoidance;**
- **Collection process for pay and chase activity and how it will be accomplished;**
- **How subrogation activities will be conducted;**
- **How you handle coordination of benefits in your current operations and how you would adapt your current operations to meet contract requirements;**
- **Whether you will use a subcontractor and if so, the subcontractor's responsibilities; and**

### **Coordination with DHH and Compliance with TPL Requirements**

WellCare performs cost avoidance and post-payment recovery activities under well-defined policies and procedures that conform to federal requirements. We will adapt our processes as necessary to meet Louisiana-specific requirements. For example, we will not pursue recovery against providers; we will seek DHH approval before accepting a settlement on claims equal to or greater than \$25,000; we will comply with reporting requirements; and we will cooperate with DHH and/or DHH's cost recovery vendor.

WellCare uses four vendors to assist us with cost avoidance and/or post-payment recovery: Health Management Systems (HMS), a vendor that is currently partnered with more than 45 Medicaid agencies, including DHH, and more than 50 government sponsored plans to perform cost avoidance and cost recovery; TransUnion, a medical eligibility clearinghouse; Syrtis Solutions, a real-time point-of-sale cost avoidance service for pharmacy claims; and First Recovery Group, a subrogation claims recovery vendor.

In 2010, WellCare avoided approximately \$129 million in medical claims and recovered approximately \$22 million.

### **Diagnosis and Trauma Edits**

WellCare contracts with First Recovery Group to identify subrogation opportunities (see Subrogation below). As part of its subrogation activities, First Recovery uses trauma code edits to identify the existence of potential third party liability. WellCare seeks reimbursement in accident/trauma related cases when claims equal or exceed the threshold set by the state (\$500 for Louisiana) and may seek reimbursement for cases when claims are less than the state threshold.

## **Provider Education to Maximize Cost Avoidance**

Our provider relations staff uses multiple methods, including initial provider orientation, provider contract language, the provider handbook, and ongoing training to educate providers about their obligation to coordinate benefits.

Prior to submitting a claim to WellCare, providers must determine if another payer has primary responsibility for claim payment. If another payer is primary, the provider is expected to bill the primary payer prior to billing WellCare. Any balance due after the receipt of payment from the primary payer should be submitted to WellCare. The claim must include information verifying the payment amount received from the primary plan, as well as a copy of their explanation of payment (EOP) statement with the name of the primary payer and the member's primary subscriber ID number.

## **Collection Process for Pay and Chase**

Pursuant to federal regulations, we do not cost avoid claims for certain services (e.g., EPSDT). Instead, we pay the claim and then seek payment from any liable third party. In some cases, we do not establish the probable existence of third party liability until after the claim has been paid. In both of these situations, our standard process is to pursue recovery from the provider (or the carrier if more than 10 months have passed since the date of service). And, if a refund from a provider is not received within 60 days, we adjust future claims to offset the over-payment amount. However, since Louisiana, like Georgia, does not allow us to pursue recovery from a provider, we will instead bill the carrier. This function will be performed by HMS. As required by the RFP, and consistent with our practice in other states, we will void/replace encounters to reflect any recoupment.

We generally pursue all recovery opportunities. However, if we do not pursue a recovery opportunity because it would not be cost effective, we document the occurrence, including a copy of the claim and the reason for not pursuing reimbursement.

## **Subrogation**

WellCare contracts with First Recovery Group to identify claims with accident-related diagnoses (e.g., sprains, fractures and head and back injuries) that represent potential worker's compensation benefit cases or other subrogation opportunities. First Recovery also attempts to identify treatment for incidents such as car accidents, injuries on someone else's property, work-related injuries, animal bites and other accidents. We send monthly medical and pharmacy claims and eligibility data feeds to the vendor. First Recovery generates monthly reports documenting potential subrogation claims and the amount incurred. First Recovery investigates claims by sending a state-approved letter and questionnaire to members. Members can complete and return the form in a postage-paid envelope or call the vendor at a toll-free number. If the vendor identifies cases where a third party is responsible for payment of claims paid by WellCare, then notice of our right of recovery is provided to the third party and to the attorney handling the member's case, if any.

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## Coordination of Benefits

The COB process begins by updating member records to include information regarding other insurance. This information is collected from a variety of sources, including: files from the state (e.g., the eligibility/enrollment file); member contact, both as part of our initial outreach activities and as part of routine follow-up during member telephone contacts; provider claims with explanation of payment (EOP) attachments; and vendors. With regard to state eligibility/enrollment files, we systematically upload Medicare coverage to our *other coverage* table but perform 100 percent validation on all commercial coverage policies provided in the state file. Our EES also routinely sweeps claims/encounter coverage data and compares it to the member records for updating as necessary. See Exhibit P.1.a for an overview of our COB/cost avoidance process.

We currently use HMS, TransUnion, and Syrtis Solutions to identify Medicaid members who have other insurance coverage. We send monthly eligibility batch files to HMS and TransUnion. HMS and TransUnion match our files with commercial coverage information and send a return feed to us containing other insurance information. In addition to validation of other insurance information, WellCare proactively submits 270 transactions each month to TransUnion so they can validate that a member's known commercial coverage is still active. We use Syrtis Solutions to identify members with other pharmacy coverage within 48 hours of receiving approval from our pharmacy benefit manager (PBM). Syrtis Solutions sends batch files to SureScripts (an e-prescribing vendor) who houses real-time eligibility information for almost all PBMs and carriers within the United States.

Once we have validated other insurance coverage, we update the *other coverage* table in our EES. As claims are entered into our core processing system they are placed on hold for COB and then processed according to our COB policies and procedures. If other insurance is discovered after a claim is paid, our standard process is to pursue recovery from the provider (or the carrier if more than 10 months have passed since the date of service). And, if a refund from a provider is not received within 60 days, we adjust future claims to offset the overpayment amount. However, since Louisiana, like Georgia, does not allow us to pursue recovery from a provider, we will not pursue recovery from the provider but instead will bill the carrier. HMS will perform this function. As required by the RFP, and as we do in other states, we will void/replace encounters to reflect any recoupment.

## Subcontractors

As described above, WellCare uses four vendors to assist with cost avoidance and/or post-payment recovery: HMS, TransUnion, Syrtis Solutions, and First Recovery Group.

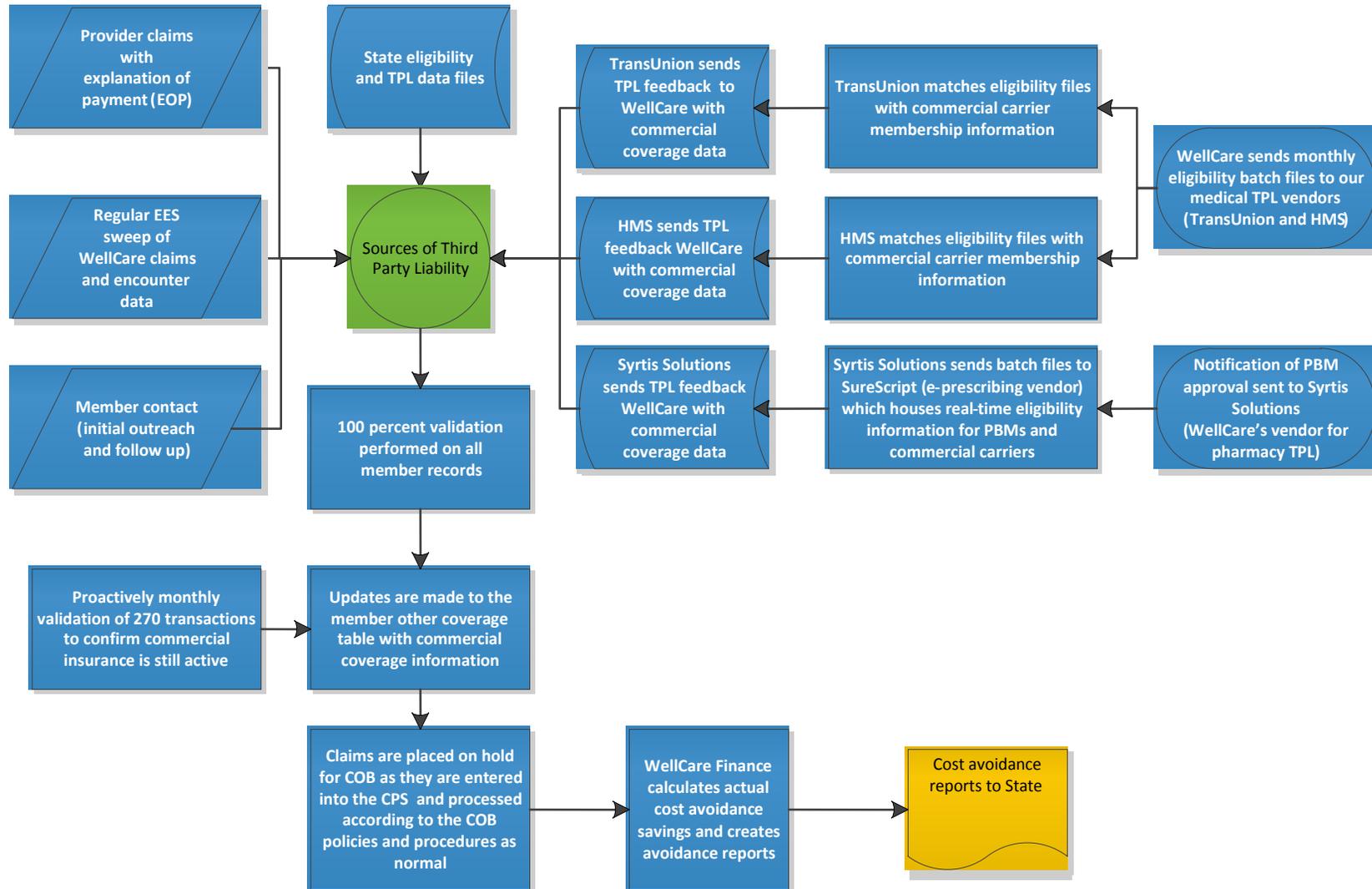
## Testing, Validating, and Updating Enrollment and TPL Data

We validate enrollment data through a series of edits to confirm the completeness and accuracy of enrollment records. Edits include confirmation of permissible values within each field (including null), and comparison of identifying and demographic data to previously-loaded enrollee records (e.g., birth date, address). When an error is indicated, an error report is generated from the system for manual review.

Member enrollment analysts review every record contained in the error report to reconcile and correct any discrepancies. Upon completion of the manual review, an error report is generated that includes any enrollee records that may have incomplete or inaccurate information. This report is forwarded to the state's enrollment broker via the specified file transfer protocols. Enrollment rosters also are reconciled with capitation reports to ensure that payments (by rate cell) tie to enrollment. Any discrepancies between capitation payment amounts and enrollment rosters are reported to the state. WellCare's corporate policy is to update the enrollment database within 24 hours of receipt of the enrollment file and procedures to accomplish this have been implemented. The automated enrollment process concludes with delivery of plan materials and ID cards for new members. For additional information on our business processes to test, update, and validate enrollment data, please see our response to Section D.1, R.6, and R.11.

WellCare employs automated processes that work with our enrollment and eligibility system (EES), our core processing system (CPS), and our vendors to test, update, and validate TPL data. Prior to using vendor TPL data, it must pass a manual validation of three consecutive months at 95 percent accuracy. Once this standard is achieved we move to a quarterly sample validation.

**Exhibit P.1.a – COB/Cost Avoidance Process**



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INSERT TAB HERE  
Section Q  
Claims Management

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Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		<b>Section Q: Claims Management (Section § 17 of RFP)</b>	<b>80</b>		
<b>Section Q Page 1</b>	<b>All</b>	<b>Q.1</b> Describe the capabilities of your claims management systems as it relates to each of the requirements as specified in Electronic Claims Management Functionality Section and the Adherence to Key Claims Management Standards Section. In your response explain whether and how your systems meet (or exceed) each of these requirements. Cite at least three examples from similar contracts.	<b>30</b>		
<b>Section Q Page 10</b>	<b>All</b>	<b>Q.2</b> Describe your methodology for ensuring that claims payment accuracy standards will be achieved per, Adherence to Key Claims Management Standards Section. At a minimum address the following in your response: <ul style="list-style-type: none"> <li>• The process for auditing a sample of claims as described in Key Claims Management Standards Section;</li> <li>• The sampling methodology itself;</li> <li>• Documentation of the results of these audits; and</li> <li>• The processes for implementing any necessary corrective actions resulting from an audit.</li> </ul>	<b>25</b>		
<b>Section Q Page 12</b>	<b>All</b>	<b>Q.3</b> Describe your methodology for ensuring that the requirements for claims processing, including adherence to all service authorization procedures, are met.	<b>25</b>		

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## Section Q: Claims Management

### Q.1

**Describe the capabilities of your claims management systems as it relates to each of the requirements as specified in Electronic Claims Management Functionality Section and the Adherence to Key Claims Management Standards Section. In your response explain whether and how your systems meet (or exceed) each of these requirements. Cite at least three examples from similar contracts.**

WellCare has processed claims for government-sponsored health care programs for 25 years. Last year, we processed more than 16 million claims for seven Medicaid states plus Medicare Advantage. We recognize the importance of electronic transactions as well as prompt and accurate payment and have a fully developed infrastructure for leveraging electronic transactions as well as measuring and monitoring our processing performance.

WellCare has extensive experience with electronic transactions and we are able to fully support all providers with electronic claims receipt and processing, electronic funds transfer and real time transactions, including claim status, member eligibility, and authorization. Our high rate of electronic commerce with our providers contributes to our high auto-adjudication rates and speed of payment for our providers. Examples of our performance with three of our largest health plans are included in the following table:

2010 Performance Results					
Plan	EDI %	EFT %	AA %	15-calendar day TAT %	30-calendar day TAT %
FL Medicaid	90%	59%	88%	97%	99%
GA Medicaid	93%	76%	84%	96%	99%
OH Medicaid	89%	75%	85%	95%	99%

As can be seen in the table, our high electronic claim rate drives fast payment with over 95% in 15 calendar days in all three plans. This also translates to a high through-put rate measured by the auto-adjudication rate (AA) for each state.

### WellCare's Capabilities Regarding Electronic Claims Management (ECM) Functionality

#### System

The hub of our claims processing and management system is our core processing system (CPS) which is based on the Dell Services Xcelys platform. WellCare has used this platform since 1998 and is currently using it to support all Medicaid and Medicare business. CPS consists of an open architecture built on standard technologies, such as Oracle 11g and Java/J2EE, enabling seamless integration with other applications to support all of WellCare's member, provider, claim, benefit, and reporting functions. The WellCare CPS has been benchmarked as scalable in its present form to support more than a doubling of our membership.

WellCare's claims processing system and procedures meet all of the requirements of DHH for claims processing and is designed to ensure that claims are paid and reported accurately and timely. WellCare's CPS supports detailed auditing, capturing date and time stamps for all

manual and system activity, including adjudication results, claim status, and all subsequent activities taken on the claim. The detailed claims data is available to claims processors and customer service representatives (CSRs), who are able to provide information regarding claims status, appeals and grievances, adjudication and claims payment information such as payment amounts, denial reasons, date of payment, check date and check number. Claims processors and CSRs can also provide information relative to other forms of payment such as electronic funds transfer (EFT).

### Claims Submission

WellCare places a premium on driving an industry-leading EDI claim rate and has a dedicated team of provider connectivity analysts who work directly with the provider community to convert paper claim submitters to electronic submissions. The team understands how the fields of a paper claim correlate to the loops and segments of an electronic transaction. Each state is assigned dedicated analysts who conduct provider outreach and serve as a primary point of contact for issues and resolutions. This proactive approach to partnering with the states and providers reduces provider concerns and is particularly valuable to providers with little or no EDI experience.

Our staff will encourage our providers to submit and receive claim information through electronic data interchange. WellCare market representatives work cohesively with providers, offering education sessions in which providers are made familiar with claim submission processes. Discussion topics in these sessions include:

- Fraud, waste and abuse
- Member eligibility
- Authorizations
- Covered services
- Provider resources
- Provider web portal
- Claims
- Care coordination model

Providers are also given helpful resources such as, the provider handbook, a quick reference guide (with claim submission instructions and other helpful tips), authorization forms, and sample claim forms. WellCare's provider handbook, available to provider's in hard copy and on [wellcare.com](http://wellcare.com), describes the process for the submission and acceptance of claims, as well as the requirements for a clean claim.

Providers will also receive training regarding web functionality available at [wellcare.com](http://wellcare.com), including but not limited to:

- Member eligibility lookup and report – Contains member plan, PCP and co-pay information;
- Prior authorization submission and status inquiry – Allows registered providers to submit prior authorizations and check status;
- Claim inquiry and report – Contains claim review and status information;

- Claim DDE portal – Allows registered providers to submit individual fee for service claims and encounters; and
- Online provider directories and provider search capabilities.

WellCare provides three channels for the providers to submit their encounter data: (1) paper forms (e.g., 1500, UB-04); (2) HIPAA standard EDI format (e.g., 837 EDI 4010/5010); and (3) easy-to-use web interface where the providers can manually enter the claim data. WellCare will contract with RelayHealth, an industry-leading clearinghouse, for the receipt of both paper and electronic claims and encounters. RelayHealth will convert paper claims into industry standard electronic claim transactions using optical character recognition (OCR) mapping of the paper claim form to an electronic transaction. RelayHealth will conduct a manual review of critical claim fields to ensure OCR accuracy, and then, combined with electronically submitted claims, transmit the claims to WellCare within one to two days (two days for paper claims).

The electronic version of a paper claim is processed the same way as a transaction received electronically, including populating the received date of the claim in the ISA segment of the 837 transaction. WellCare does not receive any funds from the use of electronic filing functionality and/or services offered by WellCare or any third parties. WellCare's practices regarding information exchange and data management are consistent and compliant with the guidelines outlined in Louisiana's RFP and the CCN-P Systems Companion Guide.

After a claim has been received by WellCare, a series of automated SNIP (Strategic National Implementation Process) edits are applied to the claims to identify any issues related to accuracy, completeness, and compliance with DHH billing manuals. This editing process occurs within the first day of receipt at WellCare, as claims that fail one or more edits will be promptly returned to the provider, with all known defects identified, for correction and resubmission. After a claim has been validated for the industry-standard and state-specific SNIP edits, the claim is processed through a series of WellCare business rules to validate the provider (attending and billing providers) and member information as well as to evaluate the propriety of certain information on the claim (e.g., validate that the diagnosis and procedure codes are current for the dates of service). Where issues are identified with the claim, a manual review is performed by WellCare associates to validate if a correction is necessary or if the claim should be sent back to the provider for evaluation and possible correction (e.g., if the member number on the claim is ineligible on the date of service).

### Claims Processing

After the front edits and business rules are applied, the claim is adjudicated through CPS using member, provider, claim, and history information to determine the appropriate payment and outcome. Through this process:

- Claims are systematically matched to pre-service authorizations;
- Covered services are evaluated for the member;
- The claim is evaluated for timely filing; and
- The services are passed through a comprehensive set of coding edits to test the validity of codes (e.g., diagnoses, revenue codes, procedure codes), test relationships across data elements (e.g., gender/procedure code, procedure code/place of service), and review for adherence to clinical policy and national correct coding requirements and guidelines.

Across all of WellCare's plans the average auto-adjudication rate is approximately 83 percent. Our 2010 auto adjudication performance in a number of our plans includes Georgia Medicaid at 84 percent, Florida Medicaid at 88 percent, and Ohio Medicaid at 85 percent. Claims that hold for the manual review of specific issues, for example potential duplicate or coordination of benefits, are worked by a combination of WellCare associates or WellCare's vendor, IBM. The processors follow strict written SATs, available in real time via an internal website, for the processing of the specific hold reasons. After a claim has auto-adjudicated or been released from a hold reason, it is processed through check run for payment to the provider via EFT or a paper check, according to the provider's preference.

WellCare does not deny claims on the basis of untimely filing situations regarding coordination of benefits (COB) or subrogation in which the provider is pursuing payment from a third party. In situations of third party benefits, the timeframes for filing a claim begin on the date that the third party completes resolution of the claim. Our CPS is configured to systematically hold claims for manual review based on the Member COB information. Once a claim is held, a claims processor follows written instructions in our step action tables (SATs) to review for timely filing by comparing the primary carrier's EOB payment or denial date with the WellCare received date. Where WellCare is the secondary payer, the date of the primary carrier's explanation of payment (EOP) is used as the basis for the beginning of the timely filing period.

Throughout the entire process, WellCare's providers can obtain the status of their claim via real time electronic inquiry and response (the 276/277 transactions), online via wellcare.com, or by calling our customer service team. When a claim is rejected back to the provider, the communication is done either electronically or via a paper letter notifying the provider of the rejection. In either communication method there is a single communication for each rejected claim and all pertinent information regarding the claim and rejection reason is included with the communication (including claim number, member name and number, date of service, total billed charges and the date of report generation).

## **Capabilities Regarding Prompt Payment to Providers**

### Provider Payments

WellCare does not contract with providers who are excluded from participation in Medicare, Medicaid, or the CHIP program. If a provider is sanctioned for fraud or abuse, the provider is terminated from the claims/provider payment system and is not reactivated until that provider has been removed from the program exclusion list and has been re-credentialed. The configuration department may be notified by the credentialing department, special investigation unit or the regulatory affairs department of any provider that has been sanctioned. When notified, the configuration department will immediately suspend the provider within the CPS preventing any payments from being made.

There are several methodologies by which WellCare pays providers, including fee-for-service, prospective payment systems, capitation, etc. WellCare abides by the provisions and guidelines set forth by CMS and state guidelines. WellCare routinely runs at least three payment cycles weekly, all on the same days (Monday, Wednesday and Thursday), exceeding DHH's minimum requirement. Additional payment cycles are easily added when needed, to ensure continued prompt payment to providers.

WellCare delivers the payments, using a secure transmission engine, to Payformance, a payment vendor contracted by WellCare with a web portal named PaySpan Health and using the 835 (Health Care Payment/Remittance Advice). If the vendor/provider is registered in PaySpan Health to be paid via EFT (also known as ACH), all remittances will accompany an EFT and they will balance to the 835. Registration to the PaySpan portal can be accomplished online and is free of charge to the vendor/provider. The vendors/providers are able to view, download, and print their EOP's (Explanation of Payments) online and download their 835. The EFT payments generally are received by providers within 24 hours of delivery of the 835. There are a few bridges in between, such as Positive Pay to allow debit from WellCare's accounts and producing NACHA files which will exchange with the Federal Reserve and finally to the Vendor/Providers bank.

WellCare can ensure that 90 percent of clean claims for payment of services delivered to a member are paid to the provider within 15 business days of the receipt of such claims. In 2010 and across all of WellCare's Medicaid plans, we processed approximately 93 percent of claims in 15 calendar days and more than 99 percent of claims in 30 calendar days. In the unlikely event that a clean claim remains unadjudicated beyond the 30-day claims processing deadline, WellCare will pay providers interest at 12 percent per annum, calculated daily for the full period for which the claim remains unadjudicated. Interest will be paid at the same time the claim is adjudicated.

- WellCare has extensive experience providing explanation of benefits (EOBs) to members according to states requirements, including in Hawai'i, Georgia, New York and Ohio. WellCare has existing and highly configurable processes to meet DHH requirements regarding the timing (45 calendar days) and notice information (including services and dates furnished, provider and member name, and payment amount) and can meet the sampling approach described by DHH for selecting the EOBs to send to members.

#### Approach to Provider Capitation Payments

WellCare's capitation cycle begins around the 22<sup>nd</sup> of every month and finalizes the 10<sup>th</sup> of every month. For those providers with whom we enter into capitation agreements, the terms of how the payment is calculated are included in their individual contracts. The membership actively assigned to a given provider, at the time of the capitation, is used to calculate the current month's payment due to the provider. Our capitation calculation methodology incorporates a six month look-back process to ensure any payments and or recoveries for any retroactive changes not captured in previous payment cycles are fully reflected within the next cycle. Capitated provider contracts, when initially configured in the core processing system, are tested against our capitation payment model to ensure payments will be accurately calculated.

#### ASO/Ancillary Agreements:

WellCare utilizes some vendor contracts in the continuum of care delivery services, such as vision, dental and other ancillary services. The providers in turn build their network panel, and can do so under capitation arrangements. When we enter these types of contracts, we ensure that the agreement includes the process by which we complete data transfers for support and how payments are made to them under capitation. These few particular vendors may be managed by different departments within WellCare based on the services to be provided (i.e.,

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Rx managed/monitored by WellCare Pharmacy department), but every effort is made to verify data and to ensure that payment is facilitated in a prompt manner.

## **Claims Dispute Management**

WellCare has documentation, with detailed step actions, regarding internal claims disputes and arbitration requests (if applicable). These policies and procedures are reviewed annually to ensure that WellCare's process for resolving claims disputes is timely and efficient. Our procedures will be submitted to DHH for review and approval within 30 days from the date the contract is signed.

### Internal claims dispute procedure

The claim payment dispute process is designed to address claim denials for issues related to untimely filing, incidental procedures, bundling, unlisted procedure codes, non-covered codes, etc. Claim payment disputes may be submitted by the provider to WellCare in writing within 90 days of the date of the EOB.

WellCare will attempt to resolve claims disputes internally and WellCare's claims dispute process will also allow the provider the option to request binding arbitration. All claim payment disputes received will be scanned into an internal repository for review by the Plan. The WellCare associate assigned the dispute will thoroughly review the disputed claim and apply WellCare's written policies and procedures in making the determination. If the decision is favorable to the provider, the provider will receive a new EOB with adjusted claim details. If the decision is adverse to the provider and the dispute decision is upheld, a written notification from WellCare will be sent that advises the provider of the next level of available administrative remedies, up to and including binding arbitration.

### Binding Arbitration

The claims dispute process will allow providers the option to request binding arbitration for adverse decisions regarding claims that have denied, underpaid claims, or a group of claims bundled. If the provider is not satisfied with WellCare's decision on a claims dispute, he or she may submit a request for binding arbitration to WellCare within 15 business days of the notice of WellCare's adverse action.

Arbitration will be by a private arbitrator who is certified by a nationally recognized association that provides training and certification in alternative dispute resolution. If WellCare and the provider are unable to agree on an association, the rules of the American Arbitration Association shall apply.

The arbitrator shall have experience and expertise in the health care field and shall be selected according to the rules of his or her certifying association. Arbitration shall be binding on all parties. The arbitrator shall conduct a hearing and issue a final ruling within ninety (90) days of being selected, unless WellCare and the provider mutually agree to extend this deadline. All costs of arbitration, not including attorney's fees, shall be shared equally by the parties.

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## Encounter Data

Encounter data processing, submission and reporting for the CCN program will be performed at the WellCare corporate level. WellCare maintains an encounter processing system (EPS), within our information system suite. WellCare has reviewed DHH requirements and attests that EPS manages and validates all necessary data elements for submitting the required format. WellCare's EPS will be ready to submit encounter data to DHH's fiscal intermediary (FI) within 60 days of operation in the geographic service area. WellCare will incur all costs associated with certifying HIPAA transactions prior to submitting encounter data to the FI in accordance with the CCN-P Systems Companion Guide.

As previously mentioned, WellCare provides three channels for providers to submit their encounter data: (1) paper forms (e.g., 1500, UB-04); (2) HIPAA standard EDI format (e.g., 837 EDI 4010/5010); and (3) easy-to-use web interface where the providers can manually enter encounter data. We also will offer a batch submission capability at no cost to the provider for providers who want to bypass the clearinghouses. WellCare will contract with RelayHealth for the receipt of both paper and electronic claims and encounters. RelayHealth will convert paper claims into industry standard electronic claim transactions using optical character recognition (OCR) mapping of the paper claim form to an electronic transaction. On average, WellCare intakes over 150,000 paper claims monthly via our paper-to-EDI conversion process.

Non-Medical encounters including dental, vision, hearing, transportation as well as certain types of medical-related claims including DME are received from vendors and processed through our transaction manager. All encounters will be submitted in accordance with DHH provided 837 formats for professional, institutional, and ancillary encounters. WellCare has a steering committee charged with addressing all applicable aspects of the Patient Protection and Affordable Care Act (ACA), including Section 6507 regarding National Correct Coding Initiatives.

WellCare uses all industry and national standard code sets including HCPCS Level II and Category II CPT codes, and has the flexibility to accommodate future versions as required. Through a coordinated effort across our Compliance, Regulatory Affairs, Operations and IT organizations, updates to the standard code sets are identified in a timely manner and loaded into WellCare's systems. Our systems then use these standard code sets for operational processing, presented below:

- Logical Observation Identifier Names & Codes (LOINC)
- National Drug Code (NDC)
- Health Care Financing Administration Common Procedural Coding System (HCPCS)
- National Council for Prescription Drug Programs (NCPDP)
- Current Procedural Terminology (CPT) Code
- International Classification of Diseases (ICD-9)
- Home Infusion EDI Coalition (HEIC) Product Codes
- American Dental Association Current Dental Terminology (CDT-4)
- Diagnosis Related Group (DRG)
- CMS HIPAA Remittance Remarks Codes
- Claim Adjustment Reason Codes

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## Processing and Updating Encounter Data

Encounters and adjudicated (paid or denied) claims are captured in EPS. EPS performs a series of checks and edits (including those performed by the DHH FI's system to identify errors). EPS generates an error report to identify data that must be reviewed and corrected prior to submission to the FI.

WellCare's integrated suite provides the capability to define the claims data elements that must be included in encounters. A series of automated SNIP (Strategic National Implementation Process) edits are applied to received claims to identify any issues related to accuracy, completeness, and compliance with DHH billing manuals. Claims that fail one or more edits are returned to the provider for correction and resubmission. Additional front-end edits are applied to validate provider and member information. Claims that fail these edits are output to a work queue for manual review. Claims that cannot be corrected are returned to the provider.

WellCare applies the same front-end edits and data quality control processes to providers with whom WellCare has a capitation arrangement. WellCare will ensure the level of detail associated with encounters from capitated providers shall be equivalent to the level of detail associated with encounters for which WellCare received and settled a fee-for-service claim. WellCare's EPS will submit both paid and denied encounters.

Prior to submission of encounter data, WellCare will ensure that the data complies with our internal quality controls, corporate compliance procedures and DHH-approved version of the claims processing system (edits and adjudication). EPS will transmit data to and from the FI through Secure File Transfer Protocol (SFTP) in accordance with DHH and FI published processes, procedures, and protocols. WellCare employs Secure Sockets Layer (SSL) technology, the standard for Internet security, and SFTP ensures that data transmissions sent over the Internet will be unreadable without a proper digital certificate. The EPS is an adaptable system that will enable WellCare to submit encounters in the format specified by DHH. The EPS also will incorporate all DHH accuracy and completeness edits, thereby assuring DHH that submitted encounters will be accurate and usable.

WellCare will submit 95 percent of encounter data at least monthly no later than the 25th calendar day of the month following the month in which they were processed and approved/paid unless a different time frame is approved by DHH. A WellCare officer will certify the accuracy, completeness and truthfulness of encounter data and provide a letter of certification with every submission, in accordance with 42 CFR 438.604 and 438.606.

EPS includes a scheduling component to ensure that encounter data is submitted in accordance with DHH submission timelines. EPS tracks the timeliness and completeness of provider claims/encounters on a monthly basis and compares the volume of current month submissions to historical data. If a provider's volume falls below the expected range, the provider is contacted to ascertain whether a problem occurred in the data feed or if all encounters have in fact been submitted. If there is a problem with data that a provider has submitted, WellCare will contact providers in order to correct the issues. If there are problems with incoming third party or delegated vendor data, WellCare will reach out to them to correct the issues. Other WellCare functions supplement the edit and audit processes performed by EPS to ensure that encounter reports are timely and accurate. These functions include provider education activities, provider audits, and quality control/corporate compliance activities.

The WellCare EPS tracks each individual encounter submission and automatically reconciles response files from the FI with our submitted encounters. Any submission which contains fatal errors that prevent processing, or that does not satisfy defined threshold error rates, will be remediated and resubmitted to the FI in accordance with DHH-approved processes and procedures.

WellCare's EPS is flexible and will support the capture of transaction status from the FI. EPS will record encounter denial codes as repairable or nonrepairable. WellCare has extensive experience working with FI systems and will adapt processes to meet the requirements related to FI exception codes and dispositions for the purpose of repairing denied encounters. As one example, for NPI rejects, we have worked with states to correct missing or invalid NPI codes on their systems (e.g., missing providers in their roster file). We have worked with states when the claims frequency code (i.e., used to identify a new, void, or replacement claim) is a different value than the state is expecting. In this case, we have resubmitted files and/or modified values to meet state needs.

WellCare's integrated suite enables reporting across multiple systems enabling us to address any issues that prevent processing of an encounter. From the moment a claim, paper or electronic, is received, a unique identifier is assigned by WellCare enabling us to track the claim from receipt through reporting to DHH including reconciliation of a receipt transaction from the FI. This enables us to meet and exceed the service levels defined by DHH including 90 percent of reported repairable errors being addressed within 30 calendar days and 99 percent of reported repairable errors within 60 calendar days or within a negotiated timeframe approved by DHH.

WellCare's EPS reports settled claims and claim adjustments or voids, utilizing a consistent approach across multiple states where we support Medicaid submissions. We support void and replacement logic handling adjustments due to payment errors, in-cycle and out-of-cycle adjustments and we accommodate processing for both capitated and fee-for-service arrangements across states.

WellCare will submit encounters records such that payment for discrete services which may have been submitted in a single claim can be ascertained in accordance with WellCare's applicable reimbursement methodology for that service. Individual procedure codes and their respective reimbursement amounts are distinguishable, regardless of whether WellCare paid a provider for multiple services as part of one claim.

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## Q.2

**Describe your methodology for ensuring that claims payment accuracy standards will be achieved per, Adherence to Key Claims Management Standards Section. At a minimum address the following in your response:**

- **The process for auditing a sample of claims as described in Key Claims Management Standards Section;**
- **The sampling methodology itself;**
- **Documentation of the results of these audits; and**
- **The processes for implementing any necessary corrective actions resulting from an audit.**

### **WellCare Audits Claims on a Routine Basis and As Part of Implementation**

As part of our implementation quality assurance process, we conduct an audit of all claims processed for the first two to three months of operation of a new program, or until our quality standards are achieved. We accomplish this with little effect on turnaround. In addition, we have maintained our timeliness and accuracy while adding additional lines of business, demonstrating the capacity to expand business without adversely affecting service levels.

Our audit function resides in the finance department, which is independent of claims management. Our internal audit program includes both processor quality and end-to-end audits. The processor quality audit examines claim processing details and data entry methods to ensure processes and procedures are followed by the claims associate to ensure financial and clerical accuracy. The end-to-end audit verifies all variables impacting the payment of the claim, including the minimum attributes identified in RFP Section 17.5.3.2. Attributes not identified in the previously identified section are: contract configuration, fee schedule validation and coordination of benefits. The end-to-end audit, in addition to finding errors on individual claims, identifies where corrections are required in the claim processing system.

The processor quality audit is based on a random sample of approximately 2,000 claims from the previous month's production, exceeding DHH's requirement of 200 claims. WellCare performs the following monthly end-to-end audits to identify opportunities to minimize financial risk: Sarbanes-Oxley audit of (1,000 claims), top provider audit (800 claims), targeted audit (500 claims), high dollar audit (all claims with an allowable of \$50,000 or more), and a semi-annual state audit (500 claims). With the exception of the high dollar audit, all claims are randomly sampled and stratifications are applied to the Sarbanes-Oxley and targeted audits as necessary. This logic can be further modified to ensure that DHH's requirements are met.

### **WellCare Uses Audit Findings to Drive Improvement**

The audit results and sampled claims are stored for quality control purposes. WellCare maintains a log that includes:

- Results for each attribute tested for each claim selected;
- Amount of overpayment or underpayment for each claim processed or paid in error;
- Explanation of the erroneous processing for each claim processed or paid in error;
- Determination if error was manual or systemic; and

- Claims processed or paid in error have been corrected.

An intranet tool was created to provide all impacted departments with the ability to run reports and review errors for rebuttal or corrective action. Corrective action can take the form of re-configuration of the claims processing system or changes in documentation for training employees.

Audit reports are summarized and distributed and presented monthly to the VP of Operations, CAO and CFO. We will also submit a claims payment accuracy percentage report to DHH on a monthly basis.

### Q.3

***Describe your methodology for ensuring that the requirements for claims processing, including adherence to all service authorization procedures, are met.***

WellCare's claims processing systems and procedures meet all of DHH program requirements and are designed to ensure that claims are paid and reported accurately and timely, in accordance with state-specific benefit limits and service thresholds. Key components of the claims processing function include intensive and routine inventory management, claim and code validation and editing, benefit and pricing adjudication, and post-payment review.

#### **Daily Inventory Management**

Cross-functional daily management meetings are conducted to review the end-to-end processes and touch-points related to the claims process, from the point of receipt through check run. The review includes all reconciliation points, inventory and claim aging statuses, receipt volume and trends, internal claims audit results, activities around routine testing and configuration activities, and provide dispute inventory volumes and trends. This time is also dedicated for other input areas in operations that have an impact on claims processing such as IT, configuration, correspondence, provider resolution, coding/compliance, and vendor support units/training and education.

#### **Claim Receipt, Validation and Editing**

As mentioned in response to Q1 and Q2, WellCare provides three channels for providers to submit their claims:

- Paper forms (e.g., 1500, UB-04);
- HIPAA standard EDI format (e.g., 837 EDI 4010/5010); and
- The WellCare web interface where providers can manually enter in the claim data.

WellCare contracts with RelayHealth for the receipt of both paper and electronic claims and encounters. RelayHealth converts the paper claims into industry standard electronic claim transactions using optical character recognition (OCR) mapping of the paper claim form to an electronic transaction, including a manual review of critical claim fields to ensure OCR accuracy. Within one day of receipt, all claims pass through SNIP edits to identify any syntax, syntactical or balancing issues with the claims. If issues are identified with a specific claim, the claim is sent back to the provider via a 997 transaction, or a letter advising the provider of the rejection reasons and the pertinent claim information, including claim identifier number, provider and member identifiers, date of service(s), and billed charges. WellCare is able to fully meet all of DHH's reporting requirements when communicating to providers. Claims that pass the SNIP edits are then transmitted to WellCare within one to two calendar days (up to two days for paper claims).

After receipt at WellCare, the claim passes through additional SNIP edits to identify any situational, accuracy, or completeness issues and to meet the claim and encounter requirements of DHH. Claims that do not pass one or more edits are returned to the provider for correction and resubmission, in the same manner and with all necessary information as described above. Front end business rules are then applied to validate the provider and

member information, including member eligibility for the dates of service on the claim. Claims that require manual intervention are output to a work queue for manual review and correction. Claims that cannot be corrected by WellCare are returned to the provider for correction and resubmission (for example, a claim with an invalid NPI number).

Claims that pass the validation processes are loaded to the core processing system (CPS) for pricing, pre-service authorization validation, benefit adjudication and correct coding evaluations.

### **Core Processing System Adjudication and Evaluation**

When claims are loaded to the CPS, the claim is immediately evaluated for authorization requirements, evaluated for exact and possible duplicate matches to previously processed claims, it is priced, and it is evaluated for appropriate benefit determinations (e.g., covered services, member liability and benefit and quantity limitations). The services on the claim are then evaluated for correct coding requirements.

The pre-service authorization is created when a provider contacts WellCare for an authorization either through a phone call or via the WellCare provider portal. The provider, member, and service information is entered into the Enterprise Medical Management Application (EMMA), which is an integrated component of the CPS. At the time the claim is entered into the CPS, the authorization on the claim will be validated against the authorized information captured in EMMA to ensure the authorization on the claim corresponds to the services that were initially authorized. If the claim does not have an authorization, systematic matching rules will match the authorization to the claim based on pre-defined matching logic (e.g., member, provider, date of service). If the authorization could not be systematically matched to the claim, the claim will be added to a hold queue for a claims processor to manually match the authorization.

Pricing of the claim is done systematically according to the terms of the provider contract. Out-of-network providers are paid according to the prevailing Medicare or state fee schedules.

A comprehensive set of correct coding edits are applied, ranging from testing the validity of codes (e.g., diagnosis, procedure codes) to testing relationships across data elements (e.g., gender/procedure code, procedure code/place of service) and checking for duplicate claims. WellCare then reviews the claims for adherence to National Correct Coding Initiative (NCCI) edits and also according to rules set by DHH including any limitations on service coverage and quantity.

WellCare's auto-adjudication rate exceeds 80 percent, allowing most claims to rapidly finalize to payment and driving our high payment timeliness rate in 15 calendar days. Of the less than 20 percent of claims that hold, WellCare has experienced claims processors in-house and at our vendor that rapidly evaluate the claim for the hold reason in accordance with our step action tables and then release the claim for finalization.

### **Post-payment Review**

Clinical staff conducts retrospective review of a sample of claims to ensure that services provided were medically necessary. Retrospective review staff performs a thorough assessment of inpatient coding related to the medical record. This review focuses on adherence to accepted coding guidelines. Retrospective review assesses the payment methodology submitted by the

provider and, where applicable, identifies areas of potential recovery in the claim. Emergency department prudent layperson (ED PLP) services reviews provider submitted emergency room medical records as they relate to prudent layperson guidelines. A nurse coordinator, as well as a medical director, both of whom are medically trained and licensed by the State in which the plan is operating, review ED PLP records. A determination is made on the claim relative to PLP guidelines. Follow-up communication is sent to the provider via an internal department process.

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Section R  
Information Systems

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Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		<b>Section R: Information Systems (Section § 16 of RFP)</b>	<b>200</b>		
<b>Section R Page 1</b>	<b>All</b>	<p><b>R.1</b></p> <p>Describe your approach for implementing information systems in support of this RFP, including:</p> <ul style="list-style-type: none"> <li>• Capability and capacity assessment to determine if new or upgraded systems, enhanced systems functionality and/or additional systems capacity are required to meet contract requirements;</li> <li>• Configuration of systems (e.g., business rules, valid values for critical data, data exchanges/interfaces) to accommodate contract requirements;</li> <li>• System setup for intake, processing and acceptance of one-time data feeds from the State and other sources, e.g., initial set of CCN enrollees, claims/service utilization history for the initial set of CCN enrollees, active/open service authorizations for the initial set CCN enrollees, etc.; and</li> <li>• Internal and joint (CCN and DHH) testing of one-time and ongoing exchanges of eligibility/enrollment, provider network, claims/encounters and other data.</li> <li>• Provide a Louisiana Medicaid CCN-Program-specific work plan that captures: <ul style="list-style-type: none"> <li>○ Key activities and timeframes and</li> </ul> </li> </ul>	<b>25</b>		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		<ul style="list-style-type: none"> <li>○ Projected resource requirements from your organization for implementing information systems in support of this contract.</li> <li>● Describe your historical data process including but not limited to:               <ul style="list-style-type: none"> <li>○ Number of years retained;</li> <li>○ How the data is stored; and</li> <li>○ How accessible is it.</li> </ul> </li> </ul> <p>The work plan should cover activities from contract award to the start date of operations.</p>			
Section R Page 12	All	<p><b>R.2</b></p> <p>Describe your processes, including procedural and systems-based internal controls, for ensuring the integrity, validity and completeness of all information you provide to DHH (to their Fiscal Intermediary and the Enrollment Broker). In your description, address separately the encounter data-specific requirements in, Encounter Data Section of the RFP as well as how you will reconcile encounter data to payments according to your payment cycle, including but not limited to reconciliation of gross and net amounts and handling of payment adjustments, denials and pend processes. Additionally, describe how you will accommodate DHH-initiated data integrity, validity and provide independent completeness audits.</p>	15		
Section R Page 18	All	<p><b>R.3</b></p> <p>Describe in detail how your organization will ensure that the availability of its systems will, at a minimum, be equal to the standards set forth in the RFP. At a minimum</p>	15		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		<p>your description should encompass: information and telecommunications systems architecture; business continuity/disaster recovery strategies; availability and/or recovery time objectives by major system; monitoring tools and resources; continuous testing of all applicable system functions, and periodic and ad-hoc testing of your business continuity/disaster recovery plan.</p> <p>Identify the timing of implementation of the mix of technologies and management strategies (policies and procedures) described in your response to previous paragraph, or indicate whether these technologies and management strategies are already in place.</p> <p>Elaborate, if applicable, on how you have successfully implemented the aforementioned mix of technologies and management strategies with other clients.</p>			
Section R Page 23	All	<p><b>R.4</b></p> <p>Describe in detail:</p> <ul style="list-style-type: none"> <li>• How your <i>key production systems</i> are designed to <i>interoperate</i>. In your response address all of the following:               <ul style="list-style-type: none"> <li>○ How identical or closely related data elements in different systems are named, formatted and maintained:                   <ul style="list-style-type: none"> <li>- Are the data elements named consistently;</li> <li>- Are the data elements formatted similarly (# of characters, type-text, numeric, etc.);</li> <li>- Are the data elements</li> </ul> </li> </ul> </li> </ul>	15		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		<p>updated/refreshed with the same frequency or in similar cycles; and</p> <ul style="list-style-type: none"> <li>- Are the data elements updated/refreshed in the same manner (manual input, data exchange, automated function, etc.).</li> <li>o All exchanges of data between key production systems. <ul style="list-style-type: none"> <li>- How each data exchange is triggered: a manually initiated process, an automated process, etc.</li> <li>- The frequency/periodicity of each data exchange: “real-time” (through a live point to-point interface or an interface “engine”), daily/nightly as triggered by a system processing job, biweekly, monthly, etc.</li> </ul> </li> <li>• As part of your response, provide diagrams that illustrate: <ul style="list-style-type: none"> <li>o point-to-point interfaces,</li> <li>o information flows,</li> <li>o internal controls and</li> <li>o the networking arrangement (AKA “network diagram”) associated with the information systems profiled.</li> </ul> </li> </ul> <p>These diagrams should provide</p>			

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
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		insight into how your Systems will be organized and interact with DHH systems for the purposes of exchanging Information and automating and/or facilitating specific functions associated with the Louisiana Medicaid CCN Program.			
Section R Page 34	All	<p><b>R.5</b></p> <p>Describe your ability to provide and store encounter data in accordance with the requirements in this RFP. In your response:</p> <ul style="list-style-type: none"> <li>• Explain whether and how your systems meet (or exceed) each of these requirements.</li> <li>• Cite at least three currently-live instances where you are successfully providing encounter data in accordance with DHH coding, data exchange format and transmission standards and specifications or similar standards and specifications, with at least two of these instances involving the provision of encounter information from providers with whom you have capitation arrangements. In elaborating on these instances, address all of the requirements in Section 17. Also, explain how that experience will apply to the Louisiana Medicaid CCN Program.</li> <li>• If you are not able at present to meet a particular requirement contained in the aforementioned section, identify the applicable requirement and discuss the effort and time you will need to meet said requirement.</li> </ul>	15		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		<ul style="list-style-type: none"> <li>Identify challenges and “lessons learned” from your implementation and operations experience in other states and describe how you will apply these lessons to this contract.</li> </ul>			
Section R Page 38	All	<p><b>R.6</b></p> <p>Describe your ability to receive, process, and update eligibility/enrollment, provider data, and encounter data to and from the Department and its agents. In your response:</p> <ul style="list-style-type: none"> <li>Explain whether and how your systems meet (or exceed) each of these requirements.</li> <li>Cite at least three currently-live instances where you are successfully receiving, processing and updating eligibility/enrollment data in accordance with DHH coding, data exchange format and transmission standards and specifications or similar standards and specifications. In elaborating on these instances, address all of the requirements in Sections 16 and 17, and CCN-P Systems Companion Guide. Also, explain how that experience will apply to the Louisiana Medicaid CCN Program.</li> <li>If you are not able at present to meet a particular requirement contained in the aforementioned sections, identify the applicable requirement and discuss the effort and time you will need to meet said requirement.</li> <li>Identify challenges and</li> </ul>	15		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		“lessons learned” from implementation in other states and describe how you will apply these lessons to this contract.			
Section R Page 41	All	<b>R.7</b> Describe the ability within your systems to meet (or exceed) each of the requirements in Section §16. Address each requirement. If you are not able at present to meet a particular requirement contained in the aforementioned section, identify the applicable requirement and discuss the effort and time you will need to meet said requirement.	15		
Section R Page 43	All	<b>R.8</b> Describe your information systems change management and version control processes. In your description address your production control operations.	10		
Section R Page 45	All	<b>R.9</b> Describe your approach to demonstrating the readiness of your information systems to DHH prior to the start date of operations. At a minimum your description must address: <ul style="list-style-type: none"> <li>• provider contract loads and associated business rules;</li> <li>• eligibility/enrollment data loads and associated business rules;</li> <li>• claims processing and adjudication logic; and</li> <li>• encounter generation and validation prior to submission to DHH.</li> </ul>	15		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
Section R Page 47	All	<p><b>R.10</b></p> <p>Describe your reporting and data analytic capabilities including:</p> <ul style="list-style-type: none"> <li>• generation and provision to the State of the management reports prescribed in the RFP;</li> <li>• generation and provision to the State of reports on request;</li> <li>• the ability in a secure, inquiry-only environment for authorized DHH staff to create and/or generate reports out of your systems on an <i>ad-hoc</i> basis; and</li> <li>• Reporting back to providers within the network.</li> </ul>	15		
Section R Page 49		<p><b>R.11</b></p> <p>Provide a detailed profile of the key information systems within your span of control.</p>	5		
Section R Page 63		<p><b>R.12</b></p> <p>Provide a profile of your current and proposed Information Systems (IS) organization.</p>	5		
Section R Page 64		<p><b>R.13</b></p> <p>Describe what you will do to promote and advance electronic claims submissions and assist providers to accept electronic funds transfers.</p>	5		
Section R Page 66		<p><b>R.14</b></p> <p>Indicate how many years your IT organization or software vendor has supported the current or proposed information system software version you are currently operating. If your software is vendor supported, include vendor name(s), address, contact</p>	Included/Not Included		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		person and version(s) being used.			
Section R Page 67		<b>R.15</b> Describe your plans and ability to support network providers' "meaningful use" of Electronic Health Records (EHR) and current and future IT Federal mandates. Describe your plans to utilizing ICD-10 and 5010.	15		
Section R Page 82		<b>R.16</b> Describe the procedures that will be used to protect the confidentiality of records in DHH databases, including records in databases that may be transmitted electronically via e-mail or the Internet.	10		

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## Section R: Information Systems

### R.1

**Describe your approach for implementing information systems in support of this RFP, including:**

- **Capability and capacity assessment to determine if new or upgraded systems, enhanced systems functionality and/or additional systems capacity are required to meet contract requirements;**
- **Configuration of systems (e.g., business rules, valid values for critical data, data exchanges/interfaces) to accommodate contract requirements;**
- **System setup for intake, processing and acceptance of one-time data feeds from the State and other sources, e.g., initial set of CCN enrollees, claims/service utilization history for the initial set of CCN enrollees, active/open service authorizations for the initial set CCN enrollees, etc.; and**
- **Internal and joint (CCN and DHH) testing of one-time and ongoing exchanges of eligibility/enrollment, provider network, claims/encounters and other data.**
- **Provide a Louisiana Medicaid CCN-Program-specific work plan that captures:**
  - **Key activities and timeframes and**
  - **Projected resource requirements from your organization for implementing information systems in support of this contract.**
- **Describe your historical data process including but not limited to:**
  - **Number of years retained;**
  - **How the data is stored; and**
  - **How accessible is it.**

**The work plan should cover activities from contract award to the start date of operations.**

### Capability and Capacity Assessment

WellCare of Louisiana, Inc. will operate on the WellCare information system suite, a fully integrated suite of applications capable of meeting all operational, regulatory and reporting requirements for the CCN program. Exhibit R.1.a below shows the key components of WellCare's information system suite. WellCare recognizes the value of best-in-class information technology to promote efficient business operations in support of the Louisiana Medicaid CCN program.

Our information system suite has the system capacity and scalability to fully support the CCN program. WellCare does not require additional systems capacity to meet contract requirements. The hub of WellCare's information system suite is WellCare's core processing system (CPS), based on the Dell Services Xcelys platform. WellCare has been using this platform since 1998 to support all of our Medicaid and Medicare business. WellCare's CPS consists of an open architecture built on standard technologies, such as Oracle 11g and Java/J2EE, enabling seamless integration with other applications to support all of WellCare's member, provider, claim, benefit, and reporting functions.

CPS is interfaced with a suite of best-in-class applications to support self-service, fulfillment, encounters, case management, and reporting operations. Our Enterprise Medical Management

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Application (EMMA) supports WellCare's assessment, planning and coordination functions. EMMA provides the foundation for the development of a customized case management and care coordination system.

WellCare's quality reporting system uses McKesson's CareEnhance Resource Management Software (CRMS) to provide an integrated clinical and financial view of care delivery to measure and improve performance. As one of the applications in the suite, CareEnhance HealthPlan Reporter streamlines the complex HEDIS reporting process by centralizing existing claims, membership, medical records, and other narrative information the user selects, creating a single source of clean data.

WellCare's enhanced electronic enrollment processing application, enrollment and eligibility system (EES), has the capability to receive, process, and update enrollment data daily into our core processing system (CPS). This application tracks and reconciles each individual transaction from receipt, through membership update and on to delivery of ID cards into the U.S. mail stream.

WellCare's encounter processing system (EPS) uses data from other systems to develop complete and timely encounter data for submission to state partners. All paid and denied claims and encounter records (for capitated services) are extracted from our transaction manager and CPS and are loaded into our EPS, which performs a series of checks to identify errors that must be reviewed and corrected prior to submission to the state.

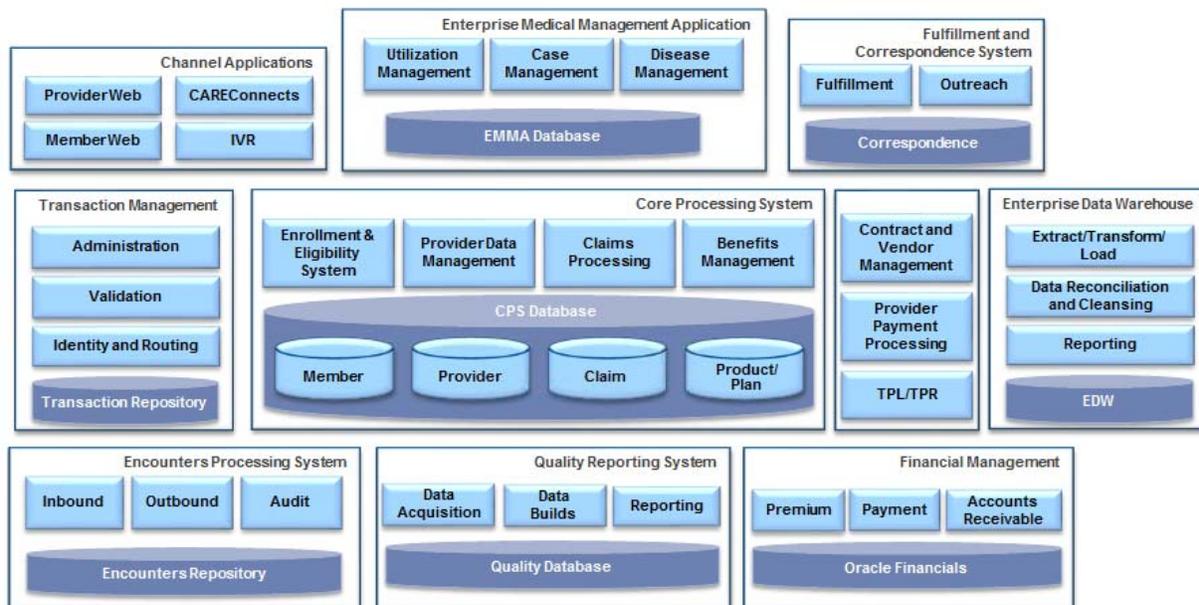
WellCare's CPS is currently managing over 2.3 million active members, with the certified capacity to support more than 6 million active members and the capacity to process 50,000 claims per hour. The enrollment/eligibility subsystem processes over 40,000 members each hour, over 10 million fulfillment transactions annually, and produces ID cards and welcome kits within 48 hours of receipt of new enrollment information. On average, over 25,000 member and provider transactions are performed via our provider and member web applications on a daily basis.

The WellCare information suite uses system and storage virtualization to maximize overall available capacity and to position the environment for speed-to-market opportunities in response to customer requests. WellCare stores less data and uses less CPU processing and memory than system capacity allows in order to mitigate any risk of surges in demand, causing performance or capacity issues. WellCare's current hardware and network infrastructure has the capacity to support the additional growth of members and provider data from the Louisiana Medicaid CCN program.

## **Configuration of Systems**

The WellCare information suite is designed to be highly configurable to quickly and cost effectively meet the configuration requirements (e.g., business rules, valid values for critical data, data exchanges/interfaces) of the CCN program. Upon contract award, WellCare will deploy a team of experts to configure our applications to support contract requirements. They will be responsible for providing technical support, including coordinating resolutions for technical issues, and developing any required enhancements related to data exchange and interfaces. The team will set up a test account, load configurations, test and validate configurations to ensure that our systems meet all DHH requirements.

## Exhibit R.1.a – Overview of WellCare Information System Suite and Applications



### System Setup

As we configure our systems, WellCare will conduct system set-up for intake, processing and acceptance of one-time data feeds from the State and other sources (e.g., initial set of CCN members, claims/service utilization history for the initial set of CCN members, active/open service authorizations for the initial set CCN members). We will work with the State specifications and companion guides to prepare for initial and ongoing data feeds. We will conduct tests in our non-production environments to validate all setup activities. WellCare is capable of setting up an ad hoc process to transfer files following any secure protocol that the State of Louisiana currently has in place.

After successful testing, WellCare will migrate all required setup activities to our production environment. Our infrastructure and application support standard operating procedures include controls to ensure the integrity of our network infrastructure and the security of all production and non-production environments. These controls ensure that data entered into our systems and any modifications made to existing data are controlled and tracked. WellCare can trace data back to its source file or document through the different systems it may pass through, as each processing step records audit trails including a unique processing ID and processing date for the transaction recorded within the system. These processes are designed to ensure the security and integrity of all data within our systems.

### Internal and Joint (CCN and DHH) Testing

WellCare operates Medicaid health plans in several states and enrollment currently stands at approximately 2.3 million active members. We will work closely with DHH and other partners to ensure as smooth of an implementation as possible. WellCare will conduct pre-implementation planning, testing and readiness activities prior to the program's start date. Prior to

implementation, we will meet with the State to discuss the coordination of testing and develop a plan for data exchanges. We will share with DHH the lessons learned from previous program startups and recent fiscal intermediary (FI) changes among our current state Medicaid programs. Based on our experience, we have developed a playbook to help verify that all pre-program start-up activities are complete prior to processing the first enrollment file.

Our implementation and development process includes provider contract loads, member/enrollment data loads, historical claims, prior authorizations, claims processing, and encounters reporting. We will work closely with DHH and other state partners to demonstrate the readiness of our information systems and ensure quality products are provided through defined, repeatable, and flexible processes.

WellCare ensures that high performance technical solutions are achieved and that the functionality requested by our business partners meets or exceeds requirements. Testing is conducted in non-production environments to ensure usability and the achievement of productivity goals. Throughout these procedures, WellCare has processes in place to capture metrics, track defects through resolution, and control the promotion of development code through non-production environments and into production environments through a defined, audited change and release management process.

To facilitate the development and testing process, a highly skilled WellCare IT quality assurance (QA) team participates in the initial identification of the scope of work and the delivery of the technical specifications. Non-production environments are secured in order to test in an isolated state. During testing, the QA team will map requirements to documented and controlled test cases prepared for each project. Using business logic and software tools, the team confirms that the expected output is presented accurately for the scenario being tested. During the tests, we query data to confirm both source and target locations. Our defect tracking process records all identified incidents to provide a thorough audit history through the point of resolution for the business as well as technical teams.

For audit and repeatability purposes, all testing information is kept in a reference library which can be accessed in the event subsequent requests are received and validation of services performed is required. The QA team’s approach to testing not only ensures the functionality requested in the requirements document is satisfied but also ensures that capabilities have been tested end-to-end. Exhibit R.1.b below illustrates the components of an end-to-end fulfillment test.

**Exhibit R.1.b – Example End-To-End Test Components**

Key Process	Goal	Key Activities
Screen Content	Ensure that the format requested and designed meets the layout specification	All user screens validated for formatting and layout; spelling and grammatical inconsistencies identified and corrected
Edits and Validations	Test known and expected edits and validations that would prohibit an end user from entering erroneous data	Any clarification is raised as a test issue to be researched and resolved
Interface/ Integration	Test combined parts (code modules, individual applications, client and server applications) of an application to	Test all systems using environments that simulate the configuration of the expected final system in production to ensure

Key Process	Goal	Key Activities
	determine if they function together	accurate functionality
Data Validation	Review both the source and the target files/databases to ensure data is not compromised when the application is integrated with another system	Conduct functional testing; non-conformance to an expected result is communicated with the business partner and acceptable parameters are defined
Functional (Black Box) Testing	Verify the end-to-end operability of business requirements as implemented in the software system	Confirm new and existing critical business transactions behave in accordance with business requirements via functional testing

QA processes will be used to ensure readiness of provider contract loads, eligibility/enrollment data loads, claims history loads, prior authorization loads, and claims processing in conjunction with a Louisiana DHH specific test plan and test scenarios. Tests will be run first by the QA team to ensure processing accuracy. User acceptance and business end-to-end testing will be conducted before sign off that the solution is ready for Louisiana CCN operations. Once business operations certifies readiness, WellCare IT will engage in several phases of testing with the State and vendors. Each phase has gating and success criteria, as outlined in Exhibit R.1.c.

**Exhibit R.1.c - Key Process Test Parameters and Success Criteria**

Key Process	Test Parameters	Success Criteria
Connectivity Testing	Connectivity between the CCN and State/vendor	Ability to upload and delete files between FTP sites
Data Exchanges: File and Field Level Validation	Ensures the CCN and/or State/vendor are transmitting data (e.g., Eligibility, Provider data) in the correct format as prescribed in the companion guide and defined through the weekly IT meetings; performed in test environments with test data	Ability for the CCN and/or State/vendor to transmit data in the correct format to be accurately processed and reported by associated systems
Data Exchanges: Volume Testing and Reconciliation	Various use case scenarios are tested to insure the data is being transmitted correctly as well; performed in test environments with test data	Ability for the CCN and/or State/vendor to correctly transmit the expected volume of data in the correct format
Post Deployment and Continuous Improvement	Ongoing effort to ensure that data provided by the CCN or State /vendor is supporting the business needs	Modifications to system after it has been deployed to production

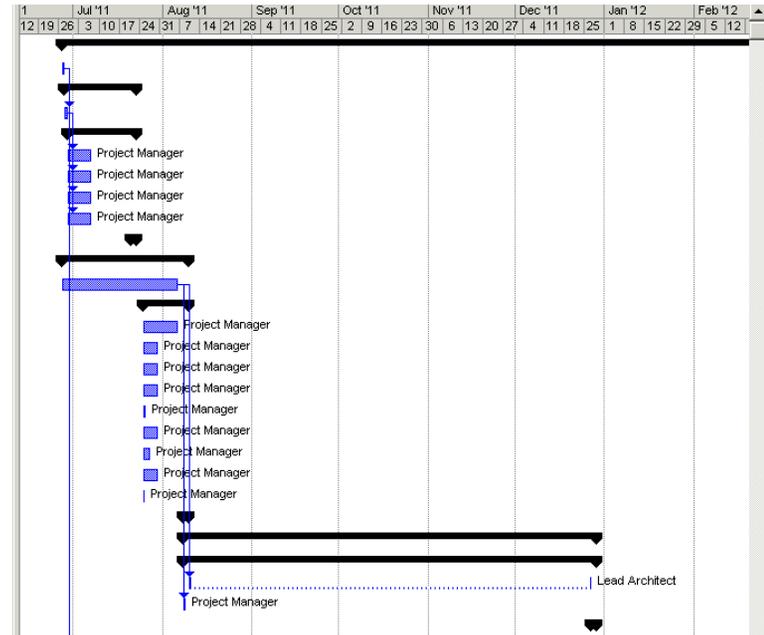
**Louisiana Medicaid CCN-Program-Specific Work Plan**

As soon as possible following contract award, WellCare’s project management team will meet with DHH to review, develop, and finalize data transmission protocols and schedules for data files relating to membership information, provider listings, claims, authorization, and encounter information. During these meetings, WellCare will work with DHH to finalize reporting requirements and report formats. Upon contract award, WellCare will begin the provider

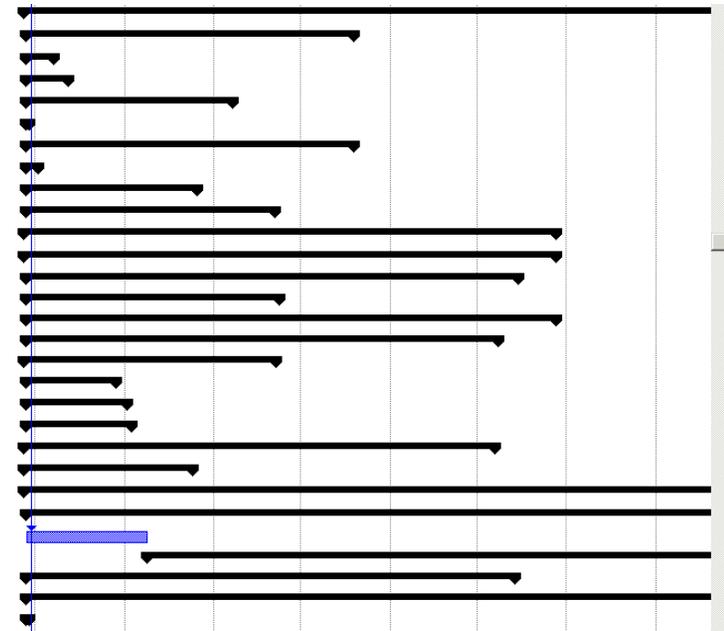
credentialing and contracting process, load contracted providers into our core payer system, and conduct system testing. The actual resource requirements will be finalized at the time of contracting. Preliminarily we rely on groups/leadership to support the requirements gathering and execution efforts; tied closely to the cross functional implementation team. A full sample draft project work plan is attached below (Exhibit R.1.d).

### Exhibit R.1.d – Draft Project Work Plan

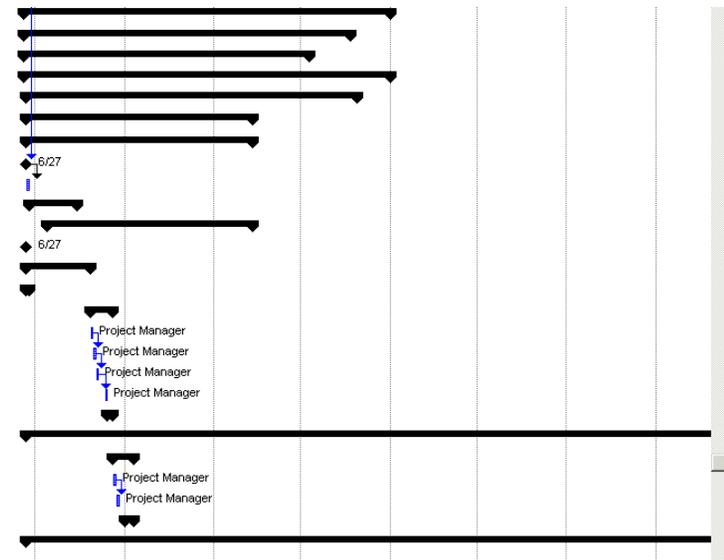
Task Name	Duration	Start	Finish	Resource Names
<b>Louisiana Expansion IT Implementation Project Plan</b>	189 days?	Mon 6/27/11	Wed 3/21/12	
Commencement of Work Efforts	1 day?	Mon 6/27/11	Mon 6/27/11	
<b>Initiate Phase</b>	18 days?	Tue 6/28/11	Fri 7/22/11	
Receipt of Project Supporting Documentation from PMO	1 day?	Tue 6/28/11	Tue 6/28/11	
<b>Initiate Phase PMO Deliverables</b>	17 days?	Wed 6/29/11	Fri 7/22/11	
Complete Project Charter	5 days?	Wed 6/29/11	Wed 7/6/11	Project Manager
Complete SDLC Checklist	5 days?	Wed 6/29/11	Wed 7/6/11	Project Manager
Create Project Cost Model / Forecast	5 days?	Wed 6/29/11	Wed 7/6/11	Project Manager
Complete Impact Assessment Questionnaire	5 days?	Wed 6/29/11	Wed 7/6/11	Project Manager
Project Management Gating	2 days?	Thu 7/21/11	Fri 7/22/11	Project Manager
<b>Planning Phase</b>	31 days?	Mon 6/27/11	Tue 8/9/11	
<b>Determine Specific Deliverables - add to Construct Phase</b>	29 days?	Mon 6/27/11	Fri 8/5/11	
<b>Planning Phase PMO Deliverables</b>	12 days?	Mon 7/25/11	Tue 8/9/11	
Create Project Plan and Schedule	10 days?	Mon 7/25/11	Fri 8/5/11	Project Manager
Create Communications Plan	5 days?	Mon 7/25/11	Fri 7/29/11	Project Manager
Develop Roles and Responsibilities Matrix	5 days?	Mon 7/25/11	Fri 7/29/11	Project Manager
Develop High Level Test Plan	5 days?	Mon 7/25/11	Fri 7/29/11	Project Manager
Create Business/Functional Requirements Docs for each development item	1 day?	Mon 7/25/11	Mon 7/25/11	Project Manager
Create Implementation Plan	5 days?	Mon 7/25/11	Fri 7/29/11	Project Manager
Complete work estimates Document	2.5 days?	Mon 7/25/11	Wed 7/27/11	Project Manager
Update Project Cost Model	5 days?	Mon 7/25/11	Fri 7/29/11	Project Manager
Baseline Project Plan	0.13 days?	Mon 7/25/11	Mon 7/25/11	Project Manager
Project Management Gating	2 days?	Mon 8/8/11	Tue 8/9/11	Project Manager
<b>Design Phase</b>	99.2 days?	Mon 8/8/11	Thu 12/29/11	
<b>Design Phase PMO Deliverables</b>	99.2 days?	Mon 8/8/11	Thu 12/29/11	
Complete Technical Specification for each development effort	1 day?	Wed 8/10/11	Tue 12/27/11	Lead Architect
Update Project Cost Model (Budget and Forecast)	1 day?	Mon 8/8/11	Mon 8/8/11	Project Manager
Project Management Gating	2 days?	Tue 12/27/11	Thu 12/29/11	Project Manager



[-] Construct Phase	184.75 days?	Mon 6/27/11	Thu 3/15/12	
[-] Infrastructure	79.72 days?	Mon 6/27/11	Wed 10/19/11	
[-] Field Office Setup	6.75 days?	Tue 6/28/11	Thu 7/7/11	Dir of Facilities
[-] Telecom Setup	9.75 days?	Mon 6/27/11	Tue 7/12/11	Telecom Team
[-] Network Setup	49.63 days?	Tue 6/28/11	Wed 9/7/11	Network Team
[-] Right Fax Modification	1 day?	Mon 6/27/11	Tue 6/28/11	Network Team
[-] IVR Modification	79.72 days?	Mon 6/27/11	Wed 10/19/11	Telecom Team
[-] Server Design/Setup	4 days?	Mon 6/27/11	Fri 7/1/11	Infrastructure Team
[-] Computer HW/SW/License Acquisition/Imaging	42 days?	Mon 6/27/11	Thu 8/25/11	Infrastructure Team
[-] Architecture	60 days?	Mon 6/27/11	Wed 9/21/11	Lead Architect
[-] Core Processing	127.5 days?	Mon 6/27/11	Wed 12/28/11	
[-] Enrollment to Fulfillment (E2F)	127.5 days?	Mon 6/27/11	Wed 12/28/11	Enrollment/Eligibility Team
[-] 834 Driver modifications (inc. PCP AA/ table load)	118.13 days?	Tue 6/28/11	Thu 12/15/11	Enrollment/Eligibility Team
[-] Previous Claims History	61.75 days?	Tue 6/28/11	Fri 9/23/11	Enrollment/Eligibility Team
[-] ID Cards	126.5 days?	Tue 6/28/11	Wed 12/28/11	Enrollment/Eligibility Team
[-] HOH Kits	113.75 days?	Tue 6/28/11	Thu 12/8/11	Enrollment/Eligibility Team
[-] Letters/Correspondence	61.88 days?	Mon 6/27/11	Thu 9/22/11	Enrollment/Eligibility Team
[-] EDI Front End Operations	22 days?	Mon 6/27/11	Thu 7/28/11	EDI Team
[-] EFT/Payformance Setup	24 days?	Tue 6/28/11	Mon 8/1/11	Finance Team
[-] Surround Applications	25.25 days?	Tue 6/28/11	Wed 8/3/11	Core Team
[-] DER Modification (modified to exclude LA)	113.48 days?	Mon 6/27/11	Wed 12/7/11	Core Team
[-] Pharmacy/WHI Elig Feed (to exclude LA from feed)	41.5 days?	Mon 6/27/11	Wed 8/24/11	WHI Team
[-] Enterprise Data Management	184.75 days?	Mon 6/27/11	Thu 3/15/12	
[-] Regulatory Reporting	183.75 days?	Tue 6/28/11	Thu 3/15/12	Regulatory Reporting Team
Dependency - Receipt of All required Reports/Formats/Timetframes	29 days	Tue 6/28/11	Mon 8/8/11	
[-] RPT 1	149.5 days?	Tue 8/9/11	Thu 3/8/12	
[-] RPT 2	117.34 days?	Tue 6/28/11	Wed 12/14/11	
[-] RPT 3	183.75 days?	Tue 6/28/11	Thu 3/15/12	
[-] EPSDT	1 day?	Tue 6/28/11	Tue 6/28/11	Core Team



Encounters Effort	89 days?	Mon 6/27/11	Mon 10/31/11	Encounter Management Team
Encounters Institutional	79.25 days	Mon 6/27/11	Tue 10/18/11	
Encounters Professional	69 days?	Mon 6/27/11	Mon 10/31/11	
Encounters Dental	89 days	Mon 6/27/11	Mon 10/31/11	
Premium Reconciliation - 820	80.75 days?	Tue 6/28/11	Thu 10/20/11	Premium Recon Team
Health and Channel Services	54.5 days?	Mon 6/27/11	Wed 9/14/11	
WEB Modification	54.5 days?	Mon 6/27/11	Wed 9/14/11	Web Team
Dependency - Receipt of Decision re: New LOB	0 days?	Mon 6/27/11	Mon 6/27/11	
Meet with Business/IT/Market owners to determine requirements - WEB	1 day?	Tue 6/28/11	Tue 6/28/11	
Phase I	11.75 days?	Wed 6/29/11	Fri 7/15/11	
Phase II	50.5 days?	Tue 7/15/11	Wed 9/14/11	
Medical Management (EMMA)	0 days?	Mon 6/27/11	Mon 6/27/11	Medical Mgmt Team
EDI Claim Operations	15 days?	Tue 6/28/11	Tue 7/19/11	EDI Team
Salesforce	1 day?	Tue 6/28/11	Tue 6/28/11	Salesforce Team
Construct Phase PMO Deliverables	6 days?	Wed 7/20/11	Wed 7/27/11	
Complete Code Review & Sign-off	1 day?	Wed 7/20/11	Wed 7/20/11	Project Manager
Complete Test Cases/Test Results	1 day?	Thu 7/21/11	Thu 7/21/11	Project Manager
Perform User Acceptance Testing	1 day?	Fri 7/22/11	Fri 7/22/11	Project Manager
Complete Readiness Assessment	1 day?	Mon 7/25/11	Mon 7/25/11	Project Manager
Project Management Gating	2 days?	Tue 7/26/11	Wed 7/27/11	Project Manager
Closure Phase	188 days?	Tue 6/28/11	Wed 3/21/12	Project Manager
Closure Phase PMO Deliverables	5 days?	Thu 7/28/11	Wed 8/3/11	
Conduct Post Implementation Survey	1 day?	Thu 7/28/11	Thu 7/28/11	Project Manager
Complete Post Implementation Report	1 day?	Fri 7/29/11	Fri 7/29/11	Project Manager
Project Management Gating	3 days?	Mon 8/1/11	Wed 8/3/11	
Chargable Time/Tasks	188 days?	Tue 6/28/11	Wed 3/21/12	Project Manager



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## Historical Data Process

### Retention Periods

WellCare applications have the capacity and the capability to maintain more than six years of production documents, files, and data, including applicable audit trails and audit logs. The WellCare information suite supports online retrieval and access to documents and files for at least six years for audit and reporting purposes and at least ten years in archival systems. WellCare does not purge claims from CPS. Claims for services that have a once in a life-time indicator (i.e., appendix removal, hysterectomy) remain in the claims history to verify member eligibility for a service. Production data, files, and documents are stored without purging and are copied to an archival system that will be maintained for more than ten years (the retention period may be extended as required by the State for ongoing audits or other purposes). Archives are created on a daily, weekly, monthly, and yearly basis. Weekly tapes are preserved for a month, monthly tapes for a year, and yearly tapes are preserved indefinitely.

### Storage and Retrieval of Records

Company records are maintained in a safe, secure environment that is appropriate for each record's use and classification. Records are maintained in an accessible environment such that they can be retrieved for the length of time required by WellCare's records retention schedule.

Records required for audit purposes are made available in hard copy or on a current computer system according to applicable requirements and expectations of federal and state agencies and regulators, including but not limited to the Internal Revenue Service and the Securities and Exchange Commission.

The combination of the WellCare information system suite and archive system will provide 48 business hour turnaround or better on requests for access to information that is six years old, and 72 business hour turnaround or better on requests for access to information in machine readable form, that is between six to ten years old. If an audit or administrative, civil or criminal investigation or prosecution is in progress or resulting findings, investigations or prosecutions are unresolved, information shall be kept on tape until all related tasks or proceedings are completed.

The WellCare information system suite supports extensive audit capabilities. For example, CPS supports basic row auditing features for data insertions and modifications that track the unique identifier of the user or process along with the date and time stamp for the action that is viewable through an application interface. Online access to claims in CPS and across the WellCare information suite is available by Medicaid recipient ID, provider ID and ICN (internal control number which within WellCare is denoted as WCN). Modification history and data deletion history is stored for major data entities (e.g., member, eligibility, and provider) using audit tables. The date and identification stamp is available through the application interface and for reporting.

WellCare's financial management application, Oracle Financials, has extensive built-in auditing functionality that tracks data insertions and modifications by a unique user identifier process along with the date and time stamp for the action. Modification history and data deletion is stored for major data entities using audit tables. Using the unique processing ID and the

processing date for a transaction recorded within the system, we can trace data back to its source file/document through the different systems it may pass through, as each processing step records audit trails.

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## R.2

***Describe your processes, including procedural and systems-based internal controls, for ensuring the integrity, validity and completeness of all information you provide to DHH (to their Fiscal Intermediary and the Enrollment Broker). In your description, address separately the encounter data-specific requirements in, Encounter Data Section of the RFP as well as how you will reconcile encounter data to payments according to your payment cycle, including but not limited to reconciliation of gross and net amounts and handling of payment adjustments, denials and pend processes. Additionally, describe how you will accommodate DHH-initiated data integrity, validity and provide independent completeness audits.***

### **Procedural and Systems-Based Internal Controls**

WellCare uses a variety of procedural and systems-based controls to ensure the integrity, validity, and completeness of all information used for internal business management as well as reporting to business partners and, in this case, DHH. Our standards, policies, and procedures are well documented and we routinely review compliance with plan standards. WellCare maintains detailed files and preserves audit trails to allow research and reconstruction of data. Our controls support the integrity of our systems and the data held within them, as described in greater detail below.

WellCare will accommodate DHH-initiated data integrity, validity, and completeness audits. WellCare currently works with a number of states to facilitate data audits to support the validity of HEDIS measures and other data reported to our state partners, including encounters. We cooperate with yearly audits with many of our clients and maintain audit trails and other data documentation to facilitate review of our data and processes.

### Data Integrity and Standards Compliance

For us, data integrity starts at the basic network layer. Standard transport and application protocols defined by Internet Engineering Task Force/Internet Engineering Steering Group (IETF/IESG) are utilized throughout the network infrastructure where applicable for data communications with TCP/IP as the primary, default protocol implemented on systems within our span of control.

To maintain data integrity across the network and our applications, WellCare uses Microsoft Windows Domains and Microsoft Active Directory for centralized management of all corporate users. Active Directory acts as the central authority for network security, letting the operating system readily verify a user's uniquely assigned identity (authentication) and control his or her access (authorization) to network resources. Active Directory provides the opportunity to implement integrated security through trusted connections; otherwise, applications will support their own internal security mechanism that allows for the unique identification of a user and access control to application system functionality.

Systems are protected through authentication and authorization protocols with the least privilege required principle (to perform a task) as defined in standard operating procedures. Security templates are developed for basic network infrastructure access and major application access and system functionality, which provide for a requesting authority to designate the appropriate security access or system functionality to be applied to an individual user. This

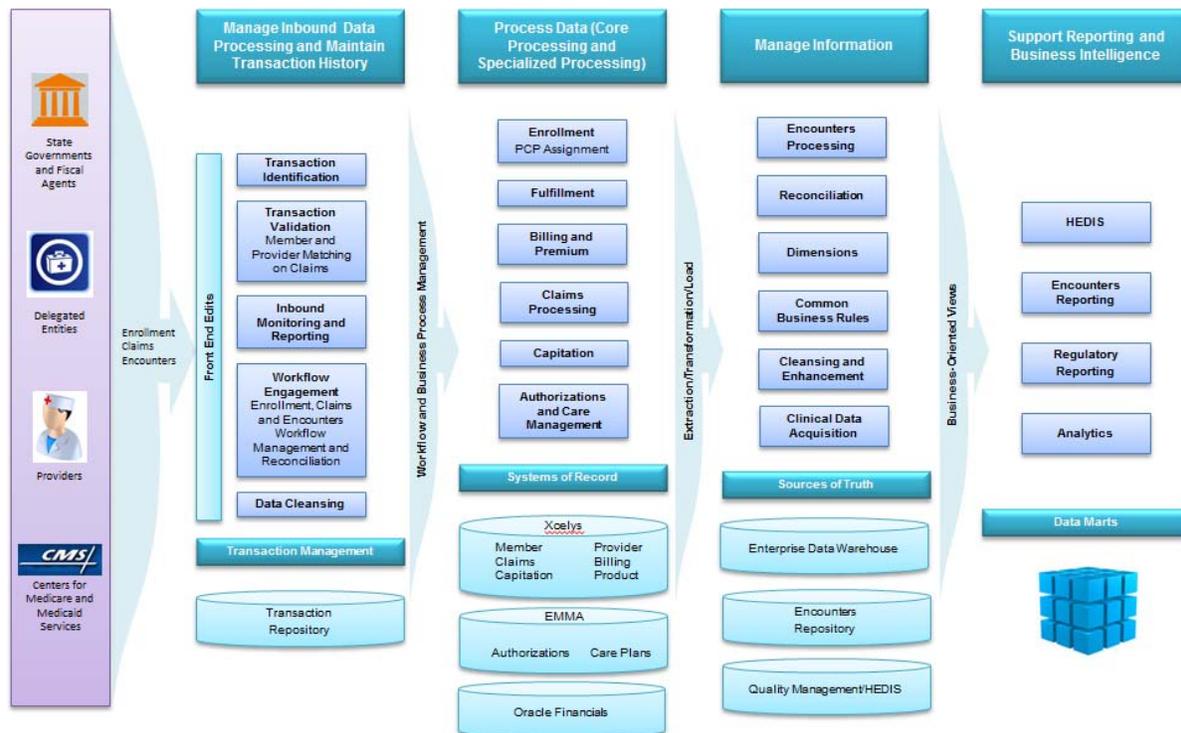
request is initiated by the WellCare associate’s direct manager, verified by the technology service desk as a valid request, implemented at the appropriate layer, and periodically reviewed for compliance by Information Security.

The Information Controls and Security Policy details the standards and guidelines, the process, and the reporting standards related to system access by role-based definitions, including the global access to all functions. This policy and procedure defines the review and auditing of access authorization and is the standard by which WellCare is externally audited (e.g., Sarbanes-Oxley Information Technology Audit). The Information Security department reviews network server application and security logs periodically for security issues and investigates any incidents escalated as a threat.

For persistent data storage, WellCare uses industry standard relational database management systems including Oracle Enterprise Edition and Microsoft SQL Server Enterprise Edition which are ANSI SQL and Open Database Connectivity (ODBC) compliant. The associated Online Transactional Processing (OLTP) databases are designed in normalized, relational data models.

Exhibit R.2.a illustrates the high-level flow of data into WellCare and through our integrated information systems suite.

**Exhibit R.2.a – High level Data Flow**



WellCare’s systems adhere to the standard code sets listed below through a documented set of policies and procedures. Through a coordinated effort across WellCare IT and WellCare

business areas, updates to the standard code sets are identified in a timely manner and loaded into WellCare's systems.

- Logical Observation Identifier Names & Codes (LOINC)
- Health Care Financing Administration Common Procedural Coding System (HCPCS)
- Current Procedural Terminology (CPT) Codes
- Home Infusion EDI Coalition (HEIC) Product Codes
- Diagnosis Related Group (DRG)
- Claim Adjustment Reason Codes
- National Drug Code (NDC)
- National Council for Prescription Drug Programs (NCPDP)
- International Classification of Diseases (ICD-9)
- American Dental Association Current Dental Terminology (CDT-4)
- Remittance Remarks Codes

WellCare has a steering committee charged with addressing all applicable aspects of the Affordable Care Act (ACA), including Section 6507 regarding National Correct Coding Initiatives, and has initiated plans for achieving compliance.

### HIPAA Compliance

The Chief Compliance Officer oversees WellCare's implementation and compliance with all current and future HIPAA standards. Reporting to the Chief Compliance Officer, the Chief Privacy Officer oversees three workgroups for privacy, security, and records and information management. Our Information Systems group partners with appropriate business units to oversee transactions and code sets, analyzes the impact of the new transaction sets on WellCare's systems and implements required changes using WellCare's Software Development Life Cycle. Policies and procedures are developed to govern the receipt and loading of transaction set updates into WellCare's systems.

WellCare maintains policies and procedures describing the types of information to be safeguarded and the proper release of protected health information (PHI). WellCare is sensitive to the need for confidentiality of information. All WellCare associates must attend mandatory HIPAA privacy and security training courses within their first 30 days (and annually thereafter), which cover the principles of PHI and associated HIPAA requirements. Additionally, associates attend general compliance (iCare) training designed to instill WellCare's core values and ethics. WellCare maintains corporate policies that address system access management and information accessibility at a corporate level.

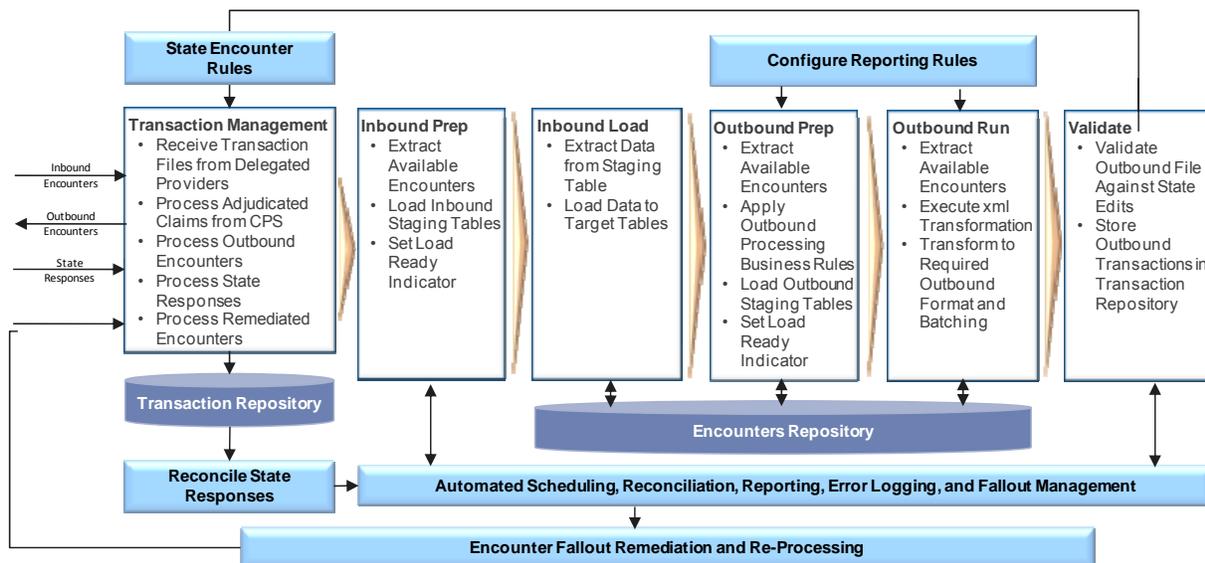
### **Encounter Data-Specific Requirements**

#### Encounter Data Submissions

Encounter data processing, submission and reporting for the LaCHIP, FITAP and ABD/SSI programs will be performed at the WellCare corporate level. WellCare maintains our encounter

processing system (EPS), within our information system suite. WellCare has reviewed DHH requirements and attests that EPS manages and validates all necessary data elements for submitting encounters in 837 format. All claims and encounter records are extracted from our transaction manager and CPS into EPS. EPS then performs a series of checks and edits (including those performed by the DHH FI's system to identify errors). EPS generates an error report to identify data that must be reviewed and corrected prior to submission to DHH. Data will be submitted in accordance with DHH provided 837 formats for professional, institutional, and ancillary encounters. Rejected encounters will be reported back to WellCare by DHH for research and resubmission. The encounter processing and reporting process is illustrated in Exhibit R.2.b

**Exhibit R.2.b - WellCare Detailed Encounter Processing and Reporting**



EPS will transmit data to and receive data from DHH through SFTP. WellCare will interface with DHH's systems using DHH-specified software. WellCare employs secure sockets layer (SSL) technology, the standard for Internet security, and SFTP ensures that data transmissions sent over the Internet will be unreadable without a proper digital certificate. The EPS is an adaptable system that will enable WellCare to submit encounters in the format specified by DHH. The EPS also will incorporate all DHH accuracy and completeness edits, thereby assuring DHH that submitted encounters will be accurate and usable.

### Encounter Data Integrity

WellCare utilizes a proven process to monitor claim and encounter integrity and accuracy. To convert claims adjudication information into encounter data, paid claims, denied claims and encounter records (for capitated services) are extracted from CPS and our transaction manager and loaded into EPS. Encounter submissions are created directly out of the EPS. The EPS performs a series of checks (including Strategic National Implementation Process level 1 through 7 edits) and generates an error report to identify data that must be reviewed and corrected prior to submission to DHH.

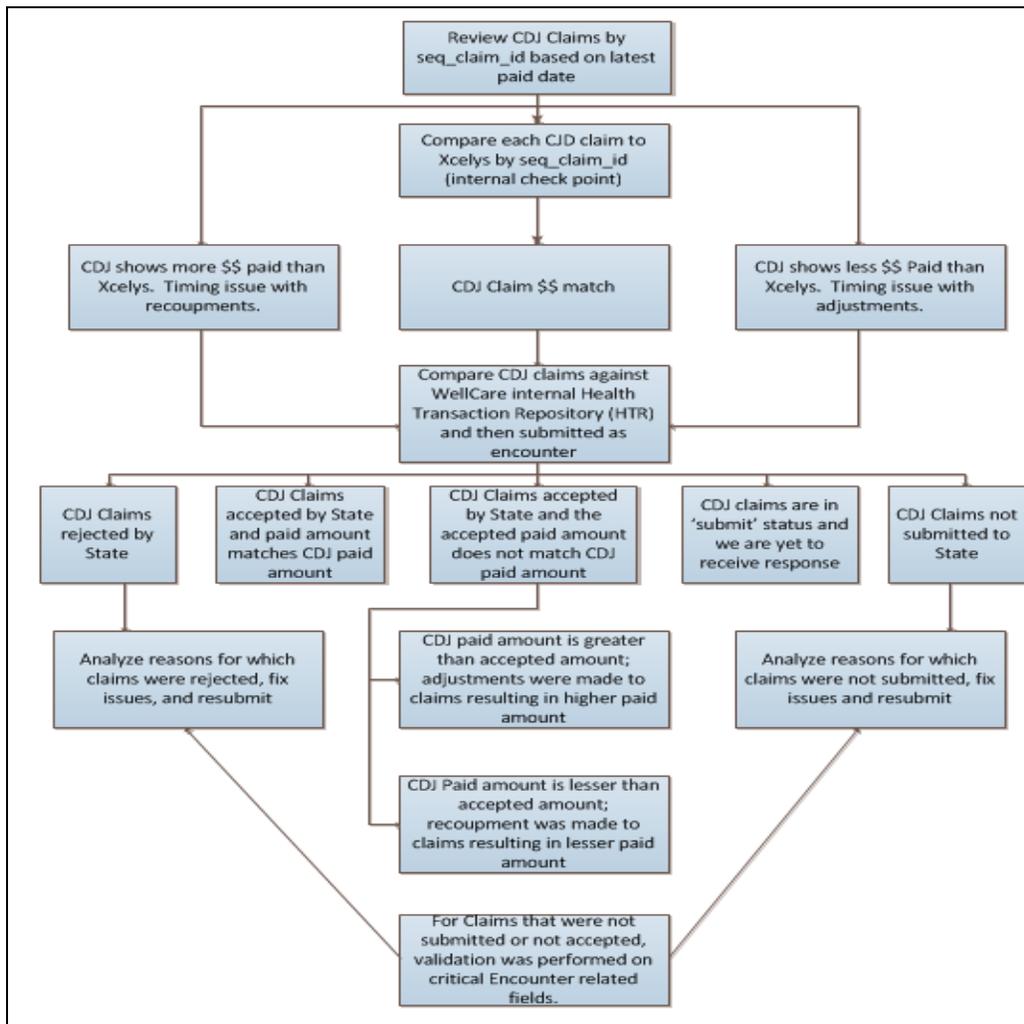
WellCare monitors the completeness of encounter and claim data through multiple channels. WellCare reviews its claim and encounter data on a monthly basis to ensure that expected services are being reported by providers and vendors, particularly those who are capitated. WellCare generates periodic reports for large capitated PCP groups to identify potential underreporting of encounters. Our Delegation Oversight Committee has a vendor encounter data sub-group that reviews monthly reports detailing volume by date received and by month of service for each vendor and all applicable lines of business, and trends lag as well as volume.

### Encounter/Payment Reconciliation

In addition to monitoring the delegated and capitated providers, we reconcile encounter data to payments according to our payment cycle, including reconciliation of gross and net amounts and handing of payment adjustments, denials and pend processes.

Exhibit R.2.c below illustrates our reconciliation process.

#### **Exhibit R.2.c – Reconciliation Process**



Prior to submission of encounter data, WellCare will ensure that the data complies with our internal quality controls and corporate compliance procedures. WellCare will certify the accuracy, completeness and truthfulness of encounter data and provide a letter of certification with every submission in accordance with 42 CFR 438.604 and 438.606. The EPS includes a scheduling component to ensure that encounter data will be submitted in accordance within DHH submission timelines. Other WellCare functions supplement the edit and audit processes performed by the EPS to ensure that encounter reports are timely and accurate; these functions include provider education activities; provider audits and quality control/corporate compliance activities. In Georgia, WellCare has a record of submitting encounters that reconcile at 99 percent of cash disbursement.

### Application Audit Trails

Audit trails shall be incorporated into all systems to allow information on source data files and documents to be traced through the processing stages to the point where the information is finally recorded. Exhibit R.2.d below lists audit requirements and compliance status of our key applications.

The audit trail shall:

- Contain unique log-on or terminal id, date and time, action taken (create, modify, delete), ID of system job that effected the action.
- Have the date and identification “stamp” displayed on any online inquiry.
- Have the ability to trace data from the final place of recording back to its source data file and/or document.
- Be supported by listings, transaction reports, update reports, transaction logs, or error logs.
- Facilitate auditing of individual claim records as well as batch audits.

**Exhibit R.2.d – Systems Reviewed and Results of Review**

Requirement	Key Applications			
	Xcelys	DER	EMMA	EES
Contain unique log-on or terminal id, date and time, action taken (create, modify, delete), ID of system job that effected the action.	Yes	Yes	Yes	Yes
Have the date and identification “stamp” displayed on any on-line create, modify, or delete function.	Yes	Yes	N/A	Yes
Have the ability to trace data from the final place of recording back to its source data file and/or document.	N/A	Yes	Yes	Yes
Be supported by listings, transaction reports, update reports, transaction logs, or error logs.	Yes	Yes	Yes	Yes
Facilitate auditing of individual claim records as well as batch audits.	Yes	N/A	N/A	N/A

**R.3**

**Describe in detail how your organization will ensure that the availability of its systems will, at a minimum, be equal to the standards set forth in the RFP. At a minimum your description should encompass: information and telecommunications systems architecture; business continuity/disaster recovery strategies; availability and/or recovery time objectives by major system; monitoring tools and resources; continuous testing of all applicable system functions, and periodic and ad-hoc testing of your business continuity/disaster recovery plan.**

**Identify the timing of implementation of the mix of technologies and management strategies (policies and procedures) described in your response to previous paragraph, or indicate whether these technologies and management strategies are already in place.**

**Elaborate, if applicable, on how you have successfully implemented the aforementioned mix of technologies and management strategies with other clients.**

**Strategies to Ensure System Availability**

WellCare has a robust set of strategies, processes, technologies, monitoring tools and resources, problem identification and resolution processes in place for our information systems suite and telecommunications infrastructure to meet all DHH business continuity/disaster recovery; availability and recovery time objectives.

As stated previously, WellCare of Louisiana, Inc. will operate on the WellCare information system suite, a fully integrated suite of applications currently serving over 2.3 million active Medicaid/CHIP and Medicare members. In support of all our Medicaid programs, we are able to document and report overall system availability that has exceeded 99% since January, 2008, more than 41 consecutive months.

WellCare’s information systems have been designed to support growth in our business. WellCare has made significant investments in our information systems, telecommunications, and facilities over the past 24 months in preparation for membership growth and to meet the needs of new programs such as the CCN program. To illustrate the success of these investments, our major systems availability objectives matrix is shown in Exhibit R.3.a below.

**Exhibit R.3.a – Availability Objectives for Major Systems**

Key Production System	Enterprise Application	Availability Objective	Actual
Member Enrollment	Core Processing System	99.0%	99.8%
	Enrollment and Eligibility System	99.0%	100%
Case Management and Care Coordination	McKesson CRMS 5.73	99.0%	100%
	Enterprise Medical Management Application	99.0%	99.9%
Provider Payment and Network Management	Core Processing System	99.0%	99.8%/100%
Claims Payment	Core Processing System	99.0%	99.8%

Key Production System	Enterprise Application	Availability Objective	Actual
Reporting and Program Management	WellCare Data Warehouse	99.0%	100%
Financial Data	Oracle Financials DB/APP	99.0%	100%

Our success is based on a dynamic, flexible and redundant network and computing infrastructure; a proactive and responsive approach to the management of the infrastructure; and continuous monitoring and testing. WellCare’s infrastructure is highly virtualized. This means that our information systems suite is hosted on a computing and storage infrastructure that dynamically adapts to application requirements. Network, computing platform, and storage devices are redundant with no single points of failure. In the unlikely event of a network, computing platform, or storage failure, our applications can be quickly migrated to new, standby components with no loss of data. WellCare’s telephony and network infrastructure is fully redundant which significantly reduces the probability that a single event (e.g., component failure) will result in an outage. WellCare’s data center is hosted at a highly secure, fully redundant commercial hosting center. Exhibit R.3.c provides the technology infrastructure for our information systems suite.

WellCare proactively monitors systems 24 hours a day, 7 days a week. We staff systems engineers, network technicians, and production support personnel through three shifts, 24 hours per day. WellCare has implemented tools that provide the appropriate level of alerting, alarming, and management required to ensure a stable and secure computing environment. WellCare IT has an institutionalized SWAT process to ensure recovery time for critical issues, typically in minutes. We follow a root-cause analysis process to ensure that remediation follows every downtime incident and a permanent fix is implemented where needed.

### Disaster Recovery

WellCare understands the criticality of disaster recovery. We maintain a comprehensive IT business continuity and disaster recovery plan, designed to provide immediate response and subsequent recovery from any unplanned business interruption, such as a loss of utility service, building evacuation, or a catastrophic event such as a major fire. The WellCare IT business continuity disaster recovery plan are complementary to the WellCare emergency preparedness plan (EPP) discussed in Section M. Collectively IT plans address the following scenarios:

- The central computer installation and resident software are destroyed or damaged;
- System interruption or failure resulting from network, operating hardware, software, or operational errors that compromise the integrity of:
  - Transactions that are active in a live system at the time of the outage;
  - Data maintained in a live or archival system; and
  - Transactions or data maintained in a live or archival system, but does prevent access to the system

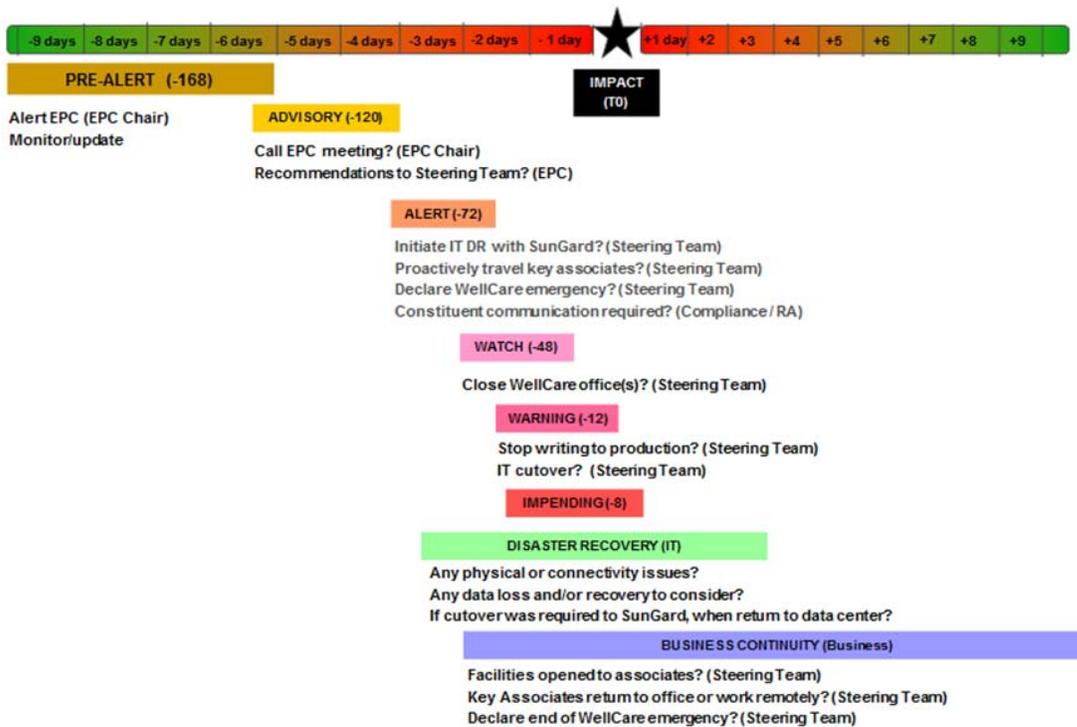
WellCare is contracted with SunGard Planning Solutions for the enterprise business continuity and disaster recovery plan (BC-DR), which addresses catastrophic failures and disasters. It includes hardware and software redundancies along with utilizing a daily, weekly, monthly, and yearly tape backup on-site/off-site storage and retention plan. The contracted business

continuity services include providing redundant mobile devices, workstations, telecommunication systems, and networking and data infrastructure at a cold site for continuing operations after a catastrophic disaster. The disaster recovery plan was tested successfully in May 2011 with SunGard Planning Solutions, and is annually revised and tested to ensure functionality and success.

The following diagram (Exhibit R.3.b) illustrates the planning scenario for a disaster resulting from a major hurricane. This scenario is the basis for our annual testing.

**Exhibit R.3.b – Hurricane Preparedness**

## 2011 EPC Timeline: Hurricane Scenario



**Exhibit R.3.c – Information Systems Suite Applications and Technology Infrastructure**

Key Production Sub-System	Key Functions	Enterprise Application	Hardware Platform	OS Platform	Database Platform
Member Enrollment	Enrollment processing Reconciliation Capitation validation Customer Service	Core Processing System	IBM Power 795	IBM AIX 6.1	Oracle Enterprise 11g 11.2.0.1
	Fulfillment and correspondence tracking	Fulfillment and Communication System	VMWare ESX - HP 495 Blades/IBM Power 795	Windows 2008 Enterprise Edition Service Pack 2, 64 bit/ IBM AIX 6.1	Oracle Enterprise 11g 11.2.0.2
Case Management, Care Coordination and Quality Reporting	Care coordination and oversight Member health status assessment Care plan development Service utilization Outcomes evaluation and reporting	Enterprise Medical Management Application	VMWare ESX - HP 495 Blades	Windows 2008 Enterprise Edition Service Pack 2, 64 bit	MS SQL Server Enterprise 2008 R2
	HEDIS EPSDT	Quality Reporting System	IBM Power 795	IBM AIX 6.1	Oracle 10g Enterprise Edition 10.2.0.5
Provider Payment and Network Management	Provider contracts Provider credentialing Network monitoring Payment processing Data exchanges of provider network Information	Core Processing System	IBM Power 795	IBM AIX 6.1	Oracle Enterprise 11g 11.2.0.1

Key Production Sub-System	Key Functions	Enterprise Application	Hardware Platform	OS Platform	Database Platform
Claims Payment	Claims intake (electronic and paper) Claims validation and editing Adjudication	Core Processing System	IBM Power 795	IBM AIX 6.1	Oracle Enterprise 11g 11.2.0.1
Encounter Data	Encounter submission and reporting Data validation Data exchange	Encounters Processing System	VMWare ESX - HP 495 Blades - IBM Power 795	Windows 2008 Enterprise Edition Service Pack 2, 64 bit - IBM AIX 6.1	Oracle Enterprise 11g 11.2.0.1 – MS SQL Server Enterprise 2008 R2
Reporting and Program Management	Financial Member Services Provider Services Health Services Related	Enterprise data Warehouse	IBM Power 795	IBM AIX 6.1	Oracle Enterprise 11g 11.2.0.2
Call Center	Call center statistics System availability data Satisfaction survey data	Call Center Statistics Global Navigator 4.05	NECExpress/ 5800	SCO Unix	N/A
Financial Data	System of record for revenue and expense transactions Financial statement information	Oracle Financials DB/APP	IBM Power 795	IBM AIX 6.1	Oracle Enterprise 11g 11.2.0.2

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## R.4

### *Describe in detail:*

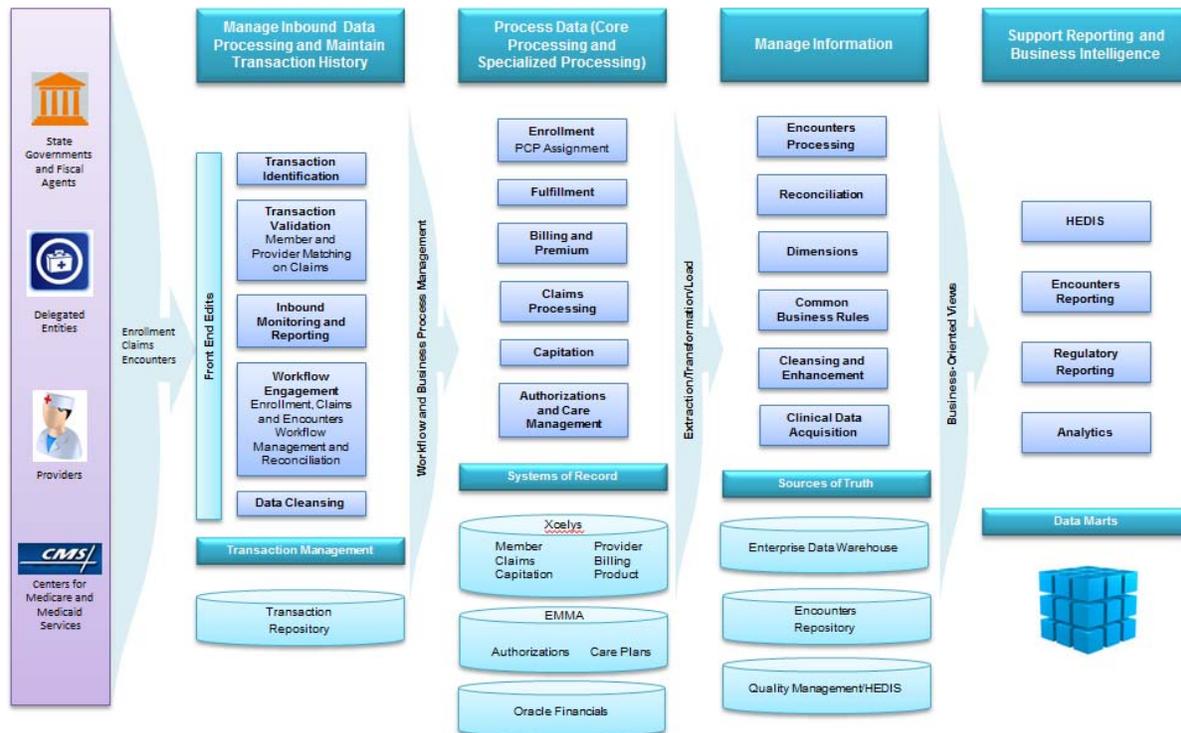
- ***How your key production systems are designed to interoperate. In your response address all of the following:***
  - ***How identical or closely related data elements in different systems are named, formatted and maintained:***
    - ***Are the data elements named consistently;***
    - ***Are the data elements formatted similarly (# of characters, type-text, numeric, etc.);***
    - ***Are the data elements updated/refreshed with the same frequency or in similar cycles; and***
    - ***Are the data elements updated/refreshed in the same manner (manual input, data exchange, automated function, etc.).***
  - ***All exchanges of data between key production systems.***
    - ***How each data exchange is triggered: a manually initiated process, an automated process, etc.***
    - ***The frequency/periodicity of each data exchange: “real-time” (through a live point to-point interface or an interface “engine”), daily/nightly as triggered by a system processing job, biweekly, monthly, etc.***
- ***As part of your response, provide diagrams that illustrate:***
  - ***point-to-point interfaces,***
  - ***information flows,***
  - ***internal controls and***
  - ***the networking arrangement (AKA “network diagram”) associated with the information systems profiled.***

***These diagrams should provide insight into how your Systems will be organized and interact with DHH systems for the purposes of exchanging Information and automating and/or facilitating specific functions associated with the Louisiana Medicaid CCN Program.***

### **Interoperable Design**

The WellCare information systems suite is designed to be robust, flexible, interoperable and standards-based. Interoperability is based on an Enterprise Service Oriented Architecture built on our Enterprise Service Bus. The integrated suite supports service-based interfaces to all of our systems with some services available to our subcontractors and to government agency clients. For example, all authorizations are stored in EMMA as part of the utilization management function. Once an authorization is approved, a web service is executed by EMMA to add the authorization to CPS where it is used to authorize the claim. The integrated suite also uses extraction, transformation, and load capabilities based on Informatica Power Center. WellCare has built a very flexible data interfacing capability for processing data and for maintaining data in a consistent format across all sources of data. Exhibit R.4.a below illustrates the information flow through WellCare’s information systems suite.

### Exhibit R.4.a – Information Flow



WellCare’s information management strategy is standards based. Transaction data is received in standard formats such as HIPAA X12 electronic transactions. This data, when received and validated is stored in our Transaction Management repository where data elements are named in a manner that is consistent with the X12 transaction set. When possible, the data element format (e.g., # of characters, type-text, numeric, etc.) is preserved as data is processed in our applications such as EES, CPS, and EMMA, WellCare names data elements consistently across systems and in the enterprise data warehouse (EDW) when possible. Because some of our systems are vendor supplied, not all of our data elements can be named consistently. In these cases, when data is moved from one system to another, we use our standard mapping tools, both web service based and batch based, to define standard mappings from the data element in one system to the data element in another system or in the enterprise data warehouse. These rules are maintained and, when applicable, services are reused to maintain data element integrity.

Our information management strategy and our system architecture are designed to eliminate the need to maintain redundant data across systems. Data is available in real-time through our web services as part of our service-oriented architecture. For systems such as EDW, the data elements are updated and refreshed within 24 hours through daily/nightly processes as triggered by pre-defined system processing needs (e.g., job, biweekly, monthly, etc.).

When possible, data elements are updated or refreshed using the web services available in our service oriented architecture or through our standard extraction, transformation, and load capability. The exchange of data in this manner is most often triggered or initiated on demand or through our automated scheduler.

## Management Information System Information Flows

The hub of WellCare’s information system is WellCare’s core processing system (CPS), based on the Dell Services Xcelys platform. CPS supports all of WellCare’s member, provider, case management and reporting functions.

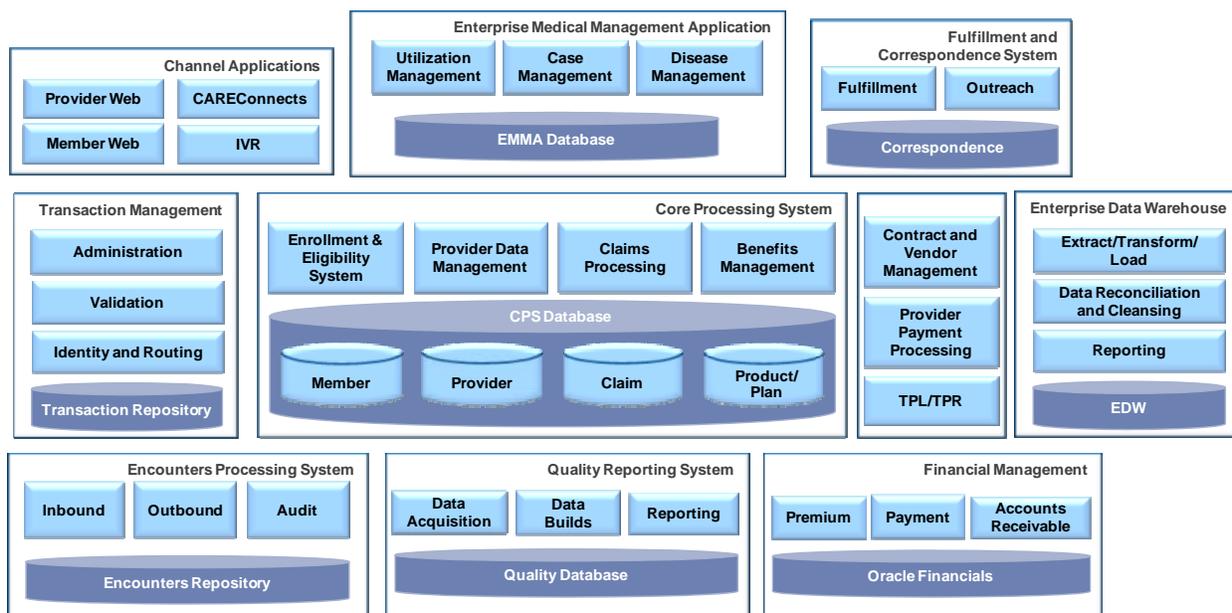
Our enhanced electronic enrollment processing application, enrollment and eligibility system (EES), has the capability to receive, process and update enrollment data daily into our core payer system. This application tracks and reconciles each individual transaction from receipt, through membership update and on to delivery of identification cards through the U.S. mail.

WellCare’s assessment, planning and coordination functions are supported by our Enterprise Medical Management Application (EMMA). EMMA provides the foundation for the development of a customized case management and care coordination system to provide patient-centered case management and care coordination services to our members.

WellCare’s clinical performance measurement and improvement efforts are supported by our HEDIS system, McKesson’s CareEnhance Resource Management Software (CRMS), version 5.73, by providing an integrated clinical and financial view of care delivery. Furthermore, CRMS includes CareEnhance HealthPlan Reporter, an application that streamlines the complex HEDIS reporting process by centralizing existing claims, membership, medical record and other narrative information the user selects, creating a single source of “clean” data.

Exhibit R.4.b provides an overview of the key applications in WellCare’s information systems suite.

### Exhibit R.4.b – Key Production Subsystems



## Member Processing

Member processing is anchored by WellCare's enrollment and eligibility system (EES) and fulfillment and correspondence system, which include the following functions:

- Electronic receipt of enrollment rosters
- Validation and reconciliation of enrollment records
- Generation of error reports
- Generation of fulfillment materials
- Maintenance of all current and historical data
- EPSDT services and correspondence
- Capitation validation
- Transfer of enrollment data to CPS
- Provider selection and assignment
- Correspondence delivery
- Processing of TPL data
- Eligibility data distribution

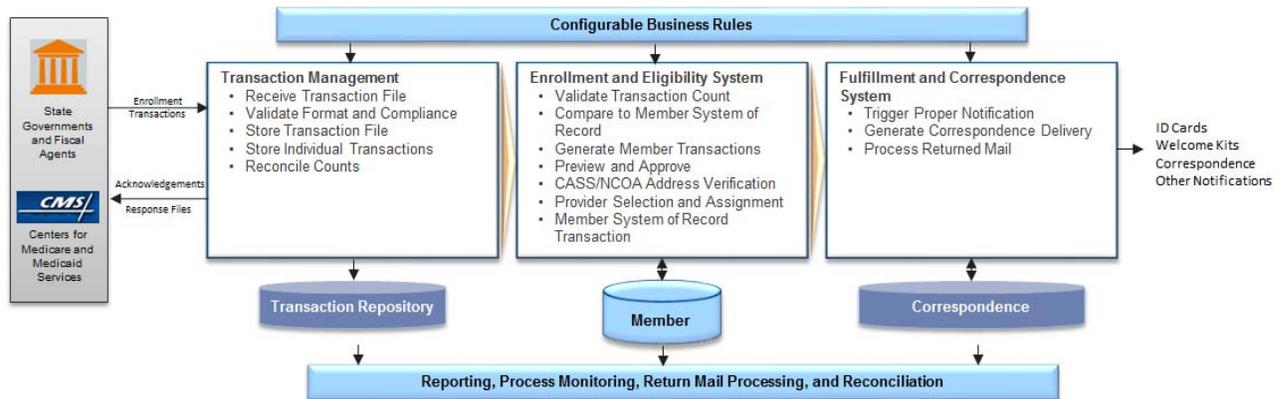
WellCare will obtain enrollment/disenrollment rosters and third party liability data electronically. Our EES and fulfillment and correspondence system process enrollment transactions for multiple states and have the capacity to receive and send data in the structure and format required by the State.

The enrollment roster is validated through a series of edits to confirm the completeness and accuracy of enrollment records. Edits include confirmation of permissible values within each field (including null), and comparison of identifying and demographic data to previously-loaded member records (e.g., birth date, address).

After electronic processing of enrollment/eligibility files, should any errors arise, an error report is generated from the system for manual review. Member enrollment analysts review every record contained in the error report to reconcile and correct any discrepancies. Upon completion of the manual review, an error report is generated which includes any member records that may have incomplete or inaccurate information. This report will be forwarded to DHH via the specified file transfer protocols. Enrollment rosters also are reconciled with capitation reports to ensure that payments (by rate cell) tie to enrollment. Any discrepancies between capitation payment amounts and enrollment rosters will be reported to DHH for reconciliation.

Upon receipt of all enrollment/eligibility files, WellCare will place the files into a queue for timely processing. WellCare maintains a corporate policy to ensure that all files are processed and the enrollment database is fully updated within 24 hours of receipt of the enrollment roster. Please refer to Exhibit R.4.c for an illustration of the member subsystem.

### Exhibit R.4.c – WellCare Member Subsystem



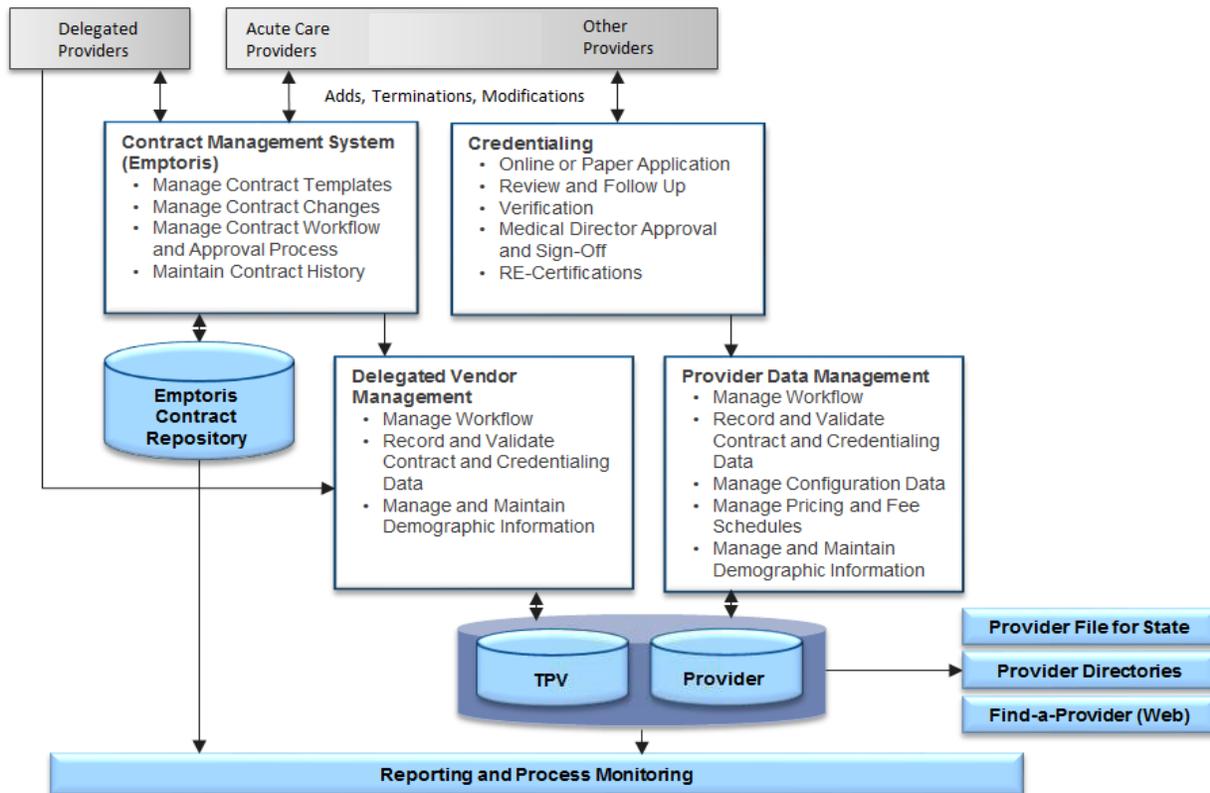
### Provider Processing

The provider subsystem is responsible for provider data management including demographic, credentialing and contract data. Network providers are credentialed through our credentialing process. Data for credentialed providers is sent and loaded into the core processing system. Delegated vendors send detailed provider information, which is also loaded into the core processing system. The provider network information will be transmitted on the desired frequency to DHH in the DHH-specified format. Both network and out-of-network providers will be sent according to DHH requirements. DHH response files then will be processed to identify errors and resubmitted when reconciliation is complete.

WellCare has recently migrated to an enterprise-wide contract management system (Emptoris) which helps streamline the end-to-end contract management process for providers, procurement, and vendors. Some of the benefits provided by Emptoris are improved cost management through the use of standardized contract language; and improved operations with more robust contract version control and an efficient approval and execution process.

Exhibit R.4.d outlines the processes for credentialing and contracting, and the framework for loading providers into CPS. This is a proven and scalable process that is fully capable of meeting the capacity required by DHH and providing data in the required structure and format.

## Exhibit R.4.d – Credentialing and Contracting Processes



## Encounter/Claims Processing Subsystem

WellCare's claims processing system and procedures meet all of DHH's requirements and are designed to ensure that claims are paid and reported accurately and timely. WellCare will use our existing platform, CPS, to process claims. CPS is fully integrated with other systems, permitting the free flow of member, provider, encounter and financial data. The claims processing/encounter subsystem captures all service data, including medical supplies, using standards as rendered by medical providers to all eligible members. The subsystem is capable of tracing the encounter anywhere within the system using the unique identification number.

Key encounter/claims processing subsystem functions include:

- Intake – WellCare receives provider claims in both electronic and paper formats, and supports batch billing. WellCare works with major clearinghouses. Paper claims are electronically scanned, manually reviewed for accuracy, and converted to an electronic claim format.
- Validation and Editing – A series of automated SNIP (Strategic National Implementation Process) edits are applied to claims received to identify any issues related to accuracy or completeness. Claims that fail one or more edits are returned to the provider for correction and resubmission. Additional front-end edits are applied to validate provider and member information. Claims that fail these edits are routed to a work queue for

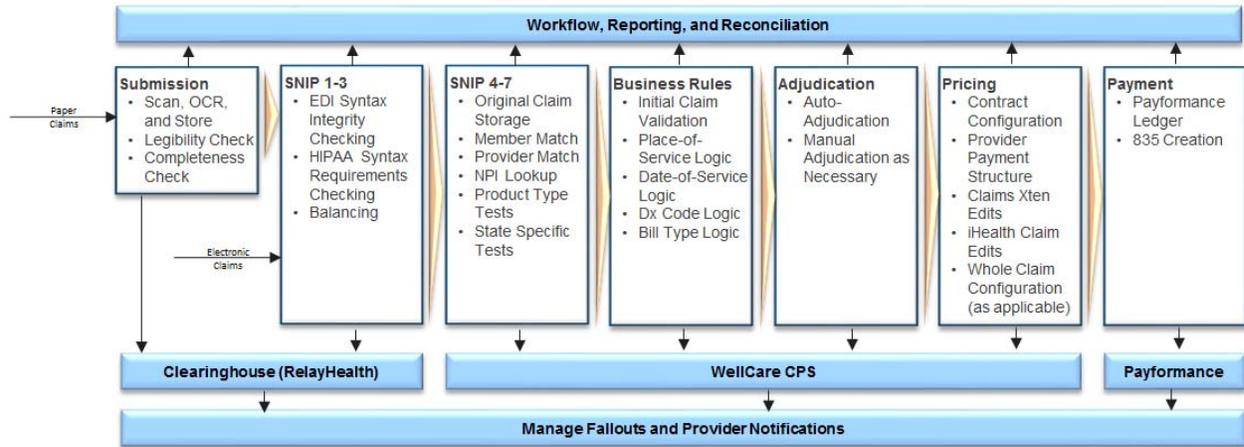
manual review and validation. Claims that cannot be corrected are returned to the provider.

- Adjudication – Once determined to be complete, claims are entered into CPS and adjudicated by the fully integrated platform, relying on member, utilization management, and provider data. A comprehensive set of edits are applied to test the validity of codes (e.g., diagnoses, revenue codes, procedure codes), test relationships across data elements (e.g., gender/procedure code, procedure code/place of service), and review for adherence to clinical policy and correct coding.
- Reporting – A payable claim is routed for payment processing. The claim is also captured in WellCare's encounters processing system (EPS). Claims that are not paid are returned to the provider with a detailed explanation of why the claim could not be paid or requesting additional information for payment, if appropriate.
- Audit – WellCare utilizes a claim audit trail provided by CPS for recording and tracking all actions taken on the claim. WellCare also has a dedicated audit function that performs monthly, statistically valid, claims audits for financial, payment and clerical accuracy. Additionally, the auditors conduct routine focused audits of claims processors, audits of top providers, and audits of high dollar claims.

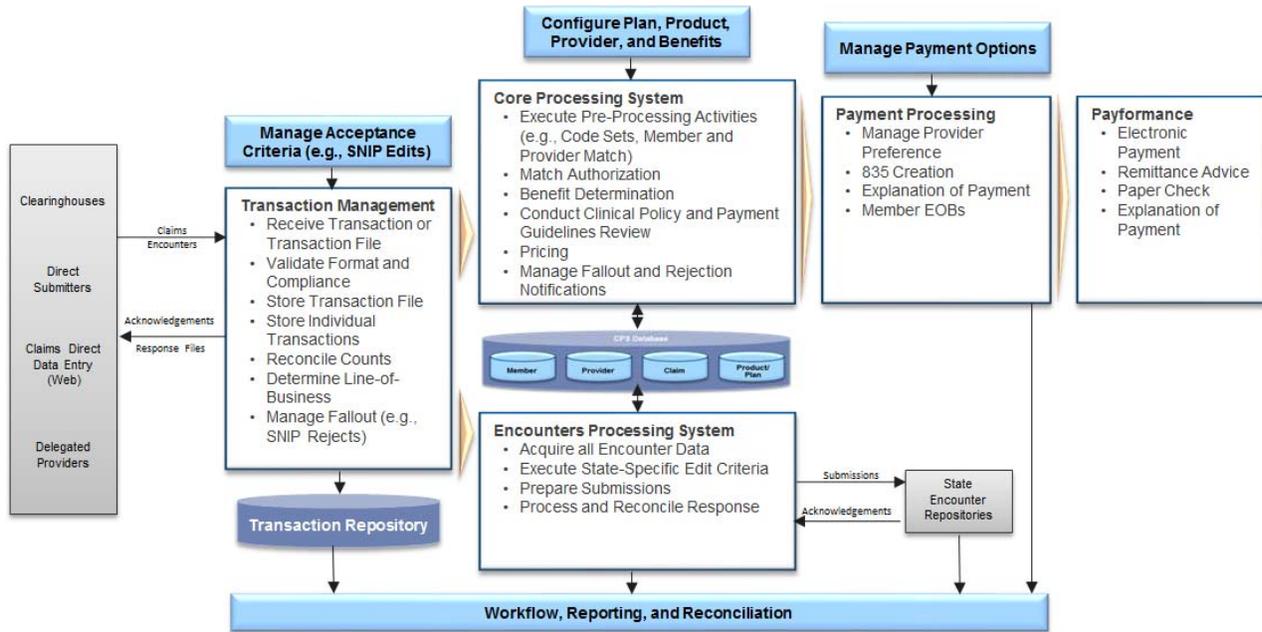
WellCare provides three channels for providers to submit claims and encounter data: (1) paper forms (e.g., 1500, UB-04) (2) HIPAA standard EDI format (e.g., 837 EDI 4010/5010) and (3) easy-to-use web interface where the providers can manually enter in the encounter data. After a claim has been received it is processed through a series of business rules to validate the provider and member information as well as evaluate the propriety of the information on the claim (e.g., validate that the diagnosis and procedure codes are current for the dates of service). Where issues are identified with the claim, a manual review is performed to validate if a correction is necessary. After the business rules are applied, the claim is adjudicated through CPS using member, provider, claim, and history information to determine the appropriate payment and outcome. The claim is then processed through check run for payment.

Exhibit R.4.e illustrates the claims front-end workflow process while Exhibit R.4.f shows the interactivity between CPS and EPS. As mentioned previously, CPS has the capacity to meet provider requirements for claims processing and payment and to provide data in the structure and format required by DHH.

### Exhibit R.4.e – Claims Front-end Workflow Process



### Exhibit R.4.f – WellCare Claims and Encounter Processing Overview

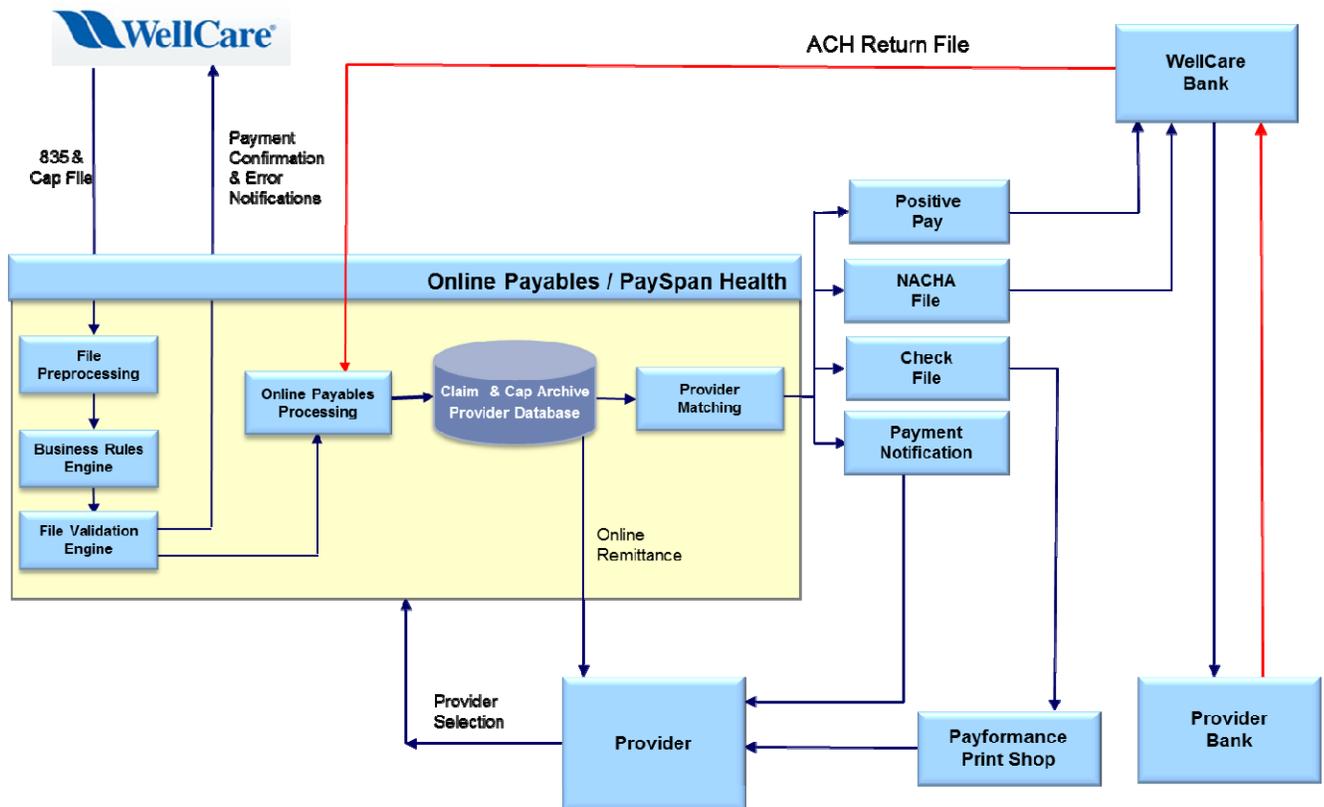


### Financial Subsystem

The financial subsystem uses Oracle Financials database and applications for interfacing with users and other key production subsystems. This subsystem is responsible for collecting and storing data and information related to revenue and expense transactions, and financial statement information. All financial data is stored and processed according to generally accepted accounting principles (GAAP) guidelines.

WellCare has an existing contract with Payformance to facilitate payments to our network providers. WellCare retains accountability for all claims processing and payment functions and associated service level agreements. See Exhibit R.4.g for a summary diagram of the relationship between WellCare’s management information system and Payformance’s payment process.

**Exhibit R.4.g – WellCare Provider Electronic Funds Transfer Process**



Formed in 1985, Payformance provides electronic funds transfer (EFT) and electronic remittance advice (ERA) services to over 3,500 clients, both providers and payers, in every state across the country. PaySpan Health, Payformance’s propriety automated payment solution, is an adjudicated claims settlement solution that optimizes the payer’s payment process and facilitates the delivery of both electronic and paper payment and remittance data to health care providers. The solution offers a transaction-based service that payers can utilize to create on their behalf HIPAA 835 formatted electronic notices and the delivery of remittances to providers. Providers also are provided with a self-service environment to manage electronic payments, access ERAs, and retrieve historical settlement information.

Providers will be notified that they must register and how to do so online with Payformance to receive payments via direct deposit. Providers will submit claims for payment to WellCare. Then we transmit information for claims to be paid, via HIPAA-compliant 835 files, to Payformance for processing. Payformance then sends payment instructions to WellCare’s financial institution and notifies the provider via e-mail of the payment. Finally, an EFT is remitted from WellCare’s financial institution to the provider’s designated financial institution. Providers have the ability,

via the provider portal, to review/search claims histories, ERAs, settlement information, and directly download 835 files.

WellCare's financial subsystem and Payformance's payment processing capability have the system capacity to provide data in the structure and format required by the State.

#### Utilization/Quality Improvement Processing

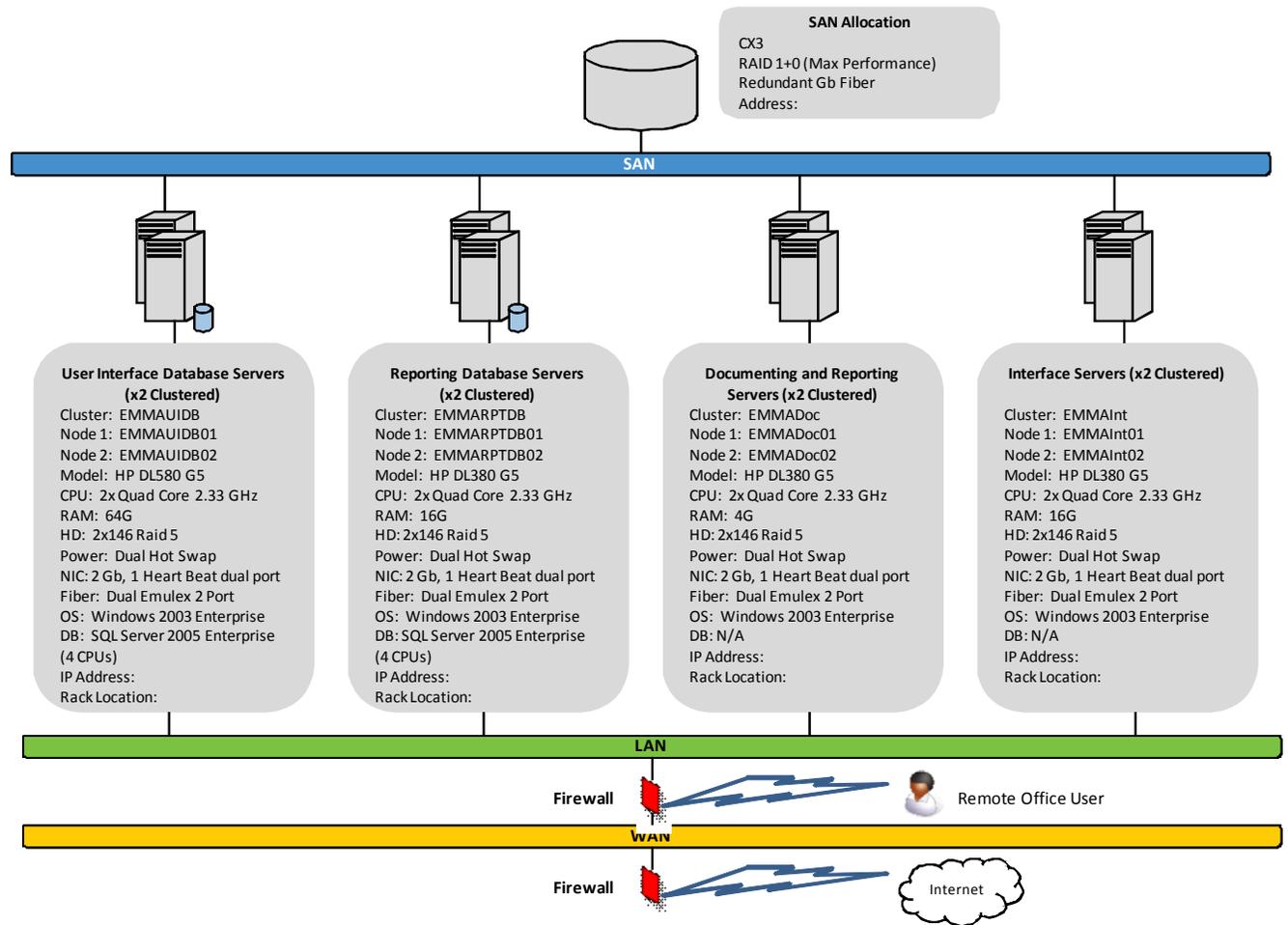
Utilization management and quality improvement will be managed using EMMA. The customer relationship management capabilities of EMMA enable our care coordinators and other clinicians to effectively manage services for our members, regardless of the complexity of their medical or social needs. EMMA, which is used today to support our existing programs, is functionally very rich and provides users with member, provider, claims, authorization, customer contact and pharmacy data organized in a patient-centered way to facilitate improved health delivery. At a glance, a case manager, care coordinator, or fully authorized service representative can view each member's current and historical records of services, including services performed by any ancillary vendors.

Member, provider and claims data will be provided to EMMA via interfaces with CPS. WellCare accepts authorization requests through our self service provider web application, fax, telephone, or mail. EMMA will send service authorizations to CPS via the interface between the two systems. Data collected by EMMA will be applied to automated, predictive modeling algorithms that are designed to improve care outcomes. Assessment and service data will be applied to customized predictive algorithms to identify problems, goals and interventions. These algorithms support the care planning process by identifying the optimal level of services to improve outcomes. Exhibit R.4.h below outlines the architecture and design of EMMA.

As mentioned previously, our information system application suite also includes our HEDIS system, CRMS, which provides an integrated clinical and financial view of care delivery to measure and improve performance. CRMS also streamlines HEDIS reporting processes by centralizing member information, claims/encounter data, medical records, and data from state registries and narrative information to create a single source of retrospective medical, service and case management data.

WellCare's medical management application, EMMA, and our quality reporting system based on CRMS have demonstrated the ability to support the system capacity to data structure and format required by DHH.

**Exhibit R.4.h – WellCare’s Enterprise Medical Management Application (EMMA)**



**Reporting Subsystem**

The reporting subsystem is used for reporting and program management, including data-driven analysis of business functions throughout the organization and generation of most contractually-required reports. The integration of WellCare’s information system enables us to generate routine, custom and ad hoc reports that are both accurate and timely. WellCare relies on standard management reports to assess performance of individual business units and ensure compliance with all reporting obligations. The system includes real time data analysis and reporting functions to support the following activities:

- Financial transaction
- Financial reporting
- Fraud and abuse
- Other Reports as required
- Call Center monitoring
- Grievances and Appeals
- Claims processing

As a function of our integrated system, each system has the reporting capacity to provide data in the structure and format required by the State.

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**R.5**

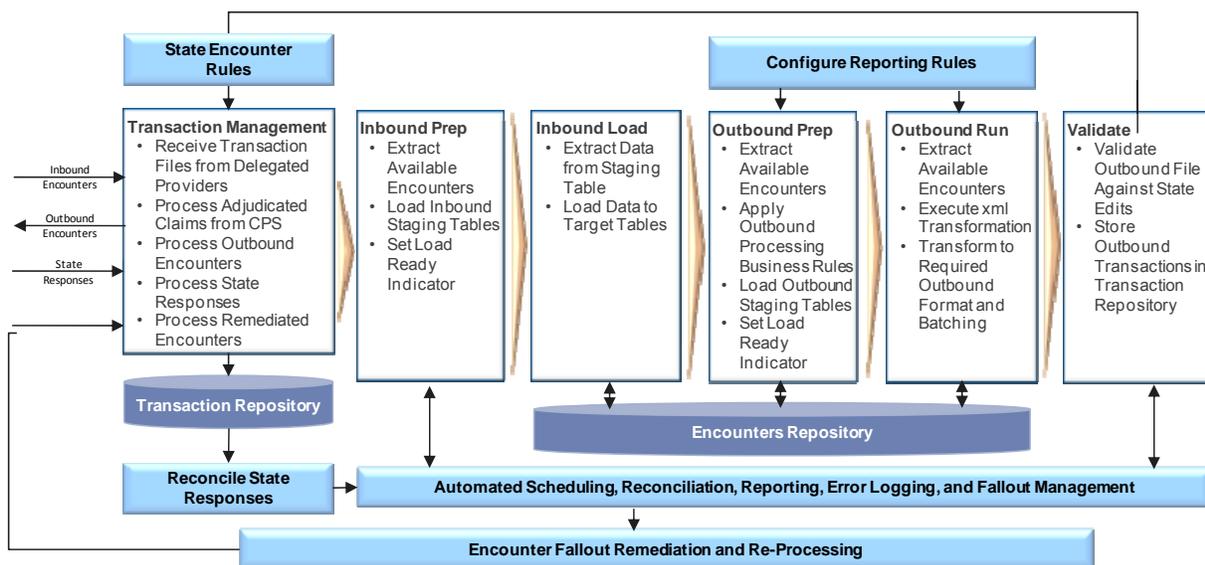
**Describe your ability to provide and store encounter data in accordance with the requirements in this RFP. In your response:**

- **Explain whether and how your systems meet (or exceed) each of these requirements.**
- **Cite at least three currently-live instances where you are successfully providing encounter data in accordance with DHH coding, data exchange format and transmission standards and specifications or similar standards and specifications, with at least two of these instances involving the provision of encounter information from providers with whom you have capitation arrangements. In elaborating on these instances, address all of the requirements in Section 17. Also, explain how that experience will apply to the Louisiana Medicaid CCN Program.**
- **If you are not able at present to meet a particular requirement contained in the aforementioned section, identify the applicable requirement and discuss the effort and time you will need to meet said requirement.**
- **Identify challenges and “lessons learned” from your implementation and operations experience in other states and describe how you will apply these lessons to this contract.**

**Encounter/Claims Processing Subsystem**

Encounter data processing, submission and reporting for the CCN program will be performed at the WellCare corporate level. WellCare maintains our encounter processing system (EPS), within our information system suite. WellCare has reviewed DHH requirements and attests that EPS manages and validates all necessary data elements for submitting encounter data in the required format. Exhibit R.5.a provides an overview of WellCare’s member enrollment file processing system.

**Exhibit R.5.a – WellCare Encounters Processing**



WellCare currently receives and submits encounter data through secure FTP for all our Medicaid lines of business. We have the capability to support other forms of submissions as requested by the State. The submission files are batched either based on number of encounters, region, line of business, or claim type as required by the State.

WellCare's integrated suite provides the capability to define the encounter data elements that must be included in encounters. A series of automated SNIP edits are applied to received claims and capitated encounters to identify any issues related to accuracy, completeness, and compliance with DHH billing manuals. Claims or encounters that fail one or more edits are returned to the provider for correction and resubmission. Additional front end edits are applied to validate provider and member information. Claims or encounters that fail these edits are output to a work queue for manual review. Claims that cannot be corrected are returned to the provider. WellCare will configure the edits to align the data requirements of the CCN-P Systems Companion Guide.

Non-Medical encounters including dental, vision, hearing, transportation as well as certain types of medical-related claims including DME are received from vendors and processed through our transaction manager. All encounters will be submitted in accordance with DHH provided 837 formats for professional, institutional, and ancillary encounters. WellCare has a steering committee charged with addressing all applicable aspects of the Affordable Care Act (ACA), including Section 6507 regarding National Correct Coding Initiatives.

The submission files are batched (based on number of encounters, region, line of business, or claim type) as required by the State or FI companion guide. WellCare submits voids and or replacements to report any adjustments. The submissions of the voids and replacements are supported through the X12 format specifications. We currently have this capability for Georgia, Florida, and Missouri. Using our transaction manager and Health Transaction Repository (HTR), WellCare stores and maintains all encounter data in preparation for submission.

WellCare currently receives and processes error reports from all our Medicaid states. The error reports that we currently support are TA1s, 997s, 835s, 824s, 277s and proprietary formats as requested by the state or fiscal intermediaries. The errors are resolved within 30, 60 or 90 days in accordance with the service levels defined by each State. For Louisiana we will address 90 percent of reported repairable errors within 30 calendar days and 99 percent of reported repairable errors within 60 calendar days. We maintain greater than 95 percent acceptance rate with Georgia, Florida and Missouri. WellCare receives denial codes in our response files from Florida and Georgia similar to the codes mentioned in the RFP. We receive both repairable and non-repairable edits. WellCare is familiar with the edits and we currently have the capability to resolve these issues in a timely manner and resubmit them to the State.

Within 60 days of operation in the geographic service areas, our system will be ready to submit encounter data to the FI in the required format. Any encounter data received from our subcontractors will be compiled into one file for submission. WellCare will test readiness with our transaction manager to certify HIPAA transactions prior to submitting encounter data to the FI. Any submission which contains fatal errors that prevent processing or that do not satisfy defined threshold error rates, will be corrected immediately and resubmitted to the FI. Our staff is will be trained to address all FI exception codes and dispositions for the purpose of repairing denied encounters.

WellCare will submit 95 percent of encounter data at least monthly no later than the 25th calendar day of the month following the month in which they were processed and approved/paid unless a different time frame is approved by DHH:

Prior to submission of encounter data, WellCare will ensure that the data complies with our internal quality controls and corporate compliance procedures. WellCare will certify the accuracy, completeness and truthfulness of encounter data and provide a letter of certification with every submission, in accordance with 42 CFR 438.604 and 438.606. EPS includes a scheduling component to ensure that encounter data is submitted in accordance with DHH submission timelines. EPS tracks the timeliness and completeness of provider claims/encounters on a monthly basis and compares the volume of current month submissions to historical data. If a provider's volume falls below the expected range, the provider is contacted to ascertain whether a problem occurred in the data feed or if all encounters have in fact been submitted.

WellCare will submit encounters records such that payment for discrete services which may have been submitted in a single claim can be determined in accordance with WellCare's applicable reimbursement methodology for that service.

WellCare currently has the capability to report certain denials or zero paid encounters as requested by the State. We currently support a similar request from Georgia and Florida markets (refer to Exhibit R.5.b).

**Exhibit R.5.b – Experience with Encounters in Other States**

	Florida	Georgia	Missouri
<b>Batching Capability</b>	<p>The batching solution is capable of supporting the following batching needs of Florida 837 extracts submission in ANSI X12 standards</p> <p>a) Only one Interchange (ISA/IEA) per logical file</p> <p>b) 5000 CLM segments within a ST/SE envelope</p>	<p>The batching solution is capable of supporting the following batching needs of Georgia 837 extracts submission in ANSI X12 standards</p> <p>a) Only one Interchange (ISA/IEA) per logical file</p> <p>b) 5000 CLM segments within a ST/SE envelope</p> <p>c) Multiple files are created based on the region code (L1000A NM109) value</p>	<p>The batching solution is capable of supporting the following batching needs of Missouri 837 extracts submission in ANSI X12 standards</p> <p>a) Each encounter is wrapped in a transaction set (ST/SE)</p> <p>b) No limit to the number of encounters within an ISA interchange</p> <p>c) Only one ISA interchange within a file</p>
<b>Batching Configurations</b>	<p>a) Line of business</p> <p>b) Claim type</p> <p>c) Total number of claims in a file</p> <p>d) Total number of claims in a batch</p>	<p>a) Claim type</p> <p>b) Total number of claims in a file</p> <p>c) Total number of claims in a batch</p>	<p>a) Claim type</p> <p>b) Total number of claims in a file</p> <p>c) Total number of claims in a batch</p>
<b>Transmission</b>	Secured transmission Via FTP	Secured transmission Via FTP	Secured transmission Via FTP

	Florida	Georgia	Missouri
<b>Capitation Arrangement</b>	Capitated encounters are processed along with regular encounters	Capitated encounters are processed along with regular encounters	Capitated encounters are processed along with regular encounters
<b>Submission Timelines</b>	Monthly	Monthly	Monthly
<b>Submission Percentage</b>	>95%	>95%	>95%
<b>Archive Process</b>	Automatic archival of files after submission	Automatic archival of files after submission	Automatic archival of files after submission

## Lessons Learned

- Align FFS companion guide with encounters companion guide. States which have established encounter submission criteria that is different than from the criteria for claim submission have inadvertently created confusion for providers. We have worked with one State partner in particular to better align the companion guides and make it easier for providers to submit claims to a CCN plan and a fee-for-service system.
- Provide flexibility on the criteria for atypical encounters. Allowing for some flexibility in the criteria applied to some transportation encounters and home-based services enables improved submission rates. WellCare has worked with multiple state partners to facilitate a near 100% encounter submission success rate.
- Inbound and Outbound Data Quality -The Encounters Processing system is currently being re-engineered in multiple phases in order to improve the quality of encounters /claims received inbound to WellCare. The quality of our outbound submissions has also been improved through these enhancements. Additionally, we aspire to reduce the complexity of the system and increase maintainability, and increase quality of internal processing.
  - The first two phases were implemented in 2010. This included implementing industry standard front-end SNIP (Strategic National Implementation Process) edits. The SNIP core purpose is to improve the quality, affordability and availability of health care through effective and efficient information exchange and management.
  - The front-end SNIP edits ensure that key pieces of claims data and file formats on X12 transactions sent to WellCare are syntactically correct and complete, as submitted by providers, before they are permitted to enter WellCare systems.
- Implementation of State Requirements companion guide - Coding standards and logic correlating directly to Companion Guide requirements have presented challenges in getting to a complete, efficient and accurate process to submit/receive encounters. We have found that exchanging a wide array of test files spanning over multiple rounds of testing, both submission and response, have made an immeasurable impact on meeting contract requirements as well as state expectations.

## R.6

**Describe your ability to receive, process, and update eligibility/enrollment, provider data, and encounter data to and from the Department and its agents. In your response:**

- **Explain whether and how your systems meet (or exceed) each of these requirements.**
- **Cite at least three currently-live instances where you are successfully receiving, processing and updating eligibility/enrollment data in accordance with DHH coding, data exchange format and transmission standards and specifications or similar standards and specifications. In elaborating on these instances, address all of the requirements in Sections 16 and 17, and CCN-P Systems Companion Guide. Also, explain how that experience will apply to the Louisiana Medicaid CCN Program.**
- **If you are not able at present to meet a particular requirement contained in the aforementioned sections, identify the applicable requirement and discuss the effort and time you will need to meet said requirement.**
- **Identify challenges and “lessons learned” from implementation in other states and describe how you will apply these lessons to this contract.**

### Receiving, Processing, and Updating Enrollment Data

WellCare will receive enrollment/disenrollment rosters and third party liability data electronically from the State and/or enrollment broker. The enrollment roster will be validated through a series of edits to confirm the completeness and accuracy of enrollment records. Edits include confirmation of permissible values within each field (including null), and comparison of identifying and demographic data to previously-loaded member records (e.g., birth date, address) to identify any potential duplicates. In addition to using the Medicaid ID, all members receive a WellCare member ID. Should any member disenroll from WellCare and then return, matching edits are in place to ensure that the member receives the same WellCare ID upon re-enrollment.

An error report is generated from the system for manual review. Member enrollment analysts review every record contained in the error report to reconcile and correct any discrepancies. Upon completion of the manual review, an error report is generated which includes any member records that may have incomplete or inaccurate information. This report will be forwarded to DHH via the specified file transfer protocols. Enrollment rosters also are reconciled with capitation reports to ensure that payments (by rate cell) tie to enrollment. Any discrepancies between capitation payment amounts and enrollment rosters will be reported to DHH.

WellCare maintains a corporate policy and has implemented procedures to update the enrollment database within 24 hours of receipt of the enrollment roster. The automated enrollment process concludes with delivery of plan materials and ID cards for new members. Exhibit R.6.a provides an overview of WellCare’s member enrollment file processing system. Depending on the size of the enrollment file, this process typically takes only several minutes to process and the new or revised membership is fully viewable by approved internal staff immediately upon processing.

WellCare’s Enrollment Eligibility System (EES) is used to support nearly identical 834-based processing for Medicaid in New York, Illinois, Missouri, Ohio, Georgia, Hawai’i and Florida. In

several of these states, there are multiple lines of business. For each of these states, WellCare is successfully receiving, processing and updating eligibility/enrollment data in a manner that is consistent with DHH coding, data exchange format and transmission standards and specifications. This standard framework provides a scalable, robust, proven solution which, while adaptable to State-specific companion guides, is highly re-usable. This platform will be used to support the Louisiana eligibility processing as well.

### Lessons Learned

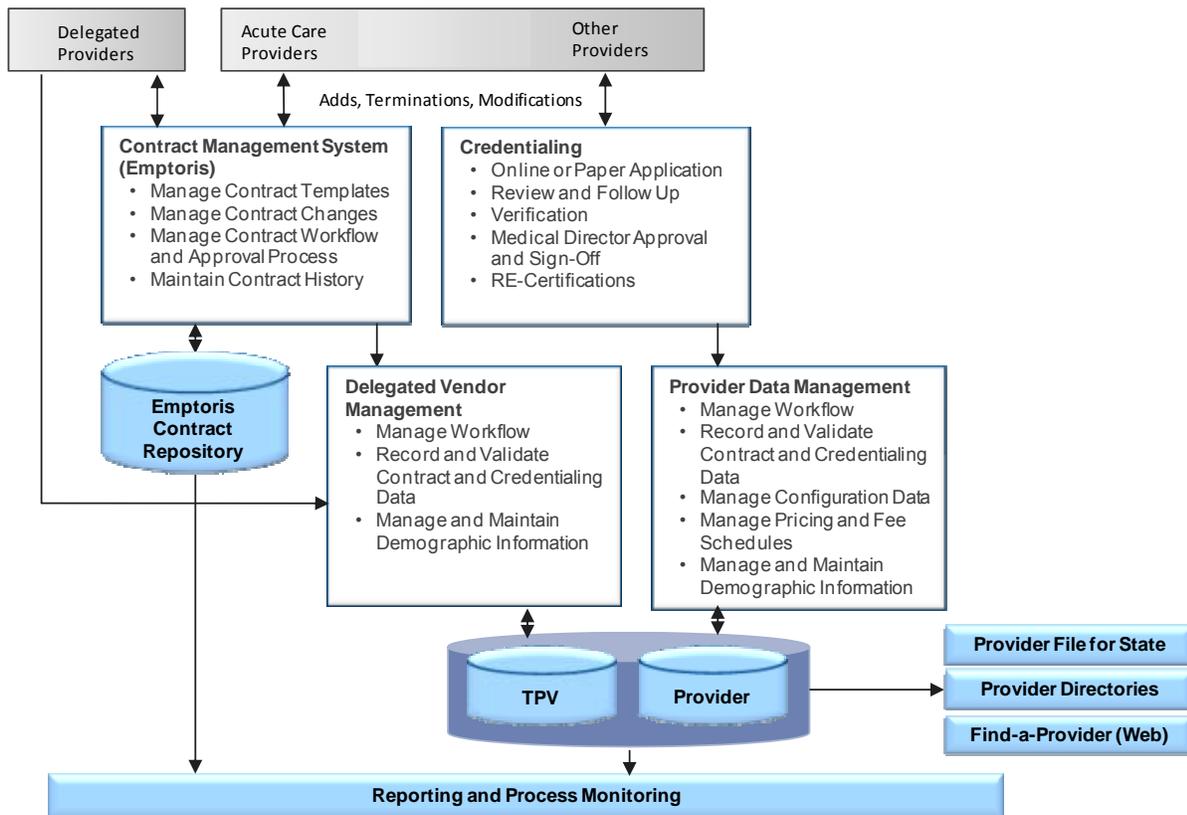
- One state fiscal intermediary (FI) has implemented a quarterly reconciliation process. WellCare submits a quarterly 834 eligibility file to the state FI. The state FI generates a similar quarterly file, compares the results, and identifies variances. This method of ensuring that the State and WellCare enrollment records improves the overall enrollment process and enables an effective reconciliation and issue resolution process. WellCare would welcome the opportunity to work with DHH on this or a similar process for enrollment reconciliation.
- WellCare has experienced challenges with the use of eligibility qualifiers within the 834 as applied to eligibility date vs. benefit date. Companion guides are not always clear in whether the change applies retroactively or from current date forward. In our review of the companion guide, WellCare would ensure thorough review and clarification on this topic during the implementation activities including confirmation of any interpretation of the companion guide with DHH.
- WellCare has worked with multiple State partners and FIs on the resolution of enrollment duplicates where the same individual has multiple Medicaid IDs. While the volume has traditionally been low, it is our experience that resolution can be challenging. WellCare would welcome the opportunity to work with DHH on this or a similar process for enrollment reconciliation.

### **Receiving, Processing, and Updating Provider Data**

The provider database is fully integrated within CPS and maintains provider records for purposes of monitoring office locations, services available, credentialing status and payment rates. The provider database also is the foundation for network analysis to ensure WellCare meets or exceeds all program access standards. Each state has a unique system to issue and maintain master provider files. WellCare will work with DHH to ensure a seamless transfer of information to meet the requirements. In some of our other states, we provide a bi-weekly or monthly update to the state roster (in the proper format). For example, in Hawai'i, we provide a bi-weekly update document with any new or changed provider information along with a quarterly full provider file.

The provider subsystem is also responsible for provider credentialing and contracting processes. Network providers are credentialed through our credentialing application. Data for credentialed providers is sent and loaded electronically into the core payer system, where provider contracts are finalized. Delegated vendors are sent proprietary files of detailed provider information, which is stored in a third party database. The provider network information will be transmitted on the desired frequency to DHH in the DHH-specified format; both network and out-of-network providers will be sent according to DHH requirements. DHH response files then will be processed to identify errors and resubmitted when reconciliation is complete. Exhibit R.6.a outlines the process for credentialing, contracting and loading providers into our CPS.

**Exhibit R.6.a – WellCare Provider Credentialing, Contracting and Loading Process**



**Receiving, Processing, and Updating Encounter Data**

Information regarding encounter data can be found in Section R.5

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**R.7**

**Describe the ability within your systems to meet (or exceed) each of the requirements in Section §16. Address each requirement. If you are not able at present to meet a particular requirement contained in the aforementioned section, identify the applicable requirement and discuss the effort and time you will need to meet said requirement.**

WellCare’s current systems will meet or exceed contract requirements as described in Exhibit R.7.a below.

**Exhibit R.7.a – WellCare’s Capabilities**

Section	RFP Requirement	WellCare Meet/Exceed	WellCare’s Capabilities
16.1.1.	The CCN shall maintain an automated Management Information System (MIS), hereafter referred to as System, which accepts and processes provider claims, verifies eligibility, collects and reports encounter data and validates prior authorization and pre-certification that complies with DHH and federal reporting requirements...	Meets	WellCare maintains a fully integrated, automated Management Information System to support DHH’s requirements including claims, enrollment, encounter, and reporting
16.1.2.	The CCN’s application systems foundation shall employ the relational data modeling its database architecture, which would entail the utilization of a relational database management system (RDBMS) such as Oracle®, DB2®, or SQL Server®	Meets	WellCare’s application system consists of an open architecture built on standard technologies, such as Oracle 11g and Java/J2EE, enabling seamless integration with other applications to support all of WellCare’s member, provider, case management and reporting functions
16.1.3.	All the CCN’s applications, operating software, middleware, and networking hardware and software shall be able to interoperate as needed with DHH’s systems and shall conform to applicable standards and specifications set by DHH.	Meets	WellCare’s applications, operation systems, software and hardware are fully able to interoperate as required to support DHH
16.1.4.	The CCN’s System shall have, and maintain, capacity sufficient to handle the workload projected for the begin date of operations and shall be scalable and flexible so that it can be adapted as needed, within negotiated timeframes, in response to changes in the Contract requirements.	Meets	WellCare confirms that all systems are designed to be fully scalable and flexible to meet requirements of DHH

Section	RFP Requirement	WellCare Meet/Exceed	WellCare's Capabilities
16.2.1.	The System shall be able to transmit, receive and process data in current HIPAA compliant or DHH specific formats and/or methods, including, but not limited to, secure File Transfer Protocol (FTP) over a secure connection such as a Virtual Private Network (VPN), that are in use at the start of Systems readiness review activities...	Meets	WellCare's system is fully able to support transmittal, receipt and processing of all data in a HIPAA compliant format. WellCare uses secure FTP as its standard format for such transactions
16.2.2.	All HIPAA-conforming exchanges of data between DHH and the CCN shall be subjected to the highest level of compliance as measured using an industry standard HIPAA compliance checker The System shall conform to the following HIPAA-compliant standards for information exchange. Batch transaction types include, but are not limited to, the following:	Meets	WellCare ensures that all data transfers follow specific HIPAA compliant protocol
16.2.3.1	ASC X12N 834 Benefit Enrollment and Maintenance;	Meets	WellCare fully supports X12 transactions
16.2.3.2	ASC X12N 835 Claims Payment Remittance Advice Transaction;	Meets	
16.2.3.3	ASC X12N 837I Institutional Claim/Encounter Transaction;	Meets	
16.2.3.4	ASC X12N 837P Professional Claim/Encounter Transaction;	Meets	
16.2.3.5	ASC X12N 270/271 Eligibility/Benefit Inquiry/Response;	Meets	
16.2.3.6	ASC X12N 276 Claims Status Inquiry;	Meets	
16.2.3.7	ASC X12N 277 Claims Status Response;	Meets	
16.2.3.8	ASC X12N 278/279 Utilization Review Inquiry/Response	Meets	
16.2.3.9	ASC X12N 820 Payroll Deducted and Other Group Premium Payment for Insurance Products.	Meets	

## R.8

***Describe your information systems change management and version control processes. In your description address your production control operations.***

### **Change Management Process**

WellCare uses a formal change management policy and procedures to ensure that changes are properly communicated, coordinated, tested and authorized prior to being introduced to a production environment.

WellCare has established corporate procedures that outline the requirements for standard and emergency change management processes. The procedures are used for changes to production networks, operating systems, application software, databases, telecommunications and hardware that is managed or maintained by WellCare.

Change requests are initiated through the need for system enhancements, upgrades, or defect remediation. There are three types of change requests:

- **Planned Change** – A change that follows the standard change control board (CCB) process and is implemented in the designated release schedule.
- **Critical Change** – A change that requires implementation outside of the designated release schedule. All necessary approvals must be obtained and documented in a change request form prior to implementation.
- **Emergency Change (Efix)** – A change that requires immediate implementation. The necessary approvals are obtained prior to implementation.

Version control is maintained by formal change request documentation, as mentioned above. During this process, any modifications to DHH business rules from contract inception are tracked via project change request to mitigate operational gaps related to version controls issues. WellCare uses the BMC Service Desk Express ticketing system (Magic) for change requests, incident reporting, and work order tracking. A Magic ticket is used to initiate a change request and to maintain the documentation of the change as part of the change record. The ticket also documents an assessment of the risk level, the complexity, and the impacts, including the user groups, systems, and services being impacted. The IT employee responsible for documenting these details of the change is known as the IT change owner.

Planned and critical changes are subject to testing prior to implementation. This may include unit testing, integration (QA) testing, and user acceptance testing (UAT). Prior to implementation, the appropriate level of management from quality assurance (QA Manager or QA Lead) evaluates the testing and approves or rejects the change. The application development team is responsible for performing the unit testing. Once unit testing has been completed, a code promotion form is sent to QA along with the unit testing results. The quality assurance team reviews the changes for evidence of unit testing before proceeding to execute QA testing for the change. If no unit testing has been performed the change is returned to the application development team. Testing activities performed are documented in the change form and any supporting documentation is stored in the designated repository. The results of QA testing are also documented in the WellCare quality center (QC) system. Changes affecting a user application are also subject to UAT and business area approval of UAT. The QA team

coordinates with the business users to execute the UAT. The UAT results are also documented in QC, and the user is required to approve the change on the UAT form.

The QA manager (or QA lead analyst) is a core member of the CCB and is the primary evaluator of the testing standard. The QA manager inspects each change request and evaluates the level of testing to offer their approval or rejection accordingly. Additionally, all members of the CCB are expected to review and, if necessary, question the level of testing and approve or reject accordingly.

Changes must be approved by the appropriate CCB members prior to implementation. Approvals are documented in the Magic change ticket or via e-mail and attached to the Magic ticket. Required approvals include the business owner, quality assurance, IT department manager, and either corporate compliance or the CCB Lead. Approvals are also required from each group identified as a deplorer. The Magic ticket is disseminated to the approvers, and each approver responds with an approval/rejection of the change. Magic maintains all of the approvals in the ticket as part of the overall change record and in adherence to SOX compliance. If no business approval is required, a justification for no approval is documented in the ticket. Emergency changes (eFix) (classified as Severity (SEV) 1 or SEV 2) require the approval of at least two direct reports to the CIO. The End User Verification of an eFix would suffice for the validation that the change is correct and that it is approved.

The change control board (CCB) meets once a month for content review and once a month to review and approve planned changes scheduled for implementation. The CCB is comprised of the change control lead and a representative member from release management, IT infrastructure, quality assurance, corporate compliance or IT security, application support, technology service desk, telecom, and the DBA group. Each IT change requestor attends to present the proposed changes. Each change is discussed and reviewed to ensure that all pertinent data is recorded on the request form and that all required approvals have been received and documented for the request. If a change is rejected by any member, the change is put on hold until the issue is resolved. When testing is completed and approvals are obtained, the change is scheduled for implementation.

For all change requests, a rollout and back-out plan is required. These are used to guide the deployers during implementation and, in the event an issue occurs, how to return the system to pre-implementation condition. The use of tabs within the ticket, allows deployers and developers to add individualized instructions for specific issues and concerns.

Modifications to production libraries and in-scope databases are reconciled, via a weekly audit report, to confirm only approved changes were implemented. Reconciliation is done by release management to the production libraries for the specified reporting period, while IT compliance reconciles the database object changes for the same period.

## R.9

**Describe your approach to demonstrating the readiness of your information systems to DHH prior to the start date of operations. At a minimum your description must address:**

- **provider contract loads and associated business rules;**
- **eligibility/enrollment data loads and associated business rules;**
- **claims processing and adjudication logic; and**
- **encounter generation and validation prior to submission to DHH.**

WellCare's approach to readiness activities is to leverage its development and deployment lifecycles to simulate production outcomes as closely as possible prior to production use.

WellCare leverages the fact that provider contracting and benefit information is a configuration activity within its CIS, and therefore the actual information for these key elements are able to be copied and used in the test environment. These key data elements also require completion well in advance of production use.

As a final readiness test, after the provider, provider contracting, and benefit configuration activities are completed in the production environment, WellCare will migrate a full copy of the production environment into the appropriate user acceptance testing (UAT) environment, complete with all the configuration data above. WellCare then executes a series of tests to validate the processing results. These tests include, but are not limited to:

- A full cycle run of a test 834 eligibility file (preferably received from DHH) from end to end, beginning with the simulated receipt of the file, through the staging, loading, and updating processes, and concluding with the validation of all ID Card, welcome kit, and other correspondence generation. This test completes the validation of the eligibility processing and also validates portions of provider contracting and benefit configuration.
- A full cycle run of test claims (professional and institutional) from simulated receipt of the data files through the loading, adjudication, pricing, code and clinical editing processes, and ending with the generation of 835 payments. This test completes the validation of the entire claims cycle and in particular validates the remainder of the provider contracting and benefit configuration.
- In addition to the inclusion of the test claims above, a full set of test encounters will be loaded into the encounters processing system, starting with the loading of the data files. The complete load, validation, selection, and output generation cycles – ending with the 837 outputs – will be generated and reviewed. This cycle completes the validation of the entire encounters processing system, including all claim types and payment methodologies.
- For other operational functions, such as provider capitation payments, authorization entry, and customer service events (e.g., provider file exchange and testing), WellCare executes similar end-to-end tests. Additionally, some of these tests (such as authorization processing) support and interact with the claims testing cycles.

In each of these end-to-end test cycles, the processing results are reviewed and validated against the expected, documented outcomes, ensuring that production results are predictable and match WellCare and DHH expectations.

### **Provider Contracts**

All provider contracts are properly loaded and associated business rules are applied. The provider contracting team oversees the contracting and credentialing process. Once provider contracts are obtained, a full and detailed credentialing process occurs prior to loading into our provider management system.

### **Enrollment File Processing**

All processes necessary to ensure correct enrollment file processing will be completed. The enrollment team, under the supervision of the project manager ensures that the enrollment file will be properly received and processed per the requirements. The team will use State provided companion guides to ensure strict compliance with State guidelines.

### **Claim Logic**

All adjudication and claim logic will be completed in advance of commencing CCN operations. The claims team oversees the configuration to the claims management system to ensure that all claims received are adjudicated and paid appropriately.

### **Encounter Generation and Validation**

All necessary activities surrounding encounter preparation will be completed. The encounters team will ensure that all encounter requirements are met. The team will use State provided companion guides to ensure strict compliance with State guidelines.

## R.10

**Describe your reporting and data analytic capabilities including:**

- **generation and provision to the State of the management reports prescribed in the RFP;**
- **generation and provision to the State of reports on request;**
- **the ability in a secure, inquiry-only environment for authorized DHH staff to create and/or generate reports out of your systems on an ad-hoc basis; and**
- **Reporting back to providers within the network.**

For all regulatory and state-mandated reports, WellCare uses a formal development lifecycle to document requirements, technical specifications, and test cases along with formal change control and project management functions. All such regulatory reporting requirements are tracked and monitored by the information technology (IT) operations area for timely submission. This monitoring includes status reporting of submissions during daily morning IT operational meetings.

WellCare's reporting subsystem consists of real-time reporting capabilities that support day-to-day health plan operations and an analytical decision support component that allows us to make informed decisions regarding health plan activities as well as comply with all client reporting requirements. Our reporting subsystem is both integrated and interfaced. Our reporting mechanism is integrated with other core systems including member/eligibility, financial, provider, encounter/claims processing, and utilization /quality improvement /assurance. It also supports a variety of activities.

### **Generation and Provision of State Management Reports**

The reporting subsystem has the capability to generate reports in various formats. We have a proven track record of responding to any and all state requests. WellCare is able to respond quickly because of our use of industry standard relational database storage within Oracle. WellCare's reporting subsystem uses several enterprise data extract tools including SAS, SQL, and PL/SQL.

DHH can be given access to our secure web portal, which gives constituents the autonomy needed to interact with WellCare's systems on an ad-hoc basis in a secure, inquiry-only environment. The self-service model is a value-added alternative to our traditional service mechanisms. Our strong web presence has a high degree of interactive functionality and time-tested ease of use, but uses secure socket layer (SSL) technology, which encrypts communication between the client and the server to ensure data security. The portal empowers constituents to perform numerous administrative functions and obtain the data they need. Users can access the portal to perform the following functions:

- Check on the status of a claim: View and download a complete claims history or specific claim.
- Verify eligibility: Confirm eligibility by keying in the member's identification (ID) number.
- View referrals: Referrals may be viewed via the website.
- Look up a provider: View the entire provider network or search for a specific provider.

- View resources: Access plan information, including the provider handbook and other health education and medical resources.
- Generate reports: Collect data in a format of the user's preference; reports can be sorted and downloaded in several formats including Excel, PDF, Word, and Rich Text Format. Currently WellCare produces several hundred different reports to meet specific requirements of each client state. Some states have specific PDF requirements, while others mandate Excel formats. WellCare is flexible enough to support each requirement. Once developed, our automated scheduler will kick-off the report in accordance with the established process and deliver accordingly.

WellCare will map all contract requirements tied to reporting within our Compliance 360 application. We can define in this application report specifications, owners, due dates, and other business rule tie-backs to work required within the core processing system to support any and all reporting elements defined under Section 18 of the RFP. WellCare provides provider membership reports on a not less than monthly basis to ensure that the providers are kept abreast of the latest membership rolls. A provider can always view eligibility 24/7 via our secure web portal.

For any delegated vendors, WellCare works with the vendor to ensure full transfer capability and to ensure that membership is properly transferred on a not less than monthly basis. Some vendors have a weekly data feed and others utilize a bi-weekly document in X12 834 format.

## **R.11**

***Provide a detailed profile of the key information systems within your span of control.***

### **Management Information System Requirements**

WellCare believes the value of a management information system (MIS) is ultimately determined by its ability to allow for efficient and accurate claims adjudication; to promote quality of care through effective case management tools; and to provide the data management and reporting capabilities necessary for assessing the positive impact we are having on our members. The WellCare MIS achieves these objectives, and is capable of supporting and meeting all the requirements of the FITAP, LaCHIP and ABD/SSI programs.

### **Management Information System**

The hub of WellCare's information system is WellCare's core processing system (CPS), based on the Dell Services Xcelys platform. WellCare has been utilizing this platform for years to support all of our current Medicaid and Medicare business. WellCare's CPS consists of an open architecture built on standard technologies, such as Oracle 11g and Java/J2EE, enabling seamless integration with other applications to support all of WellCare's member, provider, case management and reporting functions. The WellCare CPS is scalable in its present form to support a doubling of our membership.

WellCare's assessment, planning and coordination functions are supported by our Enterprise Medical Management Application (EMMA). EMMA provides the foundation for the development of a customized case management and care coordination system to provide patient-centered case management and care coordination services to our members.

WellCare's clinical performance measurement and improvement efforts are supported by our HEDIS system, McKesson's CareEnhance Resource Management Software (CRMS), version 5.73, by providing an integrated clinical and financial view of care delivery. Furthermore, CRMS includes CareEnhance HealthPlan Reporter, an application that streamlines the complex HEDIS reporting process by centralizing existing claims, membership, medical record and other narrative information the user selects, creating a single source of "clean" data.

Our enhanced electronic enrollment processing application, enrollment and eligibility system (EES), has the capability to receive, process and update enrollment data daily into our core payer system. This application tracks and reconciles each individual transaction from receipt, through membership update and on to delivery of identification cards into the U.S. mail. Exhibit R.11.a provides an overview of the key functions (production subsystems) managed by the WellCare information system. Exhibit R.11.b below provides a summary of production subsystem hardware and system architecture specifications.

**Exhibit R.11.a – Key Production Subsystems**

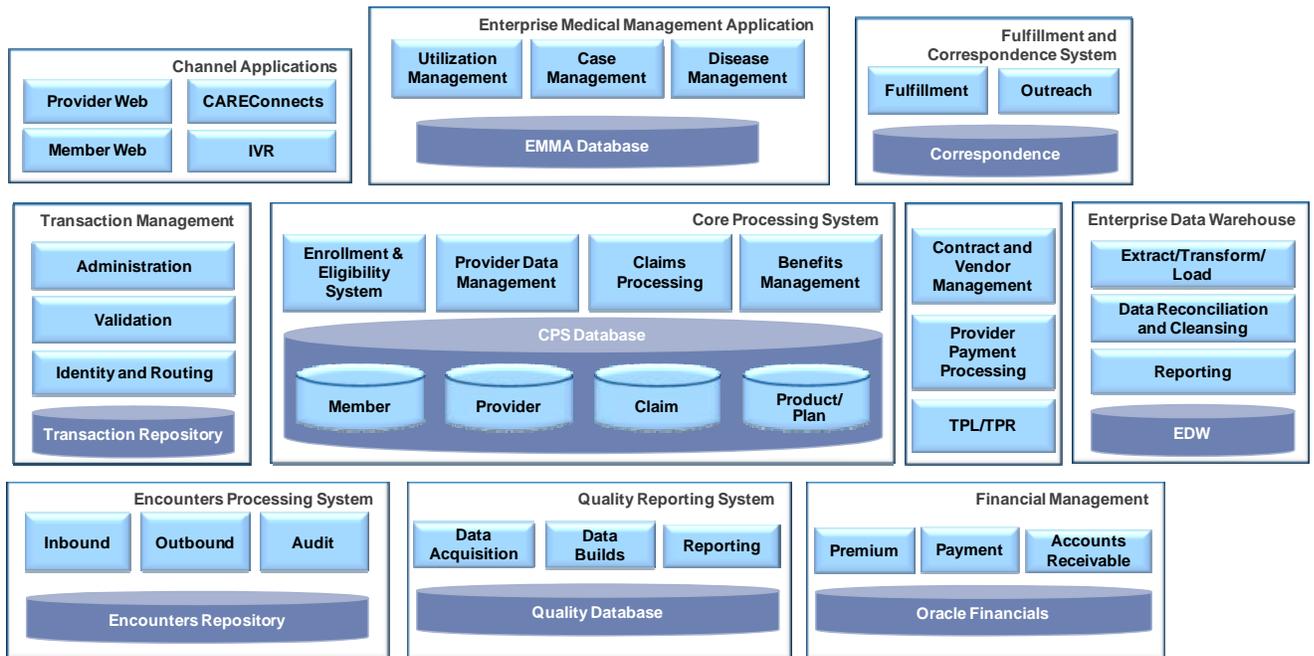


Exhibit R.11.b below shows a detailed breakdown of the key production sub-systems with application, hardware platform, operating system platform, and database platform for each.

**Exhibit R.11.b – Key Production Subsystems**

Key Production Sub-System	Key Functions	Enterprise Application	Hardware Platform	OS Platform	Database Platform
Member Enrollment	Enrollment processing Reconciliation Capitation validation Customer Service	Core Processing System	IBM Power 795	IBM AIX 6.1	Oracle Enterprise 11g 11.2.0.1
	Fulfillment and correspondence tracking	Fulfillment and Communication System	VMWare ESX - HP 495 Blades/IBM Power 795	Windows 2008 Enterprise Edition Service Pack 2, 64 bit/ IBM AIX 6.1	Oracle Enterprise 11g 11.2.0.2
Case Management, Care Coordination and Quality Reporting	Care coordination and oversight Member health status assessment Care plan development Service utilization Outcomes evaluation and reporting	Enterprise Medical Management Application	VMWare ESX - HP 495 Blades	Windows 2008 Enterprise Edition Service Pack 2, 64 bit	MS SQL Server Enterprise 2008 R2
	HEDIS EPSDT	Quality Reporting System	IBM Power 795	IBM AIX 6.1	Oracle 10g Enterprise Edition 10.2.0.5
Provider Payment and Network Management	Provider contracts Provider credentialing Network monitoring Payment processing Data exchanges of provider network	Core Processing System	IBM Power 795	IBM AIX 6.1	Oracle Enterprise 11g 11.2.0.1

Key Production Sub-System	Key Functions	Enterprise Application	Hardware Platform	OS Platform	Database Platform
	Information				
Claims Payment	Claims intake (electronic and paper) Claims validation and editing Adjudication	Core Processing System	IBM Power 795	IBM AIX 6.1	Oracle Enterprise 11g 11.2.0.1
Encounter Data	Encounter submission and reporting Data validation Data exchange	Encounters Processing System	VMWare ESX - HP 495 Blades - IBM Power 795	Windows 2008 Enterprise Edition Service Pack 2, 64 bit - IBM AIX 6.1	Oracle Enterprise 11g 11.2.0.1 – MS SQL Server Enterprise 2008 R2
Reporting and Program Management	Financial Member Services Provider Services Health Services Related	Enterprise data Warehouse	IBM Power 795	IBM AIX 6.1	Oracle Enterprise 11g 11.2.0.2
Call Center	Call center statistics System availability data Satisfaction survey data	Call Center Statistics Global Navigator 4.05	NECExpress/ 5800	SCO Unix	N/A
Financial Data	System of record for revenue and expense transactions Financial statement information	Oracle Financials DB/APP	IBM Power 795	IBM AIX 6.1	Oracle Enterprise 11g 11.2.0.2

## Key Production Subsystems

### Core Processing System

As stated previously, WellCare's core processing system (CPS) is based on the Dell Services Xcelys platform. WellCare's CPS has the capacity and capabilities to meet the contractual requirements for the CCN program. CPS and our application suite are currently managing over 2.3 million members. CPS has the certified capacity to support more than 6 million additional members and the capacity to process 100,000 transactions and 50,000 claims per hour.

### Member Subsystem

The member subsystem is anchored by WellCare's enrollment and eligibility system (EES) and fulfillment and correspondence system, which include the following functions:

- Electronic receipt of enrollment rosters
- Validation and reconciliation of enrollment records
- Generation of error reports
- Generation of fulfillment materials
- Maintenance of all current and historical data
- Monitoring of EPSDT requirements
- Capitation validation
- Transfer of enrollment data to CPS
- Provider selection and assignment
- Correspondence delivery
- Processing of TPL data
- Triggering of EPSDT correspondence

WellCare will obtain enrollment/disenrollment rosters and third party liability data electronically. Our EES and fulfillment and correspondence system process enrollment transactions for multiple states and have the capacity to receive and send data in the structure and format required by the State.

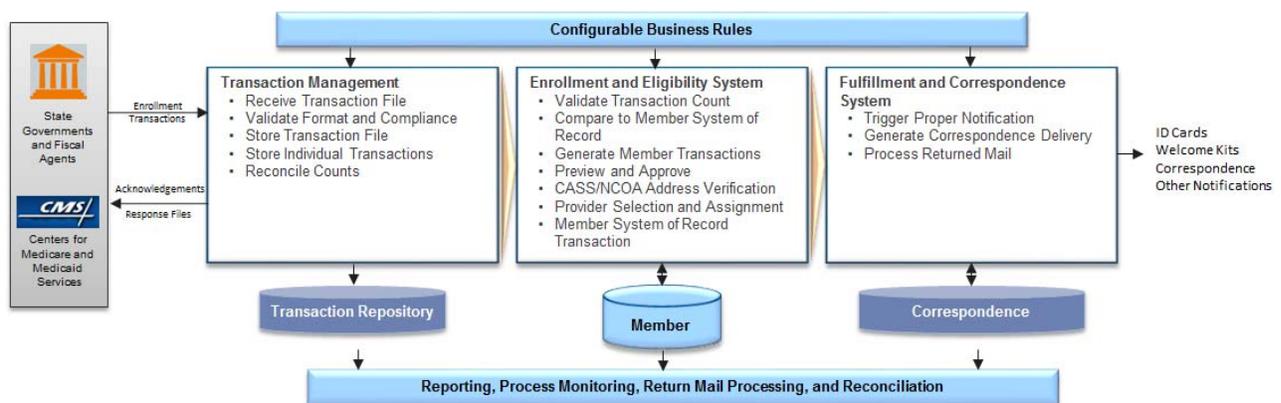
The enrollment roster is validated through a series of edits to confirm the completeness and accuracy of enrollment records. Edits include confirmation of permissible values within each field (including null), and comparison of identifying and demographic data to previously-loaded member records (e.g., birth date, address).

After electronic processing of enrollment/eligibility files, should any errors arise, an error report is generated from the system for manual review. Member enrollment analysts review every record contained in the error report to reconcile and correct any discrepancies. Upon completion of the manual review, an error report is generated which includes any member records that may have incomplete or inaccurate information. This report will be forwarded to DHH via the specified file transfer protocols. Enrollment rosters also are reconciled with capitation reports to ensure that payments (by rate cell) tie to enrollment. Any discrepancies between capitation payment amounts and enrollment rosters will be reported to DHH for reconciliation.

Upon receipt of all enrollment/eligibility files, WellCare will place the files into a queue for timely processing. WellCare maintains a corporate policy to ensure that all files are processed and the enrollment database is fully updated within 24 hours of receipt of the enrollment roster.

Our EES application can process over 10,000 members each hour and over 7 million fulfillment transactions annually. Our Fulfillment and Correspondence system processes and prints ID cards within 48 hours of receipt of new enrollment information. The current average backlog of ID cards is less than 50 per week (across approximately 2.2 million members). On average, over 25,000 member and provider transactions are performed via our provider and member web applications on a daily basis. Exhibit R.11.c provides an overview of WellCare's EES.

### Exhibit R.11.c – WellCare Member Subsystem



### Provider Subsystem

The provider subsystem is responsible for provider data management including demographic, credentialing and contract data. Network providers are credentialed through our credentialing process. Data for credentialed providers is sent and loaded into the core processing system. Delegated vendors send detailed provider information, which is also loaded into the core processing system. The provider network information will be transmitted on the desired frequency to DHH in the DHH-specified format. Both network and out-of-network providers will be sent according to DHH requirements. DHH response files then will be processed to identify errors and resubmitted when reconciliation is complete.

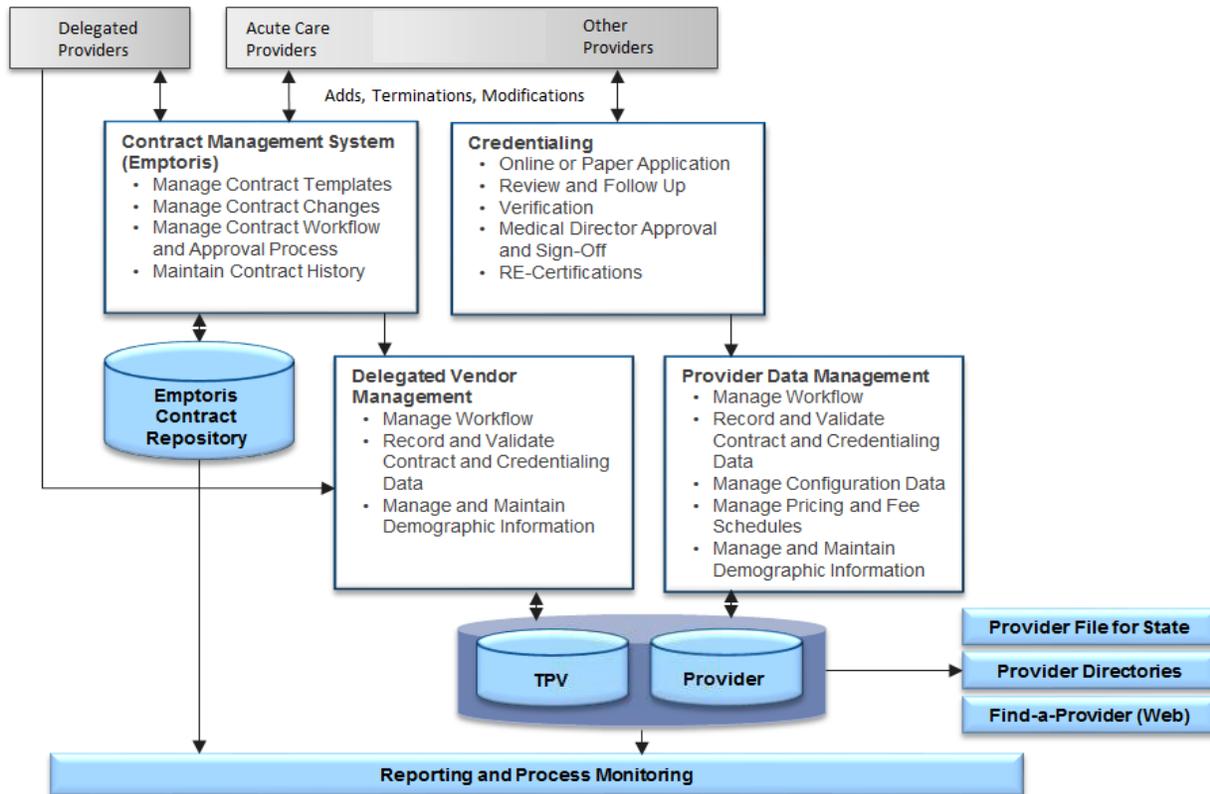
WellCare has recently migrated to an enterprise-wide contract management system (Emptoris) which helps streamline the end-to-end contract management for providers, procurement, and vendors. Some of the benefits provided by Emptoris are:

- Better cost management using standardized contract language; and
- Increased business reliability, with more robust contract version control, and an efficient approval and execution process.

Exhibit R.11.d outlines the processes for credentialing and contracting, and the framework for loading providers into CPS. This is a proven and scalable process that is fully capability of

meeting the capacity required by the State and providing data in the required structure and format.

**Exhibit R.11.d – Credentialing and Contracting Processes**



Encounter/Claims Processing Subsystem

WellCare’s claims processing system and procedures meet all of the requirements of the CCN program and are designed to ensure that claims are paid and reported accurately and timely. WellCare will use our existing platform, CPS, to process CCN claims. CPS is fully integrated with other systems, permitting the free flow of member, provider, encounter and financial data. Encounter data for each state is electronically submitted per the requirements of each state. The claims processing/encounter subsystem captures all service data, including medical supplies, using standards as rendered by medical providers to all eligible members. The subsystem is capable of tracing an encounter anywhere within the system using the unique identification number.

Key Encounter/Claims Processing Subsystem functions include:

- Intake – WellCare receives provider claims in both electronic and paper formats, and supports batch billing. Approximately 88 percent of claims submitted to WellCare are electronic. Paper claims are electronically scanned, manually reviewed for accuracy, and converted to an electronic claim format.

- Validation and Editing – A series of automated SNIP (Strategic National Implementation Process) edits are applied to claims received to identify any issues related to accuracy or completeness. Claims that fail one or more edits are returned to the provider for correction and resubmission. Additional front-end edits are applied to validate provider and member information. Claims that fail these edits are routed to a work queue for manual review and validation. Claims that cannot be corrected are returned to the provider.
- Adjudication – Once determined to be complete, claims are entered into CPS and adjudicated by the fully integrated platform, relying on member, utilization management, and provider data. A comprehensive set of edits are applied to test the validity of codes (e.g., diagnoses, revenue codes, procedure codes) test relationships across data elements (e.g., gender/procedure code, procedure code/place of service), and review for adherence to clinical policy and correct coding.
- Reporting – A payable claim is routed for payment processing. The claim is also captured in WellCare’s encounters processing system (EPS). Claims that are not paid are returned to the provider with a detailed explanation of why the claim could not be paid or requesting additional information for payment, if appropriate.
- Audit – WellCare utilizes a claim audit trail provided by CPS for recording and tracking all actions taken on the claim. WellCare also has a dedicated audit function that performs monthly, statistically valid, claims audits for financial, payment and clerical accuracy. Additionally, the auditors conduct routine focused audits of claims processors, audits of top providers, and audits of high dollar claims. WellCare’s financial accuracy goal is a minimum accuracy of 99 percent, which is routinely exceeded. WellCare has a service level requirement for its claims processing vendor, IBM, of a minimum of 99.5 percent accuracy, and IBM has consistently exceeded that requirement, based on auditing performed by WellCare’s audit team.

WellCare maintains policies and procedures regarding the timeliness and accuracy of claims payment. Since January 2010, WellCare has paid more than 93 percent of clean and unclean claims within 15 days of receipt and 99 percent of clean and unclean claims within 30-days of receipt. Claims timeliness reports are generated on a daily basis and reviewed to ensure that claims are paid within the time frames specified in our policies and procedures, as well as the time frames established by DHH.

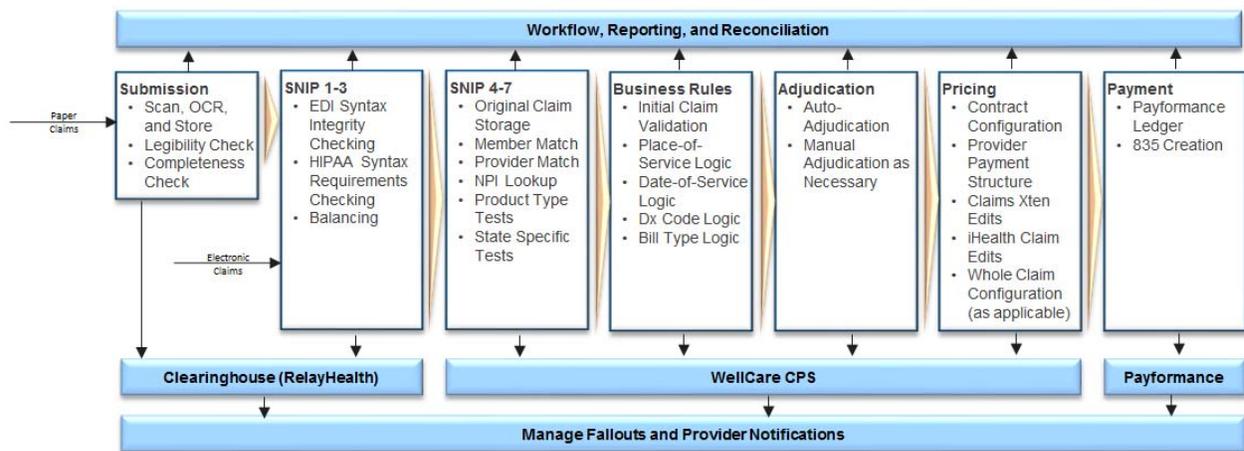
WellCare provides three channels for the providers to submit their claims and encounter data: (1) paper forms (e.g., 1500, UB-04) (2) HIPAA standard EDI format (e.g., 837 EDI 4010/5010) and (3) easy-to-use web interface where the providers can manually enter in the encounter data. After a claim has been received it is processed through a series of business rules to validate the provider and member information as well as evaluate the propriety of the information on the claim (e.g., validate that the diagnosis and procedure codes are current for the dates of service). Where issues are identified with the claim, a manual review is performed to validate if a correction is necessary. After the business rules are applied, the claim is adjudicated through CPS using member, provider, claim, and history information to determine the appropriate payment and outcome. The claim is then processed through check run for payment.

WellCare places a premium on driving an industry-leading EDI claim rate and has a dedicated team of provider connectivity analysts who work directly with the provider community to convert paper claim submitters to electronic submissions. The team understands how the fields of a

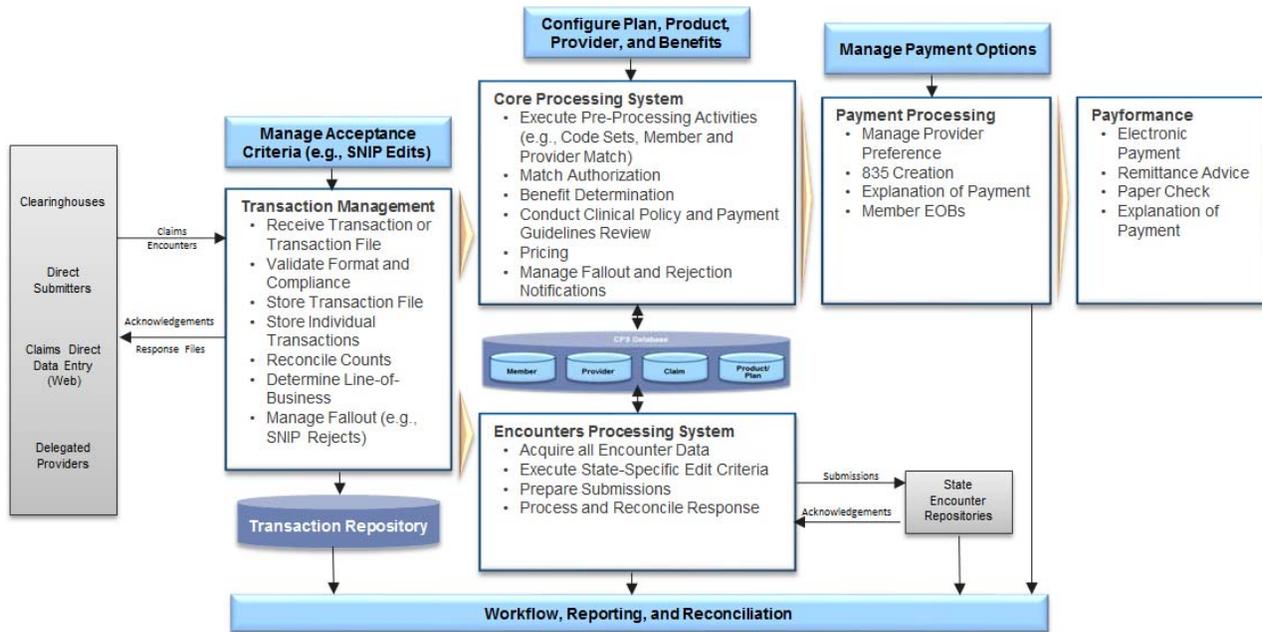
paper claim correlate to the loops and segments of an electronic transaction. Each state is assigned dedicated Analysts who conduct provider outreach and serve as a primary point of contact for issues and resolutions. This proactive approach to partnering with the states and providers reduces provider concerns and is particularly valuable to providers with little or no EDI experience.

Exhibit R.11.e illustrates the claims front-end workflow process while R.11.f shows the interactivity between CPS and EPS. As mentioned previously, CPS and WellCare’s claims processing capability has the capacity to meet DHH requirements for claims processing and payment and to provide data in the structure and format required by the State.

**Exhibit R.11.e – Claims Front-end Workflow Process**



**Exhibit R.11.f – WellCare Claims and Encounter Processing Overview**

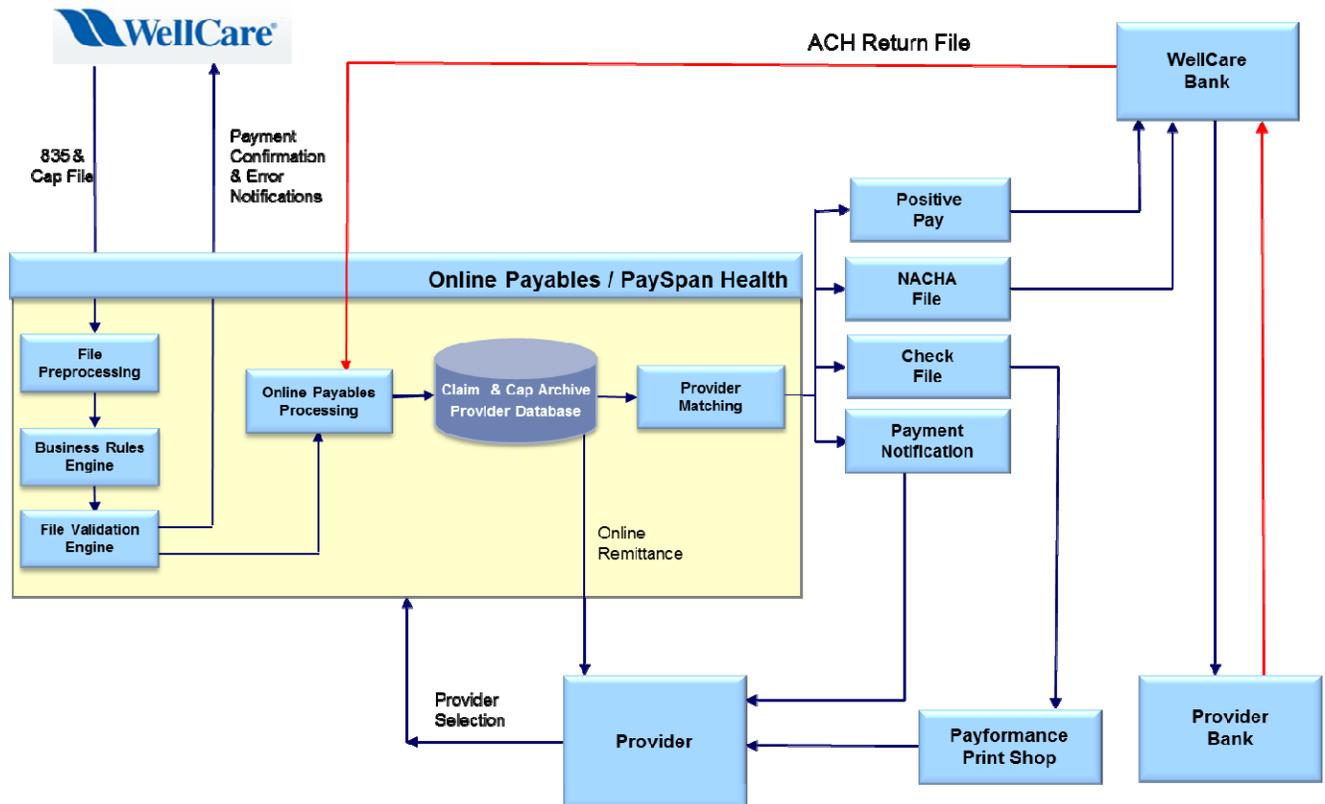


Financial Subsystem

The financial subsystem uses Oracle Financials database and applications for interfacing with users and other key production subsystems. This subsystem is responsible for collecting and storing data and information related to revenue and expense transactions, and financial statement information. All financial data is stored and processed according to generally accepted accounting principles (GAAP) guidelines.

WellCare outsources the provider payment function. WellCare has an existing contract with Payformance to facilitate payments to our network providers. WellCare retains accountability for all claims processing and payment functions and associated service level agreements. See Exhibit R.11.g for a summary diagram of the relationship between WellCare’s management information system and Payformance’s payment process.

### Exhibit R.11.g – WellCare Provider Electronic Funds Transfer Process



Formed in 1985, Payformance provides electronic funds transfer (EFT) and electronic remittance advice (ERA) services to over 3,500 clients, both providers and payers, in every state across the country. PaySpan Health, Payformance’s propriety automated payment solution, is an adjudicated claims settlement solution that optimizes the payer’s payment process and facilitates the delivery of both electronic and paper payment and remittance data to health care providers. The solution offers a transaction-based service that payers can utilize to create on their behalf HIPAA 835 formatted electronic notices and the delivery of remittances to providers. Providers also are provided with a self-service environment to manage electronic payments, access ERAs, and retrieve historical settlement information.

Providers will be notified that they must register and how to do so online with Payformance to receive payments via direct deposit. Providers will submit claims for payment to WellCare. Then we transmit information for claims to be paid, via HIPAA-compliant 835 files, to Payformance for processing. Payformance then sends payment instructions to WellCare’s financial institution and notifies the provider via e-mail of the payment. Finally, an EFT is remitted from WellCare’s financial institution to the provider’s designated financial institution. Providers are given capability, via the provider portal, to review/search claims histories, ERAs, settlement information, and directly download 835 files.

WellCare’s financial subsystem and Payformance’s payment processing capability have the system capacity to provide data in the structure and format required by the State.

### Utilization/Quality Improvement Subsystem

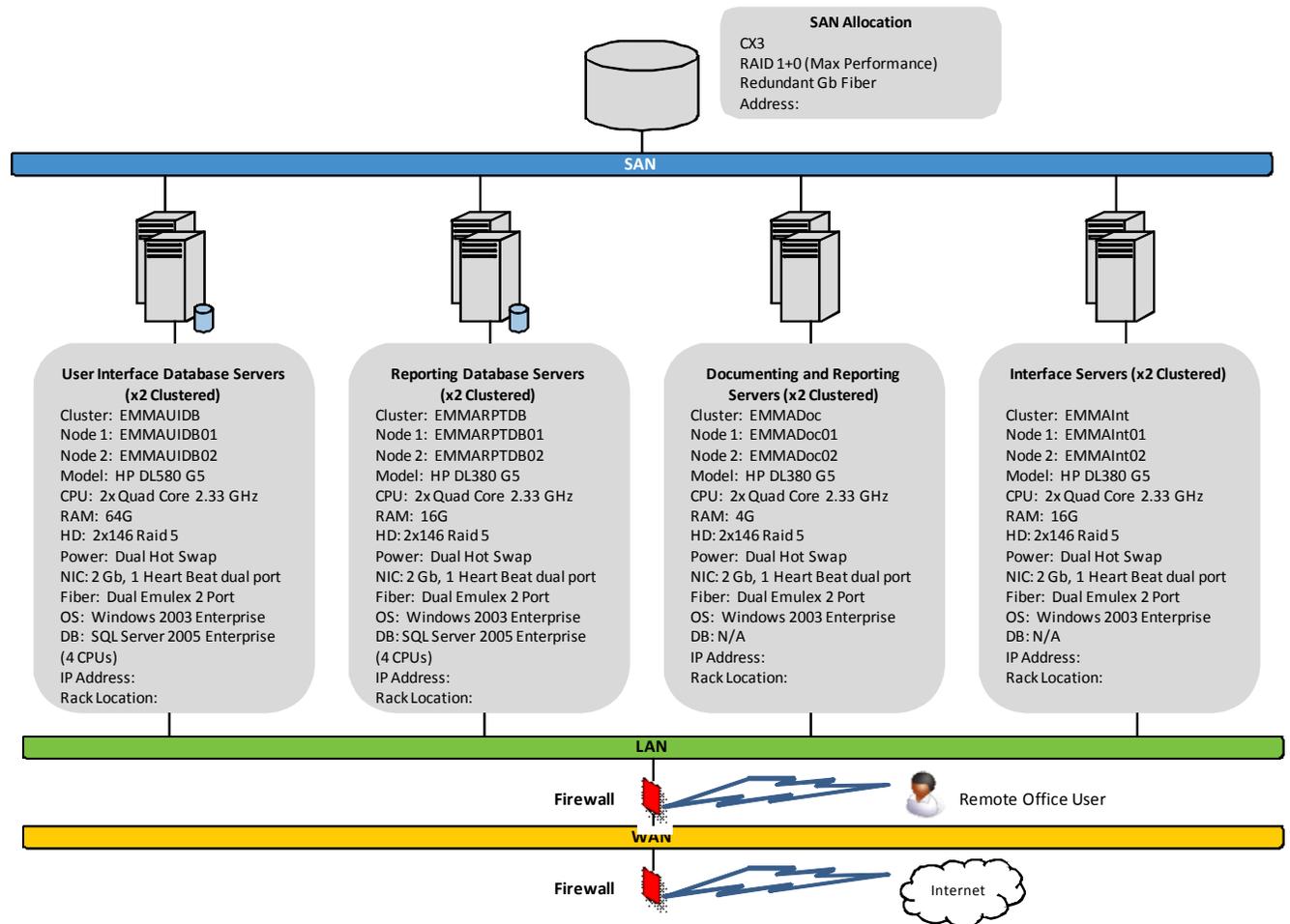
Utilization management and quality improvement will be managed using EMMA. The customer relationship management capabilities of EMMA enable our care coordinators and other clinicians to effectively manage services for our members, regardless of the complexity of their medical or social needs. EMMA, which is used today in our existing programs, is functionally very rich and provides users with member, provider, claims, authorization, customer contact and pharmacy data organized in a patient-centered way to facilitate improved health delivery. At a glance, a case manager, care coordinator, or fully authorized service representative can view each member's current and historical records of services, including services performed by any ancillary vendors.

Member, provider and claims data will be provided to EMMA via interfaces with CPS. WellCare accepts authorization requests through our self service provider web application, fax, telephone, or mail. EMMA will send service authorizations to CPS via the interface between the two systems. Data collected by EMMA will be applied to automated, predictive modeling algorithms that are designed to improve care outcomes. Assessment and service data will be applied to customized predictive algorithms to identify problems, goals and interventions. These algorithms support the care planning process by identifying the optimal level of services to improve outcomes. Exhibit R.11.h below outlines the architecture and design of EMMA.

As mentioned previously, our information system application suite also includes our HEDIS system, CRMS, which provides an integrated clinical and financial view of care delivery to measure and improve performance. CRMS also streamlines HEDIS reporting processes by centralizing member information, claims/encounter data, medical records, data from state registries and narrative information to create a single source of retrospective medical, service and case management data.

WellCare's medical management application, EMMA, and our quality reporting system based on CRMS have demonstrated the ability to support the system capacity to data structure and format required by the State.

**Exhibit R.11.h – WellCare’s Enterprise Medical Management Application (EMMA)**



**Reporting Subsystem**

The reporting subsystem is responsible for reporting and program management, including data-driven analysis of business functions throughout the organization and generation of most contractually-required reports. The integration of WellCare’s information system enables us to generate routine, custom and ad hoc reports that are both accurate and timely. WellCare relies on standard management reports to assess performance of individual business units and ensure compliance with all reporting obligations. The system includes real time data analysis and reporting functions to support the following activities:

- Financial transaction
- Financial reporting
- Fraud and abuse
- Other Reports as required
- Call Center monitoring
- Grievances and appeals
- Claims processing

As a function of our integrated system, each system has the reporting capacity to provide data in the structure and format required by the State.

## Interface Subsystem

WellCare has developed a robust, flexible, and standards-based interface subsystem to provide integration across all functions and systems. Our interface subsystem is based on an enterprise service oriented architecture built on our enterprise service bus. This system supports service-based interfaces to all of our systems with some services available to our subcontractors and to our government clients. For example, all authorizations are stored in EMMA as part of the utilization management function. Once an authorization is approved, a web service is executed by EMMA to add the authorization to CPS where it will be used to authorize the claim.

WellCare will interface with DHH regarding the transmission and receipt of transaction data for processing of enrollments and any other transactions. WellCare's data infrastructure supports diverse reporting, extraction and interfacing capabilities. WellCare will generate files in the required formats for uploading to DHH systems as directed specifically for program integrity and compliance purposes.

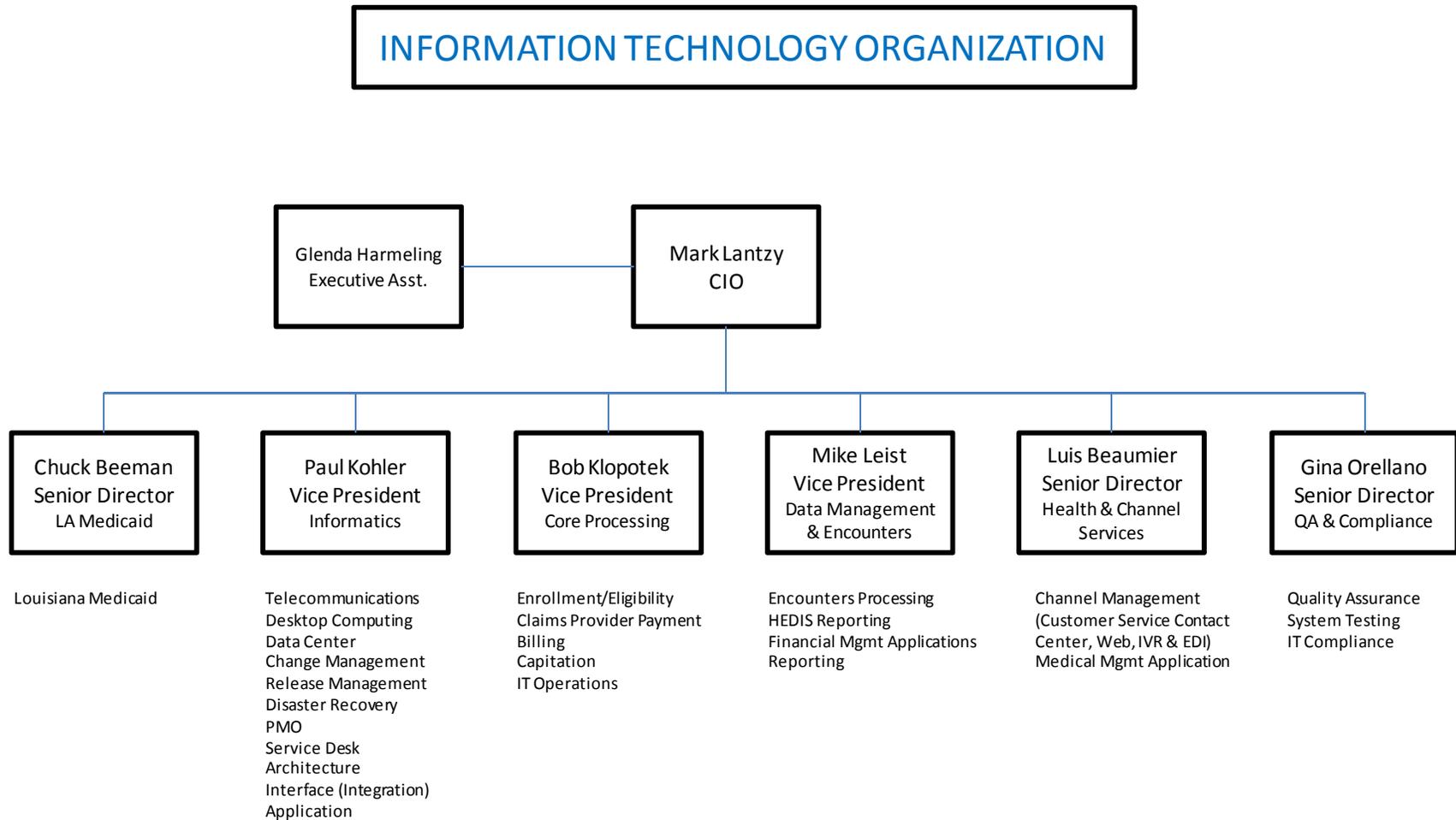
A second key component of our interface subsystem is our extraction, transformation, and load capabilities based on Informatica Power Center. WellCare has built a very flexible data interfacing capability for processing data and for maintaining our data warehouse with requisite control and balancing reports that tie the data warehouse to the primary data sources. Exhibit R.11.e shows the seamless movement of data from our transaction management system and CPS to our encounters processing system. This enables WellCare to deliver accurate and timely reporting data to DHH and to rapidly respond to ad hoc reporting requests.

Our interface subsystem is built to be flexible and scalable and is able to meet the data structure and format requirements, as well as the capacity, required by the State.

**R.12**

**Provide a profile of your current and proposed Information Systems (IS) organization.**

**Exhibit R.12.a – WellCare IT’s Current and Proposed Organization**



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**R.13**

***Describe what you will do to promote and advance electronic claims submissions and assist providers to accept electronic funds transfers.***

**Electronic Claims Processing and Payments**

Exhibits R.13.a and R.13.b present the volume of electronic and paper claim submissions and encounters for the past year. WellCare is proficient at receiving electronic submission from providers and places a premium on driving an industry-leading Electronic Data Interchange (EDI) rate. WellCare has a dedicated team of provider connectivity analysts who work with the provider community to convert paper claims to electronic submissions. The team understands how the fields of a paper claim correlate to the loops and segments of an electronic transaction. The team mission is to provide guided and exceptional HIPAA-compliant (Electronic Data Interchange, or EDI) solutions, analysis and training to providers and billing offices, enabling them to accurately submit EDI transactions so as to consistently receive timely payments. Each state is assigned dedicated representatives who conduct provider outreach and serve as a primary point of contact for issues resolutions. This proactive approach to partnering with the states and providers reduces provider concerns and is particularly valuable to providers with little or no EDI experience.

WellCare provides three channels for the providers to submit their encounter data: (1) paper forms (e.g., 1500, UB-04) (2) HIPAA standard EDI format (e.g., 837 EDI 4010/5010) and (3) easy-to-use web interface where the providers can manually enter in the encounter data. We also will offer a batch submission capability for providers who want to bypass the clearinghouses, at no cost to the provider.

WellCare will work with providers as needed to ensure that EFT transfers are made available to them where possible.

**Exhibit R.13.a – Summary of WellCare Electronic and Paper Claim Submissions, CY 2010**

Fee for Service (CY 2010)					
Month	Institutional		Professional		Total
	EDI	Paper	EDI	Paper	
January	182,267	20,641	1,053,647	168,096	1,424,651
February	173,396	20,754	1,032,243	170,265	1,396,658
March	204,116	23,115	1,191,966	201,523	1,620,720
April	194,158	23,302	1,094,183	178,617	1,490,260
May	184,770	19,465	1,036,967	166,797	1,407,999
June	192,381	19,089	988,911	161,542	1,361,923
July	184,588	22,170	1,046,201	161,599	1,414,558
August	185,600	20,413	1,044,737	149,975	1,400,725

Fee for Service (CY 2010)					
Month	Institutional		Professional		Total
	EDI	Paper	EDI	Paper	
September	194,232	19,812	1,077,984	142,418	1,434,446
October	191,682	18,518	1,102,570	148,990	1,461,760
November	207,586	13,417	1,140,030	149,482	1,510,515
December	201,197	15,661	1,145,814	153,464	1,516,136
<b>Grand Total</b>	<b>2,295,973</b>	<b>236,357</b>	<b>12,955,253</b>	<b>1,952,768</b>	<b>17,440,351</b>

**Exhibit R.13.b – Summary of WellCare Electronic and Paper Encounters, CY 2010**

Encounters (CY 2010)						
Month	Dental	Institutional		Professional		Total
	EDI	EDI	Paper	EDI	Paper	
January	64,766	6,071	155	380,788	11,957	463,737
February	62,614	3,385	41	268,244	7,395	341,679
March	79,701	5,954	150	213,517	11,553	310,875
April	74,948	5,598	1	205,057	3,047	288,651
May	50,437	4,441	0	255,113	4,604	314,595
June	77,088	5,464	0	279,758	2,878	365,188
July	88,552	11,444	31	376,095	16,042	492,164
August	68,726	10,220	1	509,248	1,985	590,180
September	81,021	13,188	0	1,509,421	4,995	1,608,625
October	70,182	10,386	0	353,904	1,208	435,680
November	97,275	11,740	0	383,521	152	492,688
December	91,000	8,503	966	409,707	8,161	518,337
<b>Grand Total</b>	<b>906,310</b>	<b>96,394</b>	<b>1,345</b>	<b>5,144,373</b>	<b>73,977</b>	<b>6,222,399</b>

**R.14**

**Indicate how many years your IT organization or software vendor has supported the current or proposed information system software version you are currently operating. If your software is vendor supported, include vendor name(s), address, contact person and version(s) being used.**

As in other states, the hub of our management information system in Louisiana is WellCare's core processing system (CPS), based on the Dell Services Xcelys platform. The version to be in production for the CCN program go-live is version 6.1. WellCare has used this platform since 1998 and is currently using it to support all Medicaid and Medicare business.

WellCare is supported by :

Mr. Jack Case  
Dell Services  
2300 W. Plano Parkway  
Plano, TX 75075  
972-577-5267

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## **R.15**

***Describe your plans and ability to support network providers' "meaningful use" of Electronic Health Records (EHR) and current and future IT Federal mandates. Describe your plans to utilizing ICD-10 and 5010.***

WellCare has reviewed in detail the Louisiana Medicaid Electronic Health Records (EHR) Incentive Program as presented on the Making Medicaid Better site.

After review, WellCare is confident in its capacity and capabilities to meet the contractual requirements required to support the State of Louisiana's EHR program.

Two of the key components of the EHR requirements are the web services and continuity of care document (CCD) transfer. WellCare is accustomed to providing web services that meet expectations and is very comfortable in executing the web service requirements to meet EHR's needs.

WellCare will make CCD (HITSP C32) information available to the EHR using the web service option rather than the XDS option.

WellCare intends to provide a public facing web service that corresponds to the WSDL described in the Participant Connectivity Guide, Chapter 5. It is anticipated that it will be invoked in the scenario described as Gold Pull. In the WellCare integrated information system, web services are implemented in several layers. A proxy service is implemented in the XML security appliance. This device inspects the contents of requests and verifies that it passes a number of criteria, including authentication and authorization. Upon acceptance the request is passed on to the internal ESB, where the actual implementation resides.

The EHR service will receive the QRY^T12 request from EHR, request a CCD (HITSP C32) from the WellCare CCD service, format the CCD document as a valid DOC^T12 message and respond the web service request. The WellCare CCD service is intended to gather data from a variety of data sources, including our enterprise data warehouse, and construct a valid CCD (HITSP C32) document. The data is transformed and formatted as XML in the CCD service.

The EHR service will then process the CCD document into the form required for DOC^T12 and return it to the XML appliance. The XML appliance inspects the data for compliance with the WSDL and returns it to the client upon success.

The CCD service and EHR service will be implemented on Websphere ESB as SCA components.

## **5010 Compliance**

WellCare is upgrading its applications to meet internal metrics and 5010 compliancy standards. WellCare is on schedule to be 5010 compliant by January 1, 2012. See Exhibits R.15.a – Exhibit R.15.h for a copy of WellCare's 5010 compliance plan proposed timeline for meeting the deadlines for being 5010 compliant, while Exhibit R.15.i and Exhibit R.15.j outline the plan for ICD-10 compliance.

## WellCare HIPAA 5010 Compliance Plan

HIPAA requires standards for electronic transactions, such as claims, remittance, eligibility, claims status requests and responses, and others; current versions of these standards, X12 version 4010/4010A1 and NCPDP version 5.1, with version 5010 and version D.0, respectively.

The new standards will be implemented between January 1, 2011 and January 1, 2012. This means that all systems will be ready to handle the new standards, as well as the old, by January 1, 2012. Effective January 1, 2012, providers will be required to submit claims electronically using the X12 version 5010 and NCPDP version D.0, and the previous versions will no longer be accepted.

HIPAA 5010 Transaction Files are listed below in Exhibit R.15.a.

### Exhibit R.15.a – HIPAA 5010 Transaction Files

File	Description
834	Health Plan Enrollment
820	Premium Payments
270/271	Eligibility Inquiry and Response
278	Health Care Services; Request Authorization
837	(I, P, D); Health Care Claims/Encounters
NCPDP	Pharmacy
276/277	Health Care Claim Status Request and Response
277CA	Claims Reject/Accept
997/999	File acknowledgment
835	Health Care Claim Payment/Remittance Advice

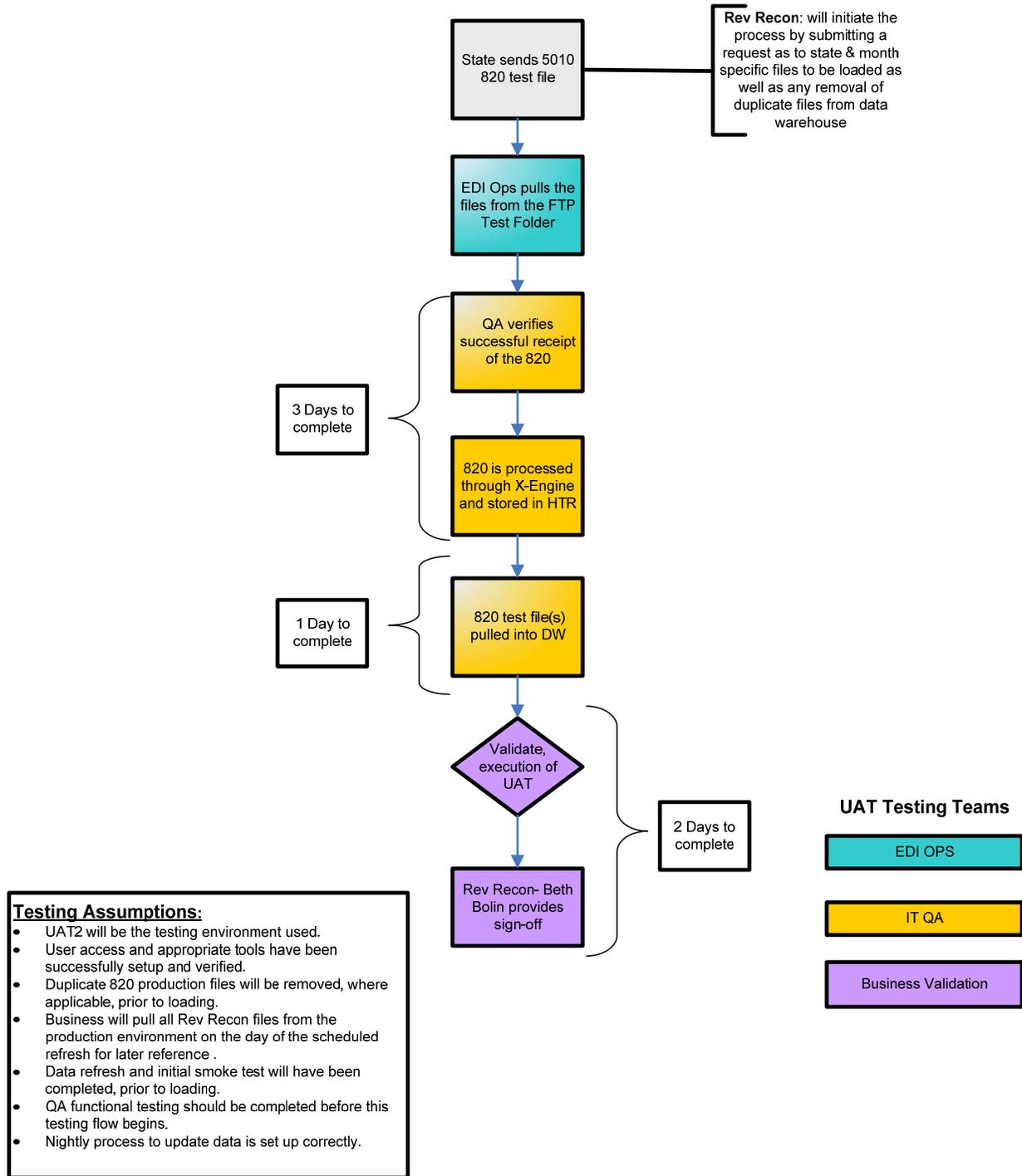
Implementation milestones for WellCare's HIPAA 5010 Compliance Plan are presented in the timeline on the following page, followed by HIPAA 5010 file testing workflows for the files listed below:

- 820 – Premium Payments
- 834 – Health Plan Enrollment – Inbound
- 834 – Health Plan Enrollment – Outbound
- 837 – (I, P, D); Health Care Claims
- 837 – (I, P, D); Encounters
- 835 – Health Care Claim Payment/Remittance Advice – Inbound

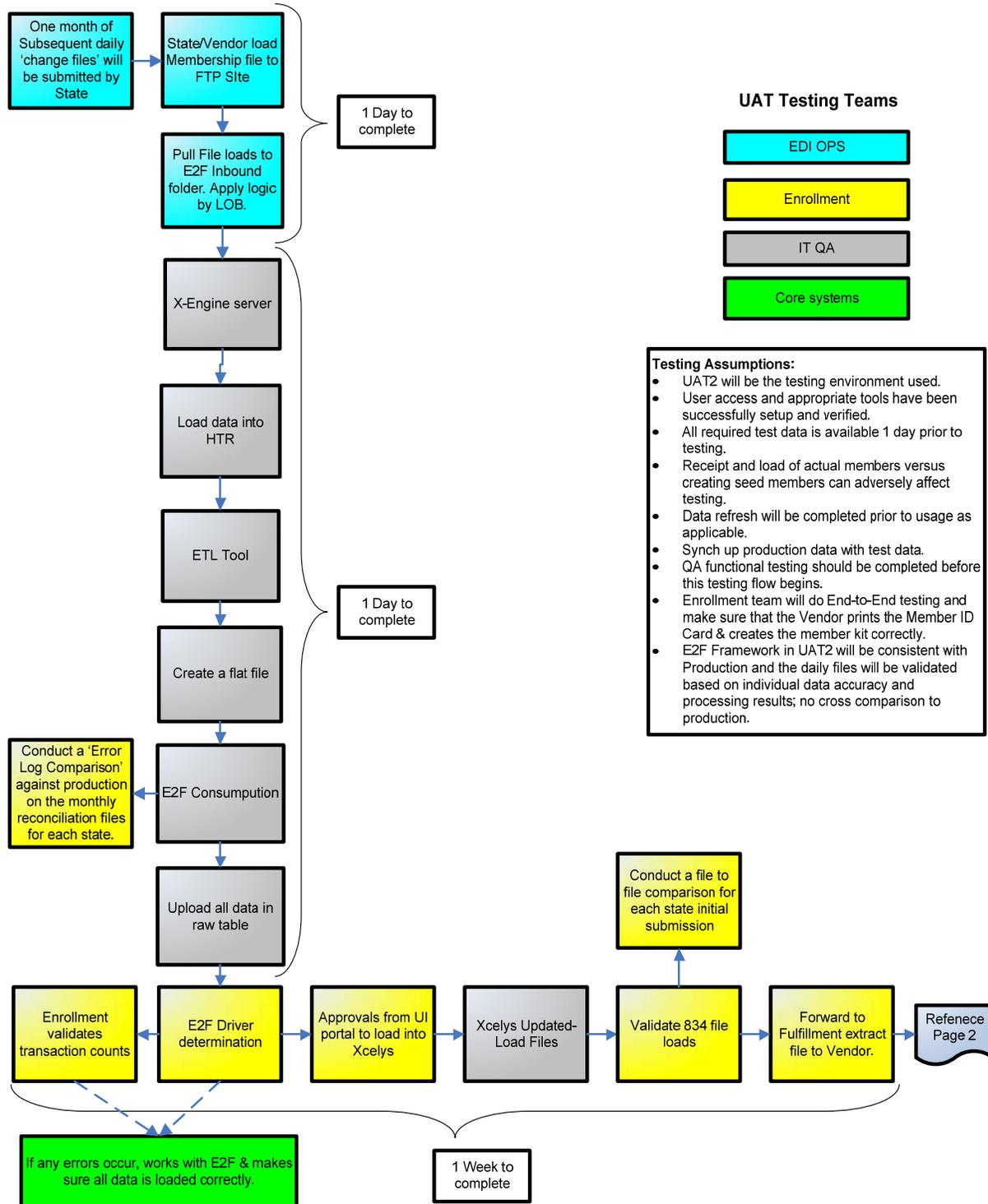
**Exhibit R.15.b – WellCare HIPAA 5010 Compliance Plan – Implementation Milestones**

ID	Task Name	Start	Finish	2011												2012
				Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
1	HIPAA 5010 Major Milestones	1/10/2011	1/1/2012	[Gantt bar from Jan 10 to Dec 31]												
2	Level II – HTR / 820 / Xcelys 3.X (5010)	1/10/2011	4/15/2011	[Gantt bar from Jan 10 to Apr 15]												
3	Level II – Inbound Structural Verification: Delegated Vendors; Facilities; Clearinghouses i.e. 837 into HTR	1/10/2011	4/29/2011	[Gantt bar from Jan 10 to Apr 29]												
4	820 with Xcelys 3.X (5010)	5/1/2011	5/1/2011	[Vertical tick mark in May]												
5	5010 Claim Generation: A) 4010-based; B) New Scenarios	4/1/2011	5/30/2011	[Gantt bar from Apr 1 to May 30]												
6	UAT2 Availability & Verification; Initial Claims Processing with Updated X-Engine with Errata	5/16/2011	5/30/2011	[Gantt bar from May 16 to May 30]												
7	Formal 837 Claim Execution (UAT): End-to-End with Xcelys 6.1 WC	6/6/2011	7/29/2011	[Gantt bar from Jun 6 to Jul 29]												
8	Level II – Begin Outbound 834 Submission & Verification	6/24/2011	10/20/2011	[Gantt bar from Jun 24 to Oct 20]												
9	Level II – Begin Inbound Formal UAT Verification on 835 & 837 Encounter Transaction Files	7/6/2011	12/30/2011	[Gantt bar from Jul 6 to Dec 30]												
10	Level II – Begin Inbound Formal UAT Verification on 834 & 820 Encounter Transaction Files (Market Level)	6/24/2011	12/30/2011	[Gantt bar from Jun 24 to Dec 30]												
11	Level II – Begin Outbound 837 Verification	7/6/2011	12/30/2011	[Gantt bar from Jul 6 to Dec 30]												
12	Xcelys 6.X Production Deployment	9/4/2011	9/6/2011	[Vertical tick mark in Sep]												
13	HIPAA 5010 Go Live – All Markets	1/2/2012	1/2/2012													[Vertical tick mark in Jan]

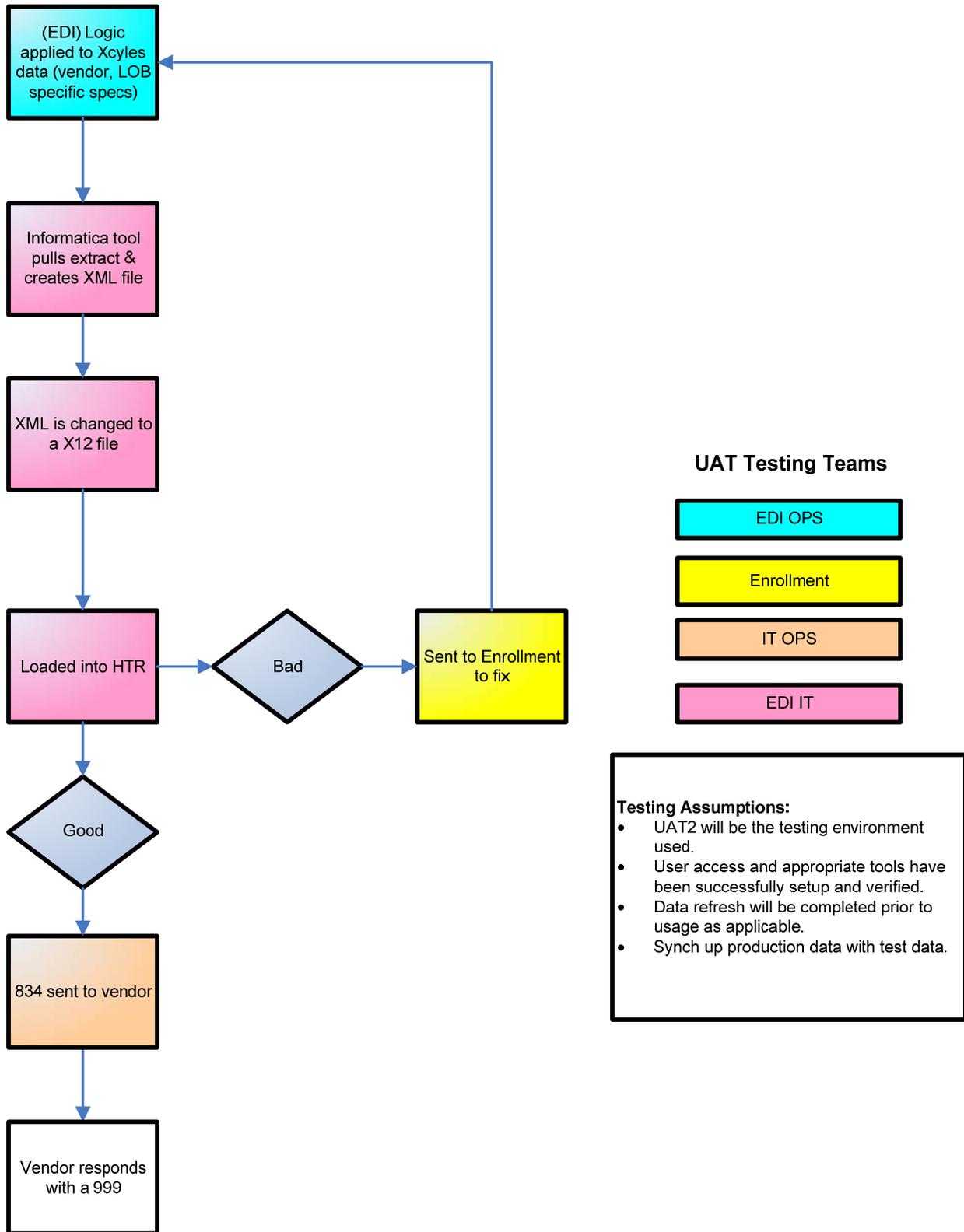
**Exhibit R.15.c – WellCare HIPAA 5010 Compliance Plan – 820 Testing Workflow**



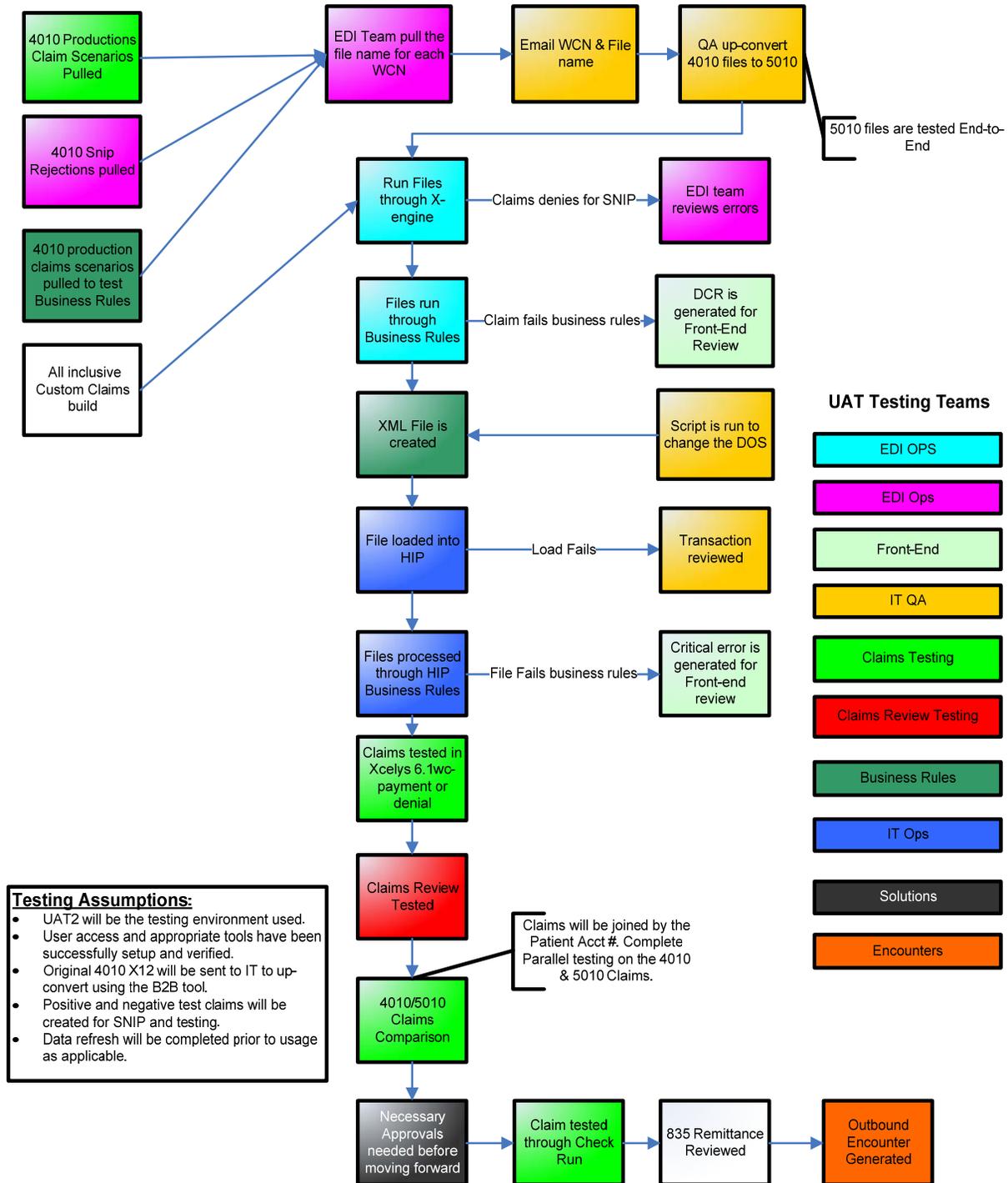
**Exhibit R.15.d – WellCare HIPAA 5010 Compliance Plan – 834 (Inbound) Testing Workflow**



**Exhibit R.15.e – WellCare HIPAA 5010 Compliance Plan – 834 (Outbound) Testing Workflow**



**Exhibit R.15.f – WellCare HIPAA 5010 Compliance Plan – 837 (Claim) Testing Workflow**



**Exhibit R.15.g – WellCare 5010 HIPAA Compliance Plan – 837 (Encounter) Testing Workflow**

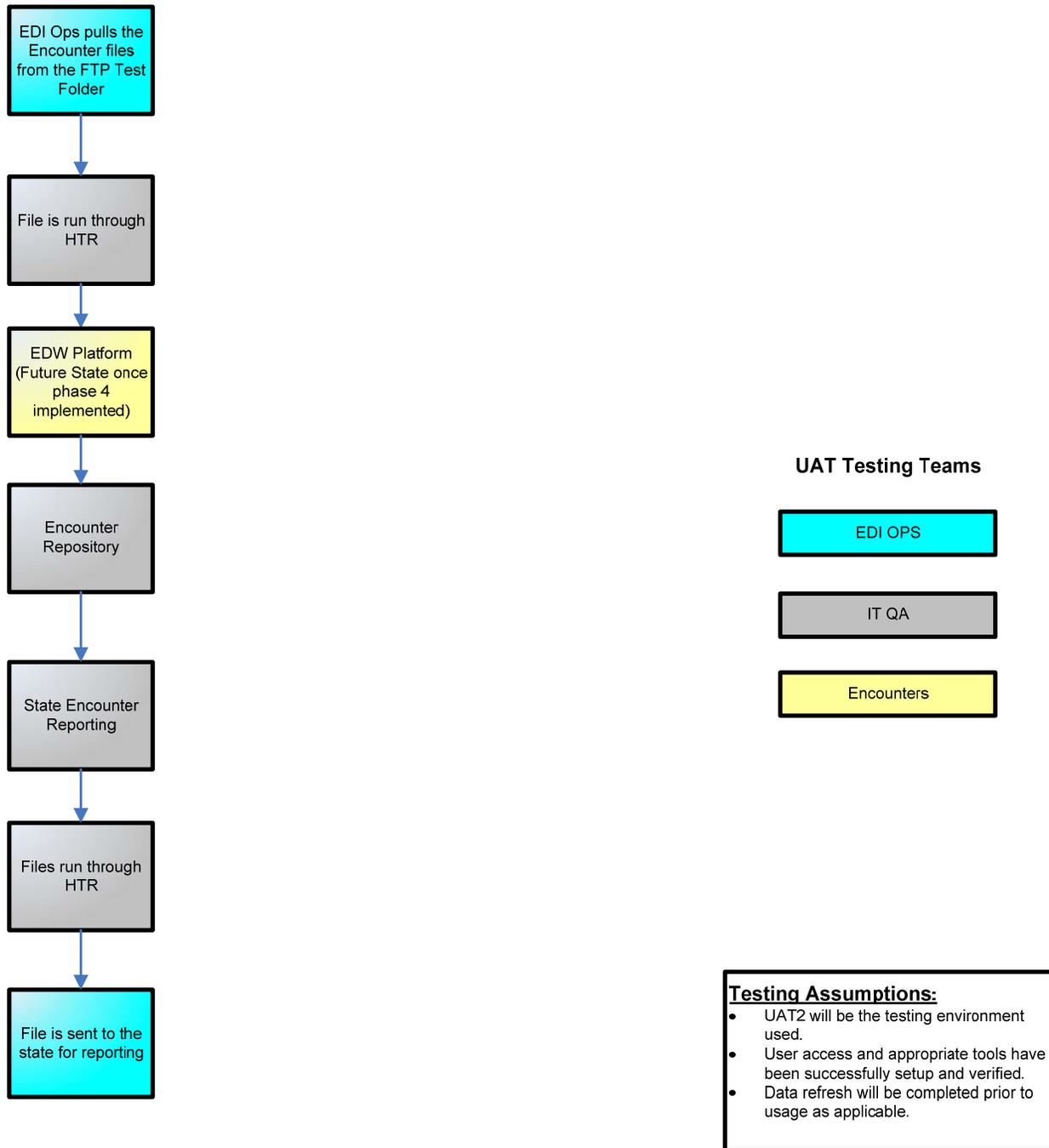
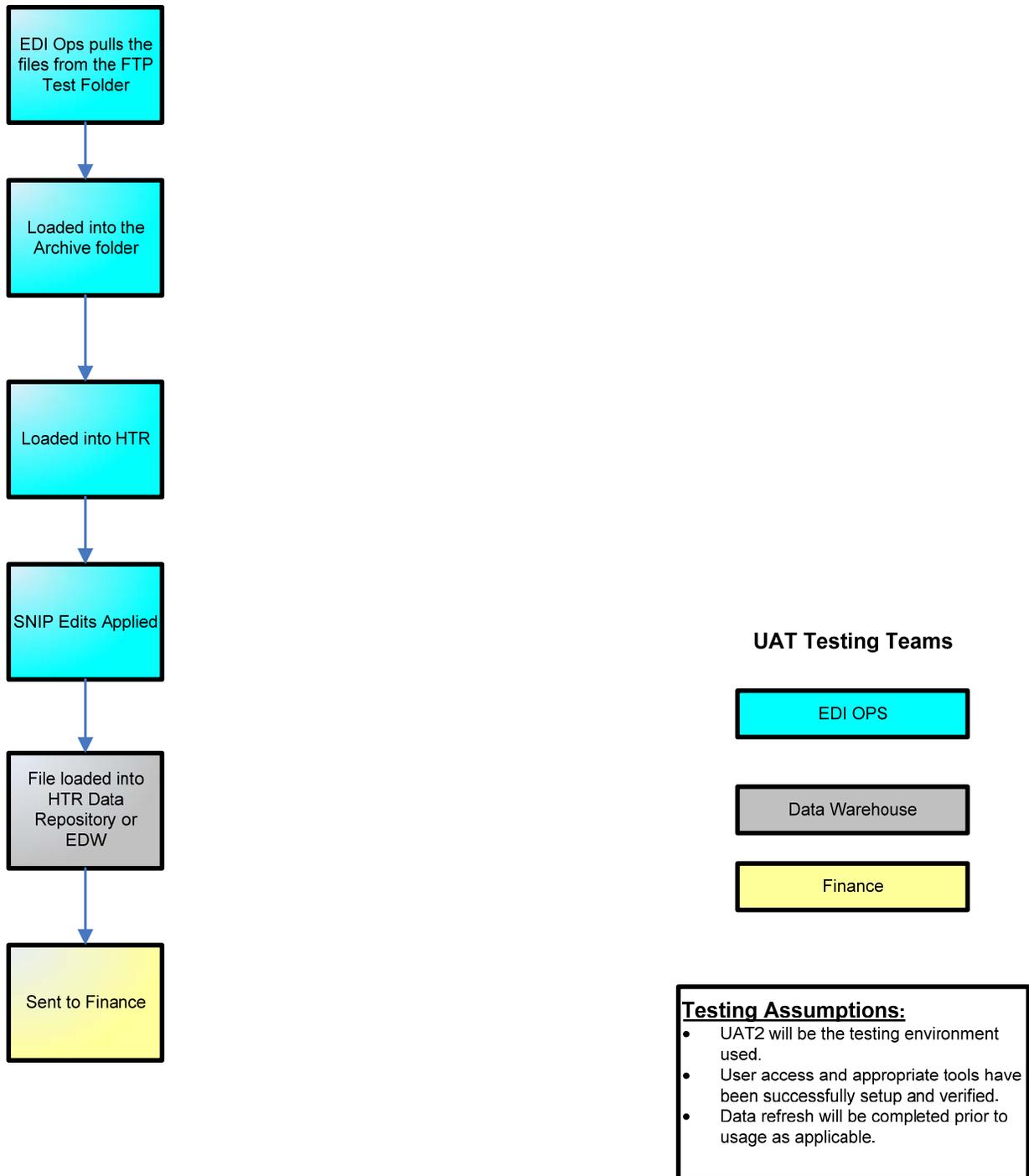


Exhibit R.15.h – WellCare HIPAA 5010 Compliance Plan – 835 Inbound Testing Workflow



**Exhibit R.15.i – ICD-10 Program Management Summary**

	<b>Initiatives</b>	<b>Description Summary</b>
<b>1.0</b>	<b>ICD-10 Program Management</b>	
1.1	Plan, Mobilize and Acquire Resources	Establish and run the program management office (PMO) overseeing all work, business and IT, related to migrating to ICD-10. This includes defining and rolling out the process and standards for governance, project management, integrated work planning, project resource planning/acquisition/training, and financials and business case management.
1.2	Monitor and Control Program	Manage the process and standards for governance, project management, integrated work planning, resource planning and acquisition, and financials and business case management. Establish an ICD-10 command center to serve as the primary focal point for information sharing and issue management across all impacted functional areas post-implementation.
<b>2.0</b>	<b>Integrated Roadmap</b>	
2.1	IT Impact Assessment (business component)	Assess and document inventory of impacts to IT systems for remediating for ICD-10.
2.2	IT Refresh of Roadmap and Estimates	Integrate business roadmap from the business assessment and systems roadmap or system impacts knowledge from the IT assessment to create a unified plan and approach across the enterprise to migrating functions, process and systems to ICD-10.
<b>3.0</b>	<b>Business Partner Readiness</b>	Implement a formal process to monitor vendor progress and identify risks and issues during the pre-implementation period for ICD-10. Incorporate post-implementation monitoring activities into ICD-10 Command Center process.
<b>4.0</b>	<b>ICD-10 Code Mapping</b>	
4.1	Approach Definition	Develop approach and analysis tools for the mapping from ICD-9 to ICD-10 (e.g., benefits policies, service code groupings, medical management triggers, pre-certification requirements, etc), including the definition and roll-out of governance process and infrastructure for making and communicating decisions. Determine ICD-10 value opportunities to implement and track.
4.2	Functional Area Code Mapping	Analyze ICD-9 codes and decide which ICD-10 codes to map to by key business process, including cross-functional reviews to reconcile differences.
4.3	Predictive Financial Assessment	Develop approach and tools to quantify estimated financial impact. Estimate financial impact of selected ICD-10 value opportunities based on code mapping decisions.
<b>5.0</b>	<b>ICD-10 Remediation Activity</b>	
5.1	Transition Processing Approach	Determine the approach to process transactions during the transition period following the ICD-10 compliance date where transactions with dates prior to 10/1/13 contain ICD-9 codes and transactions with dates on or after 10/1/13 contain ICD-10 codes. If usage of a crosswalk is selected, then evaluate options for the enterprise solution that maps ICD-9 codes and ICD-10 codes.
5.2	Migration Roll-Out Strategy	Determine approach for migrating systems and process to ICD-10. Potential options include migrating by system, LOB,

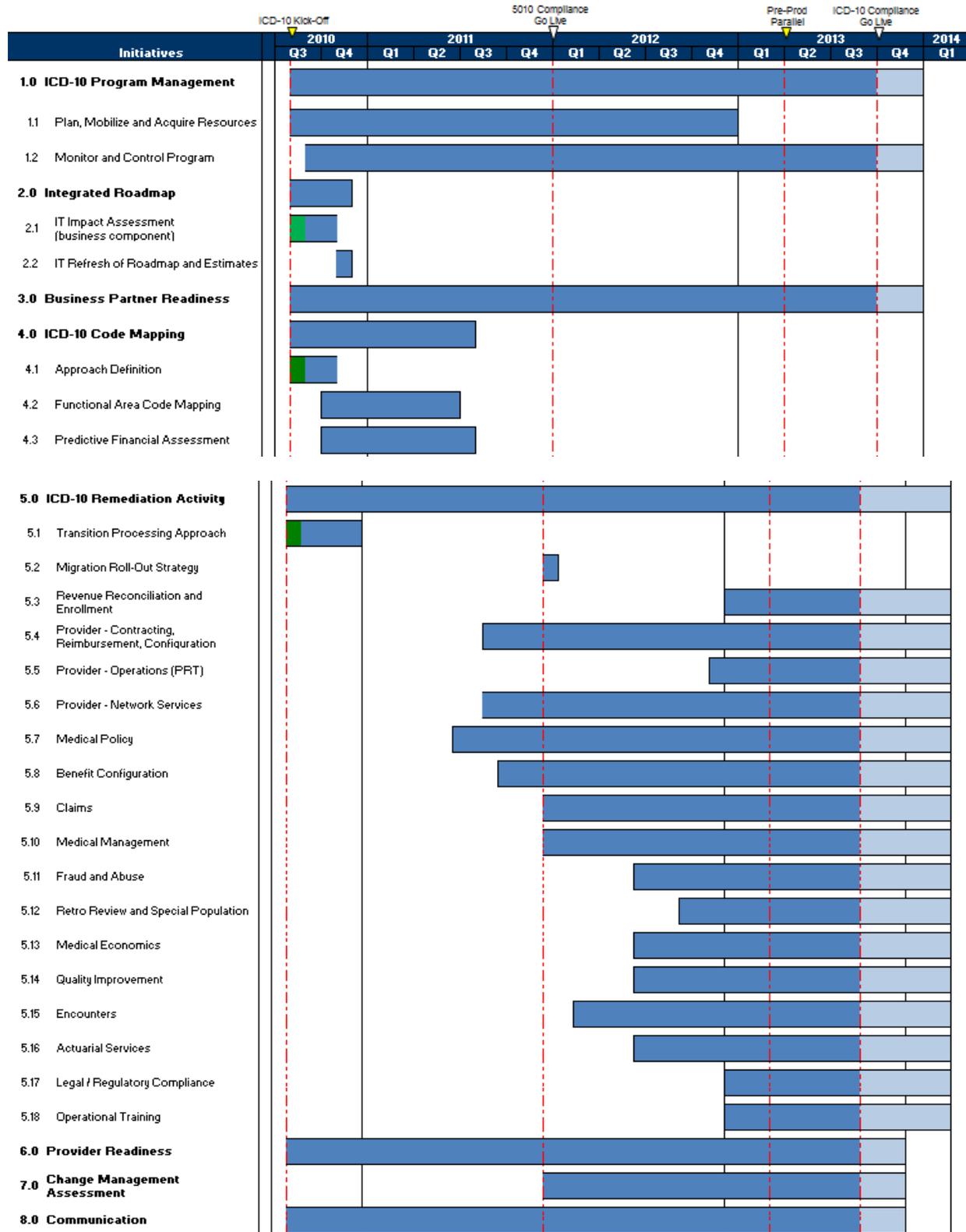
	Initiatives	Description Summary
		provider, function, etc.
5.3	Revenue Reconciliation and Enrollment	Analyze, develop, approve and implement changes to business rules and protocols (e.g., update reports). Initiate detailed planning and execute SDLC to update all business and IT-owned applications and reports that support the revenue reconciliation and enrollment process, including inbound and outbound interfaces, using ICD-9 codes. Develop and execute plan for installation and testing of ICD-10 related versions of all vendor supplied applications and services. Plan and roll-out a pre-production parallel with a select set of providers. Monitor and adjust for operational readiness for business and IT. Develop approach and tools to quantify actual financial impact of ICD-10 changes after changes are implemented.
5.4	Provider - Contracting, Reimbursement, Configuration	Analyze, develop, approve and implement changes to business rules and protocols (e.g., templates, contracts, amendment language). Initiate detailed planning and execute SDLC to update all business and IT-owned applications and reports that support the provider contracting and reimbursement process, including inbound and outbound interfaces, using ICD-9 codes. Develop and execute plan for installation and testing of ICD-10 related versions of all vendor supplied applications. Plan and roll-out a pre-production parallel with a select set of providers. Monitor and adjust for operational readiness for business and IT. Develop approach and tools to quantify actual financial impact of ICD-10 changes after changes are implemented.
5.5	Provider - Operations (PRT)	Analyze, develop, approve and implement changes to business rules and protocols (e.g., dispute protocols). Initiate detailed planning and execute SDLC to update all business and IT-owned applications and reports that support the provider operations process, including inbound and outbound interfaces, using ICD-9 codes. Develop and execute plan for installation and testing of ICD-10 related versions of all vendor supplied applications. Plan and roll-out a pre-production parallel with a select set of providers. Monitor and adjust for operational readiness for business and IT. Develop approach and tools to quantify actual financial impact of ICD-10 changes after changes are implemented.
5.6	Provider - Network Services	Analyze, develop, approve and implement changes to business rules and protocols (e.g., provider services and methods). Initiate detailed planning and execute SDLC to update all business and IT-owned applications and reports that support the provider network services process, including inbound and outbound interfaces, using ICD-9 codes. Develop and execute plan for installation and testing of ICD-10 related versions of all vendor supplied applications. Plan and roll-out a pre-production parallel with a select set of providers. Monitor and adjust for operational readiness for business and IT. Develop approach and tools to quantify actual financial impact of ICD-10 changes after changes are implemented.

	Initiatives	Description Summary
5.7	Medical Policy	Analyze, develop, approve and implement changes to business rules and business protocols (e.g., clinical policy guidelines, McKesson, and iHealth). Initiate detailed planning and execute SDLC to update all business and IT-owned applications and reports that support the medical policy process, including all interfaces, using ICD-9 codes. Develop and execute plan for installation and testing of ICD-10 related versions of all vendor supplied applications. Plan and roll-out a pre-production parallel with a select set of providers. Monitor and adjust for operational readiness for business and IT. Develop approach and tools to quantify actual financial impact of ICD-10 changes after changes are implemented.
5.8	Benefit Configuration	Analyze, develop, approve and implement changes to business rules and business protocols (e.g., MEDEF tables, reporting queries). Initiate detailed planning and execute SDLC to update all business and IT-owned applications and reports that support the benefits configuration process, including all interfaces, using ICD-9 codes. Develop and execute plan for installation and testing of ICD-10 related versions of all vendor supplied applications. Plan and roll-out a pre-production parallel with a select set of providers. Monitor and adjust for operational readiness for business and IT. Develop approach and tools to quantify actual financial impact of ICD-10 changes after changes are implemented.
5.9	Claims	Analyze, develop, approve and implement changes to claims business rules and business protocols (e.g., pend and rejection edits). Initiate detailed planning and execute SDLC to update all business and IT-owned applications and reports that support the claims process, including all interfaces as well as wrap around programs related to Paradigm and other vendor applications. Develop and execute plan for installation and testing of ICD-10 related versions of all vendor supplied applications. Plan and roll-out a pre-production parallel with a select set of providers. Monitor and adjust for operational readiness for business and IT. Develop approach and tools to quantify actual financial impact of ICD-10 changes after changes are implemented.
5.10	Medical Management	Analyze, develop, approve and implement changes to business rules and business protocols (e.g., Drug Utilization, Portal, EMMA, and Paradigm). Initiate detailed planning and execute SDLC to update all business and IT-owned applications and reports that support the medical management, including inbound and outbound interfaces, using ICD-9 codes. Develop and execute plan for installation and testing of ICD-10 related versions of all vendor supplied applications. Plan and roll-out a pre-production parallel with a select set of providers. Monitor and adjust for operational readiness for business and IT. Develop approach and tools to quantify actual financial impact of ICD-10 changes after implementation.

	Initiatives	Description Summary
5.11	Fraud and Abuse	Analyze, develop, approve and implement changes to business rules and business protocols (e.g., claim scoring algorithms and analysis triggers). Initiate detailed planning and execute SDLC to update all business and IT-owned applications and reports that support the fraud and abuse process, including inbound and outbound interfaces, using ICD-9 codes. Develop and execute plan for installation and testing of ICD-10 related versions of all vendor supplied applications. Plan and roll-out a pre-production parallel with a select set of providers. Monitor and adjust for operational readiness for business and IT. Develop approach and tools to quantify actual financial impact of ICD-10 changes after implementation.
5.12	Retro Review and Special Population	Analyze, develop, approve and implement changes to business rules and business protocols (e.g., access databases and queries). Initiate detailed planning and execute SDLC to update all business and IT-owned applications and reports that support the retro review and special population process, including inbound and outbound interfaces, using ICD-9 codes. Develop and execute plan for installation and testing of ICD-10 related versions of all vendor supplied applications. Plan and roll-out a pre-production parallel with a select set of providers. Monitor and adjust for operational readiness for business and IT. Develop approach and tools to quantify actual financial impact of ICD-10 changes after implementation.
5.13	Medical Economics	Analyze, develop, approve and implement changes to business rules and business protocols (e.g., trend reporting and queries). Initiate detailed planning and execute SDLC to update all business and IT-owned applications and reports that support the medical economics process, including inbound and outbound interfaces, using ICD-9 codes. Develop and execute plan for installation and testing of ICD-10 related versions of all vendor supplied applications. Plan and roll-out a pre-production parallel with a select set of providers. Monitor and adjust for operational readiness for business and IT. Develop approach and tools to quantify actual financial impact of ICD-10 changes after implementation.
5.14	Quality Improvement	Analyze, develop, approve and implement changes to business rules and business protocols (e.g., HEDIS). Initiate detailed planning and execute SDLC to update all business and IT-owned applications and reports that support the quality improvement process, including inbound and outbound interfaces, using ICD-9 codes. Develop and execute plan for installation and testing of ICD-10 related versions of all vendor supplied applications. Plan and roll-out a pre-production parallel with a select set of providers. Monitor and adjust for operational readiness for business and IT. Develop approach and tools to quantify actual financial impact of ICD-10 changes after implementation.

	Initiatives	Description Summary
5.15	Encounters	Analyze, develop, approve and implement changes to business rules and business protocols (reviewing rejected encounters). Initiate detailed planning and execute SDLC to update all business and IT-owned applications and reports that support the encounter process, including inbound and outbound interfaces, using ICD-9 codes. Develop and execute plan for installation and testing of ICD-10 related versions of all vendor supplied applications. Plan and roll-out a pre-production parallel with a select set of providers. Monitor and adjust for operational readiness for business and IT. Develop approach and tools to quantify actual financial impact of ICD-10 changes after implementation.
5.16	Actuarial Services	Analyze, develop, approve and implement changes to business rules and business protocols (e.g., RAPS logic, algorithms, and rules). Initiate detailed planning and execute SDLC to update all business and IT-owned applications and reports that support the actuarial service process, including inbound and outbound interfaces, using ICD-9 codes. Develop and execute plan for installation and testing of ICD-10 related versions of all vendor supplied applications. Plan and roll-out a pre-production parallel with a select set of providers. Monitor and adjust for operational readiness for business and IT. Develop approach and tools to quantify actual financial impact of ICD-10 changes after implementation.
5.17	Legal/Regulatory Compliance	Analyze, develop, approve and implement changes to business rules and business protocols (e.g., address provider contracting, corporate and medical policies). Initiate detailed planning and execute SDLC to update all business and IT-owned applications and reports that support the Legal/ Regulatory Compliance process, including inbound and outbound interfaces, using ICD-9 codes. Develop and execute plan for installation and testing of ICD-10 related versions of all vendor supplied applications. Plan and roll-out a pre-production parallel with a select set of providers. Monitor and adjust for operational readiness for business and IT. Develop approach and tools to quantify actual financial impact of ICD-10 changes after implementation.
5.18	Operational Training	Define detailed training approach and plan based on training needs; create materials for and deliver training.
<b>6.0</b>	<b>Provider Readiness</b>	Identify and monitor the readiness of key providers to process and send ICD-10 codes.
<b>7.0</b>	<b>Change Management Assessment</b>	Determine organizational implications of moving from current state of ICD-9 to future state of ICD-10 within IT, business processes and procedures, etc.
<b>8.0</b>	<b>Communication</b>	Define and execute detailed communication plan, including identification of key constituents, messages, and communication vehicles to be utilized. Distribution of internal and external communication throughout the duration of the ICD-10 migration effort.

### Exhibit R.15.j – ICD-10 Implementation timeline



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## **R.16**

***Describe the procedures that will be used to protect the confidentiality of records in DHH databases, including records in databases that may be transmitted electronically via e-mail or the Internet.***

WellCare maintains policies and procedures describing the types of information to be safeguarded and the transmission of confidential records and data. WellCare's HIPAA access control policy, based on the HIPAA security rule, defines our policy for access control, unique user identification, and transmission.

### **Access Control**

WellCare's HIPAA records and safeguard's policy protects the confidentiality and integrity of all forms of PHI, including records in databases that contain DHH and member data. Access to PHI is limited to WellCare associates and workforce members on a "need to know" basis. PHI is not to be accessed by an associate for any reason other than for servicing Members or their account, or as part of the day-to-day business operations of WellCare.

For WellCare, access control starts with physical security. The WellCare corporate campus is physically staffed 24 hours per day, 7 days per week by a security firm that monitors ingress access to our facilities and provides scheduled physical monitoring and monitoring of the closed-circuit cameras deployed throughout the campus. For contractors and visitors requiring access and use of our facility, the guards and relevant employees provide escort services. Access levels for each employee's badge are assigned and segregated in the Lenel security system. An Access Control Enrollment Form must be submitted with manager approval to Facility Security for each new employee to gain access to the facility.

Employees requiring access to the data center must be authorized through the data center provider's access ticket process. A unique, non-personal, PIN is assigned to any WellCare associate authorized to open an access ticket. All access requests must be made by an authorized employee identified by PIN. Once an access ticket is granted, all visitors must provide identification and be logged before access is granted. IT security reviews the access log on a regular basis. These logs are stored for historical reference after being reviewed. The data center facility is monitored by cameras 24 hours a day, seven days a week. In the event of a security incident, video recordings can be accessed and reviewed for investigation.

WellCare also performs an annual network external penetration test to assess the organization's ability to prevent and identify unauthorized access to the network. The results of the penetration test are presented to IT management for review and resolution of issues. Copies of audit results are available to Louisiana DHH as needed.

VPN access is restricted to WellCare employees. Access to connect to the WellCare network via VPN and Citrix is provided to WellCare active directory accounts.

All servers and computer workstations on the WellCare network are protected with a centrally administered anti-virus program. WellCare utilizes the Symantec System Center anti-virus system to protect the computers and servers on the network. Each AV client retrieves the latest AV definitions from the central server at least once a day. In the event that Symantec detects a

virus, the malicious code is automatically deleted or quarantined. This anti-virus system is centrally administered by information security. Corporate policy prohibits disabling or tampering with the program on any computer or server.

Access to databases is limited. Most workforce users access database records through applications such as our core processing system. For application access, security templates are developed for a requesting authority to designate the appropriate security access or system functionality to be applied to an individual user. This request is initiated by the WellCare associate's direct manager, verified by the technology service desk as a valid request, implemented at the appropriate layer, and periodically reviewed for compliance by information security.

Direct access to databases and records contained within them is controlled by WellCare's service account management process. Service accounts are granted to individuals based on a strict "need to know" basis and job role. The granting of access is also subject to WellCare's segregation of duties policy. This policy insures that no single individual can have control over all phases (i.e., authorization, custody, and record keeping) of transactions, functions, or activities without compensating controls. The segregation of duties avoids the possibility that a single person could be responsible for diverse and critical functions such that errors or misappropriations could occur and not be detected in the normal course of business processing. The fundamental premise of segregated duties is that an individual should not be in a position to initiate, approve, process, and review the same function or activity.

Management reviews associate job roles, responsibilities, and database access on a regular basis and as part of organizational or technology changes. WellCare's segregation of duties standard has a matrix of common roles within an information technology organization and details which roles should not be combined.

System, application, and process owners need to complete a segregation of duties assessment on a periodic basis, at a minimum annually, in accordance with the Segregation of Duties Standard. Conflicts identified during the review need to be documented and a request for exception submitted and approved per the IT exception or variance policy. The request for exception must include the compensating or mitigating control that is proposed to address the risk caused by the conflict.

### **Unique User Identification**

As described in Section R.2, WellCare's network infrastructure provides the basic layer of access control utilizing Microsoft Windows Domains and Microsoft Active Directory for centralized management of all workforce users. Active Directory acts as the central authority for network security, letting the operating system readily verify a user's uniquely assigned identity (authentication) and control his or her access (authorization) to network resources. Active Directory also provides Role based permissions, a provision/de-provisioning procedure, supports single sign on, and ensures a valid audit trail by using date/time stamping.

The information controls and security policy details the standards and guidelines, the process, and the reporting standards related to role-based definitions and system access, including the service account access to databases and associated records. This policy and procedure defines the review and auditing of user identification and access authorization and is the standard by which WellCare is externally audited (e.g., Sarbanes-Oxley Information Technology Audit). The

Information Security department reviews network server application and security logs periodically for security issues and investigates any incidents escalated as a threat. System administrator rights are reviewed quarterly and approved by the appropriate level of management.

## Transmission

WellCare's HIPAA transmission security policies cover the transmission of any confidential information including records in databases that may be transmitted electronically via e-mail or the Internet. WellCare's standard is to transmit data through secure file transfer protocol. WellCare employs secure sockets layer (SSL) technology, the standard for Internet security, and SFTP ensures that data transmissions sent over the Internet will be unreadable without a proper digital certificate.

WellCare's HIPAA handbook procedure defines the procedures for transmitting PHI and other confidential information via the Internet or e-mail.

- The WellCare e-mail system automatically scans outgoing e-mail for PHI. The e-mail is then encrypted when PHI is detected. Before receiving their first encrypted e-mail, external recipients will be required to complete a one-page self-registration on the WellCare encrypted e-mail website.
- The WellCare workforce is required to encrypt e-mail containing PHI or other confidential member information when sending to external parties. This secures the e-mail from unintended parties reading it. Our procedure identifies member information that includes but is not limited to, name, social security number, Medicaid ID, and Medicare ID. The sender must take reasonable steps to verify that e-mail containing PHI is sent to and received by the intended party, and is required to use the word [Secure], as shown with brackets, in the subject line of outgoing e-mail that contains PHI and/or member information. This will trigger the e-mail scanning system to encrypt the e-mail. Additionally, the sender must:
  - Limit the e-mail distribution to only those necessary.
  - De-identify the member information to a reasonable extent.
  - Include the minimum necessary amount of PHI to complete the intended task.
  - Not e-mail the following items without the member's authorization: psychotherapy/social work counseling/therapy; domestic violence victim's counseling; sexual assault counseling; HIV research (member authorizations are needed for each release); sexually transmitted diseases; alcohol and drug abuse records; genetic information.

The WellCare HIPAA training policy mandates that each workforce member complete HIPAA training within 30 days of being hired, and annually thereafter.

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INSERT TAB HERE  
Section S  
Added Value to Louisiana

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Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		<p><b>Section S: Added Value to Louisiana Providers and CCN Members</b></p> <p>If you are awarded a contract, the response to this section will become part of your contract with DHH and DHH will confirm your compliance. The incentives and enhanced payments, for providers and expanded benefits to members proposed herein cannot be revised downward during the initial thirty-six (36) month term of the contract, as such programs were considered in the evaluation of the Proposal. Increases in payments or benefits during the term of the contract may be implemented.</p>	200		
Section S Page 1	All	<p><b>S.1</b></p> <p>The “value added” from Provider Incentive Payments and Enhanced Payments (above the Medicaid rate floor) will be considered in the evaluation of Proposals. Responses to this section (which can be considered Proprietary) will be evaluated based solely on the quantified payment amounts reported herein, based on projected utilization for 75,000 members, and within the guidelines of the CCN program. Any health benefits or cost savings associated with any quality or incentive program shall not be included in this response and will not be considered in the evaluation of this factor.</p> <p>Pursuant to State Rules, the default payments between CCNs and providers are Louisiana Medicaid’ rates and the CCN must contract at no less than Medicaid rate in effect on the date of service; for example the Medicaid physician fee schedule or Medicaid hospital per diem amounts or FQHC/RHC PPS amounts.</p> <p>Complete RFP <b>Appendix OO</b> to identify circumstances where you propose to</p>	100		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		<p>vary from the floor reimbursement mechanism.</p> <ul style="list-style-type: none"> <li>• For increased provider payments to be considered in the evaluation, they must represent an increase in the minimum payment rates for all providers associated with the CCN's operating policies and not negotiated rates for a subset of the providers. As an example, if the CCN's physician payment policy is to pay Medicare rates, and possibly negotiate payments above that rate on a case-by-case basis, then the difference between the published Medicaid rate and the Medicare rate would be the quantifiable variance to be reported in this section; if the Medicaid rate was the base rate and anything above that rate subject to negotiation, then such amounts would not qualify for inclusion herein.</li> <li>• If you propose to contract with any providers using methodologies or rates that differ from the applicable Medicaid fee schedules, include such arrangements. By provider type, describe the proposed payment methodologies/rates and quantify the projected per member per month benefit.</li> <li>• The quantified incentives and enhanced payments reported should only represent the value exceeding the minimum Medicaid payment equivalent. If any proposals are not explicitly above the Medicaid rates, include a detailed calculation documenting how the minimum Medicaid equivalent was considered in the determination of the incentive/enhanced</li> </ul>			

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		<p>amount. For example, if the CCN proposes to pay physicians at the Medicare fee schedule during calendar year 2012, the amount reported in the attached would be determined as the projected difference between payments at the Medicare fee schedule and the Medicaid fee schedule, documenting the projected value using the Medicaid fees. Further, if capitation or alternative payments are proposed, the equivalent value of Medicaid fee payments based on projected utilization would be removed in the determination of the enhanced value.</p> <ul style="list-style-type: none"> <li>• Do not include payments for services where Federal or State requirements are currently scheduled to increase payments at a future date. In such circumstances, maintenance of effort will be expected of the CCN. For example, some Medicaid primary care rates are projected to increase to Medicare n rates in January of 2013, and the variance between the two types of rates would not qualify as an enhanced/incentive payment after January 1, 2013.</li> <li>• During the evaluation of the proposals, preferences will be given to plans based upon the cumulative amount of quantified provider benefit associated with the following: <ul style="list-style-type: none"> <li>○ higher payment rates than the required Medicaid default rate (fee for service or per diem or PPS or sub-capitated/other alternative rate);</li> <li>○ bonus payments above the required Medicaid default</li> </ul> </li> </ul>			

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		<ul style="list-style-type: none"> <li>rate;</li> <li>○ pay for performance incentive payments above the required Medicaid default rate; and</li> <li>○ other payment arrangements above the required Medicaid “floor” rate.</li> <li>● Payments for case management services may be included if paid to unrelated practitioners, e.g., physicians, clinics, etc.</li> <li>● For bonus pools or Pay For Performance (P4Q) programs, describe the eligible categories of provider, the basis for paying the applicable bonus pools and the proposed terms and conditions in the template. You may attach additional information, as appropriate.</li> <li>● Indicate if any bonus pool is to be held in escrow, and if so who will be the escrow agent.</li> </ul> <p>If any part of the proposed bonus pool is to be funded by withhold from subcontracted provider payments, confirm that the initial provider payment net of withhold would not be less than the Medicaid rate.</p>			
Section S Page 7	All	<p><b>S.2</b></p> <p>Provide a listing, description, and conditions under which you will offer additional health benefits: 1) not included in the Louisiana Medicaid State Plan or 2) beyond the amount, duration and scope in the Louisiana Medicaid State Plan to members.</p> <ul style="list-style-type: none"> <li>● For each expanded benefit proposed: <ul style="list-style-type: none"> <li>○ Define and describe the expanded benefit;</li> </ul> </li> </ul>	100		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)	PART II: TECHNICAL APPROACH	For State Use Only		
			TOTAL POSSIBLE POINTS	SCORE	DHH COMMENTS
		<ul style="list-style-type: none"> <li>○ Identify the category or group of Members eligible to receive the expanded service if it is a type of service that is not appropriate for all Members;</li> <li>○ Note any limitations or restrictions that apply to the expanded benefit</li> <li>○ Identify the types of providers responsible for providing the expanded benefit, including any limitations on Provider capacity if applicable.</li> <li>○ Propose how and when Providers and Members will be notified about the availability of such expanded benefits;</li> <li>○ Describe how a Member may obtain or access the Value-added</li> <li>● Include a statement that you will provide the expanded benefits for the entire thirty six (36) month term of the initial contract.</li> <li>● Describe if, and how, you will identify the expanded benefit in administrative data (encounter Data).</li> </ul> <p>Indicate the PMPM actuarial value of expanded benefits assuming enrollment of 75,000 members, accompanied by a statement from the preparing/consulting actuary who is a member of the American Academy of Actuaries certifying the accuracy of the information.</p>			

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## Section S: Added Value to Louisiana

### S.1

***The “value added” from Provider Incentive Payments and Enhanced Payments (above the Medicaid rate floor) will be considered in the evaluation of Proposals. Responses to this section (which can be considered Proprietary) will be evaluated based solely on the quantified payment amounts reported herein, based on projected utilization for 75,000 members, and within the guidelines of the CCN program. Any health benefits or cost savings associated with any quality or incentive program shall not be included in this response and will not be considered in the evaluation of this factor. Pursuant to State Rules, the default payments between CCNs and providers are Louisiana Medicaid’ rates and the CCN must contract at no less than Medicaid rate in effect on the date of service; for example the Medicaid physician fee schedule or Medicaid hospital per diem amounts or FQHC/RHC PPS amounts.***

***Complete RFP Appendix OO to identify circumstances where you propose to vary from the floor reimbursement mechanism.***

WellCare believes that aligned financial incentives are a key component of a comprehensive network management plan. Our philosophy is that an effective provider network is one that improves the cost of care, quality of care and access to care for its members. We propose to develop and implement two categories of value added programs for Louisiana’s CCN program: 1) pay for performance quality incentive (P4Q) programs and 2) financial assistance to providers for activities related to obtaining medical home recognition.

Attachment S.1.a includes a completed Appendix OO for the P4Q programs, and Attachment S.1.b is a statement from our preparing actuary, who is a member of the American Academy of Actuaries and has experience with state Medicaid contracts where similar P4P programs are offered, certifying the accuracy of the information in Appendix OO. The financial assistance for obtaining medical home recognition will be an administrative payment, so it is not included in Appendix OO or the actuarial certification.

### **Proposed 2012 - 2015 P4Q Programs**

In all of our markets we have implemented P4Q programs that provide incentives to primary care providers (PCPs) for ensuring that members are receiving proper medical care. We believe these types of incentives – along with provider education, information sharing, preferential member auto-assignment programs and strategic decisions on network composition – are essential components of a network management program designed to improve member outcomes.

We plan to implement two P4Q incentive models – one structured for individual PCPs and the other structured for organized physician groups and similar entities. We have given careful consideration to what we believe are the most appropriate measures (and corresponding performance criteria) to reward providers through an incentive program; however, we envision further collaboration with DHH to ensure that incentives are fully aligned with DHH’s goals for CCN members. Below is a description of our proposed 2012 - 2015 P4Q programs for Louisiana’s CCN program, including estimates for amounts projected to be associated with these programs. Funds for the P4Q bonus payments will not be held in escrow.

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## Program Model 1: General Network P4Q

This program will reward individual PCPs for improving health care quality, decreasing costs and increasing member access over a multi-year period. It will be our goal to expand this program to include OB GYNs, and potentially other specialty providers in the future.

### *Year One Measures*

1. Availability of after-hours and/or weekend coverage
  - Criteria: PCP operates and has posted office hours after 6pm on any weekday or at any time on a Saturday or Sunday – at least four hours per week
  - Bonus Opportunity: \$1.00 PMPM
2. Foreign language speaking clinical staff
  - Criteria: At least one member of clinical (member facing) staff (nurse practitioner, physician assistant and/or physician) that speaks, and is listed in WellCare's provider directory as speaking, a language other than English
  - Bonus Opportunity: \$0.50 PMPM
3. Access to preventive services
  - Criteria: PCP sees 80% of his or her newly assigned members within the first 120 days of assignment (or if unsuccessful, then by December 31, 2012)
  - Bonus Opportunity: \$1.00 PMPM (within 120 days); \$0.25 PMPM (by December 31, 2012)

### *Year Two Measures*

1. Availability of after-hours and/or weekend coverage
  - Criteria: PCP operates and has posted office hours after 6pm on any weekday or at any time on a Saturday or Sunday – at least four hours per week
  - Bonus Opportunity: \$1.00 PMPM
2. Foreign language speaking clinical staff
  - Criteria: At least one member of clinical (member facing) staff (nurse practitioner, physician assistant and/or physician) that speaks, and is listed in WellCare's provider directory as speaking, a language other than English
  - Bonus Opportunity: \$0.50 PMPM
3. Adult access to preventive/ambulatory services (HEDIS measure)
  - Criteria: NCQA Medicaid national 75<sup>th</sup> percentile for current year
  - Bonus Opportunity: \$0.50 PMPM
4. Adolescent Well Care Visits (HEDIS measure)
  - Criteria: NCQA Medicaid national 75<sup>th</sup> percentile for current year
  - Bonus Opportunity: \$0.50 PMPM
5. Well Child Visits (ages 3 – 6) (HEDIS measure)
  - Criteria: NCQA Medicaid national 75<sup>th</sup> percentile for current year
  - Bonus Opportunity: \$0.50 PMPM
6. Weight Assessment in Children (BMI) (HEDIS measure)

- Criteria: NCQA Medicaid national 75<sup>th</sup> percentile for current year
- Bonus Opportunity: \$0.50 PMPM
- 7. Comprehensive Diabetes Care – Eye Exam (HEDIS measure)
  - Criteria: NCQA Medicaid national 75<sup>th</sup> percentile for current year
  - Bonus Opportunity: \$0.35 PMPM
- 8. Comprehensive Diabetes Care – HbA1c Testing (HEDIS measure)
  - Criteria: NCQA Medicaid national 75<sup>th</sup> percentile for current year
  - Bonus Opportunity: \$0.35 PMPM
- 9. Comprehensive Diabetes Care – LDL-C Screenings (HEDIS measure)
  - Criteria: NCQA Medicaid national 75<sup>th</sup> percentile for current year
  - Bonus Opportunity: \$0.35 PMPM

### *Year Three Measures*

1. Availability of after-hours and/or weekend coverage
  - Criteria: PCP operates and has posted office hours after 6pm on any weekday or at any time on a Saturday or Sunday – at least four hours per week
  - Bonus Opportunity: \$1.00 PMPM
2. Foreign language speaking clinical staff
  - Criteria: At least one member of clinical (member facing) staff (nurse practitioner, physician assistant and/or physician) that speaks, and is listed in WellCare’s provider directory as speaking, a language other than English
  - Bonus Opportunity: \$0.50 PMPM
3. Adult access to preventive/ambulatory services (HEDIS measure)
  - Criteria: NCQA Medicaid national 75<sup>th</sup> (or 90<sup>th</sup>) percentile for current year
  - Bonus Opportunity: \$0.25 PMPM (for 75<sup>th</sup>); \$0.50 PMPM (for 90<sup>th</sup>)
4. Adolescent Well Care Visits (HEDIS measure)
  - Criteria: NCQA Medicaid national 75<sup>th</sup> (or 90<sup>th</sup>) percentile for current year
  - Bonus Opportunity: \$0.25 PMPM (for 75<sup>th</sup>); \$0.50 PMPM (for 90<sup>th</sup>)
5. Well Child Visits (ages 3 – 6) (HEDIS measure)
  - Criteria: NCQA Medicaid national 75<sup>th</sup> (or 90<sup>th</sup>) percentile for current year
  - Bonus Opportunity: \$0.25 PMPM (for 75<sup>th</sup>); \$0.50 PMPM (for 90<sup>th</sup>)
6. Comprehensive Diabetes Care – Eye Exam (HEDIS measure)
  - Criteria: NCQA Medicaid national 75<sup>th</sup> (or 90<sup>th</sup>) percentile for current year
  - Bonus Opportunity: \$0.15 PMPM (for 75<sup>th</sup>); \$0.35 PMPM (for 90<sup>th</sup>)
7. Comprehensive Diabetes Care – HbA1c Testing (HEDIS measure)
  - Criteria: NCQA Medicaid national 75<sup>th</sup> (or 90<sup>th</sup>) percentile for current year
  - Bonus Opportunity: \$0.15 PMPM (for 75<sup>th</sup>); \$0.35 PMPM (for 90<sup>th</sup>)
8. Comprehensive Diabetes Care – LDL-C Screenings (HEDIS measure)
  - Criteria: NCQA Medicaid national 75<sup>th</sup> (or 90<sup>th</sup>) percentile for current year
  - Bonus Opportunity: \$0.15 PMPM (for 75<sup>th</sup>); \$0.35 PMPM (for 90<sup>th</sup>)

9. Weight Assessment in Children (BMI) (HEDIS measure)
  - Criteria: NCQA Medicaid national 75<sup>th</sup> (or 90<sup>th</sup>) percentile for current year
  - Bonus Opportunity: \$0.25 PMPM (for 75<sup>th</sup>); \$0.50 PMPM (for 90<sup>th</sup>)
10. Cervical Cancer Screening (HEDIS measure)
  - Criteria: NCQA Medicaid national 75<sup>th</sup> percentile for current year
  - Bonus Opportunity: \$0.35 PMPM
11. Lead Screening for Children (HEDIS measure)
  - Criteria: NCQA Medicaid national 75<sup>th</sup> for current year
  - a. Bonus Opportunity: \$0.35 PMPM
12. Childhood Immunizations (HEDIS measure)
  - Criteria: NCQA Medicaid national 75<sup>th</sup> percentile for current year
  - b. Bonus Opportunity: \$0.35 PMPM
13. Use of Appropriate Medications for People with Asthma (HEDIS measure)
  - Criteria: NCQA Medicaid national 75<sup>th</sup> percentile for current year
  - Bonus Opportunity: \$0.35 PMPM
14. Well Child Visits (15 months, 6 visits) (HEDIS measure)
  - Criteria: NCQA Medicaid national 75<sup>th</sup> percentile for current year
  - Bonus Opportunity: \$0.50 PMPM

#### Program Model 2: Aligned Incentive Model with Organized Physician Groups and Similar Entities in Louisiana

WellCare has experience in its other markets in developing programs for large physician organizations that provide additional funds for improvements to health care quality, cost and access. WellCare of Louisiana is now beginning to develop similar programs in Louisiana. We have entered into agreements with Baton Rouge General Health and the Acadian Health Alliance (through Verity Health) that will create incentives aligned around improved HEDIS measure scores over the next three years. We have proposed similar models with Willis Knighton, Ochsner and LSU. A key aspect of this reimbursement model is that bonus funds will be either earned by the physician organization or dedicated to programs to improve health education for members in the associated parish. We hope to enter similar agreements with several other physician organizations throughout the State. The following is an overview of the contracted arrangement in GSA B with Verity Health and proposed for other physician organizations in the State.

*Years One and Two:* The incentive model is focused on mainstream HEDIS measures of health care quality and access for a Medicaid population such as Adult Access to Preventive/Ambulatory Services, Adolescent Well Care Visits, Comprehensive Diabetes Care (Eye Exams, HbA1c Testing, and LDL-C Screenings) and Well Child Visits (ages 3 – 6).

*Year Three:* Includes the same measures as Years One and Two, but add Cervical Cancer Screening, Lead Screening for Children, Childhood Immunizations, Use of Appropriate Medications for People with Asthma and all Well Child Visits (adding 15 months 6+ visits).

Payment of the \$0.50 PMPM bonus opportunity will be distributed based on the following criteria:

- Year One:* We set the HEDIS targets at the NCQA national 50<sup>th</sup> percentile for Medicaid health plans (unless there were to be a more specific target or measure set by a DHH). WellCare provides data and analytics to support our PCPs' efforts to improve their quality scores in the form of monthly "Overdue for Visit" reports that are produced at the PCP-level and list out all the non-compliant members for each of the HEDIS measures in the P4Q program.
- If the physician organization meets this target on any three of the six measures, then the entire bonus payment of \$0.50 PMPM will be made directly to the physician organization for disbursement to its physicians.
  - If the physician organization meets 90% of this target on any three of the six measures, a percentage of the total bonus payment of \$0.50 PMPM will be made directly to the physician organization for disbursement to its physicians. The remaining percentage of the bonus payment is placed in a joint fund to be spent on "Activities that Improve Health Care Quality" (which will be activities that can be included in the medical loss ratio (MLR) as defined in RFP Appendix H - Medical Loss Ratio (MLR) Requirements for CCNs) for patient education in the applicable parishes.
  - If the physician organization does not meet 90% of this target on at least three of these six measures, then entire bonus payment of \$0.50 PMPM will be placed in a joint fund as outlined above.
- Year Two:* The same terms apply as in Year One, except that that the physician organization will need to meet the targets across all six measures as outlined for Year Two to earn the bonus payment.
- Year Three:* The same terms apply as in Years One and Two, except that the HEDIS targets will be set at the NCQA national 75<sup>th</sup> percentile for Medicaid health plans and there are additional measures. The funds would be disbursed in the same manner as in Years One and Two, except that the physician organization will need to meet the 75<sup>th</sup> percentile target on any four of the eleven Year Three measures, and meet at least the 50<sup>th</sup> percentile on the other seven.
- Year Four (Optional):* We propose the same terms as in Year Three except that the physician organization will need to meet the 75<sup>th</sup> percentile target for each Year Three measure.

### **Funding to Facilitate PCP Recognition as Medical Home**

In our response to Section G.8, WellCare proposes to contribute a sum equal to that provided by other CCN contractors, up to but not to exceed \$50,000 over three years, to support PCP efforts in obtaining medical home recognition. We consider this partial subsidization of some of the expenses to be incurred by PCPs in their effort to become recognized medical homes as another value added provider payment for Louisiana CCN.

## S.2

**Provide a listing, description, and conditions under which you will offer additional health benefits: 1) not included in the Louisiana Medicaid State Plan or 2) beyond the amount, duration and scope in the Louisiana Medicaid State Plan to members.**

- **For each expanded benefit proposed:**
  - **Define and describe the expanded benefit;**
  - **Identify the category or group of Members eligible to receive the expanded service if it is a type of service that is not appropriate for all Members;**
  - **Note any limitations or restrictions that apply to the expanded benefit**
  - **Identify the types of providers responsible for providing the expanded benefit, including any limitations on Provider capacity if applicable.**
  - **Propose how and when Providers and Members will be notified about the availability of such expanded benefits;**
  - **Describe how a Member may obtain or access the Value-added Service;**
- **Include a statement that you will provide the expanded benefits for the entire thirty six (36) month term of the initial contract.**
- **Describe if, and how, you will identify the expanded benefit in administrative data (encounter Data).**

**Indicate the PMPM actuarial value of expanded benefits assuming enrollment of 75,000 members, accompanied by a statement from the preparing/consulting actuary who is a member of the American Academy of Actuaries certifying the accuracy of the information.**

WellCare understands that to make a significant positive impact on the health outcomes of the members we serve, our approach must be customized to reflect the local service area, demographic nuances and available community resources. The deployment of utilization and quality management protocols, coupled with administrative support systems will help ensure that all members have access to covered services; and assist us in identifying opportunities to provide the most meaningful supplemental benefits and services.

### **Overview of Additional Health Benefits**

WellCare plans to provide value added benefits designed to address member needs that are not met fully under the CCN-P capitated benefit package. These benefits can be classified under the two categories: (1) benefits not included in the Louisiana Medicaid State Plan; and (2) benefits beyond the amount, duration and scope in the Louisiana Medicaid State Plan. WellCare will review the value added benefits after program implementation and potentially provide additional member incentives, and other value added benefits/services, after we have a sense of our enrolled population mix and can better gauge which programs would be most beneficial to our members.

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## Benefits Not included in the Louisiana Medicaid State Plan

### *Adult Annual Vision Exam and Glasses*

Vision benefits for adults in most state Medicaid programs tend to be limited to a select coverage category tied to a given disease state. We have extended an expanded adult vision benefit in our other Medicaid markets. This has enabled us to get members in at least annually for vision exams, which is an important screening tool for early identification of other conditions associated with vision problems. We also have found that members will seek out this benefit to receive glasses or contacts at no or marginal cost to them, which would not have been provided otherwise.

### *Cell Phones for Target Case Management Populations*

It is our experience that providing simple tools to members that allow them to proactively communicate with their caregiver team can help facilitate timely care coordination, which can lead to better outcomes. To address this in our other Medicaid markets, such as Georgia, we have provided a cell phone benefit for members in case management to stay actively engaged with them on current treatment plans where communication would have been limited due to lack of telephone services available to the member.

## Benefits Beyond the Amount, Duration and Scope in the Louisiana Medicaid State Plan

### *Unlimited Adult Office Visits*

The current Louisiana Medicaid benefit level for adult office visits for certain individuals over the age of 21 is limited to 12 per calendar year; exceptions can be made when appropriate provider documentation is provided to substantiate the need for additional services. We are confident that expanding this benefit to include unlimited access to office visits for this population will positively impact emergency room over-utilization and direct members back to more appropriate care settings.

## **Key Features of Additional Health Benefits**

The following table outlines the following key features of each additional health benefit described above:

- Service description;
- Eligible members;
- Coverage limitations/restrictions;
- Responsible providers and capacity limitations;
- Provider/member notification; and
- How members will access the benefit.

Benefit Information	Expanded Vision	Cell Phones for Target CM Populations	Unlimited Adult Office Visits
<b>Service Description</b>	<ul style="list-style-type: none"> <li>One yearly exam for adults</li> <li>Additional \$125.00 allowance for eyeglasses for adults</li> <li>\$125.00 allowance for contact lenses for adults</li> </ul>	Allows target members to receive a free cell phone (includes unlimited calls to pre-programmed numbers and unlimited free text messaging) to stay connected to their case manager, their doctor, and family members	Unlimited adult office visits, beyond FFS annual 12 visit limit and over limit exception visits
<b>Eligible Members</b>	Adults ages 21 and older	Members in select CM programs (to be further defined based on enrollment mix; tentatively planned for CHF populations)	Adults over the age of 21 and not in coverage groups (i.e., pregnant women) without this benefit limitation
<b>Coverage Limitations/Restrictions</b>	Does not cover additional fitting exam for contacts	Only provided to members in defined CM programs; benefit coverage is limited to duration of qualifying CM episode	Office visits in excess of 12 annually that are approved via the over the limit exception process consistent with that employed by DHH are not considered “expanded benefits”
<b>Responsible Providers/Capacity Limitations</b>	<ul style="list-style-type: none"> <li>WellCare network of participating vision providers</li> <li>No capacity limitations</li> </ul>	<ul style="list-style-type: none"> <li>AT&amp;T Connected</li> <li>400 units per month</li> </ul>	<ul style="list-style-type: none"> <li>WellCare network providers, including PCPs and specialists</li> <li>Benefit can be received from any open panel WellCare network provider</li> </ul>
<b>Provider/Member Notification</b>	<ul style="list-style-type: none"> <li>Providers will be notified through provider handbook, website and on-site</li> </ul>	<ul style="list-style-type: none"> <li>Providers will be notified through provider handbook, website and on-site education/training</li> <li>Members will be</li> </ul>	<ul style="list-style-type: none"> <li>Providers will be notified through provider handbook, website and on-site education/training</li> <li>Members will be</li> </ul>

Benefit Information	Expanded Vision	Cell Phones for Target CM Populations	Unlimited Adult Office Visits
	education/training <ul style="list-style-type: none"> <li>Members will be notified through member handbook, website and newsletter articles, brochures and by case manager, if applicable</li> </ul>	notified through member handbook, website and newsletter articles, brochures, and by case managers, if applicable	notified through member handbook, website and newsletter articles, brochures and by case managers, if applicable
<b>How Members will Access</b>	Members will be free to self-refer for services. Members will be invited to contact the toll-free Call Center for assistance in scheduling an appointment, if they encounter access problems	Members will access via their assigned Case Manager. The CM will put in a request for a AT&T cell phone for members identified with a need and coordinate on their behalf with the carrier to process the order.	PCPs will be free to refer members, subject to the same referral guidelines as those used for covered Medicaid benefits, for these services. Members will be invited to contact the toll-free Call Center for assistance in scheduling an appointment, if they encounter access problems

### Term of Expanded Benefits

WellCare will provide all of the value added services/benefits described above for the duration of the initial 36 month term of the contract with DHH. WellCare may seek permission from DHH to introduce additional expanded benefits following the first year of the agreement, after which time enrollment/utilization data will allow for greater emphasis on population specific needs.

### Identifying Expanded Benefits in Administrative Data

WellCare will follow any DHH protocols that relate to the reporting of expanded benefit information in administrative data. In the absence of such protocols, the vision expanded benefit can be delineated from the base benefit first by assigning an indicator code either at the provider billing level or within our data warehouse. The code will be defined at the eligible population level. We can then either report separately to DHH administrative data on the benefit or include in encounter data reporting with the indicator included in the data files. This would allow DHH to easily identify the frequency/volume and cost at which these services were provided. Reporting cell phone benefit information through administrative data methods such as encounter data has some limitations due to the fact that this benefit is not billed on a traditional CMS1500 form. However, we are able to develop monthly, quarterly, and annual supplemental reports to capture the utilization of this benefit, in conjunction with the associated case management programs to which it is tied.

With regard to the expanded adult office visit benefit, we will be able to provide administrative data for this benefit in a manner similar to that in which we will provide data for the value added vision benefit. We will utilize the exception process employed by DHH currently to monitor for required exceptions beyond the base benefit. In doing so, we will assign code indicators or values systematically to office visits that fall into the exception category. Other office visits in excess of the limit (but that would not qualify for an exception under the standard benefit) will also receive an indicator so that these visits can be easily identified and aggregated. We understand that the reporting of data associated with this benefit could have a significant impact on the rate development process should this information be included in the base data. We want to proactively work with DHH on the encounter data reporting protocols to ensure this data is captured in such a way that it does not impact the utilization reported for the base benefit

### Actuarial Value

The following represents the actuarial value of the proposed expanded benefits, based on enrollment of 75,000 members:

Expanded Benefit	PMPM assuming 75,000 members	Coverage Description	Assumptions
Expanded Adult Vision members 21 and older	\$ 0.41	1 exam per year for adults; additional allowance for glasses or contact lenses up to \$125	Based on assessment of vendor proposal of \$1.94 capitation and would apply to adult population only, which is roughly 21% of projected membership.  $(21\% \times \$1.94) + (79\% \times \$0) = \$0.41$
Stay Connected (AT&T) - Cell Phone Program	\$ 0.13	Monthly cell phone benefit for members identified via case management. Program allows some members to receive a cell phone to stay connected to their case manager, their doctor, and family members	Assumes up to 400 phones available with 75% utilization rate for 75,000 members. Unit cost is \$31.99 per phone per month.  $[(400 \times 75\%) \times (\$31.99)] / (75,000) = \$0.13$
Remove 12 physician office visit limit for adults 21 and over per calendar year	\$ 0.00	No office visit limit for members age 21 and over.	Assumes that additional office visit costs will be offset through improved care management.

Attachment S.2.a is a statement from our preparing actuary, who is a member of the American Academy of Actuaries and has experience with state Medicaid contracts where similar expanded benefits are offered, certifying the accuracy of the information provided in the above table.

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